



OVERVIEW REPORT

Domestic Abuse Related Death Review of Vera

October 2022 - on behalf of:

Safer West Sussex Partnership

Liz Cooper

Independent Chair

Submitted to the Home Office February 2026

Updated July 2026

CONTENTS

Section	Page No.
Glossary	4
1.0 Preface	
<i>DHR</i>	6
<i>Timescale</i>	8
<i>Confidentiality</i>	8
<i>Terms of Reference</i>	9
<i>Methodology</i> <i>Contributors to the review</i>	10
<i>Panel membership</i>	11
<i>Statement of Independence</i>	12
<i>Parallel Investigations</i>	12
<i>Equalities</i>	13
<i>Dissemination</i>	14
2. Background/Facts and Overview of Family Life	
2.1 Incident	14
2.2 Main subjects of the review	14
2.3 Background and information on Victim and the family	15
3. Chronology and Key Practice Episodes	16
4. Overview (engagement with agencies and IMR feedback) i. Family ii. Agencies	24-28
5. Analysis	28-36
6. Conclusions	36
7. Lessons learnt	37
8. Recommendations	40
APPENDIX One: Terms of Reference	43
APPENDIX Two: Mental Health Signposting	49

GLOSSARY

ABBREVIATION	DEFINITION
BRAG	Blue/Red/Amber and Green- police rating score for an adult who may be vulnerable Blue high, green low level of concern
CAB	Citizens Advice Bureau
CPR	Cardio Pulmonary Resuscitation
CQC	Care Quality Commission
DARDR	Domestic Abuse Related Death Review
DHR	Domestic Homicide Review
GP	General Practitioner
MASH	Multi Agency Safeguarding Hub
MHCOI	Men's Mental Health Community Interest Group
SCFT	Sussex Community NHS Foundation Trust
SPFT	Sussex Partnership NHS Foundation Trust
SCARF	Single Combined Assessment of Risk Form
The Police	Sussex police
UHS	University Hospital Sussex
VAAR	Vulnerable Adult at Risk
VCSE	Voluntary and Community Social Enterprise

The Safer West Sussex Partnership and the Domestic Homicide Panel wish to express their sincere condolences to the family and friends of Vera.

Pen Portrait

Please see family comment in section 1.7.1.2 of the DHR.

1.0 PREFACE

1.1 This Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Vera (the victim) and Trevor, her husband who killed Vera in October 2022.

1.1.1 Vera was white British and 59 years old when she died. Trevor is white British and aged 64 years old when Vera died. Vera and Trevor had been married for over 30 years and they had two grown up children. Trevor was arrested for the death of Vera, which he admitted. A lengthy criminal investigation took place and the case was listed for trial in February 2024 but shortly before this the Criminal Prosecution Service accepted a plea to Manslaughter by Diminished Responsibility on the basis of the medical evidence and in consultation with the family. Following further psychiatric report Trevor is now being held under s37 Mental Health Act until the Secretary of State agrees his release, which is unlikely to be soon. Trevor consented that his medical condition could be shared with the DARDR Panel. Since the offence was committed, Trevor has been given a working diagnosis of delusional disorder¹, which is a significant mental illness.

Delusional disorder is a type of psychosis which is a recognized condition characterised by one or more persistent, unshakeable beliefs in something untrue. Symptoms can be bizarre or non-bizarre and sufferers may also experience hallucinations or disturbed thoughts. www.nhs.uk

1.1.2 The Safer West Sussex Partnership (SWSP) determined that the criteria for a DHR had been met under DHR Statutory Guidance 2016, in particular paras 5(1)². The review will identify any agency involvement and will also seek to understand the events leading up to Vera's death, whether support was accessed within the community, whether there are identified gaps in provision and whether there were any barriers to accessing support. By taking a comprehensive approach, the review seeks to identify appropriate solutions to make the future safer.

1.2 Domestic **Homicide Reviews (DHR)** now to be known as **Domestic Abuse Related Death Reviews (DARDR)** became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household. In February 2024 the Government announced that the name of DHR's would change to Domestic Abuse Related Death Reviews (DARDR) to better reflect all deaths which fall within the scope³.

1.2.1 The Domestic Abuse Act 2021 defines domestic abuse as:

Behaviour by a person is "domestic abuse" if:

(a) Persons involved are aged sixteen or over and are personally connected to each other, and

(b) ***The behaviour is abusive.***

¹ www.nhs.uk-symptoms Psychosis.

² DHR-Statutory-Guidanc-161206.pdf(publishing.service.gov.uk

³ www.gov.uk Fatal domestic abuse renamed to recognise suicide cases.

Behaviour is "abusive" if it consists of any of the following:

- physical or sexual abuse;
- violent or threatening behaviour;
- controlling or coercive behaviour;
- economic abuse
- psychological, emotional or other abuse;

It does not matter whether the behaviour consists of a single incident or a course of conduct.

(c) **Economic abuse** is any behaviour that has a substantial adverse effect on the victim's ability to:

- acquire, use or maintain money or other property, or
- obtain goods or services.

(d) For the purposes of this Act, the perpetrator's behaviour "towards" the victim includes any conduct directed at another person linked to the victim (for example the victim's child).

e) 'Personally connected'

For the purposes of this Act, two people are "personally connected" to each other if any of the following applies:

- they are, or have been, married to each other;
- they are, or have been, civil partners of each other;
- they have agreed to marry one another (whether or not the agreement has been terminated);
- they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
- they are, or have been in an intimate personal relationship with each other;
- they each have, or there has been a time when they each have had, a parental relationship in relation to the same child;
- they are relatives.⁴

1.3 The key purpose for undertaking a DARDR is to enable lessons to be learned from homicides where a person dies and has been the victim of possible domestic abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide/unexpected death, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.4 Time scales: Following the decision by SWSP that the circumstances of Vera's death met the criteria of a DARDR at the West Sussex Domestic Homicide Oversight Panel on 8 December 2022, the subsequent review began in **July 2024** and concluded with submission to the Home Office in **January 2026**.

⁴ Domestic Abuse Act 2021 www.legislation.gov.uk

1.4.1 The Home Office guidance states that a DARDR should be completed within six months of the initial decision to establish one. This timeframe was extended for the following reasons;

- Completion of the criminal investigation, lengthy investigation into Trevor's mental health and eventual outcome.
- Sufficient time to allow the family to participate.

1.4.2 The DARDR was commissioned by SWSP in accordance with the revised Statutory Guidance for the conduct of a Domestic Homicide Review⁵ published by the Home Office in March 2016.

1.5 **Confidentiality:** The detailed findings of each review are confidential. Information was available only to participating officers / professionals and their line managers. A confidentiality agreement was signed by the DARDR Panel members at the commencement of the DARDR and reconfirmed at the start of each Panel meeting.

1.5.1 This DARDR has been anonymised in accordance with the statutory guidance. The specific date of the homicide has been removed, with only the Independent Chair and Review Panel members being named.

1.5.2 The following pseudonyms have been used to protect the identity of the victims, other parties, those of family members and the perpetrator. The family chose the pseudonyms for Vera and Trevor and themselves. The DARDR panel felt it was appropriate that the family chose the names for their parents as the children feel that they have lost a mother and a father.

Name	Relationship to Vera
Vera	N/A (Victim)
Trevor	Husband of Vera and responsible for killing Vera
Hayden	Adult child of Vera and Trevor
Jordan	Adult child of Vera and Trevor
Vera's sister	
Trevor's brother	

It should also be noted that within the chronology, contact with General Practitioners (GP) are referred to as GP A, GP B etc.

1.6 TERMS OF REFERENCE

1.6.1 Terms of Reference (TOR) were agreed by the DARDR Panel in **July 2024** and was regularly reviewed and amended as further details of events in Vera and Trevor's

⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

life emerged. The full TOR is included in Appendix One. The DARDR aims to identify the learning from this case and for actions to be taken from that learning, with a view to preventing deaths and ensuring that individuals and families are better supported.

1.6.2 The Review Panel was comprised of agencies from West Sussex as this was the area that Vera and Trevor lived at the time of Vera's death. Agencies were contacted as soon as the DARDR was established to inform them it was taking place and that their participation was required and to secure their records.

1.6.3 At its first meeting, the DARDR Panel considered the initial scoping exercise undertaken by SWSP about agency contact with Vera, Trevor and relevant family members. This indicated contact with Trevor in the last year of Vera's life and it was agreed that the review would cover the period **October 2021 until October 2022** when Vera died. The rationale for this timeline was to reflect the deterioration in Trevor's mental health, his retirement and the changes in the relationship dynamics. Agencies were asked to include any significant events prior to this which were identified as engagement due to any allegations of previous domestic abuse, mental health, other noteworthy medical issues/wellbeing issues of either Vera or Trevor.

1.6.4 Key Lines of Inquiry; The Review Panel considered both the generic issues as set out in the DARDR statutory guidance and identified the following case specific issues;

- a. *Were the family's voices listened to by professionals?*
- b. *In assessing Trevor's mental health, were the risks to Vera and the family ever considered?*
- c. *Did professionals who engaged with Trevor consider the impact of the changes in his employment status on his mental health?*
- d. *What impact did changes to Trevor's employment status have on his self-worth and structure in his life?*
- e. *Did gender inhibit Trevor disclosing the severity of his mental health issues?*
- f. *What barriers were there for Trevor's family in disclosing the severity of Trevor's mental health condition and possible barriers for seeking support to help Trevor?*
- g. *Were Trevor's support, welfare and possible care needs considered by professionals?*
- h. *Did professionals consider any risks in the relationship between Vera and Trevor?*
- i. *Did professionals utilise their professional curiosity in understanding what impact the significant events in Vera's and Trevor's life was having on his mental health, retirement, loss of his mother, his brother moving away and the potential loss of his support network?*
- j. *Were there any barriers to accessing services relating to equality and diversity, age, sex, marriage and disability?*

1.7 METHODOLOGY

1.7.1 Involvement of Family, Friends, Work Colleagues, Neighbours and the wider Community

1.7.1.1 The statutory guidance for a DARDR requires the SWSP to inform the family of the victim of the decision to conduct a DARDR. Vera and Trevor's adult children were informed of the DARDR by the Chair of SWSP in January 2023. The Independent Chair contacted the adult children in early 2023 and Hayden indicated that she wanted to

participate in the DARDR, but it was explained that contact would commence following the outcome of the criminal investigation. Following the long criminal investigation, Hayden, Vera's sister and Trevor's brother all participated in the review which built up a picture of Vera and Trevor's family life. The family spoke with the Independent Chair by phone on several occasions and met face to face to review the draft report at which the family made comments and contributed to the DARDR report. The family were supported by Victim Support Homicide workers and were provided with copies of the Home Office Domestic Homicide Review⁶ leaflet and details of Advocacy after Fatal Domestic Abuse⁷. The family were also spoken to about the publication of the report including dates to avoid.

1.7.1.2 The family were asked if they would like to include a pen portrait of Vera. They explained that their comments as detailed in section 4.1 of the DHR was sufficient and described Vera, the person.

1.7.2 Contact with Trevor

1.7.2.1 Trevor is detained under section 37 of the Mental Health Act in a place of safety. The DARDR Panel agreed that it was therefore not possible or appropriate to speak with Trevor.

1.7.3 Statutory and Voluntary Agencies:

1.7.3.1 Each involved agency submitted an Individual Management Review (IMR) in accordance with the statutory guidance. Authors were independent of the incident and the reports were quality assured by the organisation. As the review progressed, additional agencies who had contact with the family members were identified, and further information was requested. IMRs were received from:

1. Sussex Police
2. Adur Health partnership (GP practice)
3. University Hospital Sussex NHS Foundation Trust
4. West Sussex Talking Therapies, previously known as Time to Talk which is part of Sussex Community NHS Foundation Trust

1.7.3.2 The DARDR Panel gave detailed consideration and professional challenge to the IMRs submitted by agencies including inviting IMR authors to the second Panel meeting. This enabled the authors to be questioned directly by Panel members and allowed the authors to fully understand the DARDR process and the interaction between agencies involved with Vera, Trevor and their family.

1.7.4 Further contact with agencies

The local Citizens Advice Bureau and Sussex Partnership Foundation Trust Street triage nurses provided information in an appropriate manner which was proportional to their involvement with Vera and Trevor.

⁶ www.assets.publishing.services.gov.uk- Domestic Homicide Review Information Leaflets for Family Members

⁷ www.aafda.org.uk

The Independent Chair also had separate discussions with the mental health expert on the DARDR Panel and Trevor's specialist hospital consultant in order to understand the severity of Trevor's mental health condition.

1.7.5 Document Reviews

1.7.5.1 In addition to the IMRs and the interviews with agencies, other documents were reviewed including the SWSP DARDR protocol, and previous SWSP DHR/DARDR to review previous learning.

1.8 PANEL MEMBERSHIP AND REPRESENTATIVES

The Panel consisted of senior representatives from the following agencies. All Panel members were independent of any involvement with Vera, Trevor or the family.

Liz Cooper	Independent DARDR Chair / Overview Report Author
Emma Fawell	Domestic Homicide Review Lead Officer, Community Safety and Wellbeing, West Sussex County Council
Amanda Suggett	DARDR Administrator West Sussex County Council
DS Helen Upton	Statutory Safeguarding Review Lead , Sussex Police
Fiona Crimmins	Designated Nurse Safeguarding Adults Sussex NHS
Joel Gage	NHS West Sussex Talking Therapies, Sussex Community Foundation Trust
Philip Blurton	Head of Safeguarding Adults, Sussex Partnership NHS Foundation Trust
Laura Richardson	West Sussex Adult Social Care -Service Manager
Sarah Trotman	University Hospital Sussex Foundation Trust
Alison Cooke	Sussex Community Foundation Trust
Maggie Evans	Hour Glass

Dr Mark Halloran attended the first two Panel meetings in order to give an insight into the GP practice contact with the family as they were the key agency involved with Vera and Trevor.

The panel met 5 times during the review and all meetings were virtual. The SWSP DARDR Oversight Group met to review the findings of the DARDR and make comments relating to the report in November 2025 and the final report was agreed at the SWSP meeting in January 2026 for submission to the Home Office in January 2026.

1.9. Statement of Independence

1.9.1 The Chair and Author of the review is Liz Cooper, formerly Assistant Chief Executive at Spelthorne Borough Council in Surrey. Liz has a wide range of expertise including Services for vulnerable adults and children, housing, health, community safety, safeguarding and equality and diversity. Liz has conducted numerous Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has successfully completed her Certificate in Domestic Homicide

Review Chairing (level 3). Liz has also been involved with several Safeguarding Adult Reviews and joint reviews. Liz is a member of the Domestic Homicide Review Chair Network (AAFDA). Liz has no connection with any of the agencies in this case.

1.9.2 Julia Long was invited by the Independent Chair to observe this DARDR and this was agreed by the SWSP. Julia has completed her Certificate in Domestic Homicide Review Chairing (level 3) and wanted to gain practical experience of the DARDR process. Julia has no connection with any of the agencies involved in this DARDR.

1.9.3 Administrative support was provided by Amanda Suggett from the SWSP. Amanda had no connection with any of the agencies involved in this DARDR.

1.9.4 The Independent Chair thanks everyone who contributed their time, patience, cooperation and challenge.

1.10 PARALLEL INVESTIGATIONS AND RELATED PROCESSES

1.10.1 Inquest

No inquest has taken place but the Coroner has asked for a copy of the final DARDR which has been agreed.

1.10.2 Criminal Investigation

Details of the criminal investigation are described in section 1.1.1 of this report but following Vera's death in October 2022, Trevor was arrested for her murder. Shortly before the criminal trial, the Criminal Prosecution Service accepted a plea to Manslaughter by Diminished Responsibility on the basis of the medical evidence and from consultation with the family with Trevor being held under s37 of Mental Health Act until the Secretary of State agrees his release.

1.10.3 Significant Event Review⁸

Following Vera's death, Adur Health Partnership conducted a Significant Event Review soon after Vera's death to identify any learning for the GP practice. The Significant Event Review was shared with the DARDR Panel and used to inform the GP IMR, the DARDR and learning.

1.10.4 Equalities

- Vera was a heterosexual, white British female, aged 59, no known disability and religion not known.
- Trevor is a heterosexual, white British male, aged 64 at the time of Vera's death. Trevor did suffer mental health issues (the criminal investigation indicated significant mental health issues).

The nine protected characteristics of the Equality Act 2010 were considered (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex/gender, sexual orientation). Sex/gender, disability relating to mental health, marriage and age are the four characteristics which had an impact on the lives of Vera and Trevor.

⁸ www.cqc.org.uk - Significant Event Review- Part of general practice and it is a technique to reflect and learn from individual cases.

Sex - Vera was female and therefore more likely to be a domestic homicide victim and or a victim of domestic abuse. The National Police Chief's Council⁹ reported that between April 2022 and March 2023, there were 242 domestic abuse related deaths of which 80 were intimate partner homicides with the majority of the victims being female. Research has identified that domestic abuse is a gendered crime with around 74% of recoded crimes relating to females. Women's Aid -Why do we say domestic abuse is gendered.

Although there was no evidence that Vera experienced domestic abuse in her marriage, Vera did experience intimate partner violence which resulted in her death.

Marriage – Vera and Trevor had been married for over thirty years and had two children and it was seen as a “solid marriage” by family. Despite the family reporting that Trevor thought that Vera was having an affair to the police, professionals may have viewed that any risk to Vera was minimal as she and Trevor had been married for a long time and there had never been any reports of domestic abuse. The breakup of a marriage can be a trigger for an escalation in violence. Trevor was convinced that Vera was having an affair, and he may have felt that the marriage was under threat.

Age - Vera was late fifties when she died. As already stated, there was no apparent previous domestic abuse in the relationship between Vera and Trevor, according to family they loved each other and Vera was trying hard to support Trevor. When Trevor accused Vera of an affair prior to her death she may not have identified this as a risk to herself. Domestic abuse can be hidden within an older generation. Older people may not be aware of triggers such as break down in relationships or perceived break down in relationships (Trevor accusing Vera of an affair).

Disability- Although Vera had no identified mental health issues, she did visit her GP in September 2022 relating to stress around Trevor's mental health. Trevor was experiencing significant mental health episodes during 2022 which led to Vera's death. Trevor is now detained under the Mental Health Act 1983 in a secure unit.

The above equality issues will be considered further within the DARD.

1.10.5 Dissemination

The Overview Report, Recommendations and Executive Summary have been redacted to ensure confidentiality, with pseudonyms used for the victim, children, and family. The reports have been disseminated to the following groups:

- Safer West Sussex Partnership
- Agencies represented on the panel
- Vera and Trevor's family

Following approval by the Home Office to publish, the Overview Report, Recommendations and Executive Summary will be disseminated to the following:

- West Sussex Adults Safeguarding Board
- Domestic Abuse Commissioner for England and Wales
- Police and Crime Commissioner for Sussex

⁹ [Scale of homicide and suicides by domestic abuse March 2024.](#)

2 .0 BACKGROUND INFORMATION - THE FACTS

2.1 Death of Vera

2.1.1 Late October 2022, Trevor called the police and stated, " I have stabbed my wife". The police went to Vera and Trevor's home and found Vera lying unresponsive on the floor in a downstairs room in the home with a large domestic knife next to her and Trevor was sitting in a chair near her and facing her. Vera was unresponsive and not breathing, the ambulance service commenced Cardiopulmonary Resuscitation (CPR) and attempts were made to reduce further blood loss but Vera was pronounced dead at the scene.

2.1.2 Trevor was arrested for murder and in his interview, he admitted that he had stabbed Vera following an argument. Trevor said he thought that Vera was having an affair which she denied and there was no evidence found by the police to identify that Vera was having an affair. The family also confirmed that Vera was not having an affair.

2.1.3 A postmortem took place and identified that Vera had died from significant stab wounds

2.2 The main subjects of this review are:

DARDR subjects	Relationship to victim	Age at death	Ethnic Origin	Disability Y/N
Vera (Victim)	n/a	59 years old	White / British	None
Trevor (responsible for Vera's death)	Husband	64 years old	White / British	Mental health issues
Hayden	Adult Child			
Jordan	Adult Child			
Vera's sister				
Trevor's brother				

2.3 Background information on Victim and Perpetrator

Vera

2.3.1 Vera had lived in Sussex all her life, she had a twin sister, a younger brother and a younger sister. Vera's mother was alive at the time of Vera's death. Vera went to a local school and then, having completed her secondary education, she went to catering college. At seventeen Vera joined Marks and Spencer and worked with the company for nearly 40 years, retiring at 55 years old. Vera was close to her family, especially her twin sister and they often went on family holidays together. When Vera finished at Marks and Spencer she found further employment at a local nursery. According to the family, she was loved by all at the nursery, children and colleagues. Vera was "football mad" and a lifelong supporter of Liverpool. Vera would sometimes travel to Liverpool to

watch matches, sometimes on her own. Both her and Trevor's family said that she was "just a lovely person and wanted to help everyone".

Trevor

2.3.2 Trevor worked with his brother in a family building firm, which was originally their father's business and in the words of Trevor's brother "this was all he knew, workwise since he was sixteen". When Trevor's father died the brother's kept the business operating with Trevor's brother finding the work and ensuring that the business ran smoothly. Their mother lived close by and both were responsible for helping to support and care for her. Trevor also loved his football and was a Tottenham Hotspur fan and he was also fond of music. There was no medical evidence that Trevor suffered with mental health issues prior to his retirement but Hayden did speak about Trevor not wanting to speak about mental health, which she felt was due to his age and generation. The family said that once Trevor finished work, his mental health quickly deteriorated but that he was good at masking how bad it was. A family member spoke about how secretive Trevor was about his health and it was felt that this was influenced by his father, who was also secretive about his health.

Relationship between Vera and Trevor

2.3.3 Vera met Trevor through her mother's cousin, who knew Trevor through work and they married in 1989 and had two children, Hayden and Jordan. Vera and Trevor would often go together to watch Brighton and Hove Albion, their local football team. Family members spoke that until Trevor became ill, "the marriage was very good and solid".

3.0 THE CHRONOLOGY

3.1 The Independent Chair has utilised the ***Social Care Institute for Excellence (SCIE) - Learning Together***¹⁰ approach to identify the **Key Practice Episodes (KPE)** in the lives of Vera, Trevor and family in the lead up to Vera's death.

3.2 The information below has been drawn from a range of sources: the IMRs submitted by agencies (referenced where appropriate) and information from any family and friends. One of the challenges of this DARDR was that the information provided predominately related to Trevor as he had the most contact with agencies due to his mental health. Vera had one contact with her GP for her own health and the remaining contact between Vera and agencies was in her role as caring for Trevor. There was no evidence of any previous domestic abuse.

3.3 Background Information relating to Vera and Trevor

3.3.1 **Around 2020**, Trevor's brother told Trevor that he was wishing to retire and along with his family to move away from the area. Trevor himself was also reaching a retirement age, but Trevor never wanted to take on the building business as his brother had been the one to manage the business.

3.3.2 **August 2021**, Sussex Community Foundation Trust (SCFT) Musculoskeletal Service received a routine GP referral for Vera and a letter was sent to Vera for an

¹⁰ <https://www.scie.org.uk/children/learningtogether/>

appointment in October 2021. Vera attended the appointment and there were no red flags for domestic abuse.

3.3.2 Trevor's brother did move and the business ceased to operate around early 2022 and Trevor no longer had any work. Also, Trevor became the key carer for his mother due to his brother relocating. (Previously, Trevor and his brother jointly cared for his mother).

3.3.3 Up until May 2022, Vera and Trevor had no known contact with any agencies apart from their GP. The contact with the GP was for minor ailments.

3.4 Key Practice Episode One – First recorded information about Trevor's mental health

3.4.1 **6 June 2022**, Trevor had a face-to-face consultation with GP A and he stated that he was depressed. The GP issued a prescription for Sertraline¹¹ and advised that Trevor should contact Time to Talk and a follow up appointment was made. Trevor contacted the GP practice by phone the following day and had a phone consultation with a GP. Trevor explained that he felt shaky after taking the Sertraline and was not able to sleep. The GP advised Trevor to continue with the medication and was issued with Zopiclone¹² to support his sleep.

3.4.2 **13 June 2022**, Trevor had a face to face follow up appointment with GP B and Trevor explained that he could not tolerate the medication. The GP gave information about Social Prescribing and Time to Talk and suggested that Trevor had a blood test.

3.4.3 **7 July 2022**, Trevor had a further face to face appointment with GP A to review his depression. Trevor explained that he did not get on with Sertraline and he was then issued with Mirtazapine¹³ and again Trevor was advised to contact Time to Talk. (Source; GP IMR)

3.4.5 **13 July 2022**, a referral was received for Trevor by West Sussex Talking Therapies, (previously Time to Talk).

3.4.6 **18 July 2022**, Trevor had a further face to face review with a GP to review his depression. Trevor explained that he could not tolerate Mirtazapine and so a prescription of Venlafaxine¹⁴ was issued. Trevor confirmed he had contacted West Sussex Talking Therapies. (Source; GP IMR)

3.4.7 **1 August 2022**, Trevor had a telephone assessment with West Sussex Talking Therapies. Trevor explained that he was feeling less confident, that he was not working having finished three months ago, following 50 years of being employed in the same job. Trevor went on to say that he still wanted to work and that he was embarrassed with friends that he was not working and he had also lost interest in his hobbies. Trevor stated that he wanted to go back to his hobbies of football, fashion and music and be more as he was, and less miserable with his family. As part of the assessment, risks

¹¹ www.nhs.uk-Sertraline is used to treat depression, panic attacks, obsessive compulsive disorder and sometimes post-traumatic stress disorder

¹² www.nhs.uk-Zopiclone -used for treating sleeping problems (insomnia)

¹³ www.nhs.uk-Mirtazapine an antidepressant used to treat depression and sometimes anxiety

¹⁴ www.nhs.uk-Venlafaxine an antidepressant used to treat depression and anxiety

were identified including a risk from/to others. It was recorded there was no identified risk from others to Trevor nor Trevor being a risk to other. The following day, **2 August 2022**, an assessment clinician at West Sussex Talking Therapies reviewed Trevor's case and it was agreed that he would start Step Two, Guided Self Help with a review to Cognitive Behaviour Therapy or counselling. The assessing clinician contacted Trevor and Trevor agreed to participate in the Guided Self-Help treatment although he did question whether he would be motivated to it. The assessor clinician explained that Trevor would have support from his therapist. Trevor was also offered the opportunity to speak with the West Sussex Talking Therapies in house employer advisor for help in returning to work and a referral was made on **3 August 2022**. A letter was also sent the same day to the GP practice by West Sussex Talking Therapies outlining the agreed treatment plan for Trevor. (*Good practice*)

3.4.8 **5 August 2022**, Trevor had a telephone appointment with the West Sussex Talking Therapies employment advisor and it was recorded that Hayden had set Trevor up on a job search website and had helped him create a curriculum vitae. The employment advisor and Trevor discussed about the best way to seek work and Trevor was told about the National Careers Service¹⁵ and Help to Work¹⁶. The employment advisor gave contact details of both organisations to Trevor. The employment advisor closed Trevor's case and told Trevor that if further help was needed then Trevor could refer back into the service.

3.4.9 **12 August 2022**, Trevor was contacted by West Sussex Talking Therapies to arrange a telephone appointment on 18 August 2022.

3.4.10 **18 August 2022**, Trevor had his first session with West Sussex Talking Therapies. Trevor said that he wanted to work but that he had no confidence to. This was triggered by a loss of confidence and led to a feeling of being useless and sad. A discussion took place about a series of goals for Trevor and some activities proposed, however it was agreed that the activities would commence following Trevor's up and coming holiday. It was recorded that there was no change in risks to others. (*Source; SCFT IMR*)

3.4.11 **19 August 2022**, Trevor had a face-to-face consultation with GP D and Trevor explained he was unable to tolerate Venlafaxine, and Citalopram¹⁷ was issued. Trevor told his GP that he was currently on the waiting list for Talking therapies. *Trevor had already started his talking therapies so the GP did not have up to date information. This was also the fourth antidepressant change issued in two months.* (*Source; GP IMR*)

3.4.12 **7 September 2022**, Trevor phoned West Sussex Talking Therapies to cancel his appointment for the following day as he had been offered work.

3.4.13 **13 September 2022**, Trevor visited a local Citizens Advice Bureau (CAB) to get some advice about his benefit entitlement following the ending of his self-employment. Trevor was guided through the information on the CAB website to identify the benefit

¹⁵ [National Careers Service](#)

¹⁶ [Access to work](#)

¹⁷ www.nhs.uk-Citalopram is a type of antidepressant which is used to treat low mood(depression) and sometimes for panic attacks

entitlement which could be explored. In talking to the CAB advisor, Trevor did not disclose any financial risk nor was any identified by the CAB advisor. (Source- CAB info)

3.4.14 14 September 2022, Trevor had a further consultation with a GP D for a review, Trevor explained that he was unable to tolerate Citalopram, and Fluoxetine was issued and a follow up appointment was booked. A fifth anti-depressant change in just over two months. *The GP practice was treating Trevor for chronic depression (NICE Guidelines¹⁸) but there is no evidence whether psychosis was considered at this stage of Trevor's mental health issues.*

3.5 Key Practice Episode Two - Further deterioration in Trevor's mental health

3.5.1 15 September 2022, Trevor had his second session with West Sussex Talking Therapies, and Trevor told the clinician that he was feeling low and that he did not want to pursue the treatment as he felt it was not working. Trevor explained that he was in the process of trying different medication and other therapies such as counselling. The clinician took Trevor's minimum data set and his score had increased for his Patient Health Questionnaire ¹⁹ to 9 indicating a moderate depression severity (measuring depression) and his Generalized Anxiety Disorder²⁰ score of 7, indicating moderate anxiety (measuring anxiety) which reflected his change in his mood²¹. The clinician discussed Trevor's safety and it was agreed that it was the same with the addition that Trevor felt hopeless. Trevor's said he had no thoughts or plans to end his life. Trevor's safety plan was reviewed and updated and Trevor explained that his family was his protective factor. Trevor was discharged back to his GP. It was recorded that risks to others was noted as none.

3.5.2 The following day, **15 September 2022**, a discharge letter was sent by West Sussex Talking Therapies to Trevor and it included the offer of signposting Trevor to other services and a copy of the letter was sent to Trevor's GP and the GP was advised that Trevor's condition had worsened. The GP Practice received the letter on the same day. (Source; SCFT IMR)

3.5.3 26 September 2022, Trevor had a face-face contact with GP C with Hayden in attendance. A discussion took place about Trevor's mental health and it was agreed to review Trevor in three weeks (*antidepressants take 4-6 weeks to take effect and hence a wait of three weeks for a review*) and if his mental health was not improving then to consider a referral to a psychiatrist. *No evidence to indicate if Hayden made any comments at the appointment.* (Source; GP IMR)

3.5.4 4 October 2022, Vera had a face-to-face appointment with her GP. Vera spoke of feeling very stressed with what was happening with Trevor. Support was given, including the issue of Zopiclone (one or two tablets to be taken at night, fourteen tablets) and non-drug strategies for managing insomnia /good sleep were discussed. (Source; GP IMR)

¹⁸ <https://cks.nice.org.uk/topics/depression/management/ongoing-management/#referral>

¹⁹ www.patient.info Public Health Questionnaire

²⁰ www.patient.info Generalised Anxiety Disorder Questionnaire

²¹ www.nhs.uk- Generalised anxiety disorder (GAD) is a common mental health condition where you often feel very anxious about a lot of different things.

3.6 Key Practice Episode Three - Increased desperation by Vera on how best to support Trevor

3.6.1 6 October 2022- Trevor attended the local hospital Accident and Emergency in the morning with Vera, and Trevor was triaged by an A&E practitioner who carried out an e-consult focusing on mental health issues. Trevor described his symptoms as depressed and very anxious. Trevor answered no to taking an overdose, self-harm or feeling suicidal and having any unusual thoughts, visions or experience or hearing voices. Trevor said he was taking medication for his mental health and was in contact with his GP. The outcome of the triage was that Trevor and Vera was seen in the Urgent Treatment Centre (UTC) by a GP. The UTC GP noted that he had a long-standing history of anxiety and depression (It was not clear whether Vera or Trevor stated this as Trevor had only been in contact with his GP very infrequently for minor ailments up until July 2022). Trevor said that there were no particular triggers but felt that the onset was after losing his job. Vera was spoken to and described Trevor as withdrawn and that he had no emotion, he was not communicating and had become extremely paranoid. (Trevor was described by the family as being the life and soul of a party prior to his mental illness). Vera explained that Trevor's mood was at a crisis point. It was recorded that Trevor was on a low dose of Fluoxetine and he denied visual or auditory hallucinations and that had no substance misuse issues. A MIND leaflet was given to Trevor around counselling and it was agreed to take Fluoxetine 20 mg and that he would have a review the following week with his GP about increasing the dose. Trevor was advised that if he had any suicidal thoughts then he should contact the UTC, A&E or his GP. Trevor was in the hospital for an hour and a discharge summary was sent to Trevor's GP practice which was received on the same day. The GP did increase Trevor's dose of Fluoxetine. *(Source; UHS IMR)*

The Urgent Treatment Centre (UTC) at the time of Vera and Trevor's visit was commissioned by the Integrated Care Board and the IPC (which has since ceased providing services). The service provided within the UTC was provided by local GPs or locum GP's and would follow GP policies and procedures.

It was identified by the SPFT Panel member that if Trevor had been seen by practitioners in A&E there would have been the opportunity for A&E to refer Trevor to SPFT practitioners within the hospital setting, but it is unclear whether the UTC was able to refer Trevor to SPFT.

The UTC service has been recommissioned and it has been confirmed that the service specification for the co-located UTC's includes mental health with clear processes /expectations in place for UTC's and this includes onward referrals to acute services if necessary.

3.6.2 13 October 2022, Trevor had a further referral with a GP and Trevor was recorded as having mixed anxiety and depressive disorder. It was agreed that Trevor would continue with his tablets as it was felt that by taking one a day, the benefits had increased. The GP agreed to continue to observe Trevor and he was issued with Zopiclone. *(Source, GP IMR)*

3.6.3 **16 October 2022**, Vera wrote a letter to the GP raising concerns about her husband with the following;

Dear GP

"I'm writing to you as a last resort as I do not know where to turn. I feel as though my family is in crisis as Trevor's condition has worsened and is affecting the whole family. My daughter has moved out because she cannot deal with the situation anymore.

I know he has visited you on several occasions and believe he is hiding the truth from you.

The paranoia is getting worse. He is still accusing me of having an affair with his best friend and is now saying that I am spreading rumours and nobody likes him. He is convinced that I've told everyone that he is beating me up. He has never lifted a finger and of course I'm not spreading any rumours.

He hasn't shown emotions for months laughter or tears. He also doesn't speak.

When we went to A&E on 6 October the mental health doctor, we saw increased Trevor's medication to one and said that when he went to the doctors the following week this dose should be increased to two. My understanding whilst looking at his box of pills they have not increased. The hospital also recommended that he should see a councillor. However, Trevor is refusing this. He doesn't think it will help.

For my mental health I am having a few days away. The situation is very difficult and I really don't know how much longer I can take it. This has been going on for at least 6 months and getting worse.

The last few days he has refused to go out. He has lost interest in everything. I am so concerned that he will get agoraphobia.

I know I shouldn't google but I'm at a loss. He seems to exhibit at least 8 symptoms of psychosis. As a family we would like you to consider this. Would this be a different course of treatment. The current treatment is not working. I don't think this is a fault but very concerned he masks the real truth.

Yours

PS. I know all about patient confidentiality and not asking for information but really need you to be aware of the situation. I don't know where to turn and worried that things will get worse and it will be too late."

3.6.4 The letter was posted in a local post box early in the morning as Vera, her sister and her husband were on the way to the airport for a short break. Trevor had declined to go on the short holiday.

Although the letter was dated 16 October, it was delivered over the weekend and not received in the GP practice until the day of Vera's death.

3.7 Key Practice Episode Four -Trevor goes missing

3.7.1 **18 October 2022**, Hayden called the police to say Trevor was missing and that he had left home at midday saying that he would not be here anymore and that Hayden needed to look after the cats. Hayden explained that she was concerned for Trevor's mental health wellbeing which had deteriorated in the last four weeks. Hayden explained that Trevor felt that people were after him and that he thought that Vera, her mother, was having an affair. A police search commenced but Trevor did return to the family home on his own volition. Hayden and Jordan and their cousin met with the police at Trevor's home. It was explained that Vera was away on a family holiday and that Trevor did not want to go as Trevor thought he would be stopped and sectioned at border control. Hayden and Jordan expressed their concerns for Trevor, in front of Trevor but Trevor remained impassive. The police spoke separately to Trevor and he said what his family were saying was not true and he reassured the police officers that he would not harm himself. Trevor said he was on antidepressants but they were not helping and he acknowledged that he needed help. Hayden, who did not live at home full time, told officers that in view of what happened that Hayden would now be staying with Trevor who was agreeable to the arrangement. Trevor agreed not to go out on his own and the police told Hayden not to hesitate in calling the police again if Trevor left the house alone. (Source; Police IMR)

3.7.2 The police recoded the incident on Niche and Smart storm and it was arranged that SPFT Street Triage would speak with Trevor. A Single Combined Assessment and Risk Form (SCARF)²² and Vulnerable Adult at Risk (VAAR)²³ was completed and the officer's assessed BRAG²⁴ was recorded as amber and shared with Adult Social Care following a Multi-Agency Safeguarding Hub (MASH) triage. The MASH officer reduced the BRAG to green as in their view, safeguarding measures had already been taken by the police for example, Hayden was staying with Trevor at his home and Trevor had agreed not to go out alone. (Source; Police IMR)

3.7.3 **19 October 2022**, The SPFT Street Triage team contacted Trevor, following the incident the day before. The Street triage nurse recorded the following;

Trevor was orientated and appeared capacious and cogent. Trevor denied experiencing any further suicidal thoughts of self-harm since yesterday. Trevor denied any physical health issues but did speak about his mental health issues, but that his new prescribed medication seemed to be working. The day before Trevor had told the police that the antidepressants were not working which contradicts information that Trevor was providing to different professionals. Trevor explained that his mental health deteriorated since he stopped working with his brother. The SPFT street triage nurse overall risk assessment stated, that following the discussions with Trevor, he was considered as low risk in all aspects of suicide/self-harm, vulnerability, neglect and violence. Trevor had said he was appreciative of the support from the police and it was

²² www.surrey.police.uk - A SCARF is a single Combined Assessment and Risk document used to share information and make referrals to partner agencies regarding safeguarding adults who may be at risk of neglect or abuse.

²³ www.surrey.police.uk-VAAR -Special consideration to members of society who may be an adult at risk.

²⁴ BRAG-Blue, Red, Amber, Green rating used by the police to identify levels of concern, blue, red=high and amber/green=lower concern

also recorded that the nurse and Trevor had spoken about Health in Minds and that Trevor would like to look into this. It was discussed that Trevor should speak with his GP on 10 November 2022, when a planned review about his mental health was taking place. The Street Triage nurse sent a text to Trevor giving him a number to contact if he needed to use the service again. A copy of the entry was sent to the GP. (Source; SPFT)

3.7.4 20 October 2022, the GP practice received a letter SCARF report from Sussex Police.

3.8 Key Practice Episode Six - Death of Vera

3.8.1 Late **October 2022**, as already described in paragraph 2.1, Trevor killed Vera with multiple stab wounds and Trevor made a full admission of killing Vera. Trevor was taken to the local hospital following an overdose of Fluoxetine. A vulnerable patient triage tool form was completed and the form said that "Trevor was suicidal at the time but now not suicidal and that he did not regret his actions". A Senior doctor did state that Trevor appeared well and asymptomatic and that he could return to custody and if he felt unwell again, he could return to A&E. The police commenced a murder investigation. (Source; Police, UHT IMRs)

4. OVERVIEW

4.1 Overview of information from Family and Friends

Hayden

4.1.1 Hayden spoke about having a very privileged life with Vera, Trevor and Jordan. Vera and Trevor had a very positive relationship and were best friends. Vera's wider family (her sister) were very close and Vera, Trevor, and the children would go on family holidays with Vera's sisters' family. Hayden described Vera and Trevor having many friends and they each had their own circle of friends. Hayden also stated that Vera was a very loving, kind person to everyone and Trevor was the "life and soul of the party" and would speak with anyone.

Hayden explained that she felt Trevor thought he was of the generation where men did not speak about mental health. When they had conversations about mental health (general conversations), Hayden felt Trevor thought you did not talk about mental health to other people, feeling that to admit to having a mental health crisis was a stigma/weakness. Hayden explained that Trevor's mental health started to deteriorate when the family business ceased. Vera was still working, although it was supposedly "part time" work at a nursery, Vera was asked to do more sessions and as she was such a kind helpful person, she did.

4.1.2 In June 2022, the family went on holiday and Trevor was not himself, very quiet and subdued. It was agreed that Trevor should make a GP appointment on the return from the holiday. Trevor started to look for a new job and Hayden helped him produce a curriculum vitae and found online employment agencies to enable Trevor to seek work. Trevor did attend a couple of interviews but he was not successful. In July 2022, Trevor was offered some work but before starting the work, Trevor became frantic and

anxious about where he was going to park. *Whilst working in the family business, Trevor never had to worry about parking.*

In August 2022, there was no work available for Trevor and he lost his confidence and he felt hopeless. Whilst not working, Trevor did help around the home but Hayden spoke about Vera getting a bit frustrated with Trevor. During September 2022, Hayden spoke about Trevor having paranoid thoughts, including seeing birds in the home and that Vera hated him. October 2022, Vera and Trevor were meant to be going on holiday with family but Trevor felt that he could not go, he became paranoid about being "arrested at customs and being sectioned". It was agreed that Vera would go on holiday and that Hayden and Jordan would "keep an eye on Trevor". Hayden spoke of the incident when the police were called in October 2022, due to the concerns around Trevor going missing and sending concerning messages. Hayden was concerned that the police did not take the action of detaining Trevor under the Mental Health Act. *This will be discussed later within the report.* Hayden also spoke about Trevor being referred to the Street Triage Mental Health Team and she was expecting that they would speak to Hayden about what had happened when Trevor went missing.

Hayden explained that Trevor was very secretive about his health but that he always trusted Hayden until the incident with the police in October 2022 and then Hayden felt Trevor became more secretive as he had lost trust with the family. Hayden felt that professionals did not take Trevor's psychosis seriously enough and that Vera and the families voice should have been considered by professionals as they were experiencing the changes in Trevor's mental health day by day.

Vera's sister and Trevor's brother

4.1.3 Both gave an insight into background narrative of Vera and Trevor, their lives and what happened leading up to Vera's death. Their comments have been amalgamated together as the families appear very close. Vera and Trevor had a "close knit" family, going on holiday together. Vera and Trevor had been "happily married" for over 40 years. Vera was described as a lovely person, so sincere and would never harm anyone, always wanted to help people, including Trevor. It was stated that Trevor went into the family building business when he left school and following the retirement of their father, Trevor's brother led the business. Trevor seemed happy with this as he was never as confident on managing the business and therefore his brother managed the business.

4.1.4 Trevor's brother explained that he told Trevor that he was planning on retiring in a couple of years and that he planned to move away. Trevor's brother also explained that the family accountant died, who was also a close friend which appeared to have an impact on Trevor. Trevor and his brother cared for their mother up until Trevor's brother moved and that Trevor took over the daily caring duties. Their mother died in 2020. *There is no evidence that Trevor had any bereavement support around the deaths and as already highlighted, Trevor did not disclose about his mental health and this may have been related to his generation and "just getting on with things" and therefore he never considered seeking any bereavement support.*

When the family business closed in late 2021, the family began to notice a significant escalation in Trevor's mental health and desperation from Vera on how to best support

Trevor. Family said that Trevor would just sit in a room, he shut himself off, he felt everyone was plotting against him. Trevor was convinced Vera was having an affair. Trevor did not want to go on a family holiday as he was scared of being arrested or sectioned. The family felt that the drugs that Trevor was taking were not helping him and that no professionals were listening to how serious the situation was with Trevor. The family felt on reflection following Vera's death, that they had not been spoken to about Trevor's health. The only written record of the family contacting the practice was Jordan and Vera's letter.

4.1.5 A final comment from the family was that when they visit Trevor, they feel that he does not fully understand what has happened due to his significant mental illness.

4.2 Summary of Information known to the agencies and professionals involved.

Information relating to the various contacts between Vera, Trevor, the family and agencies are referenced within the chronology/fact section of this report. As already identified, Vera only had contact with health agencies as part of minor ailments and Trevor's contact was with his GP Practice, West Sussex Talking Therapies, the local hospital, Mental Health Street triage and the police in the last six months of the DARD timeline.

4.2.1 Sussex Police – the Police

4.2.1.1 The police had one contact with Trevor prior to Vera's death on 18 October 2022. Following Vera's death, the incident was referred to the Professional Standards Department (PSD) and immediately to the Independent Office for Police Standards (IOPC). It was for the IOPC to consider if the police contact might have directly impacted or contributed to Vera's death. The IOPC reported that there was no indication of misconduct and the matter was filed by the PSD and no learning was identified.

4.2.1.2 The police noted that although Trevor was convinced that Vera was having an affair, there was no history of violence between them and also in speaking with Hayden and Jordan they confirmed that there had never been any threats or violence by Trevor to Vera or anyone else. Based on the information provided, the police believed that there was no serious risk for Vera's safety. The police identified that the main concern at the time was for Trevor who was suffering with mental health episode. A SCARF, VAAR were completed by the attending response police officer with was initially BRAG rated as amber. The police officer within the Multi Agency Safeguarding Hub (MASH) reduced the BRAG rating to "green" in the light of the safeguarding measures taken by the response officer. Following the MASH triage the VAAR was shared with West Sussex Adult Social Care. Trevor was going to stay at home with Hayden, he said he would not go out unaccompanied and Hayden was told to call the police if another situation with Trevor arose. Trevor was in contact and seeing his GP and engaging in West Sussex Talking therapies.

4.2.2 GP Health Partnership

The GP Health Partnership is an NHS partnership based across four sites. There are ten partners who are all self-employed GPs. The GP Partnership provide an extensive range of services.

4.2.2.1 The GP Health partnership conducted an Internal Significant Event Analysis following Vera's death in late 2022. The GP health partnership reported the matter to the Care Quality Commission (CQC).

4.2.2.2 Vera and Trevor were registered with the GP partnership for many years. Trevor began seeing the GP practice on a regular basis from June 2022 relating to his mental health. Trevor had eight consultations of which seven were face to face and one was a telephone consultation for his decline in his mental health. Trevor was prescribed various medication but was unable to tolerate them until he settled on a medication in September 2022. Trevor was also advised to engage with Talking therapies, which he did, but only for two sessions.

4.2.2.3 The letter written by Vera on 16 October 2022 was posted over the weekend prior to Vera's death and therefore not received and recorded by the GP practice until the day of her death and therefore it was not seen by a GP.

4.2.2.4 Following on from the Significant Events Analysis and the IMR, the IMR author has made several recommendations which are included in section eight of this report,

4.2.3 Sussex Community NHS Foundation Trust- West Sussex Talking Therapies

4.2.3.1 Trevor self-referred to West Sussex Talking therapies and following an assessment he participated in two telephone treatment sessions. The first session, Trevor was referred to an in-house employment advisor and at the second, it was identified that Trevor's condition had worsened. Trevor raised concerns about his motivation with guided self-help and that he wanted to explore counselling. Trevor declined counselling by West Sussex Talking therapies. The treating clinician discussed Trevor's case the following day and Trevor was discharged back to his GP. The letter highlighted Trevor's worsening condition.

4.2.3.2 The IMR author identified that the West Sussex Talking Therapy clinician and Employment Advisor worked with Trevor within professional standards with the information provided. When Trevor symptoms worsened, he was offered a step-up high intensity treatment by the clinician but Trevor declined the offer.

4.2.4 University Hospital Sussex (UHS)

4.2.4.1 UHS had two contacts with Trevor, one prior to Vera's death 6 October 2022 and one on the day of her death. The incident 6 October 2022, Trevor arrived with Vera at A&E and spent an hour being seen. The clinician did listen to Vera about her concerns. It was noted that Trevor was on a low dose of antidepressants and the clinician increased the prescription of Fluoxetine and explained that Trevor should review this with his GP on his next follow-up which was next week. Vera and Trevor were given information about MIND in relation to seeking counselling.

4.2.4.2 The IMR author has made recommendations which are included in section eight of this report.

4.2.4.3 Details of the agency contact with SPFT Street Triage and Citizens advice Bureau are include in the chronology and there was nothing further to add.

5. ANALYSIS

5.1 This analysis is based on information provided by Vera and Trevor's family, the IMRs and any additional interviews as conducted by the Independent Chair. The analysis relates to the Key Lines of Enquiry as detailed in the TOR and issues that have arisen in consultation with professionals. Where relevant this includes an assessment of appropriateness of actions taken (or not) and offers recommendations to ensure lessons are learnt by relevant agencies. The Independent Chair and the Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight.

5.2 Were the family's voices listened to by professionals

5.2.1 There were four incidents, when Vera, or Hayden/Jordan engaged with agencies surrounding the deterioration in Trevor's mental health. The first recorded contact with a family member was when the Hayden visited the GP with Trevor. There was no evidence recorded by the GP whether Hayden expressed her concerns or not.

5.2.2 The second was when Vera took Trevor to the local A&E department at the local hospital, 6 October 2022. Vera was spoken to as part of Trevor's assessment around his mental health. Vera spoke of Trevor being withdrawn, not speaking and becoming paranoid. Vera explained that Trevor's mental health was at crisis point. Trevor's medication was increased by the professional in A&E and details around counselling provided with a referral back to the GP practice.

5.2.3 Following the visit to A&E, Vera exhibited more concern and not knowing what to do by writing to the GP practice, ten days later. Vera explained her concerns for Trevor and detailed his behaviour, which she believed was extreme paranoia. As already detailed in the chronology, (KPE Three), sadly the letter was not received until after Vera's death.

5.2.3 The final involvement with Vera and Trevor's children was when Trevor went missing 19 October 2022. The police did attend and spoke with Hayden and Jordan before Trevor returned home. Hayden did give an insight into Trevor's behaviour and the police completed a SCARF and VAAR referral to West Sussex Adult Social Care, which was good practice. It was recorded that as there had been no reports of domestic abuse incidents between Vera and Trevor that Vera was not at risk and no concerns were identified by Hayden and Jordan about any safety risk to Vera. The key priority for the police was safeguarding Trevor as a vulnerable adult.

5.2.4 In speaking with family members, they felt that Vera and the children's voices were not heard. The family were concerned that the GP practice would not speak with Vera. The family tried to see where they could get help and felt that it would be more appropriate for Trevor to be sectioned under the mental health act in order to get the help he needed.

5.2.5 The DARD Panel spoke at length about expectations by families /communities of what powers statutory agencies have. Panel members spoke of detaining a person under the Mental Health Act is seen as an action of last resort. When the police attended the incident with Trevor, Hayden and Jordan, the main action was to ensure

the safety of Trevor which included the family staying with Trevor, a referral to the Street triage mental health team and a SCARF/VAAR being submitted.

5.2.6 The police would not have had any power to detain Trevor under s136 Mental Health Act as he was inside his home and had no immediate care needs. Section 136 of the Mental Health Act 1983 states;

(1) If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons

(a) remove the person to a place of safety within the meaning of section 135, or

(b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.

(1A) The power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place, other than—

(a) any house, flat or room where that person, or any other person, is living, or

(b) any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.²⁵

5.2.7 All patients have a right to a confidential medical service but challenging situations can arise when confidentiality rights must be balanced against duties to protect and promote health and welfare of patients who may be unable to protect themselves²⁶.

5.2.8 No health professional deemed Trevor as not having capacity and therefore he gave the narrative about his mental illness. Following his arrest and psychiatric tests, clearly Trevor was under reporting or disguising the true extent of his mental illness, although the family felt that they knew the extent of his illness, and Vera's letter to the GP articulated their views but the letter was not received until the day of Vera's death.

5.2.9 There was no evidence that the family were provided with information about a Mental Health Act Assessment²⁷, nor is it clear whether professionals were aware that Vera, as Trevor's "nearest relative" could request one. The "nearest relative" is a designated family member with legal rights under the Mental Health Act 1983. One of these rights is to request an assessment under the Mental Health Act for possible compulsory admission to hospital. Requests for Mental Health Act Assessments are made to a team within the local authority who consider these requests and decide whether a Mental Health Act assessment will be undertaken. The local authority must give written reasons if they do not progress the assessment. Even if a decision is made to decline the assessment, there would be an opportunity to signpost the family to support in the community for the person concerned.

²⁵ [Mental Health Act 1983, Section 136](#)

²⁶ [Disclosures for the protection of patients and others](#)

²⁷ www.mind.org.uk - Nearest relative, sectioning and guardianship

5.2.10 The DARD Panel did identify that it may not be an easy process for a family to complete a Mental Health Assessment request if their knowledge around mental health is minimal, but it is an option available for families who may feel that they are in crisis.

5.2.11 There was no apparent evidence that Vera was seen as a carer for Trevor by professionals. Vera was trying to care for Trevor when his mental health deteriorated. According to family, Vera, along with other family members were trying to support Trevor getting a job, taking Trevor to hospital, when he was experiencing a decline in his mental health. Vera herself visited her GP in early October 2023 as she was struggling to sleep and was feeling stressed. Vera was given medication, and information about Talking Therapies but it's not clear if Vera's caring role was considered by her GP which could have provided further information/signposting for Vera which could have supported her.

5.3 In assessing Trevor's mental health, were the risks to Vera and the family ever considered and did professionals consider any risks in relationship between Vera and Trevor

5.3.1 Following the police incident in October 2022, the police did consider whether Vera was at risk. Hayden had told the police that Trevor believed that Vera was having an affair (which was not the case), but Vera was deemed to be safe as there had never been any reports or concerns raised by family members regarding any physical abuse between Vera and Trevor.

5.3.2 Vera, in her letter to the GP stated that Trevor had never been physically abusive towards her nor was any information within the IMRs or from family which indicated any controlling coercive behaviour or any other form of domestic abuse as a factor in their relationship. Trevor's mental illness was impacting on their relationship and Trevor was evidencing paranoia with the accusation of Vera having an affair which was emotional abuse. The police were aware of the allegation, when Hayden made the missing person's report. This information was included in the VAAR and was shared with the Adult Social Care Hub. The family themselves never saw this as a form of abuse and hence never sought any support.

5.3.3 The SPFT Street Triage nurse also considered the risks to others in the assessment following the incident in October 2022 when Trevor went missing. Trevor was not seen as a risk to Vera or others.

5.3.4 Professionals who engaged with Trevor, the police, GPs, mental health practitioners and hospital staff may have been influenced by Trevor always saying that his family was his protective factor and therefore any risks to family members were minimised.

5.3.5 Trevor did have an undiagnosed mental illness but as identified within discussions at the DARD panel, it is still very rare that someone with a mental illness will kill someone. Trevor is still receiving mental health support and it has been identified that his mental health disorder, disordered his thinking and this state meant that Vera was unsafe, unprotected and then attacked.

5.3.6 In assessing risk relating to a person's mental health, the focus will be on that individual but it is imperative that professionals understand the potential risk to family members and others.

5.4 Did professionals who engaged with Trevor consider the impact of the changes in his employment status on his mental illness and what impact did changes to Trevor's employment status have on his self-worth and structure in his life

5.4.1 Evidence provided by the family and within the IMRs indicate that the changes in Trevor's employment did have a profound impact on Trevor. All Trevor had known for nearly 50 years was working with his father and his brother in the family business. When Trevor's brother explained that he was retiring and moving away, Trevor felt he was not in a position to take on the business. Working in a small business as a self-employed man, Trevor would not have had access to retirement support, unlike someone who worked in a larger establishment. Family members said that Trevor appeared not to have made any plans about his working future until he had finished work. Family did say that Trevor had a couple of interviews but "nothing was working out". Family explained that Trevor did get offered some work but he started to panic about where he would park his car and in the words of the family "became frantic about a simple action".

5.4.2 The GP Practice did signpost Trevor to West Sussex Talking Therapies. In Trevor's first session he explained to the professional how much he wanted to work. The professional referred Trevor to the inhouse work advisor and Trevor did engage and was given information and sign posted to other support. Despite this support, Trevor struggled to find work and according to family, he just sat in a room at home staring at the four walls.

5.4.3 Retirement can be a positive and negative experience for individuals and it can be complicated. The Psychology of Retirement (Doreen Rosenthal and Susan Moore 2018) identified that everything can change when moving from work to non-work and everything about a person's schedule may change. Loss of work-related stress may be a great relief and good for a person's health but losing the daily structure and work relationships can be harmful to a person's health. Retirement is ranked tenth in the list of life's most stressful events. A concern for retirees who had spent many years in the workforce (Trevor over 50 years) with tasks clearly prescribed, was the lack of structure in their day. A comment within the research stated "it's hard to build structure into a life that suddenly becomes freefalling". Additionally for those whose sense of self is tied to their work identity; retirement can be a daunting prospect. The lack of challenges and excitement that daily work brought to a person's life was reflected in a loss of self-esteem and a sense of contributing to society. The research also identified that people who retired without a plan experienced decreased psychological wellbeing entering into retirement²⁸.

5.4.4 In discussion between the Independent Chair and the mental health lead on the DARD panel, it was highlighted that a person who is suffering a severe mental health crisis (which evidence now shows that Trevor was and is), a major lifestyle change such

²⁸ www.bps.org.uk Retirement, health and Wellbeing October 2018 -Older people, work, occupational

as retirement, bereavement (Trevor had lost his mother in 2020 and he had cared for her and there was a loss of a long term family) could increase the severity of a mental illness.

5.4.5 There was no clear evidence whether professionals were professionally curious on the impact of Trevor changes in employment status or considered any bereavements in assessing his treatment and potential risks to himself and others.

5.6 Did gender inhibit Trevor disclosing the severity of his mental illness

5.6.1 Trevor was a sixty plus year old man who had been involved with the building industry all his life. Trevor belonged to a generation where some men felt that their status was about working and being the main financial provider within the family. Evidence from the family and within the IMR's indicated that Trevor underplayed and masked the severity of his mental illness. Trevor was being treated for minor mental illness by his GP practice due to how Trevor presented, whereas psychiatric reports following Vera's death have identified that he was suffering a significant mental illness including paranoia and he was and is disordered in his thinking.

5.6.2 Mental Health UK have identified that societies expectations and traditional gender roles play a role in why men are less likely to discuss or seek help for their mental health. We know that Trevor struggled to talk with his family about what he was experiencing and underreporting to professionals. Society often expects men to be the breadwinner, to be strong, dominant and in control. This can make it harder for men to reach out for help and as Trevor described his feeling of worthlessness, this may have impacted on his honesty of what he was experiencing. Whilst there is no different sort of male depression, some symptoms are more common in men such as irritability, sudden anger, increased loss of control and risk taking and aggression.²⁹

5.6.3 Safer West Sussex have had two published reviews Domestic Homicide Review 005 (2023) and 009 (2024)³⁰ where there was very little evidence of domestic abuse in any form but mental health was a predominant factor in the homicide, with the mental health issues being either undiagnosed or untreated. A recommendation was included within the action plan:

The Safer West Sussex Partnership should work with relevant statutory agencies, local third sector organisations, as well as other local strategic partnerships to examine methods and activities that reach into local communities and which encourage adult males to seek support about emotional or mental health worries.

5.6.4 The actions to deliver the recommendation was based around the inclusion of communication campaigns focussed on men between 35-49 years old who had pre-existing mental illness with links to services that were acceptable and accessible to men and this action was included in the West Sussex Suicide Prevention Framework and Action Plan 2023-2027 (published in 2024) with the purpose of males having awareness of how to seek help regarding their mental health.

5.6.5 In February 2024, a group was established in West Sussex to bring together colleagues whose organisations work directly or indirectly to support men with their

²⁹ www.mensminds.org What is depression

³⁰ [Domestic Abuse Related Death Reviews](#)

mental health. The group, called Sussex wide Men's mental Health Community of Interest group (Men's MHCOI), explore how the NHS, local authorities and Voluntary Community and Social Enterprise (VCSE) colleagues work collaboratively to support men who are experiencing a mental health crisis.

5.6.6 It would be beneficial to share this DARDR with MH COI to identify how to support men suffering mental health issues and the impact that retirement can have upon mental health in an older person.

5.6.7 Professionals and the wider community need to understand that mental health can be experienced by any gender, what the symptoms look like and where to seek support.

5.7 Did professionals utilise their professional curiosity in understanding what impact the significant events in Trevor's life was having on his mental health, retirement, loss of his mother, his brother moving away and potential loss of his support network

5.7.1 It is clear that no professional had a full picture of what Vera was experiencing or what Trevor was masking. Trevor retired which meant that there was a change in the dynamics between Vera and Trevor as Vera continued to work. Trevor's brother moved from the area and they had lived nearby and worked together for nearly fifty years. Trevor had cared for his mother and when she died, a further structure and status as a carer, was removed. Trevor's brother also spoke about the impact of the death of the family accountant which also had a profound impact on Trevor. Speaking with family members has allowed the DARDR panel to build up a more expansive narrative about Vera and Trevor which was not detailed within any IMRs.

5.7.2 When Vera visited her GP in October 2022, Vera reported that she had trouble sleeping and was anxious but it's not clear from any records whether she was asked about the circumstances surrounding her anxiety and whether the GP was professionally curious. If the situation that Vera was experiencing at home had been documented then this may have provided an opportunity to cross reference with Trevor's records and identify any risks or support that could have been provided to Vera.

5.7.3 There was some positive curiosity around the impact of Trevor's' change in employment, but there was no documentation that any further questions were asked about other issues which may have impacted on Trevor's mental health.

5.7.4 The GP's had the most contact with Trevor during the last four months of Vera's life. Trevor was seen by five different GPs on his ten face to face contacts. Trevor's previous GP records identified that Trevor rarely visited his GP, and then he had ten contacts in two months, which was a significant increase. Linked to the facts as identified in section 5.6, the presentations by Trevor and the family should /could have raised more professional curiosity by the GP's to thoroughly understand what Trevor and the family were experiencing. Being seen by five different GP's may have inhibited professional curiosity. Following Vera's death, the GP partnership did consider whether more appropriate continuity of care could be implemented for patients who are suffering mental health issues. It was conceded that this would not be practical. The DARDR Panel understand the changing landscape of GP interaction with patients over several years and especially since the Covid Pandemic. More patients have telephone consultations in order to be seen in a timely fashion and patients may not have the

same GP every time they have a consultation, but professional curiosity should be embedded in professional practice. On a positive note, Trevor was seen face to face by his GP practice but due to time constraints for GP consultations it may have been difficult to have the time to be curious.

5.7.5 It should also be highlighted that General Practice is now seen as a Primary Care Team, with patients seeing Advanced Nurse Practitioner, Mental Health Practitioners. Social Prescribers, Physician Associates and others, although Trevor was always seen by a GP, which again was good practice.

5.8 Was the escalation in Trevor's mental illness shared with agencies and responded to

5.8.1 The escalation in Trevor mental health was first identified by West Sussex Talking Therapies September 2022, that Trevor was feeling low and much worse. A clinician took a minimum data set and Trevor's score indicated his changing mood. A letter was sent to his GP and the letter informed of Trevor's symptoms and his worsening condition. Trevor was reviewed by a GP and it was agreed that if Trevor's condition had not improved in three weeks, then his medication would be increased and a referral to a psychiatrist would be considered.

5.8.2 Vera attended the local A&E in early October 2022 with Trevor as she was so concerned about the deterioration in his mental health. Trevor saw a clinician, who felt that Trevor was on a low dose of medication and that it should be doubled and that this would be reviewed with his GP the following week. A letter was sent to the GP practice and Trevor was seen the following week and Trevor's dose was increased.

5.8.3 Since the death of Vera and the Significant Event Analysis by the GP partnership, internal processes have been improved. The letter from West Sussex Talking Therapies was not seen by a GP and the process now is that if there is a notified escalation in a patient's mental health or they disengage with a service then the letter is passed to a GP.

5.8.4 The Significant Event Analysis also identified that the GP partnership did not receive any correspondence from A&E about Trevor's medication change which triggered a process review at the Primary Care Federation for the way urgent treatment letters were processed. University Hospital Sussex A&E is now using the clinical system which ensures discharge summaries are generated in a timely manner.

5.9 Examples of good practice

There were some examples of good practice by agencies when supporting the family but the examples relate to Trevor and his mental health.

- I.** The Police supported the family when Trevor went missing. The police attending quickly and made several referrals including a SCARF and VAAR
- II.** The SPFT Street triage did consider whether Trevor was a risk to others, meaning Vera and other family members.
- III.** West Sussex Talking Therapies did provide employment support to Trevor
- IV.** The GP practice and USH provided information about talking therapies and counselling.

6.0 CONCLUSIONS

6.1 In reaching their conclusions the DARDR Panel focussed on the following questions;

- Has the DARDR Panel fulfilled the Terms of Reference for this DARDR by undertaking a variety of lines of enquiry, including discussing the draft chronology and a broader, strategic discussion about cross agency working?
- Will actions and suggestions for improvement improve the response to domestic abuse victims in the future.
- What are the key themes or learning points from the review?

6.2 The DARDR Panel are satisfied that the Terms of Reference have been fulfilled and that the agreed recommendations address the points raised throughout the review, particularly in relation to lessons learnt and themes discussed.

6.3 From information provided by Vera and Trevor's children and wider family members. Vera and Trevor had a "good marriage". They had been married for many years and had two grown up children. The family went on extended family holidays, Vera and Trevor worked throughout their lives and there had never been any evidence of any domestic abuse in their relationship.

6.4 Family life changed for Vera when Trevor retired due to the family businesses ceasing to operate. Vera was having to try to motivate Trevor to see his GP as she and their children were aware that Trevor had a significant, undiagnosed mental illness. In June 2022, Trevor did see his GP and he came into contact with other agencies due to a deterioration in his mental illness. Trevor underreported the extent of his mental illness with professionals, which meant the severity of his mental illness was not diagnosed and this left Vera at risk, unsafe and unprotected which resulted in her death. The family tried to explain to professionals that they felt Trevor was experiencing paranoia. Vera and the family took it upon themselves to try to identify what was wrong with Trevor where they could seek help but they found it difficult to obtain meaningful information/support.

6.5 Vera and their children were supporting Trevor but were struggling as to what they could do, resulting in Vera's letter to the GP practice which was not received until the day of her death. No agency saw any risk to Vera from Trevor as the family identified that there had never been any domestic abuse within the relationship and Trevor stated to professionals that his family were his protective factor.

6.6 Vera, herself was trying to care for Trevor but there was no evidence that there was any consideration about her as a carer and any support that she may need.

6.7 This DARDR has had its own complexities as Vera is the victim of a domestic homicide by Trevor who had a significant undiagnosed mental illness which was not identified until Vera's death resulting in his detainment under the Mental Health Act. The DARDR panel acknowledge that the family have lost Vera but have also lost Trevor due to his diminished responsibility due to his mental illness and therefore have tried to reflect this within the DARDR.

6.8 The family remember Vera and Trevor having a good marriage, the children saying that they felt they had a privileged life with both parents. Vera should be remembered as a "good wife, a great mother, fun, hardworking and kind".

7.0 LESSONS TO BE LEARNT

7.1 Vera not being seen a carer

7.1.1 Vera was seen by her GP for stress and difficulties with sleeping and Vera was also seen by practitioners when she took Trevor to hospital. There was no evidence that practitioners offered Vera any signposting for support in her caring role. Vera was caring for Trevor and she was trying to source information to best support Trevor.

7.1.2 Although The Think Family Agenda³¹ speaks about looking at the whole family including children, the DARD Panel accept that Vera and Trevor's children were adults but the family and especially Vera were impacted upon by Trevor's mental illness and there were opportunities to look at Vera's needs. Vera did visit her GP and the UTC with Trevor and this could have provided an opportunity to ask Vera if she needed any support.

7.2 Professionals to understand the need to identify the risks to others when someone has a mental illness

7.2.1 Professionals in contact with Trevor did review his risk, for example suicide ideation and risks to other was also reviewed by the SPFT Street triage team. Trevor always stated that his protective factor was his family and professionals may have viewed that the family were safe from harm, whereas Vera was in fact very vulnerable.

7.2.2 Key findings from the analysis of domestic homicides reviews; October 2019-2020 (which was assessed from 124 DHR's) identified that there were 103 male perpetrators and that 31% of perpetrators were affected by mental illness and for 23 % this was depression and 21% suicidal thoughts³².

7.2.3 Mind- Mental Health and Homicide Fact sheet 2018, identified that the vast majority of people with a mental illness will not be violent. Most research studies have tried to establish whether there is a link between mental health problems and violence have focussed on psychotic disorder, including schizophrenia but the research to date can only state that schizophrenia can increase the risk that someone may be violent; but it has not shown that schizophrenia is the cause of violence.

Experiencing mental illness can increase the risk that someone may be violent but there are other factors including;

- Relationship instability
- Employment problems
- Substance misuse
- Gender (men more likely to be perpetrators of violent crime)³³

7.2.4 The assessment of risk should not only focus on the individual who has a mental illness but the immediate family and the community. Health professionals including GPs

³¹ www.safeguarding-guide.nhs.uk

³² www.gov.uk- Key Findings from analysis of domestic homicide reviews; October 2019 to Sept 2020 (assessable) Analytics Cambridge and QE Assessments LTD

³³ www.mind.org.uk Violence and mental health Mind Factsheet 2018

should ensure that they consider the risk to others when assessing a patient's mental illness and consider what support/safety measure could be suggested/offered.

7.3 Impact of age and gender influencing the way in which men's mental health is viewed

7.3.1 Trevor was in his sixties when his mental health deteriorated. Hayden identified that in when having a discussion with her father he believed that mental health/illness was not something you spoke about and it was something that men did not suffer with. The Mental Health Foundation highlight that society expectations and traditional gender roles play a role in why men are less likely to seek help for their mental health.³⁴

7.3.2 Although Vera and Trevor both worked, Trevor was from a generation that males were the breadwinner, strong dominant and in control and it can therefore be difficult for a male to admit that they are experiencing a mental health crisis and reach out for help and open up.

7.3.3 A BBC health report, 21 April 2025, identified that men are less likely to go to a GP or be registered with a dentist. The report highlighted that the ONS Health Insight Survey commissioned by NHS England in February 2025 found that 45% of women compared to 33% of males attempted to contact their GP for themselves or other in the last 28 days. The report also highlighted that society associates masculinity with self - reliance, independence and not showing vulnerability and that men are traditionally supposed to sort things out for themselves. (Prof Brenden Gough -Leeds Beckett University).³⁵

5.3.4 Professionals treating men need to be aware that men may find it difficult to be open about their mental health and they may under report their symptoms. Also linked to gender, if a male starts presenting frequently to a service (having had limited contact in the past) then this should be considered as unusual and a potential red flag for concern not only for the individual but also the family.

7.4 Raising awareness of what support is available to a family when a family member is experiencing a significant mental health crisis

7.4.1 The family spoke of the difficulty of finding information on how best to support Trevor and although the family wanted to try to get a Mental Health Act Assessment for Trevor, they were not clear how to progress such an assessment. It is also not clear if any agency signposted the family to such an assessment. Although the DARD Panel agrees that to complete such an assessment for the local authority is complex for a lay person, and that the local authority makes the decision as to whether to progress such an assessment, but even if a decision is made not to progress the assessment it could provide an opportunity for signposting an individual/family to support.

7.4.2 The specialist mental health and Sussex NHS DARD panel members have produced a guide for professionals and the wider community relating to the different mental health pathways which is easy to understand. This guide will be promoted on

³⁴ www.mentalhealth.org.uk - Men and Mental Health

³⁵ [These men put off doctors' visits again and again. Then came a tipping point](#)

various websites and made available to professionals within agencies. The signposting guide is attached as Appendix Two.

7.5 The impact of retirement on a person's mental health

7.5.1 The loss of Trevor's work had a profound impact on his mental health. As already discussed, retirement can be positive for many people but can be negative for others, especially if there is an underlying mental health issue. Professionals need to understand the impact of significant life changing experiences, especially when a person has not had an opportunity to plan for such an event. Trevor worked in a family business and although his brother had told him in advance of his decision to retire, Trevor appeared not to have sought any advice prior to the business ceasing. There are individuals/ small businesses who may not have access to retirement advice and this review provides an opportunity to raise awareness of what pre-retirement support there is in the area for individuals working in small businesses.

7.5.2 The DARD Panel welcomes the fact that West Sussex County Council wellbeing advisors have some good links with small and medium enterprise employees and are looking at ways of pre-retirement support being built into the wellbeing conversation, Making Every Contact Count (MECC)³⁶. A short briefing is also being prepared for health settings about the importance of wellbeing planning for retirement that health hubs in West Sussex can review and adopt into conversations with patients.

Making Every Contact Count is about having a simple conversation that encourages healthy behaviour changes. West Sussex provides virtual training in how to have a MECC healthy conversation, which is available to anyone who works with the public in West Sussex.

West Sussex County Council as part of their early support programme have developed a Planning For Your Future workstream which is aiming to support residents in planning for future care and costs. It has recently been agreed that a strand of this work will include retirement and wellbeing planning, and the work is being supported by partner organisations including Carewise³⁷ and Age UK³⁸.

7.6 Greater communication between agencies and family members to manage expectations

7.6.1 The family spoke of the expectation that when the police were called to the incident when Trevor went missing that the police would detain him under the mental health act. The family also spoke of the expectation that they would be contacted by the street triage nurses following the above incident. As already discussed within the report, detaining a person in Trevor's circumstances was not possible as the police had no power to detain Trevor. Professionals need to be reminded that it is important that the rationale for decisions is explained to family members so they can understand why such action is being taken.

³⁶ [Making Every Contact Count](#)

³⁷ www.carewiseadvice.com - Expert information and advice for paying for long-term care

³⁸ www.ageuk.org.uk

7.7 Post Review Learning/Comments

7.7.1 Vera's family were concerned to be contacted by the relevant agencies now involved with Trevor (specialist hospital and Victim Support) with requests which they believed implied that Trevor may be released into the community sooner than anticipated. They had been asked various questions about any exclusion zones for his travel, living arrangements etc. The Independent Chair did speak with Trevor's specialist mental health consultant at the hospital and she confirmed that the process to rehabilitate Trevor into the community will take a long time and that if there had been confusion about the process with the family then this would be rectified. The hospital consultant confirmed that they arranged a meeting with the Victim Liaison Officer and went through the main issues and the path towards discharge.

7.7.2 The specialist hospital stated that they will learn from this misunderstanding that the family had about the pathway towards discharge.

8. DARDR RECOMMENDATIONS

8.1 Local Partnership Recommendations

Recommendation One

- a) Safer West Sussex Partnership to share the learning from this DARDR with the Sussex Wide Men's Mental Community of Interest Group.
- b) Safer West Sussex Partnership to raise awareness of what pre-retirement support is available for men and promote this with residents and the local business community.

Ownership - Safer West Sussex Partnership

Recommendation Two

Agencies involved in this DARDR, remind practitioners that they should consider support for family members who may have a caring role for a person suffering from a mental health illness.

Ownership-All agencies involved in this review

Recommendation Three

Sussex Partnership Foundation Trust (SPFT) and Neighbourhood Mental Health Teams (NMHTs) to raise awareness to the local the local community of local mental health support that is available for men.

Ownership – Sussex Partnership Foundation Trust

Recommendation Four

To improve families' understanding of the legal position of the Nearest Relative to request a Mental Health Act assessment from the local authority, Safer West Sussex Partnership to raise awareness to the local community about the role of the Nearest

Relative to request a Mental Health Act Assessment next of kin having an opportunity to ask for a Mental Health Assessment

Ownership - Safer West Sussex Partnership

Recommendation Five

The Independent Chair to produce a learning brief which can be utilised in a Safeguarding training setting for all agencies which highlights key learning from this DARDR. (Including the impact of mental illness on the safety of the family, listening to the voice of the family, impact of life changing events in someone's life and the role of gender and mental health).

Ownership - Independent Chair

8.2 Individual agency recommendations

8.2.1 The Police

No recommendations

8.2.2 The GP Partnership

- a) The Code "Vulnerable Adult" to be added to a SCARF report when it is received and if not coded, a reason why to be added.
- b) Risk assessment by GP reviewing SCARF and MARAC reports should be documented.
- c) SCARF report turnaround time for action to be reviewed.
- d) Review of workflow processes in general to be completed.
- e) Date stamping of all correspondence received, on the day received (and site), AND were, with initials.
- f) Incorporate offering same day F2F appointments in GP triage processes across all Partnership sites for patients with new or deteriorating mental health concerns

8.2.3 Sussex Community Foundation Trust – West Sussex Talking Therapies

No recommendations

8.2.4 University Hospital Sussex

- a) Staff to be encouraged to ask a patient when attending with mental health concerns whether they are a risk to not only themselves but to others. e.g. family members.

Appendix A

RELATED DEATH REVIEW (DARDR) into the Vera

DRAFT TERMS OF REFERENCE V3

Overarching aim

The over-arching intention of this review is to learn lessons from the Domestic Abuse Related Death in order to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based.
2. Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.
3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations.
4. Respecting equality and diversity.
5. Openness and transparency whilst safeguarding confidential information where possible.

Membership of the DARDR Panel

To Include but not limited to:

Independent Chair and Reviewer

Sussex Police

Sussex NHS Commissioners

WSCC Community Safety & Wellbeing Representative

WSCC Adults Services as required

WSCC Children's Services as required

Key agency representatives according to the key lines of enquiry

District or borough representatives as required

Primary care and health provider representatives as required

Domestic abuse services as required

Other specialist services

Cross border statutory or specialist services as required

Methodology for conducting the DARDR

- Appointment of an Independent Chair & report author.
- Formation of a DARDR Panel (meeting 1) & agreement about the areas of interest/lines of enquiry, Panel requests Individual Management Reports from all relevant agencies & chronological account of their involvement.
- Contact with family, Senior Investigating Officer/Family Liaison Officers/Victim Support.
- Panel meeting 2: to consider the information submitted from each agency/service and provide scrutiny and oversight on quality; plus to revisit lines of enquiry and any early contributions from the family.

- Further information gathered, where relevant and possible from agencies, plus additional sources of information from family, friends, work colleagues, community etc.
- Panel meeting 3: Draft 1 of report presented to the Panel for scrutiny and oversight.
- Family contributions
- Panel meeting 4: Draft 2 of report presented to the Panel for scrutiny and oversight.
- Date of Community Safety Partnership Executive Board to be working towards: 29 July 2025
- Further family contributions.
- Submission to the Home Office for quality assurance.

Specific areas of enquiry

The Review Panel (and by extension, IMR authors) will consider the following:

1. Each agency's involvement with the following:

- (a) The victim Vera - resident within Adur district
- (b) The alleged perpetrator Trevor - resident within Adur District.

2. Whether, in relation to the either Vera or Trevor, an improvement in communication between services following might have led to a different outcome for Vera.

3. Whether the work undertaken by services in this case was consistent with each organisation's professional standards.

4. Whether the work undertaken by services in this case was consistent with each organisation's domestic violence policy, procedures and protocols, and in light of the features of this case, whether the organisation's policy, procedures and protocols adequately address stalking and harassment.

4. The response of the relevant agencies to any referrals relating to Vera, concerning domestic violence or other significant harm from Trevor onwards until the point of the death. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

- (a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.
- (b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
- (c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
- (d) The quality of the risk assessments undertaken by each agency in respect of Vera and Trevor

5. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

6. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either adult were explored, shared appropriately and recorded.
8. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.
9. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.
10. Were there any concerns amongst family / friends / colleagues or within the community and if so, how could such concerns have been harnessed to enable intervention and support?

Specific key lines of enquiry pertinent to this review

- *Were the family's voices listened to by professionals?*
- *In assessing Trevor's mental health, were the risks to Vera and the family ever considered?*
- *Did professionals who engaged with Trevor consider the impact of the changes in his employment status on his mental health?*
- *What impact did changes to Trevor's employment status have on his self-worth and structure in his life?*
- *Did gender inhibit Trevor disclosing the severity of his mental health issues?*
- *What barriers were there for Trevor's family in disclosing the severity of Trevor's mental health condition and possible barriers for seeking support to help Trevor*
- *Were Trevor's support, welfare and possible care needs considered by professionals?*
- *Did professionals consider any risks in the relationship between Vera and Trevor*
- *Did professionals utilise their professional curiosity in understanding what impact the significant events in Vera and Trevor's life was having on his mental health, retirement, loss of his mother, his brother moving away and the potential loss of his support network?*

Family involvement and Confidentiality

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.

- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this DARDR, therefore all material received by the Panel must be disclosed to the SIO and the police disclosure officer.
- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed, and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by pseudonyms.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

All DARDRs are to be submitted to the Home Office within 6 months of notification. Any delays to this deadline will be communicated to the Home Office.

The Review will aim to finish by July 2025, subject to the conclusion of the Criminal investigation/trial. The first meeting of the Panel will be 25 June 2024, with a further meeting to be scheduled in January 2025, March 2025 and May 2025.

All meetings will be held at virtually.

Media strategy

Any media enquiries prior to the conclusion of the trial must be referred to West Sussex County Council. Post-trial, enquiries should be directed to the Chair, who will agree a media strategy with West Sussex County Council.

Chairing & Governance

An independent chair has been appointed to lead on all aspects of the review and will report to the chair of Safer West Sussex Partnership.

A Panel has been convened specifically to overlook the review process. This is a mix of statutory and voluntary sector agencies and includes specialist domestic violence services.

The Safer West Sussex Partnership will sign off the final report and submit it to the Home Office Quality Assurance process.

Agency roles and responsibilities

- Delegate a senior officer to lead on the review on behalf of their organisation
- Senior officers will attend all Panel meetings
- Complete Individual Management Reviews within agreed timeframes
- Contribute to the Review Report

Information Sharing & Confidentiality

The principles outlined in Safer West Sussex Partnership Confidentiality agreement will be applied at all times. In addition to this, further reference will be made to the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews³⁹.

³⁹ <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews>

Mental Health Signposting		
Self Help	111 & GP	High Risk Urgent Need
Online & telephone support These services offer confidential support from trained volunteers. You can talk about anything that's troubling you, no matter how difficult. Call 116 123 to talk to Samaritans, or email: jo@samaritans.org for a reply within 24hrs Text "SHOUT" to 85258 to contact the Shout Crisis Text Line, or text "YM" if you're under 19.	Call 111 111 will tell you the right place to get help. You may be able to speak to a trained mental health professional over the phone. This service is for when you need more urgent help, but it is not a life-threatening emergency. A trained operator can help you find the right support and information.	Call 999 Call 999 if someone's life is at risk e.g. they have seriously injured themselves, taken an overdose or do not feel they can keep themselves or someone else safe. A mental health emergency should be taken as seriously as a physical one.
↓	↓	or
Contact local support groups The mental health charity Mind has information on ways to help yourself cope during a crisis. This includes calming exercises and a tool to get you through the next few hours. www.pathfinderwestsussex.org.uk West Sussex Mind Home www.safespacesussex.org.uk	Discuss with GP A GP can talk to you about your mental health and helpful treatments. They can also advise you on accessing mental health services. You will need to talk to your GP to use some mental health services.	Attend Emergency Department & Referral to MH Liaison The staff should look after any immediate physical and mental health needs. The team in charge of your care will assess you and decide on the best course of care. You may be referred to the liaison psychiatry service or local mental health crisis resolution and home treatment team (CRHT). They may also refer you to other services to support your needs.
↓	↓	or
Self Refer to NHS talking therapies You may be able to refer yourself to some services. Time To Talk – NHS Self-Refer Here NHS West Sussex Talking Therapies	Referral for a Mental Health assessment Your GP can refer you for a Mental Health assessment at your local Mental Health Trust. If the referral is accepted by the Mental Health Trust, they will contact you directly to arrange an appointment.	Mental Health Act assessment Your GP or a local authority mental health team can refer you for an assessment under the Mental Health Act. The Nearest Relative of the person in crisis can also directly refer to the local authority for an assessment under the Mental Health Act.

