



Executive Summary

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

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The Review Process

1.1 This Executive Summary outlines the process and findings of a Domestic Abuse Related Death Review (DARDR) undertaken by the Safer West Sussex Partnership into the death of Vera. All the names in this review have been anonymised for the purpose of confidentiality.

1.2 The following pseudonyms have been used in this review to protect the victim, perpetrator and family.

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	

1.3 Vera was murdered by Trevor in October 2022 and the police notified Safer West Sussex Partnership (SWSP) about her death. A Domestic Abuse Related Death Review (DARDR) was convened, and it was agreed that Vera's death met the criteria for a DARDR, and an Independent Chair was commissioned to conduct a DARDR. The DARDR did not commence for a period of time as there was a lengthy criminal investigation.

1.4 The case was listed for trial in February 2024 but shortly before the criminal trial, the Criminal Prosecution Service accepted a plea to Manslaughter by Diminished Responsibility on the basis of the medical evidence. Following further psychiatric reports, Trevor is now being held under s37 Mental Health Act until the Secretary of State agrees his release, which is unlikely to be any time soon.

1.5 The Coroner has not yet listed an inquest date and is waiting for the conclusion of the DARDR.

1.6 All agencies that potentially had contact with Vera, Trevor and the family prior to the point of her death were contacted and asked to confirm any involvement with the case and the DARDR commenced late 2024.

Contributors to the Review

2.1 This DARDR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victim Act 2004 as well as the local DHR protocol developed by the Safer West Sussex Partnership.

2.2 The following agencies submitted IMRs detailing their contact with Vera, Trevor and the family:

- Sussex Police
- Adur Health partnership
- University Hospital Sussex NHS Foundation Trust
- West Sussex Talking Therapies, previously known as Time to Talk which is part of Sussex Community NHS Foundation Trust

The IMRs were completed by senior staff who had no direct management involvement with Vera, Trevor, the family or the incident.

2.3 The Panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies including inviting IMR authors to present their IMRs at a Panel meeting.

2.4 In addition, several organisations were contacted by the Independent Chair to add further information/commentary to the DARDR. These included:

- a) The local Citizen Advice Bureau
- b) Separate discussion between the Independent Chair and the Panel mental health expert
- c) Trevor's hospital consultant

2.5 Hayden, Vera's sister and Trevor's brother contributed to the DARDR and Vera's sister was supported by a Victim Liaison Officer. The family chose all the pseudonyms for the family members, including Trevor's due to the circumstances of Vera's death.

The Review Panel Members

3.3.1 The Panel consisted of senior representatives from the following agencies:

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

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

3.3.3 The Review Panel met on five occasions, all virtually, and agency representatives were of the appropriate level of expertise.

Chair of the DHR And Author of the Overview Report

4.1 The Chair and author of the review is Liz Cooper, formerly Assistant Chief Executive at Spelthorne Borough Council (Surrey). Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. Liz has conducted partnership Domestic Homicide Reviews/DARDR 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 successfully completed her Certificate in Domestic Homicide Chairing (Level 3) in September 2024. Liz is a member of AAFDA DHR Chairs Network and Liz has also been involved with several Serious Case Reviews. Liz has no connection with any of the agencies in this case.

Terms of Reference

5.1 The Terms of Reference were agreed by the DARDR Panel in July 2024 and were regularly reviewed and amended as further details of the incident emerged. The primary aim of the DARDR was to examine how effectively the agencies involved with Vera, Trevor and the family worked together to support them. A full copy of the TOR is attached in Appendix One, but of particular note for this DARDR include:

- 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?

5.2 The timeframe for this DARDR was agreed as follows, October 2021 up until October 2022 when Vera died. The rationale for this time frame was to reflect the deterioration in Trevor's mental health, his retirement and the changes in the relationship dynamics.

Summary Chronology

6.1 The DHR Panel received extensive information from the agency IMRs and the DHR panel utilised the SCIE model "[Learning Together](#)" to identify the key practice episodes (KPE) in the lives of Vera, Trevor and the family. It should be noted that this DARDR provided some challenges as most of the agency information related to Trevor and there was no previous known domestic abuse within the relationship. The family stated that the family relationship was "wonderful" up until the last few months of Vera's life.

6.2 Background information relating to Vera and James

Trevor had worked in the family building business since he was sixteen years old and around 2020, Trevor's brother told Trevor that he wanted to retire from the family business and move away from the area which meant that the family business ceased operating. In early 2022, the family business closed and Trevor had no alternative work (Trevor was in his sixties). Although Vera was in her late fifties, she continued to work.

6.3 KPE One: First recorded information about Trevor's mental health.

6.3.1 In June 2022, Trevor had his first consultation with a GP about his mental health and Trevor was given medication for his symptoms. After a few weeks Trevor saw his GP and said that he could not tolerate the medication and the GP changed the medication and advised Trevor to contact Time to Talk¹ (now West Sussex Talking Therapies).

6.3.2 Trevor did contact Talking Therapies and again visited his GP In July 2022, stating that he could not tolerate the new prescribed medication. Trevor's medication was changed again.

6.3.3 In August 2022, Trevor had a telephone assessments with Talking Therapies and Trevor explained that he had lost his confidence, he wanted to work and that he was embarrassed that he had no work. Trevor stated that he wanted to do his hobbies again and most importantly wanted "to be less miserable for his family's sake" Trevor agreed to start guided self-help and to a referral to Cognitive Behaviour Therapy or counselling.

6.3.4 Trevor and had a meeting with an employment advisor (West Sussex talking Therapies) to signpost Trevor to useful organisations who could help Trevor seek work.

6.3.5 Late August 2022 Trevor had another appointment with a GP and again he stated that he could not get on with the new prescribed medication and he was issued with another type of medication.

6.3.6 Early September 2022, Trevor visited a GP and again stated he could not tolerate the new medication. (Five different medications issued in two months).

6.4 KPE Two: Further deterioration in Trevor's mental health

6.4.1 Mid-September 2022, Trevor had a further session with West Sussex talking therapies and he stated he was very low and that he did not want to progress any further with the service as he felt it was not helping. A clinician discussed Trevor's safety plan and Trevor said that he had no plans to end his life and his family were his protective factor. Trevor was referred back to his GP.

6.4.2 Late September 2022, Trevor visited his GP and was accompanied by Hayden. A discussion took place about Trevor's mental health and it was agreed to review in three weeks.

6.4.3 Early October 2022, Vera visited her GP explaining she was very stressed about Trevor's mental health and that she could not sleep. Vera was prescribed medication but there appeared to have been no exploration of any risks to Vera relating to Trevor's mental health.

¹ [Talking Therapies West Sussex](#)

6.5 KPE Three: Increased desperation by Vera in how best to support Trevor.

6.5.1 Early October 2022, Vera took Trevor to the local hospital accident and Emergency Department and they were seen in the Urgent Treatment Centre. Trevor was triaged and his symptoms were noted as depressed and very anxious. Trevor said that his mental health had deteriorated since he stopped work. Vera was spoken to and she explained that Trevor had become paranoid and had stopped communicating and that he was at crisis point. Trevor was given information about MIND and that he should keep taking his medication and when he saw his GP next to ask about increasing the dose. Trevor was discharged and a discharge summary was sent to the GP practice.

There was no referral to the in-house hospital Sussex Partnership Mental Health Liaison Team -a potential missed opportunity. A new contract has been awarded for the delivery of the Urgent treatment Centre and included in the specification is the need to refer to the inhouse mental health team if there are concerns around a person's mental health.

6.5.2 Mid- October 2022, Trevor visited a GP again and it was agreed that Trevor would continue on his tablets and it was felt that the medication was now helping.

6.5.3 Mid-October 2022, Vera wrote a letter to her GP raising concerns about Trevor mental health,

"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. Hayden 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."

To note, the letter was not received in the GP practice until the day of Vera's death.

6.6 KPE Four: Trevor goes missing

6.6.1 Later in October 2022, Hayden called the police as she had received a strange phone call from Trevor. (Vera had gone away for a few days but Trevor had declined to go away due to fears of being detained at Border Control and being sectioned under the Mental Health Act. Hayden and Jordan had encouraged their mother to go on holiday for a break and confirmed they would look after Trevor). The police arrived at Trevor's home and found Hayden and Jordon. Hayden explained the concerns around Trevor's mental health and that Trevor thought people were out to get him and that Vera was having an affair (which there was no evidence of). Trevor did arrive at home and he said that the family were overstating his mental health. It was agreed that Hayden would stay with Trevor and the police said if Hayden had further concerns then to contact the police again. The police completed various risk assessments for a vulnerable adult and also made a referral to Sussex Partnership Foundation Trust Street Triage Team. The following day the Street triage nurse did contact Trevor and an assessment took place and Trevor was identified as being low risk in all aspects of self-harm, vulnerability, neglect and violence.

6.7 KPE Five: Death of Vera

6.7.1 Late October 2022, 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 his medication. A vulnerable patient triage tool form was completed. The form said that Trevor was suicidal at the time but not currently 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.

Conclusion/ Key Issues Arising from the Review

7.1 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.

7.2 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.

7.3 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.

7.4 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 and therefore have tried to reflect this within the DARDR.

7.5 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".

Lessons to be Learnt

8.1 Vera not being seen a carer

8.1.1 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.

8.1.2 Although the Think Family Agenda² speaks about looking at the whole family including children, the DARDR 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.

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

8.2.1 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.

8.2.2 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 thoughts³.

8.2.3 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

² www.safeguarding-guide.nhs.uk

³ www.gov.uk- Key Findings from analysis of domestic homicide reviews; October 2019 to Sept 2020 (assessable) Analytics Cambridge and QE Assessments LTD

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.

8.2.4 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) 4

8.2.4 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 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.

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

8.3.1 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.⁵

8.3.2 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.

8.3.3 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 associate's 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)⁶.

8.3.4 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.

⁴ www.mind.org.uk Violence and mental health Mind Factsheet 2018

⁵ [Men and Mental Health](#)

⁶ [BBC article](#)

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

8.4.1 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 Assessment⁷ 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.

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

8.5 The impact of retirement on a person's mental health.

8.5.1 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 work in small businesses.

8.5.2 The DARD Panel welcome that 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)⁸. 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 provide virtual training in how to have a MECC healthy conversation, which is available to anyone who works with the public in West Sussex.

8.5.3 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 Carewise⁹ and Age UK¹⁰.

⁷ [Mind Legal Rights](#)

⁸ [West Sussex Wellbeing – Making Every Contact Count](#)

⁹ [Carewise](#)

¹⁰ [Age UK](#)

8.6 Greater communication between agencies and family members to manage expectations.

8.6.1 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 are explained to family members so they can understand why such action is being taken.

8.7 Post Review Learning/Comments.

8.7.1 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.

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

DARDR Recommendations

9.1 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 DARD. (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

9.2 Individual agency recommendations

9.2.1 The Police

No recommendations

9.2.2 The GP Partnership

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.

Risk assessment by GP reviewing SCARF and MARAC reports should be documented.

To engage with West Sussex Talking therapies to ask them to make letters where they have concerns about a patient to be more obvious so the letter is passed to a GP.

SCARF report turnaround time for action to be reviewed.

Review of workflow processes in general to be completed.

Date stamping of all correspondence received, on the day received (and site), AND were, with initials.

Incorporate offering same day F2F appointments in GP triage processes across all Partnership sites for patients with new or deteriorating mental health concerns

9.2.3 Sussex Community Foundation Trust – West Sussex Talking Therapies

No recommendations

9.2.4 University Hospital Sussex

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

Objective, independent & evidence-based

Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.

Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations

Respecting equality and diversity

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 DARD 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:

The victim Vera - resident within Adur District

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.

5. 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
6. 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.
7. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.
8. 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.
9. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.
10. 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.
11. 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 Reviews¹¹.

¹¹ [Domestic Homicide Reviews Statutory Guidance](#)

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.

