BEXLEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the deaths of Andrea, Jordan and Sammy

December 2015

Independent chair and Author of Report: Laura Croom

Associate Standing Together Against Domestic Abuse

Date of Final: 8 January 2021

Portrait of Andrea

Andrea's sister wrote the following:

My baby sister, Andrea, was born at home. I saw her for the first time when the midwife brought her into the bedroom my brother and I shared. Until that time I do not think my brother and I had understood that our Mum was pregnant. I remember helping to change her nappies, bathe and feed her.

We grew up in a happy lovely home surrounded by cousins, aunts and uncles and the extended family. Andrea excelled at School and later at Drama School. She later obtained a 2:1 from Surrey University. Her love of drama began and was nurtured by her Infant School teacher, and it was at Infants School she learnt to read music and play the recorder. In her Junior School she learnt to play the clarinet and I remember her saying that the clarinet teacher was pleased that she could already read music. As an older sister and with our mother working part time in the evenings, I took her to drama classes, as did other family and friends. In particular a close family friend introduced and took her to drama classes, at a well-known London drama school. I watched her in drama productions and was in the audience when she played in our Borough Orchestra and was told by a clarinet teacher that they had never seen someone's fingers move so fast along the clarinet. I took her to her first pop concert to see Paul Young.

Andrea was quirky, her dress sense was kooky, and she was the first person I knew to eat organic food (long before it began fashionable) and to adopt a holistic life style. Andrea was loyal and loving to family and friends, but had all the attributes of an actress, she could be demanding of herself and others, but gave as much as she demanded. Often going to support her fellow friends and actors in productions that they were appearing in.

Family and friends were proud of her as she became a successful actress, but she never changed from the person we loved and cherished.

A friend who met Andrea in early 1990 at Drama School and wrote the following:

Songs in The Key of Life by Stevie Wonder plays . . . What luck to see her in a sea of youths whom I had nothing at all in common with - genuinely enjoying her Gimson phonetics book - the lifeline. This was not the natural domain of working-class kids, especially girls. And especially those of colour, like Andrea. Yet there she was, at home in any situation, glowing with talent, and wisdom and warmth. Wanting to learn it all. Never loud or attention seeking, (I never heard her swear even once), she was the classy one you couldn't take your eyes off - whatever she did. Funny and full of

fun, nothing was boring if she was there. You wouldn't necessarily assume this from one who lives in the library, would you? But yes, she found the joy in everything, and the good in everyone. Her eyes would twinkle and immediately you were at ease. Andrea always adored children, who she had a special way with. She also loved her family passionately, and all her friends. She cared for each of them so much that you were always aware of exactly how every single one of them was doing. Even those you didn't know. Everyone mattered to Andrea. If you were in her fold, you felt truly loved. With actor friends, she would happily attend the opening of a fridge door to support them, anywhere in the country. Boarding trains on cold November evenings in giant coats to the arse end of nowhere, she would watch with pleasure and say 'that's my friend!' and beam with pride. She would reassure you, and she would bring pink gerberas.

Prioritising her beloved two small children was essential to Andrea when they arrived, but there is no denying that her work was always breath-taking. She outclassed us all, winning almost every role she went for. Spontaneous and detailed and very intelligent. Whether it was a huge West End production, an epic audio book, a television show the world sees, or a tiny little masterpiece in a theatre above a pub - she put her all into it. Loved the work. Loved the people. Loved the opportunity. Even when there was just lunch on offer in return. She would delight in the floppy sandwich as much as the red carpet. She was a true artist. Everything pleased her about doing the job.

An unforgettable actress and an unforgettable woman. She really listened and she really saw you - way before that ever became a fashionable thing to do. If you were lucky enough to know Andrea, you can never forget her and she will always be in your corner. There was always a hug for you, some thoughtful words, and she would always suggest somewhere excellent to eat. The touch of her gentle hand will stay with me forever. Because if something was wrong, she would always be the very first to reach out. Andrea wanted nothing but good for absolutely everyone. Always.

1. Introduction

The Review Panel expresses its sympathy to the family and friends of Andrea, Jordan and Sammy for their loss and thanks them for their contributions and support for this process.

1.1 The Homicide

1.1.1 Andrea and Dean had been together as a couple for 10+ years. Andrea, Dean, and their two young children, Jordan and Sammy[1] had moved to Bexley in August 2011.

1.1.2 In mid-December 2015, Andrea attended an appointment at King's College Hospital to see a neurologist. She had had a number of appointments in order to diagnose her deteriorating strength and health. On this day the diagnosis of motor neurone disease (MND) was confirmed to her. MND is a debilitating disease that ends in death. The consultant described Andrea as distressed and depressed.

1.1.3 Two days later, she visited her family to talk through the diagnosis and arrangements for the children, who were 8 and 4 at the time. It was agreed in principle that she and the children would move back in with her mother in East London and that the children would live there following Andrea's death. That was the last time the three of them were seen by her family.

1.1.4 Five days later, an anonymous caller (later identified as a family member) rang the NSPCC Child Protection Helpline to report concerns about Andrea and the children as they had not heard from her for several days. The NSPCC notified the police and Bexley Children's Social Care the same day.

1.1.5 The police visited the family home the same day. Dean was at home. He said that Andrea had been given a diagnosis of motor neurone disease a few days earlier. He said that she and the children had gone to a friend in Cambridge for a few months because of family disagreements and because the house was being renovated and was not fit to live in. He did not have the friend's address. Dean said that Andrea's family did not like him and the call to the NSPCC was malicious. Though nervous and reluctant, he did let the police in the home. They did not find Andrea or the children and it was noted that Andrea's car was not at the address. Local processes for missing persons and missing children were begun by the police.

1.1.6 On 17 December 2015, family members received messages from Andrea's phone, purporting to be from her. The messages said she was going away for a few weeks and would not be in contact. Family members said that the messages they received

[1] Pseudonyms are used for the victims, perpetrator, family and friends in this review.

after 14 December were not in Andrea's usual style. The phone was not answered when family and police tried to contact her.

1.1.7 The house was searched several times, and from 18 December 2015, the house seemed to be deserted.

1.1.8 On 5 January 2016, a further forensic search of the property revealed the bodies of Andrea, Jordan and Sammy in shallow graves in the garden. All three had suffered blunt force trauma to the head. Andrea had a deep wound to her neck, Jordan had incised wounds that virtually encircled the neck, and Sammy had a deep stab wound to the back of the neck. Jordan had defensive wounds to his right hand. They were then buried in the garden.

1.1.9 Dean had fled abroad and was located and extradited back to the UK for trial. At the trial in June 2016, he pleaded guilty to three counts of murder for the deaths of Andrea, Jordan and Sammy. In October 2016 Dean was given a whole life sentence.

1.2 Domestic Homicide Reviews

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 (DVC&V).

1.2.2 This DHR will consider agency contact and responses to Andrea and her children Jordan and Sammy, and Dean, her partner and the father of the children.

1.2.3 In addition to agency involvement, the Review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2.4 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order 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, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2.5 This Review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.3 Parallel Reviews

1.3.1 *Criminal trial:* Dean pleaded guilty to three counts of murder and received a whole life sentence in October 2016.

1.3.2 *Judge sentencing summary:* In his summing up, the judge said, "The Defendant had the difficult task of caring for Andrea and their children as her health deteriorated and the outlook became bleaker. The Defendant accepted what he had done at an early stage, including when he was arrested . . . I accept that he entered guilty pleas at the first reasonable opportunity, after psychiatric evidence had been obtained, which made it clear that there was no defence to the charges of murder. . .

1.3.3 In my judgment this was indeed a case where each murder involved a substantial degree of premeditation or planning . . . there were serious aggravating features of this case. Each of the victims was particularly vulnerable because of age or disability . . . There was an 'abuse of position of trust'. . . There was concealment of the bodies. In addition, as I have already mentioned, there were the aggravating features in what the Defendant did after he had committed these murders. He made efforts to remove evidence of his crimes at the house, including repainting. He sought to lay a false trail by using Andrea's mobile phone. He lied to the police and others about the whereabouts of the family. He escaped abroad . . .I have been left in no doubt that this is one of those exceptional and rare cases where the requirements of punishment mean that a whole life order must be imposed, even after taking into account the mitigating factors."

1.3.4 *Coroner*. The Croydon Coroner's Court open and adjourned the inquest in the deaths of Andrea, Jordan and Sammy on 13 January 2016. The coronial proceedings were discontinued after the criminal proceedings.

1.3.5 *Police reviews*. The Metropolitan Police Service undertook three reviews of this case that reviewed their involvement. As the police involvement was after the murders, the timeframe of their review does not overlap the timeframe of this review and their focus was on the police response to the missing persons' alert.

1.3.6 *Consideration of the need for a Serious Case Review*. The Serious Incident Sub-Group (SISG) of the Local Safeguarding Children's Board (LSCB) met twice in January 2016 and reviewed the circumstances of this case. They noted the police reviews and asked questions of them. The SISG recommended to the LSCB's Board chair that the criteria for a Serious Case Review[2], as defined by the Children Act 2004, had not been met. The SISG identified some local learning from their review which was taken forward into the local learning review.

1.3.7 The National Panel of Independent Experts on Serious Case Reviews reviewed information submitted by the Bexley Safeguarding Children Board (BSCB) about

[2] Serious Case Reviews became Child Safeguarding Practice Reviews in England and Child Practice Reviews in Wales on 29 September 2019.

these decisions and agreed in March 2016 that the criteria for initiating a Serious Case Review had not been met.

1.3.8 *Safeguarding Adult Board*. The Safeguarding Adult Board determined that the case did not meet the criteria for a safeguarding adult review.

1.3.9 The chair sought information on the Learning Review that was completed in the autumn of 2018 and the action plan that followed it.

1.4 Timescale for reviews

1.4.1 The Bexley Community Safety Partnership (CSP) determined that this case did not meet the criteria for a domestic homicide review and commissioned a learning review of the events leading up to the deaths of Andrea, Jordan and Sammy. The decision not to undertake a domestic homicide review was a unanimous one taken by key partners of the Bexley Community Safety Partnership, following consideration at an extraordinary Board meeting on 26 January 2016.

1.4.2 The decision was based on the view of the CSP that there were no predictive factors, information or interventions that would have prevented the murders. The family were not known to the local authority, the police or domestic abuse services. The Home Office was notified of this decision in a letter dated 2 February 2016 and the local area understood that an agreement was reached that a proportionate local Learning Review would take place following the basic principles of a DHR with Terms of Reference that were agreed with the family. The agreement to undertake a Local Learning Review (LLR) was reached some time after the Council had written to the Home Office and explained its intention not to undertake a DHR.

1.4.3 The completed LLR was sent to the Home Office on 4 April 2018.

1.4.4 In a letter dated 22 June 2018, the Home Office wrote to say that the learning review was not appropriate for this case. They referred to the Domestic Violence, Crime and Victims Act 2004, S. 9(1) that requires that a DHR should be undertaken when someone aged 16 or over dies as a result of violence, abuse or neglect by a person to whom he or she was related or with whom he or she was, or had been, in an intimate person relationship. All parties agreed that this met that definition.

1.4.5 The Home Office letter highlighted aspects of the Learning Review that needed strengthening to meet the criteria of a domestic homicide review. They noted that the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews asks that cases where there was “little or no agency contact are a particular concern and should be examined by a review, especially in relation to any barriers the victim may have had in accessing services or why local services may not have been appealing to the victim.”

1.4.6 In these circumstances, the Bexley CSP again considered the case and the Home Office's suggestions and undertook to complete a DHR. Relevant agencies were notified of this in late September 2019 and asked to secure their records.

1.4.7 Bexley responded to this misunderstanding by addressing their approach to DHRs. Bexley now has a domestic and sexual abuse and violence (DASAV) strategic lead who has created a Toolkit for the DHR process in Bexley. In order to draw together the learnings from case reviews, audits, and inspections within a range of departments, Bexley now has a Multi-Agency Learning Forum (MALF). The group considers learning from multi-agency reviews and identifies common themes, considers how to best disseminate the learning across the wider social care system, and ensures that training is updated to include these learnings.

1.4.8 Standing Together Against Domestic Abuse (Standing Together) was commissioned to provide an independent chair for this DHR on 10 June 2019. The completed report was handed to Bexley CSP on 9 December 2020.

1.4.9 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Delays occurred due to the misunderstanding about the appropriate method of review and the time it took to complete the learning review. Having received the Home Office's response, the London Borough of Bexley (LBB) CSP considered what was needed to develop the learning review into a domestic homicide review and then decided on the next steps. There was a delay as they sought to schedule the first DHR Panel meeting.

1.4.10 In the course of this review, the spread of Covid-19 became a pandemic. The agencies involved in this DHR were those at the frontline of the country's response: health agencies, the police, children's services and domestic abuse services. There were delays in responses from agencies to information requests and actions for this DHR. Indeed, there was a six-month delay due largely to the safeguarding lead at one of the health agencies being fully engaged in the Trust's work responding to the pandemic and therefore unable to complete an individual management review (IMR) for many months.

1.4.11 As a result, the following recommendation is made for after the additional burden of the pandemic has subsided.

1.4.12 **Recommendation: That after the pandemic has subsided, the agencies represented on this DHR Panel review their safeguarding provision to ensure that they have the capacity to meet the needs of statutory review processes such as domestic homicide reviews.**

1.5 Methodology

1.5.1 Throughout the report the term “domestic abuse” is used interchangeably with “domestic violence”, and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013. It is included here to assist the reader to understand that domestic violence is not only physical violence but also includes a wide range of abusive and controlling behaviours. The definition states that domestic violence and abuse is:

1.5.2 “*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.*

1.5.3 *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

1.5.4 *Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”*

1.5.5 This definition, which is not a legal definition, includes so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.5.6 This Review follows the 2016 statutory guidance for Domestic Homicide Reviews issued following the implementation of S. 9 of the DVC&V.

1.5.7 On notification of the DHR, agencies that had been part of the Learning Review were asked to check for their involvement with any of the parties concerned and secure their records.

1.5.8 At the first meeting on 31 October 2019, agencies shared their engagement with Andrea, Jordan and Sammy and Dean. Individual Management Reviews (IMRs) were requested for all organisations and agencies that had had contact. Twenty agencies were contacted to check for involvement with the parties concerned with this Review. Fifteen agencies returned a nil-contact, three agencies submitted IMRs and chronologies, one submitted an IMR only. One supplied the limited information it had. The chronologies were combined, and a narrative chronology written by the Overview Report Writer.

1.5.9 The IMRs were distributed to the Panel and the chair had conversations with several Panel members to help create the draft report which was then discussed by the Panel via video conferencing on 28 September 2020.

1.5.10 *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received provided information that enabled the panel to analyse the contact with Andrea, Jordan, Sammy or Dean and to produce the learning for this review. Where more information was needed, the chair sent further questions to the IMR writers and some responses were received. Four IMRs made recommendations of their own and evidenced that action had already been taken on these. The IMRs have informed the recommendations in this report.

1.5.11 *Documents Reviewed:* In addition to the four IMRs, documents reviewed during the Review process have included

(a) Letter from the Consultant Neurologist to the Designated Nurse Safeguarding Children at for the Child Death Review and for the murder investigation being conducted by the police at the time

(b) King's Consultant's letter to the BSCB chair

(c) Minutes of the Rapid Response Multi-Agency planning meetings on 8 January 2016

(d) Kings College Hospital NHS Foundation Trust report for the BSCB Case Review

(e) Minutes of the meetings of the BSCB Serious Incidents Sub Group (SISG) on 13 and 26 January 2016

(f) Letter from the chair of the SISG to the Serious Case Review Panel from 5 February

(g) A Pre-sentence Report on Dean

(h) The final sentencing remarks of the Judge in the case

(i) Bexley's Combined DHR Action Plan

(j) The Learning Review of the case and its action plan

(k) Response of the Home Office to the Learning Review

(l) Emails between Andrea and the school that Jordan had attended regarding removing him and, later, seeking places for both children from spring 2016.

(m) London Borough of Bexley's Elective Home Education Policy – revised and due for review in September 2020

(n) Home Office Guidance for parents who are home-educating and for local authorities regarding home-education

(o) Additional sources listed in the Bibliography.

1.5.12 *Interviews Undertaken:* The chair of the Review has undertaken six interviews in the course of this Review. Due to the Covid-19 pandemic and the fact that several interviewees lived abroad, most interviews were done on the telephone.

(a) One face-to-face interview with Andrea's sister and a cousin

(b) Telephone interviews with Andrea's brother, another cousin, and a friend

(c) Telephone interview with Clinical Nurse Specialist for the Motor Nerve clinic at Kings Hospital regarding MND and the help the clinic would have been able to offer if Andrea had survived

(d) Telephone interview with Julie McGarry, the Safeguarding Research Lead at Nottingham University, with a speciality in the mental health of victims.

1.5.13 The chair is very grateful for the time and assistance given by the family, friends and specialists who have contributed to this Review.

1.6 Terms of Reference

1.6.1 The Terms of Reference are included at **Appendix 1**. This Review aims to identify the learning from the case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.6.2 The Review Panel comprised agencies from Bexley, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the Review was established to inform them of the Review, their participation and the need to secure their records.

1.6.3 As information was provided during the Review, it was established that Andrea had had contact with a school outside of the area and contact was sought with this school.

1.6.4 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1 August 2011, when the family moved to the area, to 13 December 2015 which was the last day that anyone had contact with Andrea, Jordan and Sammy. Agencies were asked to summarise any relevant contact they had had with Andrea, Jordan, Sammy or Dean outside of these dates.

1.6.5 Solace Women's Aid was invited to be part of the review due to their expertise in domestic abuse even though they had not been previously aware of the individuals involved. The chair sought information from Carers UK regarding the carer issues and from Children's Society about children as carers. Carers UK sent links to

research and information about the support they offer carers. The Children's Society acknowledged the initial contact but did not get in touch again.

1.6.6 *Key Lines of Inquiry:* The Review Panel considered both the "generic issues" as set out in 2016 Guidance and identified and considered the following case specific issues in addition to the issues in the Equality and Diversity section above.

(a) Analyse the communication, procedures and discussions, which took place within and between agencies.

(b) Analyse the co-operation between different agencies involved with Andrea, Jordan, Sammy and Dean

(c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.

(d) Analyse agency responses to any identification of domestic abuse issues.

(e) Analyse organisations' access to specialist domestic abuse agencies.

(f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

1.6.7 As the DHR developed, it appeared that the services most likely to have had contact or explore the case further were the Department of Education and the physiotherapist who worked very briefly with Andrea. The Panel considered the involvement of these services fully in this report and has made recommendations about how they might become involved in similar cases in the future (National Recommendation at 4.2.8 and local recommendation at 4.2.10).

1.6.8 The following issues were agreed at the first DHR Panel meeting:

(a) Analyse the family's and friend's identification of domestic abuse issues and access to specialist domestic abuse information and agencies

(b) Review the oversight of children when home-educated and what opportunities there are to identify domestic abuse

(c) Children as carers

(d) Carer stress

1.6.9 By the time this DHR was undertaken, four years had passed since Andrea, Sammy and Jordan were killed by Dean. Panel members asked that it be noted that policies and procedures have progressed since that time. Where agencies provided specific details of how those changes have addressed concerns raised in this report, this is noted. Where such assurances of change were general, recommendations have been made.

1.7 Equality and Diversity

1.7.1 The chair of the Review and the Review Panel did bear in mind all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the Review process.

1.7.2 Andrea was a Black British heterosexual woman and the family report their cultural heritage is from Jamaica, the West Indies, and India. Andrea was 43 at the time of her death. Her health had been deteriorating for two years and she had recently been diagnosed with MND, a debilitating terminal illness. She was living with Dean, to whom she was not married. She was the mother of two children and had just given birth to the second child at the beginning of the timeframe of this review, so maternity was not pertinent in the timeframe of the review. Andrea's family report that she was raised as a Christian and continued to practice her faith. When with her family, she would go to church and the children went to Sunday School.

1.7.3 Jordan and Sammy were 8 and 4 respectively when they were killed. Both children were Black British.

1.7.4 Dean was a Black heterosexual man of 48 years. His nationality is uncertain[3], but Andrea's family say he had the right to remain. He had been born abroad and had come to this country when he was young. His religious affiliation is unknown.

1.7.5 At the first meeting, the Panel identified that the following protected characteristics pertained in this case: sex, age (the children), disability, and race. Andrea was not pregnant within the timeframe of the review and the religious beliefs of Dean and Andrea were not known initially. To provide specialist input on these issues, the Panel asked Solace Women's Aid, the domestic abuse provider, to join the Panel to provide insight into the issues of domestic abuse, coercive control, and the protected characteristics. IKWRO[4] provide specialist Black and minority ethnic support in Bexley and they provided feedback on the draft report.

1.7.6 Sex should always require special consideration. Recent analysis of domestic homicide reviews reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.[5] This characteristic is therefore relevant for

[3] Dean is described variously in the paperwork as "Black British", "Black British and African", and as "mixed race". As his immigration status is not a focus of this review, we have accepted the ambiguity here.

[4] IKWRO is the abbreviation for Iranian and Kurdish Women's Rights Organisation. The charity's brief has expanded since its founding and IKWRO now provide the specialist support in Bexley for Black and minority ethnic victims of domestic abuse.

[5] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

this case as one of the victims of the homicides was female and perpetrator of the homicides was male.

1.8 Contributors to the Review

1.8.1 The following agencies were contacted but recorded no involvement with the victims or perpetrator: London Ambulance, Lewisham and Greenwich NHS Trust, Bexley Children's Social Care, Bexley Adult Social Care, Fire Brigade, Bexley Housing, London CRC, Metropolitan Police Service, and Pier Road Project, National Probation Service, Peabody, Her Centre, Bexley Women's Aid, Solace, and Victim Support.

1.8.2 The following agencies and their contributions to this Review are:

Agency	**Contribution- Chronology/IMR/Letter/Other**
Bexley CCG	IMR and chronology of GP's contact
Oxleas NHS Foundation Trust	Summary report and analysis of occupational therapy appointment IMR and chronology of HV
Kings College NHS Trust	IMR
Dartford and Gravesend NHS Foundation Trust	IMR and chronology of Andrea's contact with Darent Valley Hospital
Bexley Safeguarding Children's Board (BSCB)	Meeting notes from the BSCB's SISG's review of this case to determine if a Serious Case Review was required The letter notifying colleagues of the decision that a SCR was not required.
[redacted] School	SOE and email exchanges between the school and Andrea
Bexley Education Services	Review of the draft of this review and help in shaping education recommendations

"Analysis of the whole STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* " (June 2016), p.69.

1.9 The Review Panel Members

1.9.1 The Review Panel consisted of:

Name	Role/Agency or Organisation
Laura Croom	Chair, Associate of Standing Together
Deborah Simpson	Domestic Abuse and Sexual Violence Strategy Manager, Bexley Community Safety Partnership
Philippa Uren	Designate Nurse for Adult Safeguarding, South East London (Bexley) Clinical Commissioning Group
Heather Payne	Adult Safeguarding Head of Department, Kings College Hospital NHS Foundation Trust
Gina Tomlin	Safeguarding Adults Lead, Darent Valley Hospital, Dartford and Gravesend NHS Foundation Trust
Stacy Washington	Trust Lead for Safeguarding Adults and Prevent, Oxleas NHS Foundation Trust
Malcolm Bainsfair	Head of Adult Safeguarding and Principal Social Worker, Bexley Adult Social Care
Anita Eader	Bexley Safeguarding Adults Board Practice Review and Learning Manager, Bexley Adult Social Care
Fiona Cisneros	Deputy Director, Bexley Children's Social Care
Moksuda Uddin	Head of Children's Social Care, Bexley Children's Social Care
Amy Glover	Senior Manager, Solace Women's Aid
Russell Pearson	Detective Inspector, Specialist Crime Review Group, Metropolitan Police Service

Karen Upton	Lead GP Safeguarding Adults and Children South East London CCG (Bexley)
Clare Hunter	Designate Nurse for Children Safeguarding South East London CCG (Bexley)

1.9.2 Efforts were made to involve Bexley Education Services on the Panel but staff had changed and no one was made available. However, the draft report was read and commented on by Bexley Education Services and specific questions that arose about home-educating in the area were answered by them. The recommendations involving home-education were modified in discussion with Bexley Education Services.

1.9.3 Similarly, efforts were made to have NHS England represented on the Panel, but no response was received to our invitation. A copy of the draft and final reports were sent to the NHS England.

1.9.4 *Independence and expertise*: Agency representatives were the appropriate level of expertise and were independent of the line management of those involved in this review.

1.9.5 The chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.10 Confidentiality

1.10.1 The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is publicly available only to participating officers/professionals and their line managers.

1.10.2 This Review has been suitably anonymised to protect the identity of the victim, the perpetrator, and family members, in accordance with the 2016 guidance. The specific date of death has been removed, as has the gender of the children. Only the independent chair and Review Panel members are named.

1.10.3 The DHR uses the names agreed with the family.

(a) The victims: Andrea, Jordan and Sammy.

(b) The perpetrator: Dean.

1.11 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.11.1 Initially, the Bexley CSP notified the family of Andrea in writing of their decision to undertake a domestic homicide review in mid-October 2019 through their AAFDA peer support worker who had supported them through the learning review. The letter included the Home Office leaflet on domestic homicide reviews. The chair of the Review and the Review Panel acknowledged the important role that Andrea's family could play in the review from the outset and took steps to involve the family, friends, work colleagues, neighbours and wider community.

1.11.2 Bexley CSP agreed to the chair approaching the family members and friends who had been interviewed for the learning review. Andrea's mother, who was able to be interviewed for the learning review, has since passed away. The chair approached Andrea's sister, brother, two cousins, and two of her friends. The results of those contacts are below. The terms of reference were discussed with the sister and cousin in the face-to-face interview.

1.11.3 A cousin of Andrea's who was interviewed by the chair with Andrea's sister required a British Sign Language (BSL) interpreter. There was a misunderstanding between Andrea's sister and the AAFDA support worker and as a result, an interpreter did not attend the interview. To ensure that the cousin had the fullest opportunity to engage, a copy of the chair's notes was sent to her to edit and add to after the interview.

1.11.4 The AAFDA peer support worker who had supported the family through the Learning Review continued to provide support to them through the domestic homicide review.

1.11.5 Andrea's sister and two cousins had the draft report for a month to review. Though the draft was sent to Andrea's brother at the same time, he did not receive a copy until the week of the feedback video conference with the chair. Andrea's cousin had a BSL interpreter for the feedback session and the AAFDA support worker attended. At the feedback session, the family made suggestions and corrections and described the report as "excellent".

Identified in the review by their relation to Andrea	**Means of involvement in review (eg. TOR/ Interview/reviewed report)**
Sister	Face-to-face interview Input on the Terms of Reference
Brother	Lives abroad, so telephone interview
Cousin Sarah	Face-to-face interview Input on the Terms of Reference
Cousin Catherine	Telephone interview as lives abroad

Friend Amanda	Sent email with key points
Friend Helena	Telephone interview

1.12 Involvement of Perpetrator and/or his Family

1.12.1 Though the perpetrator pleaded guilty to murder, he decided not to provide information to the criminal justice process. Therefore, the chair agreed with the Panel that the psychiatrists' reports and the police report would be sufficient for gathering information about the perpetrator's view. Interviews with wider family were not sought as Dean had told the psychiatrists and police that he was estranged from them.

1.12.2 Later, however, after speaking to Andrea's family, several issues arose that the chair thought should be asked of the perpetrator. In agreement with the Bexley DV strategic lead, the chair sought an interview with the perpetrator.

1.12.3 A letter was sent from the chair to the perpetrator through his offender manager (OM). The letter asked if he needed support during the interview. Accompanying that letter was a Home Office leaflet explaining the DHR process and an interview consent form to sign and send back. The perpetrator confirmed on 7 September 2020 through his OM that he did not wish to be interviewed or engage with the DHR.

1.13 Chair of the Review and Author of Overview Report

1.13.1 The chair and Author of the Review is Laura Croom, an Associate DHR chair with Standing Together. She is an independent consultant who has worked in the domestic abuse sector for 17 years. In that time, she has provided frontline work, developed service standards for domestic violence services with SafeLives, reviewed the effectiveness of the coordinated community response (CCR) in 17 areas as part of Home Office-funded work from Standing Together and received Home Office DHR chairs' training in 2013. She is currently chairing her thirteenth DHR.

1.13.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the coordinated community response to domestic abuse (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the DHR process from its inception, chairing over 70 reviews.

1.13.3 *Independence:* Laura Croom has no connection with the Bexley local authorities or any of the agencies involved in this case.

1.14 Dissemination

1.14.1 The following recipients have received/will receive copies of this report:

- Bexley Community Safety Partnership
- Panel members listed above
- Andrea's family – received the draft report to feedback on
- AAFDA - received the draft report to support the family to feedback
- Standing Together DHR Team
- Bexley SHEILD partnership – the safeguarding partnership for children and young people
- Bexley Deputy Director for Educational Achievement and Inclusion
- Bexley Safeguarding Adult Board
- Mayor's Office for Policing and Crime (MOPAC)

2. Chronology

2.1 Chronology for timescales under review

2.1.1 There was little contact with local agencies in Bexley.

2.1.2 Sammy was born at Andrea's home in another London borough in **August 2011**.

2.1.3 Andrea, Dean, Sammy and Jordan moved to Bexley in **August 2011**.

2.1.4 Andrea, Sammy and Jordan registered with a Bexley GP surgery in **November 2011**. Andrea had a new patient health check. She provided details of her medical history and said she took moderate exercise.

2.1.5 The Oxleas Health Visitor (HV) completed a contact visit on **30 November 2011**. Andrea described herself as a single parent and that the father of the children lived in France and visited the family frequently. She had recently moved to the area. Andrea said that her mother who lived in East London supported her and that Jordan went to a nursery in East London. Andrea worked part-time and was on maternity leave. She expected to return to work in May 2012. The HV saw the children.

2.1.6 Jordan started in the kindergarten class at the Greenwich Steiner School on **17 January 2012**.

2.1.7 In **April 2012**, it was noted by the HV that Andrea had declined all immunizations for her children.

2.1.8 On **14 December 2012**, Jordan left the Greenwich Steiner School. Andrea gave no reason although she said that they might be joining Dean in France. The school thought that Andrea might have had problems paying the school fees. They also thought that Dean did not approve of Jordan attending the school. Andrea's family agreed that Dean influenced this decision.

2.1.9 On **22 December 2012,** "Refusal for summary care record upload" recorded by GP after an appointment for Jordan. The CCG note that it is uncommon for parents to refuse to have a record of an appointment made, but this is within the parents' rights.

2.1.10 Andrea telephoned the GP in **January 2013** to say that she does not want any immunizations for the children.

2.1.11 There were a few missed appointments at the GP in **2013**.

2.1.12 Andrea later reported to the KCH consultant that her neurological symptoms started around **September 2013**. These started with weakness in her left hand which gradually worsened. About eight months later her right hand started to gradually weaken in the same way.

2.1.13 The HV visited Andrea at home on **17 March 2014** and completed Sammy's 27th-month health review with no problems identified. Andrea said that she was home-educating Jordan while waiting for a primary placement at the Greenwich Steiner School. She wanted the children to go to school together.

2.1.14 Andrea saw her GP on **25 March 2014**, reporting a weakness in her left arm over the preceding two to three months. She then had a neurological examination at the GP on **9 April 2014** which was unremarkable, and she was asked to return if symptoms recurred.

2.1.15 Andrea saw the GP again at the end of **July 2014** with raised cholesterol and low neutrophils, that is, low levels of white blood cells that protect against infections. Andrea's low neutrophil count had been low since she was 20 and related to the diagnosis of Lichen Planus[6] at the time.

2.1.16 In **August 2014**, Andrea attended Darent Valley Hospital (DVH) A&E with pain in her left shoulder and a weakness in her left arm. She had been having symptoms, she said, for the previous 12 weeks. A CT scan was carried out and DVH referred her to Oxleas OT. Her GP was asked to refer her to physiotherapy, nerve conduction studies and an MRI scan. She stayed in DVH overnight for observation.

2.1.17 Andrea's GP referred her to a neurologist the following week.

2.1.18 Andrea attended the DVH A&E again on **1 September 2014** for a weakness in her shoulder, and pain in her upper left arm. She was advised to see her GP.

2.1.19 The Oxleas Occupational Therapist (OT) saw Andrea on **23 October 2014.** The OT recorded that Andrea was worried about symptoms as they were affecting her everyday life as she had no power in either hand. OT noted that Andrea was tearful and "fearing the worst", primarily because of the two children. This is the first recording of a seriously disabling symptom.

2.1.20 On **11 November 2014**, Andrea attended a neurology outpatient appointment at DVH. She was told there was evidence of peripheral neuropathy, that is, damage to the nerves outside the brain spinal cord which often causes weakness. During physiotherapy for her hand, new weakness had been noticed. Her fine motor skills were diminished, and she was unable to fasten buttons or zippers. She reported that she had lost about a stone and a half in weight. A letter to the GP noted that she lived with her two children and was managing daily living. Andrea was referred to the KCH consultant neurologist requesting nerve conduction studies and a procedure that would measure Andrea's muscles' response to nerve stimulation.

[6] Lichen Planus is a autoimmune disorder that results in skin rashes.

2.1.21 Andrea cancelled her OT appt on **11 November** 2014, saying she was waiting for her nerve conduction tests at KCH.

2.1.22 Andrea saw her GP on **8 December 2014** regarding her thyroid medication.

2.1.23 In **December 2014**, Andrea had nerve conduction studies which showed evidence of axonal neuropathy (acute paralysis and loss of reflexes without sensory loss) affecting the upper limbs on both sides. She also had an MRI c-spine (a scan that can detect a variety of conditions of the top seven bones of the spine) that showed mild degenerative changes.

2.1.24 Andrea cancelled her OT appointment on **13 January 2015** as she said she was waiting for nerve conduction tests at KCH. She cancelled an appointment at DVH due to work commitments. (DVH note that the letter to the GP noting the outcome of the tests was sent on 9 January, after a telephone discussion of the result with Andrea.)

2.1.25 Andrea attended the DVH lumbar puncture clinic on **5 February 2015**.The strength in her arms had improved by about 40%. She reported an increase in her weight and she continued on her thyroid medication. She had a lumbar puncture and blood tests.

2.1.26 DVH sent a letter on **24 February 2015** to the consultant neurologist at KCH referring Andrea to the peripheral nerve clinic. The weakness was noted as profound and functionally impairing. It was noted that Andrea's uncle suffered from a motor neurone syndrome.

2.1.27 The Oxleas OT service closed its file on Andrea on **14 April 2015** as no further information had been received from her and she had not re-booked the missed appointments. (This is returned to in the Analysis section.)

2.1.28 Andrea saw her GP on **29 April 2015** to discuss her blood tests. She was started on iron pills and she was to repeat the blood tests in six months.

2.1.29 On **19 June 2015**, Andrea had her first appointment with the consultant neurologist at KCH and her sister attended with her. The neurologist's opinion was that Andrea had severe progressive lower motor neurone syndrome affecting all four limbs. Initially, the neurologist suspected chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) for which the standard treatment is IVIG (intravenous immunoglobulin). This condition improves with the standard treatment.

2.1.30 On **29 July 2015**, the neurologist repeated the EMG tests and found worsening widespread active denervation changes. Andrea started the standard treatment for CIDP at KCH from **16 to 21 September 2015** as a day case. The IMR author was unable to access records relating to this intervention as they were labelled as clinical research. (There is a recommendation addressing the lack of access.)

2.1.31 Andrea attended the DVH Neurology Clinic on **29 September 2015** where the diagnosis of progressive motor neuropathy was noted and that she was under the

care of KCH. A family history of motor neurone disease was noted and that she had received a course of IVIG. She reported some improvement after the IVIG and that she was feeling better.

2.1.32 On **9 October 2015**, Andrea saw the KCH neurologist to assess her response to the IVIG treatment for CIDP. The doctor found that her muscle strength was worse in most muscles compared to her June assessment. The neurologist told Andrea that this worsening of her symptoms suggested that the diagnosis was more likely to be motor neurone disease than CIDP, but she had not had enough IVIG treatment yet to be sure.

2.1.33 Andrea had further IVIG treatment as an outpatient on **20 October 2015** and on **17 November 2015.**

2.1.34 Andrea contacted the school asking about places for both of the children on **29 November 2015**.

2.1.35 Andrea missed her appointment on 4 December with the KCH neurologist which was then rescheduled. She had her last appointment with the neurologist on **11 December 2015.** She attended alone. Andrea reported small improvement in her fingers but said her legs were weaker and she was able to do less. The doctor told her that the diagnosis was definitely MND and referred her to the motor nerve clinic and the regional specialist service for MND. The doctor told her that with MND, her condition would deteriorate, and she would eventually die. She admitted she was quite depressed, and the doctor assumed this was evidence that she was absorbing the diagnosis. The doctor noted that her hands and arms hung loose at her side and she could hardly make any movements at all with her fingers and hands. She was not able to grip anything, and she had very limited use of her hands and arms. She was very weak and though she could walk unaided, her walk was slow and unsteady.

2.1.36 Also, on **11 December 2015**, the Greenwich Steiner School contacted Andrea and offered places for the children from Easter 2016. The Head Teacher explained the school's approach to education and Andrea thought it would be a good fit for them.

2.1.37 The last time Andrea, Jordan and Sammy were seen alive was **13 December 2015**. She had Facetimed Cousin Catherine earlier, saying she was going to visit her mother and sister and could not talk then. Andrea had gone to visit Andrea's mother and sister. Her family say that Andrea told them that day that she had been diagnosed with MND and that she had been told that she probably had between one and three years to live. Andrea asked if she could move back into her mother's home and if Dean could move back in with her. Her mother said that Andrea and the children could move in, but not Dean. Andrea appeared to accept that. They talked about the children going back to the Steiner School. Andrea said that the school could not take both children until Easter, but Andrea's mother said she should "come back now" to her mother's home. They agreed that compromises regarding Andrea's

healthy eating regime (more on this below) would be made for her and the children and other differences accommodated. The family understood that this move would happen during the week of Christmas when Andrea's sister would be on holiday. Dean and the children collected Andrea and they returned to their home in Bexley. Andrea also rang a cousin that day and talked about the children's futures.

2.1.38 A family member contacted the NSPCC Child Protection hotline three days later on **16 December 2015** as she was concerned that Andrea, Jordan and Sammy had not been heard from since their visit on 13 December and might be at risk.

2.1.39 The police undertook a missing persons enquiry and visited the house several times. Dean fled the country. The bodies of Andrea, Jordan and Sammy were found buried in the back garden of their home on **5 January 2016**. They had been hit on the head, stabbed and cut, and then buried.

2.1.40 Dean was arrested abroad on **9 January 2016** and extradited back to the UK in February 2016.

2.1.41 At the sentencing hearing, Dean's actions in the aftermath of the murders included cleaning and repainting in the house, texting Andrea's family from her phone to say she was going away for a few months, taking money from Andrea's account, and fleeing the UK to another country.

3. Overview

3.1 Summary of Information from Family and Friends about Andrea, Jordan and Sammy

3.1.1 The chair contacted Andrea's sister and brother, two cousins (Cousin Sarah and Cousin Catherine) and two friends (Friend Helena and Friend Amanda). Andrea's sister and Cousin Sarah were interviewed together, then reviewed and revised notes of the interview. Andrea's brother, Cousin Catherine and one of the friends were interviewed on the phone and reviewed the notes of the interview. Another friend from childhood responded saying she found thinking about the whole situation again was too distressing and so wrote an email to the chair with information that she thought was important.

3.1.2 **Andrea**

3.1.3 Andrea was part of a large extended family that lived close to each other in another part of London. The family background is West Indian, Jamaican and Indian. Her sister described it as a large matriarchal family with strong female presence and responsibility. The extended family were very involved and looked after each other's children, meaning the cousins were very close.

3.1.4 Andrea was the youngest of three children. Her family described her as vivacious, lively, outgoing, driven and determined. She had mapped out her future at a young age. She was sociable and very physically active. She swam, cycled, did yoga and spent hours at the gym daily.

3.1.5 A friend described Andrea as a very caring person and someone who worried about her friends. She was the sensible one, very tidy and never lied. Cousin Catherine described her as innocent and as someone who chose to see the good in people.

3.1.6 Several people described her as very intelligent and said she read a great deal. One said her sharp intelligence could be overshadowed by her other successes. Andrea was very successful as an actress and also was a BSL interpreter and translator.

3.1.7 Andrea came from a large family with many aunts, uncles and cousins living in the same area and closely involved in each other's lives. It was unusual for family members to move away from the area of London where many of the family lived.

3.1.8 The family report that Andrea was diagnosed and treated for anorexia as a teenager. She then became a vegetarian in the mid-1980s, and preferred organic foods from about 2007, before this was a common choice. This heightened focus on food is noted to understand how this was exploited by Dean later.

3.1.9 **Jordan and Sammy**

3.1.10 Jordan was born in hospital when Andrea was living at her mother's house. When Jordan was eight months old, Andrea moved to her flat from her mother's. The family then learned that Dean had been living there. Sammy was born at Andrea's flat in the summer of 2011 and shortly after that the family moved to Bexley.

3.1.11 One of Andrea's cousins said that Andrea was raising the children to be self-directed and to have their own voices.

3.1.12 Andrea's mother and others suggested that she take the children to the GP for regular checks, but Andrea said that they were healthy so there was no reason. Andrea's brother thought this was Dean's idea, not Andrea's.

3.1.13 Both children were described by the family as very articulate. Jordan was described as "happy, fun, bouncy and very bright." A friend said that Andrea did not talk "baby talk" to them, that she had an academic focus for the children and read to them a great deal. Andrea's brother said that as the children seemed happy, he did not challenge her decisions about their immunisations or home-educating. The family saw that Andrea made extra effort to take the children to visit cousins of similar ages so that they had interactions with their peers.

3.1.14 Dean provided the bulk of the childcare for the children while Andrea worked. He cooked the meals and took the lead in the children's education at home. The family thought he was fond of both children and had a special bond with Sammy.

3.1.15 *Schooling.* When Andrea took Jordan out of school, she told her family that she was doing it for financial reasons. The family thought the change was driven by Dean.

3.1.16 Members of the family identified that Dean's control had grown when Jordan was taken out of school. Friend Helena noted that Andrea herself had enjoyed school, so she was surprised when Andrea decided to home-school Jordan. Helena said that all their hearts sank.

3.1.17 *Control.* The family bought items for the children that were then taken from them or acquired by Dean, for example, Andrea's sister bought Jordan a table to do his schoolwork on, but Dean took it over. Dean said they could not have things they did not need. When Andrea's sister gave the children socks, Dean asked for the receipt so he could take them back as he thought the children did not need them.

3.1.18 Andrea's sister and cousin said that Jordan slept on a double mattress on the floor. Dean slept on a special large 'holistic' mat in the second bedroom. Dean said that this mat would be best for the children and Jordan then slept on one too. Andrea agreed to this because she wanted what was best for her children.

3.1.19 After Dean killed Andrea and the children, he cleared the house of their things. As a result, the family were deprived of the comfort of keepsakes.

3.1.20 *Caring responsibilities.* Friend Helena said that the children would dial the phone for Andrea. Family members understood that the children took a lot of the caring responsibilities for Andrea. Jordan provided intimate care for Andrea from the age of five or six.

3.1.21 *Immunising the children.* Friend Helena did not understand why Andrea and Dean did not immunise the children, but she also noted that there were a number of people in their peer group who were making the same decision at the time. Her sister and her mother both agreed with the decision not to immunise.

3.1.22 *The voice of the children.* As Jordan got older, he spoke a little about their home life. Cousin Catherine reported that Jordan said that he slept with his papa. He said that their room had to be very clean or his father would get angry. Jordan said that he thought this was "unreasonable" and used that term.

3.1.23 One time, Jordan said to Andrea's mother that, "My Papa doesn't like you," suggesting that Dean may have felt jealous of Andrea's relationship with her mother.

3.1.24 Jordan also said that his parents would "scream" at each other. The adults in the family did not press the children for more details because they did not want to put them in a difficult position.

3.1.25 Jordan once rang Andrea's mother and told her that his parents were arguing. Andrea was surprised he had done this (and seemed, to her family, secretly proud of his initiative in this case) but told him not to do it again. On another occasion, Jordan told them that he would bring Sammy to his grandmother's if his parents argued again.

3.1.26 **Andrea's family's understanding of Dean**

3.1.27 Andrea told her sister that Dean moved to this country to be reunited with his mother when he was young. When he was 16, Dean's mother said he was old enough to look after himself and she moved away. The family are not sure if this is true, but described it as an abandonment.

3.1.28 Andrea's family described Dean as "not very present" and said he did not attend the birth of Jordan. When Andrea and Dean first started seeing each other, Dean came to the regular family gatherings, but was very quiet. Though family members tried to engage him in conversation, he did not seem interested in joining in. He would make an appearance and then would slip into another room. He then stopped coming and her family felt they never got to know him.

3.1.29 Cousin Catherine described Dean as good-looking and eloquent. They later found that he had lied about aspects of his life, for instance, saying that his mother was

dead. When Andrea was registering Jordan's birth, Dean said that the name the family knew him by was not his real name. Her family say they are still not sure of his real name.

3.1.30 Andrea's family knew that Dean worked in the entertainment industry as a hair and make-up artist, but they also understood that he did not keep jobs. The family later learned that he was thought to be unreliable by employers. Andrea's family described Dean as a "drifter" and a "dreamer". Friend Helena described Dean as paranoid.

3.1.31 Dean was involved with the children and took them to acting and climbing classes.

3.1.32 Some family members say that they never saw the good times in the relationship between Andrea and Dean. Some described him as a "Jekyll and Hyde" character, able to be charming one minute and controlling the next. A friend described Dean as an abusive and unpleasant man but none of them thought he was a risk to Andrea and the children.

3.1.33 **The relationship between Andrea and Dean**

3.1.34 Andrea and Dean met in the late 1990s through work. She was in her early 20s at that time and lived in the family home. Dean and Andrea dated for a year and a half and then Dean went to live in France for eight years. Their relationship started again when he returned to the UK. They were dating for a few years and the family say they were a couple for at least 10 years before Dean killed Andrea, Jordan and Sammy.

3.1.35 At the beginning of the relationship, Andrea was in charge of everything. Her career was going well and she owned property. She was the breadwinner and was in love with Dean. Andrea said that Dean had had a difficult childhood and she wanted to show him what a strong family was like. She wanted to create a family that could mend the hurt Dean felt growing up. In the early days, when Andrea was in charge of everything, she did not seem to mind that others did not like Dean.

3.1.36 At the beginning, Dean and Andrea had shared interests. As she was in the public eye, appearance was important, and he was a hairdresser and managed her hair. Cousin Catherine recalls that he bleached it one time without damaging it and Andrea loved that. Andrea worked hard to stay fit and he became her trainer and they both cared about eating healthily. He encouraged the healthy eating and eventually took that over and made the rules around this.

3.1.37 Initially, Dean moved into a flat that Andrea had bought in order to rent out as a long-term investment.

3.1.38 Andrea got pregnant and Cousin Catherine said she was very upset about the pregnancy as she did not think Dean was good for Andrea. When Andrea moved from her mother's house into the flat with Dean eight months after Jordan was born,

she had not told the family she was intending to do this. After Jordan was born, Dean was rarely away for more than a few days at a time.

3.1.39 A friend said that Andrea and Dean did not do usual couple activities such as going to family gatherings or the cinema together.

3.1.40 Some of Andrea's family thought that Andrea eventually wanted to get out of the relationship but seemed trapped.

3.1.41 **Growing control**

3.1.42 *Isolation*. Andrea moved out of her family home and into the flat she owned after Jordan was born. She and Dean moved further away after the birth of Sammy. The second move was out of the area, making it was more difficult for Andrea's mother and others to visit.

3.1.43 Andrea had taken her mother shopping on Thursday or Friday afternoons, but this stopped when Andrea moved to Bexley. The change seemed to be only partially explained by her decreasing immobility.

3.1.44 Andrea told Cousin Catherine that she hoped to make her nuclear family stronger by having some distance from the rest of the family.

3.1.45 Andrea was embarrassed by the state of the house and therefore did not encourage visits from family and friends, or cancelled visits at the last minute. Towards the end of Andrea's life, Friend Helena noticed that Andrea was starting to distance herself. Helena knew then that something was very wrong because the women had known each other for a long time and their families knew each other.

3.1.46 The family's offers to look after the children or take them on outings were often declined.

3.1.47 When the family did visit their home, Dean would go into a back bedroom and stay there until the visitor left. On other occasions, Andrea would cancel planned visits at the last minute. When Cousin Catherine tried to point out ways that Dean was controlling her, Andrea would reply, "but why would he?" Dean would often deliver Andrea to her family home for visits, wait outside and then cut their visit short by arriving early to collect her and the children.

3.1.48 Cousin Catherine reported that when anyone challenged Dean, that person would be cut off from Andrea and the children. She said that one of the aunts once said to Dean that he was useless and did not deserve Andrea to which Dean replied, "I've got her now."

3.1.49 As a result of the family's concerns, an uncle went to the house eventually to talk to Dean. Dean shut the door in his face.

3.1.50 *Emotional control.* The family asked Andrea about those times when Jordan reported that she and Dean had "screamed" at each other. Andrea said that of course they argued from time to time and that Dean was structured and strict. This may have been an example of Andrea normalising those encounters.

3.1.51 Andrea's brother said that Dean had told Andrea that no one would want her and looked at Andrea as if she were pathetic.

3.1.52 *Controlling food*. Both Dean and Andrea were vegetarians and interested in healthy eating. Andrea used homeopathic remedies and Dean taught her more about that. At first, they made decisions about their diet together but eventually Dean took that over. Andrea's family feel that Dean took Andrea's natural interests and concerns and used them to control her and the children. The family say that Andrea found it difficult to accept advice from her family about these issues too.

3.1.53 Dean encouraged Andrea to get an allotment to grow their own food. When Dean lost interest, Andrea continued the work in the allotment on her own. Dean appropriated authority on these issues by claiming that he had researched issues of nutrition and imposed restrictions based on this research.

3.1.54 The "healthy eating" regime that Dean imposed limited broader family interactions. The plan prescribed that Andrea, Dean and the children did not eat processed or mass-produced food, and no cakes or biscuits for the children. The children ate pureed food and soups, and primarily a raw diet. They ate little hot food, as Dean preferred them to eat cold food.

3.1.55 Dean did not like the children to eat food cooked by the wider family. Sammy told them that Dean thought the family's food might not be good for them. When Andrea and the children visited her family, Dean would send food in Tupperware that he had prepared and divided into specific proportions. In response to Andrea's family's worry about Sammy choking on food because he had little experience chewing it, Dean started to provide hot food with solids.

3.1.56 Andrea's family of origin went to a Chinese buffet regularly together and Andrea and the children came to the meals. They eventually stopped eating the food at the restaurant. The family felt bad eating in front of them so the family stopped the outings to the Chinese buffet with Andrea and the children.

3.1.57 This behaviour around food was particularly strange to Andrea's family as they described being "spoiled" a bit regarding food in that their mother cooked what each one of them liked and the family always ate together around the dinner table.

3.1.58 Andrea's brother recalls Andrea visiting the family home and hesitating overeating a biscuit, saying, "if Dean finds out . . ." Andrea then hid the biscuit and ate it secretly. Friend Helena also talked about Andrea guiltily eating biscuits at her mother's house.

3.1.59 *Economic impact.* Andrea was the breadwinner from her self-employed work. Dean was financially dependent on Andrea, though he appeared to have work occasionally.

3.1.60 Andrea's family saw that her career suffered after she met Dean. She appeared to purposely fail some big auditions and did not accept other jobs because Dean did not want to move nearer the work and discouraged her from travelling for work. Dean did not like her to be away for the hours that the jobs required. Friend Helena said that Andrea's work required that she socialise, but that made Dean jealous, so Andrea stopped the work socialising and started doing voice-overs.

3.1.61 Dean would not let Andrea's family into the house to help them fix it up and declined their offers to help purchase furniture. He said that he wanted to do it himself, but the family say he then did nothing. Dean did not accept the offer of the white goods that were already in the house from the previous owners – so they did not have a fridge/freezer or a cooker. They took down the previous curtains but could not afford replacements, so used black bin liners as curtains. Dean said they could not have a sofa because it would "harm the underfloor heating".

3.1.62 Towards the end of her life, Andrea told Cousin Catherine that the house they lived in had lost considerable value. When asked how she knew this, Andrea said that Dean had looked it up and told her this. Cousin Catherine said that Andrea previously would have researched this for herself, but by then she took Dean's word for things.

3.1.63 *Physical harm.* Some members of Andrea's family do not believe that, until he killed her, Dean had physically abused Andrea during their relationship. They said Andrea once had a cut lip that she said resulted when she had slipped, and they had accepted that explanation. Her family provided physical care for Andrea when she visited and reported that, apart from that cut lip, they did not see any bruises, cuts or other indications of physical harm. They described the relationship as "up and down".

3.1.64 About a year or so before Andrea was killed, Andrea told Cousin Catherine that she did not want to talk to her via the usual video-calling app as she had "fallen". Cousin Catherine asked if Dean had hit her. Andrea said it was nothing like that. But when Cousin Catherine pressed, Andrea said, "You know what I am telling you", and Cousin Catherine understood from this that Dean was nearby and Andrea was confirming that he had hit her.

3.1.65 *Demeaning Andrea.* Though Andrea was already a successful actress when they met, Dean demeaned her by saying "all actresses are prostitutes".

3.1.66 *Effects of coercive control.* The family did see that Dean was controlling Andrea, though the family did not know the term coercive control so they did not identify it as such or link Dean's control to domestic abuse.

3.1.67 The family say that Andrea changed from an outgoing, warm and happy personality to a quiet, monosyllabic one. The family said she became a “completely different person”. They saw that she had lost weight and was physically unwell.

3.1.68 Eventually Andrea just focused on the world inside her home. She lost contact with friends, did not use social media or email. When she was feeling well, she would take the children to the local shops or park.

3.1.69 Andrea said to Cousin Catherine in the spring of 2015, “Look what I’ve become.” Andrea knew that her appearance and health were declining, her confidence and morale low. Her sister thought that Andrea was worn down by the demands of the relationship. This is a common result of suffering coercive control, but this was no doubt compounded and perhaps disguised by her increasing disability.

3.1.70 **Impact of Andrea’s deteriorating health**

3.1.71 Andrea had stopped working as a BSL interpreter when her hands became too weak and she was unable to sign properly. Her family thought this was about 18 months to two years before she was killed.

3.1.72 In discussions with Andrea’s family and friends, it is apparent that Andrea’s declining health and strength created additional strains on relationships. When Andrea became ill, she was able to do less and Dean needed to do more. Friend Amanda said that Dean was doing everything for her, though others said that Dean would not help Andrea. Friend Helena said that Dean would not help Andrea as she became weaker, that he would not help her eat or get in and out of the bath. Eventually, Andrea could do very little for herself and needed to be washed, fed and dressed. Family say that Dean would not lift anything for her and rarely drove her to her family or the supermarket when she was no longer able to drive.

3.1.73 Family said that Jordan, only 7 at the time, helped Andrea get in and out of the car and helped her dress. He provided a lot of care for her, including intimate care such as changing her sanitary towels.

3.1.74 Andrea’s sister said that she went with Andrea to her first appointment at KCH, but after that Dean would drop her off at the appointments and wait with the children in the car. She thought that they arranged transport for her sometimes too.

3.1.75 Cousin Catherine said that Dean had allowed Andrea’s hair to become matted and look unkempt when the strength in Andrea’s arms meant she was no longer able to manage it. Andrea’s sister said that then Dean cut Andrea’s hair very short which horrified the family. Andrea said that he had done this as she could not manage her hair, though some thought this drastic change to her appearance was an example of his control.

3.1.76 Cousin Catherine said that though she did not engage with Dean, she could see that he was deteriorating physically. She talked to Andrea about this and also that Dean reminded the cousin of a narcissistic and maniacal character from a film they both knew. Andrea said she could see why the cousin made those comparisons.

3.1.77 Regarding the impact of his caring for her, Andrea told Friend Amanda that "he has changed, you wouldn't recognise him. He is thin and stressed." The friend said that the situation changed him. Friend Amanda felt that the stress on Dean of caring for Andrea was a significant factor in her death. (This is returned to below.)

3.1.78 Andrea asked her family if she came back to live in the family home whether they would put her in a nursing home as her health deteriorated. She was reassured when they said that they would not, and the conversation suggested to the family that Dean may have said that he would.

3.1.79 **Family and friends' views on what might have helped?**

(a) More information in the local community saying that controlling behaviour is domestic abuse and a criminal offence. They did not identify or understand Dean's control as domestic abuse.

(b) More outreach services for Andrea to access.

(c) Oversight of carers, as those being cared for are very dependent and therefore vulnerable and carers can become very stressed

(d) Some outside oversight of the children might have made the situation at home more visible to the authorities. As the children were being home-educated, they were not seen regularly by anyone outside the household. One family member suggested that home-educating itself should be a flag for further investigation of a child's home situation and random checks after that. Friend Helena said that though she was worried, she did not know how to flag those concerns with the authorities.

(e) The health services might have asked more questions about what was happening for Andrea, especially when she missed the OT appointments.

(f) Friend Helena thought that Andrea would not have identified her situation as domestic abuse as there is a stigma about that term. The friend suggested that Andrea might have identified with help that was for "controlling relationships".

(g) Friend Amanda suggested that when someone is hugely dependent on a spouse or partner, that the mental health and attitude of the partner should be looked at as the dependent person is very vulnerable and the carer could become resentful and angry.

3.1.80 It is important to the family that the lessons from this review are learned and they have asked to be kept up-to-date on the completion of the action plan that results from this review.

3.1.81 **Recommendation: Bexley Community Safety Partnership to provide regular updates to Andrea's family on the completion of this review's action plan.**

3.2 Summary of Information about the Perpetrator

3.2.1 Dean was a 48-year-old Black heterosexual male when he killed Andrea and their children. He had no disability, and his nationality is uncertain but her family understood that he had the right to remain in the UK. He had a previous conviction for cannabis. The following information was taken from the post-sentence report by Dean's offender manager (OM). As Dean declined to talk to the OM, the OM's report was based on psychological reports prepared for his criminal trial.

3.2.2 Dean was born in West Africa. His mother moved to the UK and he stayed in West Africa and lived with his grandmother until the age of 4. He then lived with his aunt and uncle until he was 8 when he was taken to London to meet and live with his mother. He described his separation from his carers in West Africa as "very traumatic".[7]

3.2.3 As a result, Dean said he "shut down" and repressed his memories of his life in West Africa. He communicated little with his mother, blaming her for taking him from his family in West Africa. When Dean was 17, his mother moved out to live with a new partner, leaving Dean at their home alone. Dean has a half-sister with whom he is now in touch.

3.2.4 Dean had a relationship with a woman when he was 18 and they had two children in quick succession. He left that relationship when he was 22 and has not had contact with them for 20 years. Dean said that the relationship ended because her religion [unspecified] was causing stress and that she was "fraternising" with men. Dean said he could be possessive in relationships, that he "gives his all and expects the same from his partners".

3.2.5 Dean met Andrea when he was in his mid-thirties, and they had a brief relationship. He then had a relationship with another woman abroad and fathered another child with her. He returned to the UK in 2005 and resumed his relationship with Andrea. They had two children, Jordan, and four years later, Sammy.

[7] From the learning review, p. 4.

3.2.6 Dean described to the psychiatrist that he saw his fathering role with Jordan and Sammy as being a “buffer between his children and the world” which he saw as a dangerous place. Jordan initially went to a school but was then removed and the children were home-educated.

3.2.7 Andrea’s family understood from the police that Dean may have grown or intended to grow marijuana in the house, but Andrea’s sister said that they did not think that this activity had any impact on the situation.

3.2.8 Dean said that he was Andrea’s main carer. He expressed “a great deal of hatred” about Andrea’s family. Dean denied controlling his family.

3.2.9 In explaining his killing of Andrea and the children, Dean told the psychiatrist that it was the result of a suicide pact, that “we were a unit, if one were to go, we were all to go”. He said that he and Andrea agreed that they did not want to leave the children with her family. He also said that he had no memory of the murders.

3.2.10 After the offence, Dean took money from Andrea’s bank account and fled to the country in West Africa where he had grown up. He was located and brought back to stand trial.

3.2.11 The psychiatrist who prepared a report for the court, concluded that Dean showed features that are consistent with a narcissistic personality structure. The judge quoted it in his summing up: “Features in this Defendant of a narcissistic personality, which affect about one per cent of the population, include a grandiose sense of self-importance, requiring excessive admiration, has a sense of entitlement, is interpersonally exploitative, puts his own needs over those of others, lacks empathy and shows arrogant, haughty behaviours or attitudes.”

3.2.12 Andrea’s family say that he seemed secretive about his past and disclosed little.

3.3 Summary of Information known to the Agencies and Professionals Involved

3.3.1 **Dartford and Gravesham NHS Foundation Trust**

3.3.2 The contact with Andrea was through the Darent Valley Hospital (DVH), in particular their A&E and outpatient departments. She was seen five times, twice in A&E and three times in outpatient clinics. The A&E records were paper notes and do not document the attendances in full.

3.3.3 Darent Valley Hospital is an acute district general hospital. Only Andrea was known to DVH.

3.3.4 Andrea attended the A&E of DVH on the evening of 9 August 2014 with pain in her left shoulder and weakness in her left arm. Tests showed some early degenerative changes in her spine and suggested Andrea might have a disorder involving the ulnar

nerve entrapment causing numbness and tingling. The plan was for a wrist splint. A discharge letter was sent to her GP noting this and asking that the GP refer Andrea for physiotherapy, nerve conduction studies and an MRI scan. A referral to a neurologist was suggested.

3.3.5 Andrea returned on 1 September 2014 with pain in the muscle of her upper left arm. She said she had had the pain for a few weeks and there was no trauma. She did not want pain relief, but did want an x-ray, though there is no record that this was done.

3.3.6 The neurologist at DVH received a letter from Andrea's GP asking that she be seen early as the problem with her arm was affecting her quality of life and causing her problems at work.

3.3.7 At Andrea's neurology outpatient appointment at DVH on 11 November 2014, there was evidence of damage to the nerves outside of the brain and spinal cord and motor problems affecting both arms. Andrea had lost her fine motor skills and could no longer fasten buttons or zips. The DVH neurologist sent a letter to the GP that noted that the weakness in her hands was affecting her work. The letter also said that she lived with her two children and was managing the activities of her daily life. A referral letter was also sent to the neurologist at King's College Hospital requesting nerve conduction studies and an EMG.

3.3.8 Tests in December 2014 showed evidence of axonal neuropathy predominantly affected the upper limbs bilaterally. And mild degenerative changes in her spine. After these results were discussed with Andrea, a letter was sent to her GP regarding these tests.

3.3.9 She attended the lumbar puncture clinic in February 2015 where her progress was reviewed, and Andrea reported an improvement in the strength in her arms and some weight gain. Tests supported this, showing a 40% improvement in her strength.

3.3.10 The DVH neurologist sent a letter to the consultant neurologist at King's referring Andrea to the peripheral nerve clinic. It noted the profound functional impairment that resulted from the upper limb weakness she had on both sides. The letter noted other pre-existing and unrelated conditions.

3.3.11 At Andrea's final clinic attendance at DVH, the diagnosis was progressive motor neuropathy. She was then under the care of King's neurologist and had received a course of IVIG. Her strength continued to deteriorate, but Andrea noticed some improvement since the IVIG treatments. The family history of MND was noted.

3.3.12 **Kings College Hospital NHS Foundation Trust (KCH)**

3.3.13 KCH provides a full range of local hospital services for people in the London boroughs of Lambeth, Southward, Lewisham and Bromley as well as specialist services for patients across the South East and beyond.

3.3.14 Andrea was referred to the Neurology Department at KCH by Darent Valley Hospital in the autumn of 2014.

3.3.15 Andrea was seen by the consultant neurologist three times, in June, October and then on 11 December 2015. At the first visit she attended with her sister and at the second and third visits she attended alone. Between the visits, she had two rounds of treatment for chronic inflammatory demyelinating polyradiculoneuropathy (CIDP), which is a treatable inflammatory nerve condition, and a repeat EMG in order to assess the impact of the treatment. The IMR writer could not access records relating to this intervention as they were marked as a "Clinical Research episode". There is a recommendation about this classification of records.

3.3.16 ***Recommendation for King's Hospital NHS Foundation Trust****: King's College Hospital to ensure that episodes of care involving IVIG/Clinical research are recorded and accessible to other professionals.*

3.3.17 By the second meeting, which Andrea attended alone, it was clear that the treatments had not improved Andrea's condition and her health had continued to worsen. Andrea was told that the diagnosis was likely motor neurone disease which she had some knowledge of as she said that her uncle had had MND.

3.3.18 At the third meeting on 11 December 2015, the consultant told Andrea that the diagnosis was definitely MND and not CIDP. The consultant noted that she was distressed, and Andrea admitted to getting quite depressed. The consultant started her on medication to slow the progress of the disease and referred her to the Motor Nerve Clinic, the regional specialist service, on 14 December 2015. The neurologist reported that he did not ask about her personal and family circumstances as he was focussed on the diagnosis and arranging tests and treatments.

3.3.19 The consultant neurologist described her physical situation: her arms hung loose at her side and she could hardly make any movements at all of her fingers and hands, and she was unable to grip anything properly. She could walk unaided but her walking was slow, unsteady and weak. The neurologist noted that Andrea would not have been able to defend herself against a violent attack.

3.3.20 **Oxleas NHS Foundation Trust – Health Visiting and Occupational Therapy**

3.3.21 Oxleas NHS Foundation Trust provide a health and social care services in South East London, specialising in community health, mental health and learning disability services. At the time in question, Oxleas provided universal services for those from 0-

19 in age and therefore the health visiting, school nursing, and specialist children's services and Children and Adolescent Mental Health Service (CAMHS).

3.3.22 Health Visiting. Andrea, Jordan and Sammy were seen at their home in Bexley by the HV service in November 2011. Between November 2011 and May 2014, the HV service had four contacts with the family: one telephone contact and three face-to-face contacts. The first meeting was in November 2011 with a "removal in" visit. This is a standard visit when "families that are new to the local area and who have a child under one year should be contacted to complete family health assessment, introduce local services, enquire about family network and to invite the family to the Child Health Clinic."[8]

3.3.23 During this first visit, the HV completed the family health assessment and learned from Andrea that Dean lived in France and that he visited frequently and for months at a time. He was helping to decorate and upgrade the house they lived in and had recently bought.

3.3.24 Andrea told the HV that she spent the days at her mother's home while Jordan attended the nursery at the Steiner School. Andrea was a sign language teacher and most of her clients lived in Greenwich. She said that she had a good relationship with her mother who supported her.

3.3.25 The children were seen, and Jordan was noted as attending a private nursery in another part of London where they had previously lived. The HV noted that Andrea had not had the children immunised and declined to do so, preferring homeopathic medicine instead.

3.3.26 No questions were asked about domestic abuse and Andrea described Dean as being supportive of her. Since 2015, HV practice has been improved and now questions about domestic abuse are routinely asked during these initial assessments.

3.3.27 In April 2012, Sammy had a repeat hearing test by an audiologist -- this was recommended at eight months due to wider family history. There were no problems detected.

3.3.28 There was a scheduled developmental review of Sammy in May 2012. This meeting was at a local Children's Centre. The health review was satisfactory, and Andrea was advised to take Sammy to the GP for follow-up as necessary.

3.3.29 The last contact the HV had with the family was in March 2014 for Sammy's 2-year health review. The HV visited the family home and there were no concerns identified and it was noted that Sammy was meeting his development milestones.

[8] Definition from the Oxleas NHS Foundation Trust IMR for this DHR.

3.3.30 At this last meeting, Andrea told the HV that she planned to send Jordan to the Steiner School in Greenwich as she liked their ethos of learning through play and there was no place for him at the local school. The HV said that Jordan was a delightful child and was relaxed in his mother's company.

3.3.31 Occupational Therapy (OT). Andrea was referred for OT following the A&E attendance at DVH in August 2014 regarding the functioning of her left hand and the progressive muscle weakness. Andrea said on this occasion that she had had the symptoms for the previous 12 weeks. (At other appointments, she dated the beginning of her symptoms to September 2013).

3.3.32 Andrea had one face-to-face appointment in October 2014. The OT made an initial assessment and identified significant neurological deficit affecting both hands. During this appointment, Andrea said that her symptoms were affecting her everyday life as she had no power in either hand. The OT noted that Andrea was tearful and "fearing the worst", being particularly concerned about her two children.

3.3.33 Andrea said that she was waiting for the MRI results and an appointment to confirm the diagnosis and prognosis. The OT gave her some gentle exercises to do while she waited.

3.3.34 Andrea rang to re-schedule the follow-up appointment, and then rang to re-schedule that appointment. The first appointment clashed with another hospital appointment and Andrea said that she was awaiting a nerve conduction test at KCH at the time of the second cancelled appointment. She was advised that she would be discharged as she did not have a specific date for the tests but could be re-referred.

3.3.35 **Education**

3.3.36 Greenwich Steiner School. Jordan went to the Greenwich Steiner School (GSS) from 17 January 2012 to 14 December 2012. After that, Jordan was home schooled.

3.3.37 GSS did not know why Andrea withdrew Jordan, though they thought the fees might have been a problem. The school felt that Jordan's father did not approve of Jordan attending the school. Jordan's father did not attend many events at the school and Jordan never mentioned their father. The school noted that Jordan was well-supported by their mother and that both children "were lovely". The school had no concerns about the children.

3.3.38 By chance, a school staff member saw Andrea in the park after Jordan left the school and said that Andrea was in good health and the children were fine.

3.3.39 Jordan and Sammy were on the waiting list to return to GSS. The headteacher rang Andrea on 11 December 2015 to tell her that Sammy and Jordan could start at the school at Easter of 2016.

3.3.40 Home-educating

3.3.41 The GSS did not inform the local authority that Andrea was home-educating Jordan. They report that there was some confusion at this time at what age a child should be when referring to the local authority about home-educating. The correct referral procedure to refer to the child's local authority when parents are home-educating is now in place at the GSS.

3.3.42 **GPs for family**

3.3.43 Dean was registered at a GP surgery in another area but there was no information in that system as he had not attended since 2006 when he registered.

3.3.44 The GP IMR notes that the children were rarely seen at the GP surgery. Routine enquiry was not standard practice at the time. See information below about training since this case.

3.3.45 Andrea was seen at the practice nine times between registering at the practice and her death. Four times were for muscle weakness of varying kinds, and the others were for blood tests, hypothyroidism, and ordinary medical issues. Jordan was not seen in the surgery after being registered there. Sammy was seen once for an earache and no concerns were raised when he was discussed as part of a routine process at the health visitors' safeguarding meeting.

3.3.46 The health visitor safeguarding meetings are the only routine meeting between the GPs and the health visitors. Children of concern are discussed, including specific safeguarding issues. Also discussed are children's health issues – such as the immunisation status if these are not complete – regardless of whether there was a safeguarding issue. Andrea said that she did not want the children immunised, that she preferred homeopathic remedies.

3.3.47 The GP had a letter from the DVH neurologist in November 2014 saying that Andrea had lost her fine motor skills but was managing her daily life that included two small children.

3.4 Any other Relevant Facts or Information

3.4.1 **Motor Neurone Disease**

3.4.2 From the Marie Curie website: "Motor neurone disease (MND) is a life-limiting, rapidly-progressing disease that affects the brain and spinal cord. MND attacks the nerves that control movement so muscles no longer work. It does not usually affect senses, for example sight, sound and touch.

3.4.3 There is no cure for MND, but there are interventions such as non-invasive ventilation and gastrostomy that can help manage symptoms. A third of people with MND die within a year of diagnosis, and more than half die within two years."[9]

3.4.4 The Clinical Nurse Specialist (CNS) at KCH MN Clinic explained that the diagnosis of MND is a differential diagnosis, that is, that there are a number of conditions that could give rise to the symptoms seen and so the doctors eliminate other possibilities before arriving at a final diagnosis. There is no single diagnostic test. The CNS said that once a diagnosis of MND is arrived at and the patient is referred to the clinic, more in-depth and tailored support is offered. The referral does not come with information about the patient's wider life.

3.4.5 The clinic has a multi-disciplinary team. A new patient is typically offered their first appointment there four to six weeks after the referral. This first clinic appointment is a long meeting with a specialist consultant. The second appointment, about four weeks later, is with the CNS and lasts about an hour. At this second appointment, CNS discusses the patient's concerns about their diagnosis and condition. The clinic aims for a bespoke approach and the CNS offers the wider support, which can include networks for support, work with therapists, equipment such as wheelchairs, and access to palliative care counsellors. KCH's MN Clinic is a national centre. For some patients, local services are more convenient and so GPs usually make the connections to local services.

3.4.6 The CNS said that the patient's family and wider network are crucial to the care of patients with MND. Their practice is to separate patients and their supporters for some of these conversations so that the patient can speak candidly. The CNS says that, given the progressive nature of the disease, they take a pragmatic approach which is sensitive to the situation, but honest too. They are used to difficult conversations.

[9] Sourced from https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/condition-specific-short-guides/motor-neurone-disease. [Accessed 26 February 2020].

4. Analysis

4.1 Domestic abuse, Andrea and the children

4.1.1 No information was shared with the local domestic abuse service about this family.

4.1.2 **Power and control wheel**

4.1.3 What is often misunderstood is that, "Significant harm is associated with coercive control, irrespective of whether it accompanies physical violence, and its role as a precursor and/or a correlate to further serious harm and homicide is undeniable."[10]

4.1.4 Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in intimate or familial relationships. The Government definition of controlling behaviour is "A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for person gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour."[11]

4.1.5 The Duluth Power and Control wheel was designed by the Duluth Domestic Abuse Intervention Program in 1984 to capture the common experiences of women who have been victims of domestic abuse. (See Appendix 3.) It provides useful headings to describe Dean's abuse of Andrea, as described by Andrea's family and friends.

4.1.6 The wheel shows the various ways that power and control are maintained in an abusive relationship and the physical and sexual violence often used to maintain the daily control in little things.

4.1.7 <u>Using coercion and threats</u>

4.1.8 When Andrea spoke to her mother and sister on 13 December 2015 about her deteriorating health, she asked if her family intended to put her in a home. The family understood from this that Dean had suggested this. Her family reassured Andrea that they would not do that.

4.1.9 <u>Intimidation</u>

4.1.10 Andrea's family and friends did not describe Dean explicitly intimidating Andrea. A friend described her as "cautious" around Dean which suggests that she was managing his reactions by controlling her own actions. Jordan spoke of them

[10] Robinson, Amanda L., Myhill, Andy, Wire, Julia, "Practitioner (mis)understandings of coercive control in England and Wales" *Criminology & Criminal Justice 2018*, Vol 18(1) 29-49 Sage Journals at https://journals.sagepub.com/doi/pdf/10.1177/1748895817728381 [Accessed on 16 March 2020]. Robinson cites (Dobash and Dobash, 2015; Home Office, 2014;, Monckton Smith et al, 2014; Myhill, 2015).

[11] Home Office [2015] *Controlling or Coercive Behaviour in an Intimate or Family Relationship, Statutory Guidance Framework.*

screaming at each other. Given Andrea's waning strength, such arguments could have been intimidating. When she was asked about it by her family, she brushed it off saying that couples argue. She may have been normalising Dean's controlling behaviour.

4.1.11 Using emotional abuse

4.1.12 Dean demeaned Andrea and her choice of work by describing all actresses as prostitutes. Andrea said that he did not want her to continue to do that sort of work.

4.1.13 Andrea told friends that Dean was jealous and obsessive, was critical of her, undermining her and being derogatory. Andrea told some family and friends of serious emotional abuse and denigration.

4.1.14 Dean, who was a hairdresser, cut Andrea's hair short when she no longer had the strength in her arms to manage it. The family report that just before a family funeral at which Andrea delivered the eulogy, Dean "butchered" her hair so that when she stood up in front of her family and friends, she was mortified.

4.1.15 Dean also allowed or required Jordan to provide intimate care for his mother, despite his young age. This was likely to have been humiliating for Andrea and emotionally abusive for Jordan.

4.1.16 Friend Helena said that she became worried over the last two or three years of Andrea's life that she was heading to a mental health breakdown.

4.1.17 Dean's controlling behaviour extended to her family. When Andrea talked to them on speakerphone, Dean would listen, so they had no privacy. After he had killed Andrea and the children, Dean sent texts from Andrea's phone to her family, thereby leading them to hope that she was okay and extending their anxiety and worry. Those texts said that the family was being overbearing. Dean also told the police that Andrea had gone to stay with friends to get away from her family. These actions showed his efforts to alienate Andrea and her family, even after her death.

4.1.18 Dean hid the bodies, which also extended the hope and anxiety of the family. When arrested, he said that he and Andrea had had a suicide pact that he had failed to complete. Again, these actions continued the emotional abuse of her family.

4.1.19 Using isolation

4.1.20 Dean encouraged the move further away from Andrea's family. He controlled what she did, who she saw and spoke to and limited her outside involvement. A risk factor for domestic abuse is pregnancy and having a very young child. After each child was born, Andrea moved further away from her family. As noted above, this was unusual for their family and interfered with Andrea's regular shopping trips with her mother. Andrea said that the move to Bexley might help strengthen her nuclear family.

4.1.21 Dean declined Andrea's family and friends' offers of time, skill and money to fix up their house. By declining this help, and not improving the house himself, Dean added to Andrea's isolation as she was embarrassed about the state of the house. Eventually, she was in touch with only two of her long-term friends.

4.1.22 Andrea had a pattern of visiting her mother's every other weekend and staying overnight. She would also drop in if she were working in the area. Her family said that they had some qualms about her driving when she lost strength in her arms. But Andrea was insistent. It may be that driving gave her some independence and time away from Dean's control.

4.1.23 As her strength deteriorated, she became reliant on Dean to drive her which he was reluctant to do. The family report that when Dean was driving, the overnight stays stopped, and the visits were shorter as Dean would drop them off and then hang about nearby and often returned earlier than planned to pick them up and take them away. He would not come into the house. The family said that it appeared that Dean was jealous of Andrea's relationship with her family.

4.1.24 The removal of Jordan from his school may have been part of an effort to keep the family isolated and to reduce information about their lives reaching outside agencies or people. It may not be a coincidence that part of Andrea's plan for the future included moving back to her mother's, leaving Dean, and sending Jordan and Sammy back to Greenwich Steiner School.

4.1.25 Andrea's family and friends said that Andrea was keenly interested in exercise and healthy food choices, and that she was anorexic when younger. There are conditions similar to anorexia that include the compulsion to excessive exercise and an eating disorder that is characterised by a fixation on eating only "healthy" foods. Efforts to maintain a healthy eating regime can be described as a neurosis where the healthy choices require strict adherence to the rules about what can be eaten, where adherence to those rules causes isolation and interferes with relationships, and where adhering to the rules actually undermines health.[12] Andrea's family report stories suggesting all of these. Whether or not Andrea suffered these other disorders, these behaviours suggest a vulnerability around her eating that appear to have been exploited by Dean to develop more extreme rules around eating which increased the isolation.

4.1.26 Another way that their life was isolated was that they did not go to the GP often, preferring to use homeopathy instead and homemade remedies researched and made by Dean. This led to members of the family thinking he might be poisoning

[12] From www.understandingnutrition.com/items/handout-from-eating-disorders-bootcamp-understanding-orthorexia-positive-vs-pathological-nutrition . {Accessed 12 September 2020]

Andrea as her health declined. Some wondered if he wanted to make her ill in order to make her better to ensure her dependence on him.

4.1.27 Minimising, denying and blaming

4.1.28 Friend Helena said that Dean made Andrea feel guilty. She said that as Andrea had not had a serious relationship before him, his words had extra power.

4.1.29 Later, when she needed more physical help, Dean minimised this need by telling her she needed to do things for herself, as if she were somehow shirking. He may also have been minimising his actions towards her and his neglect of her needs.

4.1.30 Using the children

4.1.31 Jordan told Andrea's family on one occasion that Andrea and Dean had argued and Andrea had asked her mother not to call Social Services.

4.1.32 Andrea said that they had talked about separating and Dean said, if she left and took the children, he would never see her or the children again. He had said that she could go back and live with her mother, but she could not take the children. He had also talked about taking the children to live abroad. It appears that he had talked to Jordan about this as Jordan was excited about the possibility of living in Africa with Dean.

4.1.33 Using male privilege

4.1.34 "Using male privilege" refers to behaviour where the man is enforcing traditional gender roles, such as that the "man of the house" makes the rules and all the important decisions, and the rest of the family should follow. The World Health Organisation provided a briefing on changing cultural and social norms that support violence in 2009[13]. It identifies countries were traditional beliefs include that men have a right to control or discipline women through physical means and includes Dean's country of origin. This cultural understanding needs to be addressed in the awareness raising around coercive control. There is a national and local recommendation regarding this.

4.1.35 Andrea told her family that Dean decided what clothes she and the children could have and could wear. He decided what they could eat.

4.1.36 One family member felt that Dean's denigration of Andrea's job in entertainment was evidence of his bitterness that a woman would have a role superior to his.

4.1.37 Dean was very negative about his own mother. When describing the breakdown of a previous relationship, Dean said that his previous partner was "fraternising" with other

[13] World Health Organisation (2009) "Changing cultural and social norms supportive of violence behaviour". (Switzerland: WHO Press), p.5.

men and that her religion had caused stress. We know little about those previous relationships, but what we know suggests a sense of male privilege and perhaps misogyny that pre-date his relationship with Andrea.

4.1.38 Using economic abuse

4.1.39 Dean often interfered with Andrea getting or keeping a job. He did not want her to work in the evenings and he did not want her to work far away, even when she offered to move the family to be nearer during the course of the work. As Andrea was the main breadwinner, this reduction in work put the family under strain financially. Cousin Catherine said that he seemed to enjoy this change.

4.1.40 As noted above (in 3.1.61), Dean would not allow spending on the house by others and would not accept their help to improve the condition of the house. This appeared to stop Andrea inviting friends and family to the house as she seemed embarrassed by the state of it. This added to her isolation. Also, over time, this reduced the value of the property and therefore her assets, and would have reduced her options.

4.1.41 Dean's returning gifts from Andrea's family would have reinforced to Andrea and the children that he was in control of their relationships with others and their environment. His reasoning that these gifts were not items they needed would have also signalled his dominance and control.

4.1.42 When the family had suggested that Andrea leave, Andrea said that she could not take the children and the house from Dean. She said she needed to provide support for Dean. She felt her economic responsibilities for the family required her to stay.

4.1.43 Dean's constraints on Andrea's work that reduced her ability to earn and increased the financial pressure on her simultaneously, the decision to home-school that took her time, the control over how money was spent so that she was isolated through embarrassment – this economic abuse acted with the other types of abuse to reduce Andrea's independence, her agency and her options, while increasing the weight of her responsibilities.

4.1.44 Risk factors

4.1.45 There are a number of risk factors in this situation that the family have identified. But there are risk factors that we do not have information on. In Bexley, when a victim is identified as high risk, they are referred to a Multi-agency Risk Assessment Conference (MARAC), to share information and to plan actions jointly to address the risks identified. The response to those at medium risk varies from area to area. The Bexley response is returned to below.

4.1.46 Retrospectively, the risks in this situation that can be identified retrospectively, are:

(a) *Isolation* – moving away from Andrea's family and friends. The children were being home-educated and rarely had contact with people outside the family.

Andrea eventually stopped going out with her friends and went less often to her mother's.

(b) *Depression* – Andrea told professionals that she was quite depressed. This was understood as being a normal response to her diagnosis.

(c) *Separation* – Study after study has shown separation is the time of greatest risk for a victim.[14] "…abusers are often dysfunctional and unable to handle rejection. They are frequently on a psychotic or psychopathic spectrum and in need of support or control themselves."[15]

The last time they saw her, Andrea had talked to her family about leaving Dean and moving back into her mother's home.

(d) *Conflict over child contact* – Dean had said he would never see her and the children again if she left. He had talked about taking the children to live abroad.

(e) *Constantly texting, calling, contacting, following, stalking or harassing* – Dean's monitoring and surveillance did not have to be so overt. A cousin said that Dean had created Andrea's email and its password, and she had to ask him to open her email for her.

(f) *Controlling everything she does and/or is excessively jealous* – Andrea took phone calls on speakerphone which allowed Dean to monitor phone calls. The family also report that phone conversations were recorded so Dean could listen to them later. He controlled the food the family ate, even when he was not with them. There is evidence that the likelihood of serious harm and homicide rises in cases where such coercive control exists.[16] Andrea eventually moved to doing jobs that reduced her contact with other people as that was Dean's preference.

(g) *Escalation* – Andrea's family thought that her increasing dependency increased Dean's opportunity for control. The academic[17] the chair spoke to hypothesises that a change dependency intensifies the dynamic in an abusive relationship.

(h) *Financial issues* – Dean was dependent on Andrea. Andrea had said that she was not ready to leave Dean as she wanted to work and make the family more financially secure before separating.

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[14] From full DASH RIC guidance that cites Websdale N (1999) Understanding Domestic Homicide Boston: Northeastern University Press and Regan, L., Kelly, L., Morris, A., and Dibb, R. (2007) '*If only we'd known*': *an exploratory study of seven intimate partner homicides in Engleshire*. London: Child and Woman Abuse Studies Unit at London Metropolitan University.

[15] Reference to Brown et al 2013 in Monckton Smith, J., and William, A., with Mullane, F. (2014) *Domestic Abuse, Homicide and Gender: Strategies for Policy and Practice*, Basingstoke: Palgrave McMillan.

[16] Campbell, et al, 2003, Stark, 2007, Dobash and Dobash, 2015, and Myhill, 2015.

[17] Julie McGarry, as noted at 1.5.12(d)

(i) *Problems with drugs that led to problems leading a normal life* – there is some evidence of Dean growing or preparing to grow cannabis, but we do not have definitive information to establish if this was the case. Family and friends did not identify that this was a concern and never smelled cannabis when with them.

(j) *Fear* – A central risk factor in situations of domestic abuse and violence is fear. Some of Andrea's family thought that she seemed frightened of Dean. She would generally do as he said. He would ring Andrea while she was visiting her family and pressure her to leave. When he returned to collect her, even if it was before the arranged time, she would end her visit.

Others did not think that Andrea feared Dean, though some reported that Andrea would cry when Dean yelled at her. Friend Helena described Andrea as being "cautious with Dean". Andrea did say to friends, "no one knows what I am going through". Fear develops over time in an abusive relationship and Andrea may not have yet characterised her feeling as fear. Victims of abuse often describe their lives as "walking on eggshells".[18]

4.1.47 With these risk factors, Andrea may have initially been assessed as at medium risk of serious harm if she had spoken to an IDVA.[19] As she was about to separate from her partner, take the children and, likely, sell the house, Dean's control was being challenged and, likely, about to end. The children were very young, and Andrea was increasingly debilitated, making her more vulnerable. As a consequence, an IDVA would likely have used their professional judgement to upgrade the risk here to high risk. An assessment of 'high risk' would have led to a referral to the MARAC where some of the other issues would likely have come up.

4.1.48 Stages in domestic homicides

4.1.49 Research by Monckton Smith in 2019[20] developed an understanding of risk in terms of stages that build to the decision to kill. The author reviewed other work that links the need for control to the motivation to kill when that control is threatened. "Breakdown in control can be preceded by a somewhat broad spectrum of triggers, and this often revolves around separation, but also financial ruin and mental or physical health crises." The reasons given by the men in the study for killing their

[18] This is ubiquitous in the literature about victims' experiences of domestic abuse. A recent citation: *"Like walking on eggshells'": The reality for Yorkshire victims of emotionally abusive relationships*, Yorkshire Post 29 April 2020.

[19] Independent Domestic Violence Advisor

[20] Monckton-Smith, Jane (2020) "Intimate Partner Femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide." Violence Against Women, 26 (11). pp. 1267-1285. doi:10.1177/1077801219863876

partners revolved around the withdrawal of the partner's commitment to the relationship, or separation.

4.1.50 Monckton Smith outlines eight stages leading up to a domestic homicide. We know little of Dean's previous relationships. The family have told this review that Andrea and Dean's relationship moved quickly from romantic attraction to a committed relationship. That commitment from Andrea appeared to unveil Dean's need to control her. When the withdrawal of commitment is initially threatened, the perpetrator escalates the abuse in order to re-establish their control. Included in such behaviours is increased monitoring or tracking. Family and friends noted the increasing monitoring, listening to phone calls, cutting short family visits, controlling what the family ate, even when he was not with them. In Monckton Smith's model, if this escalation does not re-establish the control, then perpetrators appear to change their thinking, believing that there is no way to resolve their outrage or sense of injustice, and feeling entitled to act in response. The research found the next stage was planning the homicide, and finally committing the homicide. The homicide itself may involve levels of violence that appear to have little relationship to the physical violence, if any, in the relationship before that.

4.1.51 The central idea is that the perpetrators' need for control is the purpose of the relationship. Threats to that control can be seen as intolerable to such perpetrators and trigger the homicides.

4.1.52 This review has a recommendation about publicising examples of coercive and controlling relationships to help the public identify them and understand their risks at para 4.2.10.

4.1.53 Domestic abuse and disability

4.1.54 Because Andrea's health was deteriorating, she became more and more dependent on Dean.

4.1.55 Studies with disabled women suggest how Andrea's physical vulnerability and dependence might have impacted her. Studies have shown that disabled women are twice as likely to experience domestic abuse as non-disabled women. Disabled women face additional barriers to seeking help, including their dependence on their carer, who may be their abuser. The abuse may be related to their disability, which the Director of Stay Safe East (an organisation run by disabled people which supports disabled survivors of domestic and sexual abuse) describes as also being a hate crime.[21]

[21] "Recognising and supporting disabled victims of domestic abuse", an article in the Practice Blog provided by SafeLives. Published on 28 November 2016. At http://safelives.org.uk/practice_blog/recognising-and-supporting-disabled-victims-domestic-abuse. [Accessed on 16 March 2020]

4.1.56 Andrea may have used the speakerphone because she was eventually unable to hold the phone. But this gave Dean the opportunity to control her communications and monitor her. This sort of behaviour is described as surveillance and such coercive control is highly correlated to future harm and death.[22]

4.1.57 The cut lip that the family noted, may have been due to a fall that resulted from Andrea's physical weakness, but many disabled women find that evidence of assaults is easily missed or dismissed in this way.

4.1.58 Andrea told a friend that she and Dean no longer had an intimate relationship and that each slept with one of the children. This seems to have happened after Sammy's birth when she reported a loss of confidence and declining health. Retrospectively, we cannot know whether this loss of intimacy was a reaction to her disability, or a decision reached mutually because of it.

4.1.59 In a 2011 study[23] of the experiences of disabled women and the services available to them, the women reported that their disability increased their vulnerability and trapped them in abusive situations. Every woman interviewed said that being disabled affected the abuse and made it worse, and that the experience of domestic violence is different for disabled women. " . . interviewees who had developed their impairment after being in the relationship reported specific and particular emotional difficulties. Where the impairment had become more severe, the abuse had often increased as the impairment/condition itself worsened."

4.1.60 The women also identified neglect as a strong feature of their abuse. "Isolating a disabled woman from other external carers had the effect of multiplying neglect, and appeared to be a direct strategy of abuse adopted by some abusive partners... Isolating strategies often left the abused woman with little energy to maintain other interactions."[24]

4.1.61 Some of the women described the emotional dilemma they faced, noting that their partner had been doing all the caring and work in the home, and that the disabled person might have been the main income source. Victims said that to leave them, to take the house, the income, and the children, seemed too harsh. Women also reported that the abuser would reinforce the disabled woman's dependence as a way of asserting and maintaining control.

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[22] Robinson, Myhill, and Wire, Ibid

[23] Hague, G., Thiara, R., Mullender, A (2011) "Disabled Women and Domestic Violence: Making the Links, a National UK Study" *Psychiatry, Psychology and Law, 18:1, 117 – 136.* DOI: 10.1080/13218719.2010.509040. Full report at https://www.safershetland.com/assets/files/resources-and-publications/Disabled-women-Making_the_Links_-_full_length_report_large_print11.pdf

[24] Ibid.

4.1.62 In some of these situations, women reported that their "reluctance to name the abuse left family members powerless to do anything until after the separation… Even where women were well supported however, they were anxious about not knowing what was going to happen to them if they then had to leave."

4.1.63 Public Health England notes: "The severity of a [sic] impairment increases the risk of abuse. Various international studies have shown that impairments that have a more severe effect on daily living require more support, and as a condition progressively worsens or the support needs increase, the risk of sexual assault, physical assault and domestic abuse also increases."[25] Also, "Reliance on care increases the situational vulnerability to other people's controlling behaviour and can exacerbate difficulties in leaving an abusive situation."[26]

4.1.64 "Disabled people may experience more extreme exercise of power, coercion and control, and more pervasive and wide-ranging abuse, than nondisabled people. Disabled people report abuse through the form of intrusion and a lack of privacy. Abuse can also happen when someone withholds, destroys or manipulates medical equipment, access to communication, medication, personal care, meals and transportation. Disabled people also report humiliation, belittling or ridicule related to a specific impairment. Reliance for care from an abuser can be manipulated, with an abuser deliberately emphasising the woman's dependence as a way of asserting and maintaining control."[27]

4.1.65 Barriers relevant in this case

4.1.66 Andrea did not actively seek help for what was going on at home. She often deflected questions about her home life.

4.1.67 Andrea appears to have felt that her relationship with Dean was private information. She was also a person in the public eye and she may have worried that disclosing information about her domestic life created a risk that the information would make it into the public domain.

4.1.68 Dean appeared to exercise great control in the family. Coercive control both limits a victim's choices and undermines their self-confidence. This limits a victim's space for action, for making choices in their own lives and acting on them.

4.1.69 Andrea was a proactive and successful woman in other areas of her life and therefore may have resisted the notion that she was a victim. There continues to be a stigma about victims of domestic abuse as somehow responsible for the abuse they suffer.

[25] Public Health England, (2015) "Disability and Domestic Abuse: Risk, impacts and response", p. 10
[26] Ibid., p. 12-13
[27] Ibid, p. 13.

4.1.70 Andrea was dependent on Dean for her care needs (though the family made it clear they were ready and willing to help), so may have faced practical and logistical challenges when considering leaving Dean.

4.1.71 Andrea was isolated.

4.1.72 The records show a lack of response by professionals when Andrea talked of her concerns and feelings. Victims report that professionals who appear disinterested or uncaring are perceived as untrustworthy.[28] Victims must feel they can trust a professional to disclose.

4.1.73 A final concern might have been a worry about losing the children to whom she was devoted. She might have feared that without Dean there, her inability to care for the children due to her disability would be disclosed. She might have feared that disclosing would invite concerns about the safety of the children. She might have worried that, following a separation, Dean would gain custody of the children and she feared for them in that environment without her protection.

4.1.74 Carer stress and domestic abuse

4.1.75 A friend of Andrea's thought that her terminal illness was a major factor in her murder. Andrea explained the impact on Dean of her increasing disability and said that he had "changed. You wouldn't recognise him. He is thin and stressed." Friend Amanda noted that Dean's appearance had changed substantially, and Andrea had said he was very stressed. That friend suggested that if Andrea had not got ill, then she would been alive today, believing that the stress of caring for Andrea was overwhelming for Dean.

4.1.76 The chair contacted Carers UK for information about the stress of caring. They provided a study on the value of breaks for carers. The charity's report, State of Caring 2019[29], provides the results of a survey of 7000+ carers in the UK. Of the carers who had not had a break in a year or more, 73% reported a deterioration in their mental health. Sixty-five percent reported a deterioration in their physical health. Of all carers surveyed, 39% said that they were struggling financially and 45% said they expected it to get worse. The types of help carers had or bought were help from family and friends, technology (like remove sensors), practical support from care workers, a Motability vehicle and a break from caring.

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[28] Lindhorst, T., Meyers, M. and Casey, E (2008) "Screening for Domestic Violence in Public Welfare Offices: An Analysis of Case Manager and Client Interactions *Violence against Women*, 14:5-29.Noted in Monkton J. et al, p. 63

[29] Carers UK, "State of Caring 2019" at http://www.carersuk.org/images/News__campaigns/CUK_State_of_Caring_2019_Report.pdf.(Carers UK note that due to the coronavirus, they will not be publishing their State of Caring report for 2020.)

4.1.77 The help and support that was offered by family and friends was blocked by Dean, undoubtedly increasing the strain on them all.

4.1.78 The survey found that only 27% of carers in England said they had had an assessment or a review of their assessment in the last 12 months. Of those who had received an assessment in the last year, 80% waited less than six months for this assessment, but 20% waited longer than six months.[30] The report called for, amongst other actions, that the NHS needed to be more carer-friendly, by including policies that help identify carers and to promote health and well-being resources.

4.1.79 The Care Act 2014 gives all adults caring for another adult the right to an assessment from their local authority. These assessments look at the impact of carers' caring role on all aspects of their life and what support they and their families need as a result. However, the SCIE noted in March 2019 that the number of carers' assessment carried out remained low overall and the quality was variable between councils.

4.1.80 The challenge in these situations is that carers can refuse to engage with an assessment, thus stopping further interventions in a situation. Professionals can be left in a conundrum where they have enough information to raise concerns, but without the cooperation of the carer and/or the cared for, they do not have enough information to intervene. Clumsy, incomplete or unsuccessful interventions can increase the risk for the victim.

4.1.81 The Chair consulted an academic[31] specialising in vulnerable women and domestic abuse. She suggested that there is little research on the links between carer stress and domestic abuse. It may be that the dependence of a person on their carer changes the power balance between them and creates the opportunity for abuse to start or intensify. The isolation in these situations would act to further limit the victim's ability to leave or make a change.

4.1.82 A study of gender differences in spousal caregiving showed that husbands were less likely than wives to help their sick spouses with household tasks and that wives with sick spouses provided twice the hours of care that husbands provided.[32] These suggest that there may be a gender difference in the response to the need for caring for a partner.

4.1.83 This is not to suggest that the stress of caring for Andrea (which the family saw little of) caused Dean to murder her and the children. But the stress of the situation may have exacerbated the control that he was already exerting. Her decision to move

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[30] Ibid, p. 11.

[31] Julie McGarry, as noted at 1.5.12(d)

[32] Allen, Susan M., "Gender Differences in Spousal Caregiving and Unmet Need for Care" *Journal of Gerontology*, Volume 49, Issue 4, July 1994, pages S187-S195.

back to the family and her terminal diagnosis would have threatened that control and were more likely the triggers for events as described above.

4.1.84 Domestic abuse – impact on children

4.1.85 There are several areas of concern about the children: what abuse of Andrea they might have witnessed and the effect on them of living such a controlled and isolated life. The family felt that one of the reasons that Jordan was withdrawn from the GSS at the end of 2012 was that Dean did not want his control threatened by Jordan eating the food offered at school or the school asking questions about his home life.

4.1.86 The Government acknowledged the impact on children of "seeing or hearing the ill treatment of another" by identifying this as "significant harm" that should result in an assessment incorporating a S. 47 Enquiry.[33] Long-term effects on children of abuse and neglect include emotional difficulties, mental health problems such as eating disorders, post-traumatic stress disorder, problems with drugs or alcohol, disturbing thoughts, emotions and memories that cause distress or confusion, poor physical health, struggling with relationships, worrying about the abuser's threat to themselves, lower educational attainment, and behaviour problems.[34]

4.1.87 There is little research into the different effects on children of the different methods of domestic abuse. The effects on a child of observing or experiencing coercive control by a parent, as distinct from physical abuse, are not fully understood as a result. It may be that what the children saw amounted to "seeing and hearing the ill-treatment of another".

4.1.88 In the Safe & Together programme[35], multiple pathways from domestic abuse to harm to children are identified. The programme notes the following as "Effects on family ecology": loss of income, housing instability, loss of contact with extended family, and educational and social disruptions. All these effects are clear in this case.

4.1.89 Children in the caring role

4.1.90 The family understood that Jordan was assigned some of the caring responsibilities for his mother, including intimate care, such as changing her sanitary towels. This particular act of caring may have been part of Dean's controlling tactics in that it was

[33] S. 120, Adoption and Children Act 2002.

[34] From www.iriss.org.uk/resources.

[35] Safe & Together Institute is an organisation that supports families where there is domestic abuse by focussing on perpetrator's behaviour and its impact on the family and children. Its Multiple Pathways to Harm" can be seen on Youtube accompanying a talk by David Mandel: www.youtube.com/watch?v=MQ_C14w6FPU.

likely to have been humiliating for Andrea, and would have undermined her self-esteem and sense of agency. It also would have impacted Jordan and his relationship to his mother.

4.1.91 The Government looked at young carers in a commissioned 2017 study, *Lives of Young Carers 2017*.[36] It considered carers from the age of 5 to 17 and spoke to the children and to their parents. Over half of those interviewed were caring for their mother.[37] 78% were doing practical tasks, 26% were providing nursing care and more than half were providing emotional support. The survey found that only 19% of these young carers had received an assessment of their needs by the local authority. Two-thirds were receiving no support, formal or informal.

4.1.92 The survey looked at the impact on the children, though primarily in the 11 – 17 age group. Most of these measures had to do with their performance and experience in schools. As Jordan was home-educated, there was no wider context for his behaviour to monitored within.

4.1.93 The survey found that parents of young carers "were less likely to say that their child was in 'very good' health". For carers in the 5 – 11-year-old age group, only 49% were reported to be in "very good" health, compared to 66% in the comparison survey (of children without caring responsibilities). The survey found that "although carers showed positive impacts of caring in terms of their happiness and self-esteem, for some there were feelings of anger on a more regular basis than their peers who were not carers."[38] The report went on to conclude, "Early intervention can enable young carers to participate more fully in social and education life and prevent long-term educational and health consequences for these young people."

4.1.94 Another study[39] looked at the performance of young carers at GCSE and found they performed the equivalent to nine grades lower than their peers who were not carers, were five times more likely to report their health as "not good", and a quarter of whom said they were bulled at school because of their caring role.

4.1.95 Identification of young carers is crucial to providing the support before a child becomes vulnerable. The Children and Families Act 2014 and Care Act 2014 require a whole family approach. The report identifies barriers to the implementation:

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[36] Chessbrough, S., Harding, C., Websgter, H, and Taylor, L., with Aldridge, J. "The Lives of Young Carers in England: Omnibus survey report" [2017] Government Social Research. Available at:https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582575/Lives_of_young_carers_in_England_Omnibus_research_report.pdf

[37] Ibid, p. 7

[38] Ibid, p. 57.

[39] Carers Trust and the national Centre for Social Research, "Identification Practice of Young Carers in England – Review, Tips and Tools" [2019].Available at: https://carers.org/resources/all-resources/80-identification-practice-of-young-carers-in-england-a-review-tips-and-tools. (Accessed 28 August 2020).

adequate funding, lack of clarity about who has responsibility to identify young carers, capacity issues, ineffective systems, knowledge and skills gap about identifying and responding to young carers, misunderstood, vague or non-existent duties regarding this approach.

4.1.96 The report identified key factors where these responsibilities were being effectively enacted:

(a) commitment from senior strategic leadership,

(b) transformed service and systems that identify, communicate, case manage and review,

(c) upskilling the workforce to identify young carers in a timely way and know the communication channels to that information is easily shared.

4.1.97 Home-education

4.1.98 As the children were of school-age, a likely organisation that might have had contact with the family was a school. The Panel discussed that children being home-schooled might "go under the radar" of the local authority and therefore safeguarding concerns might be missed.

4.1.99 The Department of Education's guidance[40], says that local authorities have a general duty to safeguard and promote the welfare of children, citing S 175 of the Education Act 2002. The guidance says that parents should not be using home education as a way of preventing proper oversight of children. The local authority's oversight of home-educated children is done by Ofsted through their periodic inspections of how the local authority is carrying out its duties in relation to vulnerable children.

4.1.100 Local authorities' responsibilities for home-educated children is delineated in the Education Act 1996 (S.436A). Bexley's own Elective Home Education Policy says that LBB will make enquiries in all cases where parents are home educating in order to satisfy itself that the children are receiving a suitable education. Parents are encouraged to inform the local authority of withdrawal of a child from school and schools should notify the local authority. The policy notes that child protection concerns may arise in the course of engagement with families that are home educating. Bexley maintains a register of children it knows are being home-educated. Local authorities can insist on seeing children in order to enquire about their welfare where there are grounds for concern (S. 17 and 47 Children Act 1989).

[40] Department of Education, "Elective home education: Departmental guidance for local authorities" (April 2019)

4.1.101 Bexley offers to meet with all families who are home-educating at least on a yearly basis and more frequently if the family needs additional support. The information and support provided include information about the learning resources locally, GCSE examination centres, Bexley Youth Advisory and upcoming apprenticeship events locally. Special Educational Needs support aids and strategies are provided where required, as is support for preparing Education Health and Care Plan[41] requests. Bexley's Education Services also signpost families to other advice and support.

4.1.102 In this case, where it was Andrea's intention that the children return to the private school, Bexley Education Services could have assisted Andrea to ensure the children had a smooth and successful transition back to a mainstream school, if requested. They do this through working with School Admissions, Inclusion Support Officers and the Education Welfare Service, though it is acknowledged that they have more robust connections to the state schools.

4.1.103 The Bexley policy says that "the LB Bexley does not consider it safe or acceptable for a child who is the subject of a Child Protection plan, or a child deemed to be a child in need, to be electively home educated." For a Child in Need (CiN), "the CiN review chair will make clear that continuing elective home education is a worry. It will be for the chair to decide whether a strategy meeting is required where the child is at risk of harm and this is further compounded by the education of a child at home."

4.1.104 Bexley did not know that the children were being home-educated. Parents are not required to register that they are home-educating, though they are encouraged to do this. If they had registered, Bexley Education Services may have had the opportunity to talk to Dean and Andrea about the children's education and family situation.

4.1.105 Where local authorities know where a family is moving to, it is good practice for the previous local authority to refer to the new local authority. Similarly, Bexley will alert an area that a Bexley family moves to. If Bexley are not aware of the family's new address, they explore all avenues to find it in order to make that referral.

4.1.106 In the course of the learning review, the family learned that there was little oversight of the home-education of children. The learning review proposed four actions to help the local authority keep track of children in the area.

(a) Elective Home Education to monitor effectiveness of checking students' addresses on an annual basis

Action: Yearly monitoring through Education. Completed.

[41] An Education Health and Care Plans (EHCPs) outlines a child's needs in these areas and the local authority's provision to meet that child's needs and therefore meet its responsibilities.

(b) *To encourage schools to advise the EHE when a child is removed from school education*

Action: Bexley Education Services wrote to all local schools, reminding them of the importance of informing the Local Authority Education Services when children are removed from a school register. Completed in September 2017.

(c) *EHE to consider using communication tools to encourage parents to notify EHE register e.g. Primary Times and Summer Sizzler.*

Action: Education now regularly updates schools within existing communications.

(d) *EHE to develop effective information sharing with voluntary and statutory services*

(e) **Action:** Yearly monitoring through the action plan. EHE are represented through the boards and are a member of the MARAC.

4.2 Analysis of Agency Involvement

4.2.1 Identifying and responding to domestic abuse

4.2.2 Andrea's family knew that Dean was controlling Andrea and the children, by limiting their contact and controlling their food. They did not understand that coercive control was domestic abuse and was an indication of a dangerous situation. Coercive control became a criminal offence the same month that Andrea and the children were killed.

4.2.3 The family's dilemma was that they did not know who to tell or how to characterise their worries. Members of the family and friends tried to talk to Andrea and then Dean about their concerns. This approach appeared to have worked as Andrea was planning to move to her mother's house with the children and send them back to school. The terminal diagnosis seemed to be the tipping point that gave Andrea a valid reason to leave.

4.2.4 The learning review identified learnings here and completed the following actions:

(a) *Implement multi agency training on recognising and understanding coercive control to all professionals.*

Action: The CSP developed a brochure for staff on coercive control. Training was commissioned, and 10 multi-agency sessions were delivered in 2018 – 2019. In 2019 a domestic abuse training programme has been developed including domestic abuse dynamics, including coercive control. The training programme continued to be well attended and attendees are monitored and reported to the DA operational group for oversight.

(b) Producing guidance on understanding coercive control in the context of domestic abuse

Action: Guidance developed and implemented through operational group to key members for dissemination including LSCB in April 2018.

(c) To raise awareness of public perception of domestic abuse and knowledge of coercive control

Action: A multi-agency website now developed to raise awareness. Targeted 16 days of activism including blogs, victims lived experience, public engagement and awareness raising delivered in November 2018. Solace provided an open session to public and professionals in order to raise awareness of the newly commissioned service in 2019. Work on this continues.

(d) LBB to achieve White Ribbon Authority[42] status by developing Action Plan with WRC and recruiting ambassadors

Action: This is on-going due to cost involved. Key areas being developed to meet the criteria for White Ribbon. 150 DA champions recruited to date and more being recruited constantly.

(e) Develop and monitor DA website for both public and professionals to act as a platform for raising awareness and signposting of DA

Action: Completed.

4.2.5 In such a controlled life, Andrea would have found it difficult to access information without Dean knowing. Andrea's sister said that Andrea took the children to the library on a weekly basis for a while. They also suggested that she could have accessed information in shops and perhaps in a church.

4.2.6 The CSP organised a faith workshop focussed on domestic abuse in Bexley at the beginning of 2020. Libraries in Bexley have dedicated posters that focus on coercive control. Safer Neighbourhood Police team delivered leaflets to supermarkets and shops in the first few weeks of lockdown in the spring. In Bexley, all GPs and hospitals have posters about coercive control.

4.2.7 As Andrea's family did not live locally, they would not have had access to information provided in Bexley. Older members of Andrea's family would not have sought information through the internet. Improved awareness of what coercive control is and where victims, their families and friends can get help and support continues to be

[42] White Ribbon is a global movement to end male violence against women. White Ribbon accreditation ensures organisations take a strategic approach to ending male violence against women by engaging with men and boys, changing cultures and raising awareness. From www.witeribbon.org.uk.

needed nationally and to be provided in a way that all ages and communities can access. Health services are well-placed to assist with this distribution.

4.2.8 **National Recommendation**: **Home Office to launch a campaign to help the public understand coercive control and to direct them to local sources of support. Campaign to target cultural and social norms that support, accept or disguise coercive control, particularly acknowledging the issue of shame.**

4.2.9 To ensure that efforts are made locally, the following recommendation mirrors the national one, but is aimed at the local area.

4.2.10 **Recommendation: Bexley Community Safety Partnership to launch campaign to help the public understand coercive control and to direct them to local sources of support. The campaign should target cultural and social norms that support, accept or disguise coercive control, particularly acknowledging the issue of shame.**

4.2.11 In this case, it is likely that Andrea's movement between services made it easy for agencies to assume that wider information was being collected and responded to by another practitioner. NHS England's 2017 Safeguarding Adults pocket guide says, "You should never assume that someone else will take care of domestic abuse issues." You may be the woman's first and only contact.[43]

4.2.12 Domestic abuse and coercive control are to be revisited in GP Level 3 training provided by the CCG available to all GPs annually. As a result of previous training, practices have posters in their waiting rooms. Some practices have methods by which a patient can safely signal that they are victims of DA so that the health professional can create the opportunity to discuss this. GPs in Bexley were made aware of the need for routine enquiry about domestic abuse at the 2018 Level 3 update in adult safeguarding. GPs are reminded of the need for routine enquiry about the family situation in child and adult safeguarding annual updates. The CCG notes that this is needed more now that consultations are often by telephone and video link. This was developed further in DA training available to staff in the spring of 2020.

4.2.13 Though Andrea may not have identified her situation as abusive, other patients in her situation may. KCH saw that there was an opportunity for them here to improve their response to domestic abuse:

4.2.14 ***Recommendation for King's College Hospital NHS Foundation Trust:*** *KCH Outpatient departments to make routine enquiries about domestic abuse for all patients accessing the service. This will include episodes of care involving*

[43] NHS England, *Safeguarding Adults* pocket guide, 2017, p.28.

IVIG/Clinical research. This aligns with KCH Safeguarding Adults Service on-going work to raise awareness around domestic abuse.

4.2.15 The Panel discussed whether routine enquiry was being undertaken in other hospital trusts. The DASAV strategic lead advised that the DA Health Subgroup (that reports to the domestic abuse operation group) has been set up to review practice and advise health services on the best ways to increase identification and referrals for domestic abuse in healthcare settings. The DASAV strategic lead also advised that the Health Subgroup will be using the Pathfinder Toolkit[44] to develop a unified approach by health services to domestic abuse. The Panel asked that the subgroup gather and review evidence that training staff on domestic abuse is increasing their skills and confidence to make referrals. Given the findings of this report, the Panel supports the establishment of the Domestic Abuse Health Subgroup to improve practice across the health providers in Bexley.

4.2.16 As there are several areas where the work of the DA Health Subgroup is important in responding to this DHR, the following recommendation captures them:

4.2.17 **Recommendation: That the Domestic Abuse Health Subgroup works to ensure the following:**

(a) **That health referrals to domestic abuse services are monitored as part of the evaluation of health professionals' training on domestic abuse.**

(b) **That a consistent and coordinated plan is developed for routine enquiry in health services based on best practice.**

(c) **That health training on domestic abuse includes the cultural barriers that might stop ethnic minority victims reporting and might affect health professionals' responses to ethnic minority victims.**

4.2.18 The LLR addressed routine enquiry in its action plan:

(a) CCG to implement routine enquiry for DA within induction training for all health professionals

Action: Routine enquiry embedded in the induction practice by February 2018. This continues to be reinforced through multi-agency training across the borough. A domestic abuse health group has been set up to drive forward this work to ensure that all health services in the borough are responding effectively to domestic abuse. CCG will chair the health sub-group and feed into the

[44] The Pathfinder Toolkit is the product of a 3-year national pilot project that worked across eight sites in England to transform health services' responses to domestic abuse. The Toolkit provides an overview of different interventions and models of good practice focusing on the areas of general practice, acute care and mental health.

domestic abuse operational group to drive forward the response to domestic abuse, including routine enquiry.

(b) CCG to update the DA policy to ensure that routine enquiry is part of every contact.

Action: DA Policy developed and implemented in 2018.

4.2.19 Identifying the need for help and support – the impact of Andrea's condition on her life before her diagnosis

4.2.20 Health professionals – those at DVH, GP and the OT – knew that Andrea had young children. The information that Andrea provided did not suggest domestic abuse and she might have not recognised her situation as abusive, but her health problems suggested great vulnerability for her and for her children. There were few notes to suggest that she had any support: there were no notes about a partner and mention of her sister at only the visit in June 2015. On several occasions she was upset.

4.2.21 The GP sent a letter to the DVH neurologist in October 2014 requesting that Andrea be seen as early as possible as her physical symptoms are causing her problems at work. In October 2014, she told the OT she was worried about how symptoms were affecting her everyday life. She was tearful and feared the worse.

4.2.22 The next month, the DVH neurologist noted that her fine motor skills had diminished so that she was unable to fasten buttons or zippers. The neurologist sent this information to Andrea's GP with the information that she had two small children and was managing. No further information was noted about how Andrea was able to manage two children without the use of her hands. This suggests that no further questions were asked

4.2.23 In February 2015, the DVH neurologist wrote to the KCH neurologist that Andrea's weakness was "profound and functionally impairing" and that there was a family history of MND.

4.2.24 Andrea was struggling physically at least a year before she was killed, and health professionals noted that Andrea's deteriorating physical condition was affecting her daily life. The level of disability Andrea was experiencing in October and November 2014 should have led the OT and DVH neurologist to make additional enquiries about her care and support needs. They might have written to the GP asking for further assessment of her situation. The duty to assess is triggered where "it appears to the local authority that an adult may have needs for care and support".[45]

[45] S. 9(1) Care Act 2014.

4.2.25 Similarly, the KCH neurology consultant met Andrea in June 2015 and could have asked about her support at home. While health professionals were working towards a diagnosis, Andrea's symptoms were worsening until, towards the end of Andrea's life, she needed everything done for her: washing, dressing and feeding her.

4.2.26 The concerns and worries Andrea expressed should have led to conversations with her about how she was coping and what help was available. Andrea's increasing vulnerability and her parental responsibilities should have led to a referral to Adult Social Care for an assessment. The support needs of the children is returned to below.

4.2.27 The NICE Guidance 42[46] on MND (NG42, which post-dates these events) acknowledges the need for patients and their families and/or carers to have information and support "throughout the diagnostic period, particularly during periods of diagnostic uncertainty or delay."

4.2.28 A referral for Andrea to Adult Social Care for an assessment would have been appropriate during this time and she would have been told about a carer assessment for Dean, if she had been referred. NICE Guidance 150 (NG150)[47] (2020) now recommends that health and social care practitioners actively seek to identify carers in line with the requirements of the Care Act 2014. A carer's assessment might have identified support that Dean might have been willing to access. As part of a Care Act assessment, Andrea's ability to parent effectively would have been assessed. The recommendation at 4.2.33 addresses this.

4.2.29 If the assessments had been undertaken, there could have been support for Andrea and her family, such as:

(a) Support for daily activities

(b) Strengths-based approach could have included Andrea's wider family. Through this approach, some of the barriers to getting help might have been identified and addressed

(c) Children relieved from their caring responsibilities

(d) Dean relieved of some caring responsibilities

4.2.30 If an assessment had been accepted in this case, it would have provided an opportunity not only for a professional to look at and respond to their care and support needs, but also to identify the control that Dean exercised. A health

[46] National Institute for Health and Care Excellence, (February 2016, NICE Guidance [NG42],"Motor Neurone Disease: assessment and management".

[47] National Institute for Health and Care Excellence, (January 2020), NICE Guidance [NG150],"Supporting Adult Carers".

professional regularly delivering help to the family could have gained the trust necessary for Andrea to talk about the abuse.

4.2.31 There could have been opportunities to identify the domestic abuse:

(a) Assessors and support workers in the home might have seen and understood the dynamic there. Guidance on understanding coercive control was produced and implemented through key members, including the LSCB, as a result of the learning review.

(b) Assessors and/or support workers might have developed enough trust with Andrea so that she talked to them about what was happening there.

(c) Andrea may have been referred to specialist domestic abuse agencies

(d) The children could have been supported and protected from the harm of witnessing the abuse of their mother and experiencing it themselves.

4.2.32 Andrea may have declined assessments of her care and support needs. Dean may have declined a carer's assessment. But raising the issue of assessments creates an opening through which information can be provided, even if those assessments and support are not accepted at that time. If professionals felt that more was needed, if those conversations suggested that Andrea was an adult at risk, then a safeguarding concern could have been raised by any of these health professionals.

4.2.33 The friends and family interviewed suggested that Andrea would have come to them for support rather than to professionals. However, it may be that if Dean was jealous of Andrea's connection to her family, that an "outsider" may have been able to gain access to the situation that friends and family could not.

4.2.34 The Panel noted that, as some of the concerns raised in this are already part of regular training, there might be an issue with the effectiveness of the training in improving competency. BSAB and the local authority support partners to learn and develop their safeguarding adults knowledge, including a Train the Trainer programme and a Safeguarding Adult Competency Framework. It was thought that this case could be used to embed learning across the partnership, particularly in multi-agency training,

4.2.35 **Recommendation for local health services (GP surgeries, Oxleas, KCH and DVH) to use this case in training to**

(a) **Identify the need to think about wider safeguarding issues when working with patients, including considerations of Andrea as an adult at risk, and the children being at risk of neglect**

(b) **Promote the understanding of coercive control, what it might look like in situations where the victim has a progressive illness**

(c) **Develop professional curiosity about the impact of patients' symptoms on their daily lives and how they manage their lives, relationships and children, and how to ask patients about their lives**

(d) **Identify what further support might be necessary to keep patients and their children safe and healthy and ensure the patient is connected to that support**

(e) **Consider how to improve the gathering of information about clients and sharing that information with other health agencies.**

4.2.36 Given the variety of support from which a patient might benefit, the Panel discussed social prescribing. NHS England defines "social prescribing" as "a way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' [i.e. the patient] and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support."[48]

4.2.37 The Panel also talked about a model of support that included co-ordination of the offer of medically specific help with social prescribing, via primary care. It was also noted that patients needing highly specialist medical treatment for an incurable and progressive illness or disability, especially one affecting a small number of people, rarely live close to that specialist provision. The CNS at KCH's Motor Nerve Clinic agreed with this and said that patients' GPs usually make the connection to local services for patients.

4.2.38 This supports strengthening the connection between secondary and primary care for patients with disabling symptoms and conditions.

4.2.39 In this discussion, it was noted that the NHS emphasis on GPs seeing patients quickly and on time means that appointments are short and patients may see a number of GPs in a practice. Also, some services that used to be provided by GPs are now provided by others, such as maternity care. As a result, GPs did not have as many opportunities to develop their professional relationships with patients.

4.2.40 The Panel felt that health professionals needed to be reminded of the variety of support organisations in Bexley for patients in Andrea's situation. They noted that at the start of the pandemic Bexley Voluntary Service Council (BVSC) had sent a list of all the support services available in Bexley which was an invaluable resource and would help to deliver the following recommendation.

[48] https://www.england.nhs.uk/personalisedcare/social-prescribing/

4.2.41 **Recommendation: That Bexley Community Safety Partnership and the South East London Clinical Commissioning Group work together to see that secondary and primary care health professionals in Bexley are provided with information about the variety of local support organisations in Bexley and how to refer clients to them. LBB ensures that health professionals are supplied with information to share with patients about the help that is available through these organisations.**

4.2.42 Professional curiosity

4.2.43 There seems to have been a lack of professional curiosity by all of the healthcare professionals in this case. When Andrea was distressed or upset, assumptions appear to have been made that this emotion was a result of her physical condition. Questions were not asked about it and further information was not gathered. No detail was gathered about how she was managing her own care, let alone that of the children.

4.2.44 Research has found several themes that undermine the use of professional curiosity. They include confirmation bias which "relates to the practice of looking for evidence that supports or confirms one's pre-held views, ideas and values, and ignoring contrary information that refuges them."[49] It may be that Andrea's professional appearance and persona confirmed the health practitioners' impression that she was a capable person and therefore did not need help. So when she said that she was managing, they did not ask further questions.

4.2.45 Research shows that "partnership approaches offer a useful framework for strengthening professionally curious practice in safeguarding adults."[50] Further, the skills required to support professional curiosity include "communication skills to support a deeper process of enquiry, risk assessment, accurate recording and checking or records to identify cumulative risk, exploring networks and consulting widely with family members and professionals to gather a range of views, and the ongoing development and use of reflective/analytical skills to help understand complex situation or seek further information."[51]

4.2.46 The recommendation at 4.2.33 above addresses this.

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[49] Penhale, B. "Could Curiosity Save Lives? An exploration into the value of employing professional curiosity and partnership work in safeguarding adults under the Care Act 2014, *Journal of Adult Protection,* Vol 21, Issue number 4, published in 16 September 2019, p. 252-267, p.10

[50] Ibid, p. 19

[51] Ibid, p. 19.

4.2.47 Critical opportunities

4.2.48 The health services here have noted that they had few contacts with Andrea, and this limited the possibility for intervention. In such situations, when a patient does choose to disclose anxiety or concerns, it is even more important that the people they choose to disclose to respond to that information. The Department of Health notes that 80% of women experiencing domestic abuse seek help from health services and these are often a woman's first or only, point of contact.[52] These are critical opportunities because they are rare.

4.2.49 The responsibility for safeguarding requires further enquiry and is especially important when someone is isolated. As isolation is used by controlling people to enforce their control, someone who is isolated needs a more pro-active response to identify that risk. All professionals are responsible for safeguarding.

4.2.50 Care and support needs assessment for Andrea after her diagnosis

4.2.51 When the KCH neurologist told Andrea that she had MND in December 2015 and that she would eventually die from it, there were no enquiries into support mechanisms and no information about her family circumstances. The consultant noted that she was depressed and distressed and presumed this meant that she had accepted her terminal illness. KCH sees this as a missed opportunity to enquire about her well-being.

4.2.52 Andrea was referred to the Motor Nerve Clinic for support after her diagnosis but was killed before that appointment could be made. At the clinic, there is a clinical nurse specialist and there is more time allocated to each appointment. When Andrea attended this clinic, she would have had a full social history taken, including understanding her caring responsibilities. If she had been admitted to hospital later, a specialist multi-professional team would have been available to address her needs.

4.2.53 This kind and level of support is, no doubt, welcome to patients who attend the clinic. However, in this case, it was offered too late.

4.2.54 **Recommendation for NHS England: To ensure that health professionals giving a terminal diagnosis organise for immediate support to be available to patients to discuss the impact of their illness and the prognosis on their life, and the support likely to be needed and available.**

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[52] Department of Health (2010) *Responding to Violence against Women and Children – the role of the NHS*. [Accessed at www.health.org.uk/sites/default/files/RespondingtoViolenceAgainstWomenAndChildrenTheRoleofThe NHS guide.pdt.

4.2.55 Care and support needs of the children

4.2.56 Andrea's reduced physical capacity should have raised a referral for the assessment of the children's situation to children's social care.

4.2.57 The Oxleas OT knew that Andrea had two children and Oxleas say it would have been good practice to explore more about the support that was readily available to Andrea, given her difficulties.

4.2.58 When it was clear to the medical professionals that Andrea's health was severely impacting her life – indeed she spoke about her concerns – a referral might have been made to children's services to review the care and support needs of the children in light of Andrea's reduced physical capacity. It would have been important to make it clear to Andrea that this was about assessing her care and support needs to help the family, not about penalising her and her family for her disability. The safeguarding of the children is returned to below.

4.2.59 Bexley Children's Social Care (CSC) note that there were opportunities for intervention and that early intervention would have been appropriate in this case. Support could have been offered to Andrea and signposting, specifically regarding Andrea's debilitating health condition and the children in a caring role.

4.2.60 On reviewing this case, CSC did not identify concerns that would have led to a statutory intervention from them. They did note some missed opportunities to ask Andrea how her debilitating conditions was impacting on her parenting and whether she required any support from CSC. Probing questions about her shoulder pain and weakness may have revealed domestic abuse. Depending on the information disclosed, help might also have been offered through Children's Centres and Children and Young People's Mental Health Service.

4.2.61 Children and young people can be referred to the Young Carers project in Bexley if they are a child or young person taking on a caring role in relation to their parent or carer, or is looking after younger siblings. The youngest age is usually eight for this project. So Jordan would have been eligible for this support if the situation as described by Andrea's family was known to services.

4.2.62 Concerns were raised by the family about the welfare of Jordan and Sammy given that they had little contact with those outside their home as they were home-educated. Types of child abuse enabled by home-educating include depriving children of food or malnourishing them, and medical neglect.[53] There is no evidence

[53] www.responsiblehomeschooling.org. A US website supporting those home-educating.

that the children suffered such abuse, but it is conceivable that the food and health choices being made for the children in this case could have evolved into such abuse.

4.2.63 At the second Panel meeting, the Panel were concerned about the lack of oversight of these home-educated children and how few opportunities there were in this case to support the children and the family. There was agreement that when agencies learn that children are home-educated, noting and sharing this information would enable other professionals in contact with these families be pro-active in supporting the family and asking about the children's health and well-being.

4.2.64 There was a discussion of how home-educated children and their parents could be better supported. Bexley Education Services noted that the local authority signposts home-educating parents to resources and to elective home education parent advocacy groups and runs coffee mornings to promote socialisation. A recent Members' Scrutiny Group reviewed the elective home education provision and did not highlight a weakness there.

4.2.65 Bexley Education Services keep a register of all home-educated children that are known to them. They noted that the Government Guidance (April 2019)[54] says that "local authorities should explore the scope for using agreements with health bodies, general practitioners and other agencies, to increase their knowledge of children who are not attending school." The Guidance goes on to say that "under S. 10 of the Children Act 2004, local authorities should have arrangements in place to promote co-operation between the authority and its partners who deal with children, and under section 11, arrangements should be in place to ensure that functions are discharged with regard to the need to safeguard and promote the welfare of children. These arrangements should include information sharing protocols and it is possible for these to allow sharing of data on children who appear to be home-educated and about whom there is a concern as to the suitability of that education which amounts to possible neglect causing significant harm." (Para 4.4)

4.2.66 The Panel thought other agencies could assist Bexley Education Services and made the following recommendation.

4.2.67 **Recommendation: That Bexley CSP ask local statutory and voluntary agencies to include in their policy and practice, that when professionals learn that a client or patient is home-educating and gain consent of the parents, that the fact of their home-educating is shared with Bexley's Education Services.**

[54] Department for Education, (2019) "Elective Home Education: Departmental guidance for local authorities". Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/791527/Elective_home_education_gudiance_for_LAv2.0.pdf

4.2.68 **Recommendation: That Bexley Education Services determine and communicate the mechanism for agencies to inform them of families who are home-educating and have consented to the sharing of this information.**

4.2.69 The Panel wanted Bexley's Education Services to reciprocate by notifying the child's GP and other agencies involved with a family that a child is being home-educated. The expectation was that alerting professionals to this fact would encourage them to exercise their professional curiosity and take a more whole family approach.

4.2.70 Bexley Education Services, although noting a concern that gaining parental consent to share this information might create barriers between Education Services and home-educating parents thus limiting the local authority's abilities to exercise its responsibilities, have confirmed that they will look at updating their policy, reasoning that though consent is required, this should not preclude a discussion and asking the question.

4.2.71 In order to assist local authorities "to fulfil their duty to establish, so far as it is possible to do so, the identities of children in its area who are not receiving a suitable education" (Guidance, para 4.2), the Panel suggested the recommendation below. It is noted that this idea has been consulted on nationally.[55]

4.2.72 **National recommendation: That the Department of Education require parents who are home-educating to register this with their local authority's Education Services. That the Department of Education provide guidance on when and with whom local authority Education Services can share this information with other agencies.**

4.2.73 Particularly in a case like this, it is an uncomfortable fact that children who are home-educated may have little public visibility. Andrea's family felt strongly that there should be more responsibility placed on parents to notify local Education Services that they are home-educating and to engage with wider services. Andrea's family noted that, due to the Covid-19 Pandemic, as a society we have learned about the risks to children's social development and mental health from not having interactions with other children. They strongly supported the recommendation above.

4.2.74 It is the case that the relationship between home-educating parents and local authorities' Education Services is one based on consent. Education Services ensure that children are receiving an adequate education through annual visits and can attend more often if there are concerns. The family describe Andrea's educational provision for her children as exemplary. It may be that if Education Services had checked on this family's provision, they too might have found it exemplary. They also

[55] Sellgren, Katherine, (2 April 2019) "Plans for new register for home-educated children", BBC News.

might have had the opportunity to evaluate the wider family context and raise any concerns they had with Children's Services. Looking at the whole situation, it is more likely that interventions would have sprung from Andrea's contacts with health services than from an annual visit from Education Services.

4.2.75 Communication within and between agencies

4.2.76 There appeared to be regular communications between the agencies involved. The hospitals corresponded with the GP and vice versa. The DVH neurologist sent a letter to Andrea's GP about her symptoms. The letter might have suggested a further assessment of need by the GP.

4.2.77 The letter gave the GP the opportunity to talk to Andrea about how she was managing in light of her disability, to talk about how she was managing to care for the children. The children were also the GP's patients. However, the GP did not talk to her about how she was managing during those few GP appointments.

4.2.78 The OT and the family HV were both part of Oxleas. The OT might have alerted the HV to Andrea's situation and the HV might have attended the home to gather more information and ensure that the children were well and healthy and that their needs were being met.

4.2.79 The communications between agencies appeared to focus on the clinical role of the health professionals without acknowledging their social care role. This case provides valuable lessons in the Think Family approach and should be used in safeguarding training locally.

4.2.80 **Recommendation for Bexley Community Safety Partnership: Ensure that all safeguarding adult and children training use this case to make several points:**

(a) **Everyone has a role to play in stopping domestic abuse**

(b) **It is critical that opportunities to enquire and support patients/clients are not missed.**

(c) **If in doubt, staff should discuss domestic abuse concerns with their Safeguarding Lead and then, if appropriate, refer the case to someone more specialised**

(d) **How a Think Family approach might have opened a number of routes to safety for this family.**

(e) **Include information about local voluntary agencies that might provide additional support to patients.**

4.2.81 Policies, procedures and training

4.2.82 *Asking questions.* To support the recommendation above regarding the use of this case in training (at para 4.2.33), health services' policies should require this.

4.2.83 **Recommendation for Dartford and Gravesham NHS Trust, King's College Hospital NHS Foundation Trust and Oxleas NHS Foundation Trust and GP surgeries, and community care services: Review policies regarding care of patients with disabling conditions to ensure that conversations about support and care needs are introduced when the symptoms impact daily living.**

4.2.84 Routine enquiry in KCH's outpatients' departments is recommended above. Training to encourage the exercise of professional curiosity is noted above, as is the recommendation to use this case in safeguarding training. There were four different health providers involved here and none of them identified that Andrea and her family would have benefited from a care and support needs assessment.

4.2.85 *Oxleas NHS Foundation Trust.* Oxleas has had a domestic abuse policy since 2006 which was updated in 2016 and was re-written in 2018. The trust's safeguarding children face-to-face training has included domestic abuse training and since 2019, the safeguarding adults training has included domestic abuse. HV undertake routine "safe enquiry" and a new e-learning module on domestic abuse has been developed and is now available for all Oxleas staff. Oxleas note that training compliance is consistently high across the trust, achieving over 90% at all levels.

4.2.86 ***Recommendation for Oxleas:*** *Domestic abuse to be included in all safeguarding adults and safeguarding children training offered to trust staff.*

4.2.87 ***Recommendation for Oxleas:*** *The safeguarding team to promote the domestic abuse e-learning to all adult facing staff.*

4.2.88 The Pathfinder Toolkit to be used by the DA Health Subgroup includes a domestic abuse training assessment tool to ensure that health services' current training offer is robust enough to meet the desired outcomes.

4.2.89 *GP practices.* The CCG informed the Panel that domestic abuse is considered in the level 3 training provided by the Named GP and the Designated Doctor and Nurse for LBB. It was last included in the adult safeguarding training when the MARAC co-ordinator spoke to GPs in 2018. GPs and their staff have access to on-line training as part of their safeguarding adults training, but an audit of practices showed an absence of training on DASH assessments. As a result, practices requested more training on domestic abuse.

4.2.90 Three GP practices out of 23 locally are training to be domestic abuse champions. This is a whole practice approach where staff get extra education and at least one member of the team is trained in DASH assessment. These champion practices encourage other practices to undertake the training.

4.2.91 The CCG provides Level 3 update conferences for all clinical staff annually – one for adult safeguarding and the second for safeguarding children. Domestic abuse was central to the safeguarding training in 2018 and is due to be so again this year. In addition, there are three adult and three children's safeguarding Lead GPs meetings each year.

4.2.92 As the GP is the health professional most people have most contact with, it is an ideal place to identify domestic abuse. GPs are also encouraged to routinely ask about the family situation. Again, the Panel noted the great pressure on GPs to keep to the 10-minute appointment times and that often only one problem is able to be raised at each session.

4.2.93 *Kings College NHS Foundation Trust.* Frontline staff at KCH can access domestic abuse training and online resources as well as having the direct access to IDVAs as noted above. All KCH staff have mandatory safeguarding adults training and DA training is included in this. This is refreshed every three years. The IDVAs also provide bespoke domestic abuse training on request.

4.2.94 KCH hosted a DA awareness day in 2019.There was good attendance and an increase in domestic abuse referrals following this event.

4.2.95 *Dartford and Gravesham NHS Trust end policies and practices.* Maternity services use routine enquiry for domestic abuse. All Trust staff have safeguarding adults and safeguarding children training as part of their induction. There has been additional domestic abuse training as needed in some departments.

4.2.96 The IDVAs are on-site daily for client referrals and consultations by staff. They provide support at the hospital and out-of-hours support on the telephone. If a patient consents, all staff can refer to the IDVAs.

4.2.97 A concurrent DHR (DHR2) in Bexley has two recommendations that would assist the development of a consistent response across agencies and is also suggested by this DHR:

4.2.98 ***Overarching Recommendation 1****:CSP to share the learning from the DHR2 Review and request all organisation in Bexley to review policies, procedures, guidance and training to ensure that accurate language is adopted that reflects responsibility for domestic abuse (the nature of this will be specific to each organisation and their requirements).*

4.2.99 ***Overarching Recommendation 3****: Borough-wide training on domestic abuse to cover perpetrators use of coercive and controlling behaviours covering the criminal offence, how it impacts on victims, and how agencies need to respond.*

4.2.100 Access to domestic abuse services

4.2.101 Bexley Community Safety Partnership has revised its Domestic Abuse Strategy and is working with a national domestic abuse charity, Safe Lives[56], to introduce a one-stop shop approach to make it easier for victims to access domestic abuse services. As part of this action staff across services are being trained in better understanding of and response to domestic abuse and abuse, including coercive control.

4.2.102 KCH note that since these homicides, KCH has developed its safeguarding and domestic abuse support for staff. KCH's Safeguarding Adults Service includes IDVAs who work with employees and patients. They are employed by Victim Support and have been on the DVH and PRUH sites since 2016-2017. In December 2017, the Victim Support IDVAs joined the Safeguarding Adult team. Referrals to these IDVAs come directly or through the adult safeguarding teams at the hospitals.

4.2.103 In 2016, Bexley Women's Aid was the service commissioned by the London Borough of Bexley to provide refuge and outreach services. High risk IDVAs were part of the Housing Department and responsible for the MARAC.

4.2.104 In 2020, Solace became the commissioned provider for core services. They provide a 27-bed refuge with support and a children's worker. Solace's community outreach provides caseworkers for those at medium risk and IDVAs for those at high risk. The IDVAs are co-located with the police, housing and in the MASH unit in the Civic Centre. The MARAC is operated by the DASV Strategy Manager.

4.2.105 As noted above, Darent Valley Hospital now has IDVAs on site to support patients and staff. They are available in and out-of-hours.

4.2.106 Bexley Women's Aid continues to offer services in Bexley.

4.2.107 The CCG note that there has been access to specialist domestic abuse services for many years. However, Solace WA reported at the meeting that they had received no referrals from GPs in the year and a half that they have been providing a DA service in Bexley. The DA Health Subgroup will be looking at GP referrals.

4.2.108 Equality and Diversity

4.2.109 Andrea was a Black British heterosexual woman in her 40s. She and Dean were not married. Dean is a Black heterosexual man, originally from another country and with the right to remain in Britain. The Panel determined that the protected characteristics of age, sexual orientation, and marriage/civil partnership had no impact on the response that Andrea received. The characteristics of gender reassignment and pregnancy did not apply. Dean had no contact with agencies in the timeframe of this

[56] Safe Lives http://www.safelives.org.uk/

review. Andrea's religious affiliation may have presented an opportunity to get information to her, as noted above. There is no evidence if impacted on the service she received.

4.2.110 The Review Panel identified the following protected characteristics of Andrea as requiring specific consideration for this case: sex, disability, and race.

4.2.111 *Sex:* Andrea's interactions with agencies appear to have been effective in that her symptoms were responded to and she was referred on when symptoms persisted.

4.2.112 *Disability*. Andrea's disability would have impacted on the abuse she experienced, providing more opportunities for control as her physical strength waned. It may have also limited her view of her options in that she did not want the children raised by Dean, as evidenced by her decision to move back in with her family and her discussions with her cousin about the children's upbringing. It is possible that the barriers Andrea felt for talking about what was happening at home were increased by her disability and her growing dependence on Dean.

4.2.113 Andrea's growing disability did not appear to impact on agencies' responses. Her growing disability was actually the focus of their work. Her family thought her work as a BSL interpreter reduced and then stopped because she lost fine motor skills and could not physically do that job anymore.

4.2.114 *Race:* Andrea was Black British. There was no evidence that Andrea was treated unfairly because of her race. However, these attitudes may be unconscious and interfere with victim's understanding of their options and with professionals' efforts to help.

4.2.115 *Intersectionality:* "When it comes to social inequality, people's lives and the organisation of power in a given society are better understood as being shaped not by a single axis of social division, be it race, or gender or class, but by many axes that work together and influence each other."[57] The term "Intersectionality" is most useful where it generates actions and approaches that include people with several identities who are marginalised by the "one diversity issue per person" approach.

4.2.116 There is the possibility that being a Black woman compounded barriers for Andrea. The "strong Black woman" is a stereotype that has roots in colonial history. A recent study looked at the impact of this stereotype on the health of Black women. It found that to protect themselves from racial discrimination, Black women can feel they must present an image of strength and suppress emotions. The study found that this stereotype can both protect Black women from the negative health impact of racial

[57] Collins, P, and Bilge, S, *Intersectionality* (2016) Massachusetts: Polity Press. P. 2.

discrimination, but it can also create further harm.[58] In her article for *HuffPost*[59], Shirley McLellan describes this stereotype as regressive and as stopping Black women from being seen as multi-dimensional. In addition, Black women are much more likely than white women in the UK to suffer common mental disorders such as depression or anxiety.[60]

4.2.117 It may be that this stereotype was at work here, making it more difficult for Andrea to ask for help regarding her relationship with Dean, and to ask for help regarding her physical strength diminishing.

4.2.118 As none of the medical professionals responded pro-actively to Andrea's situation, nor did they enquire more about her expressed concerns, it may be that they too were subconsciously influenced by the strong Black woman stereotype.

4.2.119 The Panel discussed this and considered whether Andrea was asked about her family (though not recorded) which might have raised another stereotype identified by a Panel member that large Black families provide extensive care for each other.

4.2.120 The Panel concluded that there was no identifiable and overt discrimination based on the protected characteristics in this case. However, they considered that unconscious bias might have played a role in the response of professionals. They made the following recommendation as a result.

4.2.121 **Recommendation: That adult and child safeguarding training in Bexley include training on unconscious bias and systemic discrimination, including cultural attitudes that discourage people from seeking help from agencies, and professionals' understanding of cultural attitudes. Staff to be alerted to information and resources available locally to understand and address these concerns.**

4.2.122 The children's ages left them vulnerable as a result of Andrea's disability and Dean's control. Agencies had very little contact with the children and those few contacts provided no evidence of discrimination, harassment or victimisation due to their ages, sex or race. The characteristics of religion or belief, disability, sexual orientation, pregnancy, marital status or gender reassignment were not pertinent for them.

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[58] Allen, A, et al (2019) "Racial discrimination, the Superwoman schema, and allostatic load, exploring an integrative stress-coping model among African American women" Annals of the New York Academy of Sciences, Vol 1457, Issue 1.

[59] McLellan, S., "Let's End the 'Strong Black Woman' Stereotype. Can't we Be Vulnerable and Emotional Too?" 26 September 2019, *Huffpost*. Available at: www.huffingtonpost.co.uk/

[60] From Government website: www.ethnicity-facts-figures.service.gov.uk. Also McManus, S., Bebbington, P,. Jenkins, R., Brughta, T. (eds) "Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014", Leeds: NHS Digital, p. 61. Cole, Marverine, (20 July 2018) "The 'strong black woman' stereotype is harming our mental health", *The Guardian*.

5. Conclusions and Lessons to be Learnt

5.1 Conclusions

5.1.1 Dean appears to have been exercising oppressive control over Andrea. There were a number of possible routes to identifying this and offering appropriate support to Andrea:

(a) By healthcare professionals showing professional curiosity about how she was managing to cope with her children as well as her own care needs as her health and strength reduced dramatically. Exploring Andrea's care needs would have identified Dean as Andrea's carer and might have helped professionals have a better understanding of what was happening in their household. Dean's ability and willingness to provide Andrea's care could have been discussed and the impact on him of caring for her. This might also have led to an assessment of the appropriateness of Jordan's care of his mother and the impact on him and Andrea of this.

(b) By healthcare professionals identifying that Andrea was an "adult at risk" as a result of her diminishing health. Again, this would have led to assessments of her needs, Dean's ability and willingness to provide Andrea's care, the impact on him of caring for her, and the role and appropriateness of Jordan's role in her care.

(c) By professionals and family identifying Dean's behaviours as domestic abuse. Though coercive and controlling behaviour was only recognised as a crime in December 2015, these behaviours have been recognised as risk factors in domestic abuse for several decades. But these were, and are, less well-known to the general population and to professionals than physical abuse.

5.1.2 There were many missed opportunities to talk to Andrea about how she was coping at home and about her challenges in caring for the children with her increasing weakness.

5.1.3 Dean managed to stay out of the record altogether, apart from his cannabis conviction, which is unusual.

5.1.4 There was a surprising lack of professional curiosity about Andrea's care and the care of her children, given her declining health. Asking questions may not have led to disclosures of her needs, or of the controlling relationship she appeared to have been subjected to by Dean. But if she had talked about her care needs, and if she and

Dean had accepted support, it may be that this would have reduced the anxiety and stress on the whole family.

5.1.5 In this case, Andrea's ill-health was an opening for conversations she may have been willing to have and that may have created a sense of trust with professionals so that she could talk to them about her relationship with Dean.

5.1.6 It may be that if professionals had taken the opportunities to ask Andrea how she was coping with her physical limitations and her childcare responsibilities, that interventions may have been put in place. It also may be that Andrea may have declined these offers of help, as she had declined offers from her family and friends.

5.1.7 The police concluded that Dean killed Andrea and their children because she was leaving him. If through the discussions of her care needs, Dean's control became known then there would have been opportunities to intervene to keep her safe.

5.1.8 Andrea's family say that she would not have described herself as a victim of domestic abuse because Dean did not hit her. Neither Andrea nor her family knew that the control he exercised was abusive behaviour. The criminal offence of coercive behaviour became law later in the month that Andrea and the children were killed.

5.1.9 Family and friends describe Andrea as a confident professional woman who, when the relationship with Dean started, was someone well accustomed to having and exercising control over her life. As happens in coercive and controlling relationships, Andrea's agency was diminished by Dean and that loss was accelerated by her deteriorating health.

5.2 Lessons learned

5.2.1 Those suffering in coercive and controlling relationships, particularly where they have not been physically abused, may not think they are suffering domestic abuse. As a result, they may not access help that is identified as being for victims of domestic abuse. The same is true for family and friends. When raising awareness about domestic abuse, it is important to identify controlling behaviours as criminal.

5.2.2 All services need to create the opportunity for victims to disclose any abuse they may be suffering at home.

5.2.3 For families who use services less often, the importance of taking those rare opportunities to ask about patients' situation is critical.

5.2.4 Illness and disability increase the vulnerability and risk for victims of domestic abuse, but also create more opportunity for professionals to have contact and build trust with victims. Victims are more likely to talk about the abuse with people they trust. These opportunities need to be identified and grasped.

6. Recommendations

6.1 National Recommendations

6.1.1 **Recommendation 1**: Home Office to launch a campaign to help the public understand coercive control and to direct them to local sources of support. Campaign to target cultural and social norms that support, accept or disguise coercive control, particularly acknowledging the issue of shame.

6.1.2 **Recommendation 2:** NHS England to ensure that health professionals giving a terminal diagnosis organise for immediate support to be available to patients to discuss the impact of their illness and the prognosis on their life, and the support likely to be needed and available.

6.1.3 **Recommendation 3:** The Department of Education require parents who are home-educating to register this with their local authority's Education Services. That the Department of Education provide guidance on when and with whom local authority Education Services can share this information with other agencies.

6.2 Overview Report Recommendations

6.2.1 The recommendations below should be acted on through the development of an action plan, with progress reported on to the Bexley Community Safety Partnership within six months of the review being approved by the partnership.

6.2.2 **Recommendation 1**

After the pandemic has subsided, the **agencies represented on this DHR Panel** review their safeguarding provision to ensure that they have the capacity to meet the needs of statutory review processes such as domestic homicide reviews.

6.2.3 **Recommendation 2**

Bexley Community Safety Partnership to launch a campaign help the public understand coercive control and to direct them to local sources of support. Campaign to target cultural and social norms that support, accept or disguise coercive control, particularly acknowledging the issue of shame.

6.2.4 **Recommendation 3**

Bexley Community Safety Partnership to ensure that all safeguarding adult and child training use this case to make several points:

(a) Everyone has a role to play in stopping domestic abuse

(b) It is critical that opportunities to enquire and support patients/clients are not missed.

(c) If in doubt, staff should discuss domestic abuse concerns with their Safeguarding Lead and then, if appropriate, refer the case to someone more specialised.

(d) How a Think Family approach might have opened a number of routes to safety for this family.

(e) Include information about local voluntary agencies that might provide additional support to patients.

6.2.5 **Recommendation 4**

Dartford and Gravesham NHS Trust and King's College Hospital NHS Foundation Trust, Oxleas NHS Foundation Trust, Bexley GPs, and community care services: Review policies regarding care of patients with disabling conditions to ensure that conversations about support and care needs are introduced when the symptoms impact daily living.

6.2.6 **Recommendation 5**

That the Domestic Abuse Health Subgroup works to ensure the following**:**

(a) That health referrals to domestic abuse services are monitored as part of the evaluation of health professionals' training on domestic abuse.

(b) That a consistent and coordinated plan is developed for routine enquiry in health services based on best practice

(c) That health training on domestic abuse includes the cultural barriers that might stop ethnic minority victims reporting and that might affect health professionals' responses to ethnic minority victims.

6.2.7 **Recommendation 6**

Local health services (GP surgeries, Oxleas, KCH and DVH) to use this case in training to

(a) Identify the need to think about wider safeguarding issues when working with patients, including considerations of Andrea as an adult at risk, and the children being at risk of neglect

(b) Promote the understanding of coercive control, what it might look like in situations where the victim has a progressive illness

(c) Develop professional curiosity about the impact of patient's symptoms on their daily lives and how they manage their lives, relationships and children, and how to ask patients about their lives

(d) Identify what further support might be necessary to keep patients and their children safe and healthy and ensure the patient is connected to that support

(e) Consider how to improve the gathering of information about clients and sharing that information with other health agencies.

6.2.8 **Recommendation 7**

6.2.9 **That Bexley CSP** ask local statutory and voluntary partners to include in their borough-wide policy and practice, that when professionals learn that a client or patient is home-educating and gain consent of the parents, that the fact of their home-educating is shared with Bexley's Education Services.

6.2.10 **Recommendation 8**

6.2.11 That the **Bexley Education Services** determine and communicate the mechanism for agencies to inform them of families who are home-educating and have consented to the sharing of this information.

6.2.12 **Recommendation 9**

That the **Bexley Community Safety Partnership and the South East Clinical Commissioning Group** work together to see that secondary and primary care health professionals in Bexley are provided with information about the variety of local support organisations in Bexley and how to refer clients to them. That LBB ensures that health professionals are supplied with information to share with patients about the help that is available through these organisations.

6.2.13 **Recommendation 10**

That **adult and child safeguarding training in Bexley** include training on unconscious bias and systemic discrimination, including cultural attitudes that discourage people from seeking help from agencies, and professionals' understanding of cultural attitudes. Staff to be alerted to information and resources available locally to understand and address these concerns.

6.2.14 **Recommendation 11**

Bexley Community Safety Partnership provide regular updates to Andrea's family on the completion of this review's action plan.

6.3 IMR Single Agency Recommendations

6.3.1 **Dartford and Gravesham NHS Trust:**

6.3.2 **Recommendation 1**

When a physical health condition is identified as having an impact on activities of daily living, a referral to occupational therapy would be recommended to assess for appropriate support for patient to manage their daily activities.

6.3.3 **Recommendation 2**

Records of consultations and appointments to include the identity and relationship of the person attending with the patient.

6.3.4 **King's College Hospital NHS Trust:**

6.3.5 **Recommendation 1**

King's College Hospital outpatient departments to make routine enquiries about domestic abuse for all patients accessing the service. This will include episodes of care involving IVIG/Clinical research. This aligns with KCH Safeguarding Adults Service on going work to raise awareness around domestic abuse.

6.3.6 **Recommendation 2**

King's College Hospital to ensure that episodes of care involving IVIG/Clinical research are recorded and accessible to other professionals.

6.3.7 **Oxleas NHS Foundation Trust:**

6.3.8 **Recommendation 1**

Domestic abuse to be included in all safeguarding adults and safeguarding children training offered to trust staff.

6.3.9 **Recommendation 2**

The safeguarding team to promote the domestic abuse e-learning to all adult facing staff.

6.3.10 **Bexley Clinical Commissioning Group:**

CCG to advise that GP palliative care meetings should be extended to consider anyone with a new diagnosis of a life-limiting condition in order to review their situations and ensure that appropriate support is offered to those:

(a) with caring responsibilities for a child or vulnerable adult

(b) who may have no support themselves

(c) who may rely on young members of their households as carers

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Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Andrea, Jordan, Sammy and Dean following the deaths of Andrea, Jordan and Sammy in December 2015.

The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Andrea, Jordan, Sammy and Dean during the relevant period of time 16 August 2011 through 13 December 2015. To summarise agency involvement prior to August 2011.
2. To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
3. To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
5. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
6. To contribute to a better understanding of the nature of domestic violence and abuse.
7. To highlight good practice.

Definitions: Domestic Violence and Coercive Control

8. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government definition states that domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

9. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of Andrea, Jordan, Sammy and Dean (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child).
10. The Review Panel identified the following protected characteristics of Andrea, Jordan, Sammy and of Dean as requiring specific consideration for this case: sex, age (the children), disability and race/ethnicity.
11. The following issues have also been identified as particularly pertinent to this homicide: children as carers, carer stress.
12. Consideration has been given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' Definition in Section 42 the Care Act 2014:

    "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."

    Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.

If it is the case that any party is an adult at risk, the review panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.

The Care Act 2014 states; “Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.”

13. *Expertise:* The Review Panel will therefore invite Solace BME specialist e.g. BME community org/faith representative, LGBT, substance misuse, disability organisation etc to the panel as an expert/advisory panel member to the chair to ensure they are providing appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide.
14. If Andrea, Jordan, Sammy and Dean have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with those communities. The following person/agency will be invited to contribute to the review to represent the voice of this community: Specialist BME worker.
15. The CSP will make the link with relevant interested parties outside the main statutory agencies.
16. The Review Panel will review the impact on Andrea, Jordan, Sammy and Dean’s or immigration status and how agencies responded to their needs.
17. The Review Panel agrees it is important to have an intersectional framework to review Andrea, Jordan, Sammy and Dean’s life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one’s experience with local services/agencies and within their community.

Parallel Reviews

18. If there are other investigations or inquests into the death, the panel will agree to either:
    a. Run the review in parallel to the other investigations, or
    b. Conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

c. The panel will do the following to ensure the DHR process dovetails with other reviews:
   i. Review SCR/Child Death Review that was completed
   ii. Review Learning Review previously completed and the material prepared for that
   iii. Review the action plan that was put in place following the Learning Review
   iv. It will be the responsibility of the review panel chair to ensure contact is made with the chair of any parallel process.

[Criminal trial disclosure dealt with in disclosure paragraph below]

Membership

19. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
20. The following agencies are to be on the Review Panel:
    a) Bexley Clinical Commissioning Group
    b) Oxleas NHS Foundation Trust --- provided occupational therapy and health visiting
    c) Kings College Hospital NHS Foundation Trust
    d) Dartford and Gravesham NHS Foundation Trust
    e) Bexley Adult Social Care Services
    f) Bexley Children's Social Care Services
    g) Bexley Community Safety Partnership
    h) Bexley Education Services and/or School(s)
    i) Solace Women's Aid
    j) NHS England
    k) Police (Borough Commander or representative, Senior Investigating Officer (for first meeting only) and IMR author)
21. Andrea, Jordan, Sammy and Dean lived in another local authority area before August 2011. The Review Panel considered this and the following agencies will be invited to contribute to the review: the private school that the older child attended in 2012.
22. The following will be asked to contribute to the review as experts:
    a) Carers UK
    b) Solace
    c) Black and ethnic minority specialist

Collating evidence

23. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.
24. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Andrea, Jordan, Sammy and Dean during the relevant time period:
    a. Kings College Hospital NHS Trust – IMR and chronology
    b. CCG for Bexley GP – IMR and chronology
    c. Bexley Health Visiting – IMR and chronology
    d. Darent Valley Hospital, Dartford and Gravesham NHS Trust – IMR and chronology
    e. Oxleas NHS Foundation Trust – summary of involvement of occupational therapist
    f. Oxleas NHS Foundation Trust Health Visiting– IMR and chronology
25. Further agencies may be asked to completed chronologies and IMRs if their involvement with Andrea, Jordan, Sammy and Dean becomes apparent through the information received as part of the review.

Key Lines of Inquiry

26. In order to critically analyse the incident and the agencies' responses to Andrea, Jordan, Sammy and/or Dean, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Andrea, Jordan, Sammy and Dean [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
    g) Review the oversight of children when home-educated and what opportunities there are to identify domestic abuse.
    h) Children as carers
    i) Carer stress

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

27. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Bexley Community Safety Partnership on their action plans within six months of the Review being completed.
28. Bexley Community Safety Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

29. The review will sensitively attempt to involve the family of Andrea, Jordan and Sammy in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the police.
30. Consideration will be given to inviting Dean to participate in the review.
31. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
32. The Review Panel discussed involvement of other informal networks of Andrea, Jordan, Sammy and Dean and agreed it was proportionate to the DHR to invite a sibling and a cousin to be involved in the DHR.

Media handling

33. Any enquiries from the media and family should be forwarded to the Bexley Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Bexley Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.
34. The Bexley Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

35. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

Disclosure

36. As the criminal trial had completed at the start of this DHR, there were no disclosure issues.
37. The sharing of information by agencies in relation to their contact with the victim and/or the perpetrator is guided by the following:
    a) The Data Protection Act 2018 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs(Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.

Appendix 2: Duluth Power and Control wheel

DOMESTIC ABUSE INTERVENTION PROGRAMS
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.theduluthmodel.org

Appendix 3: Table of Abbreviations

Abbreviation	Meaning
BSL	British Sign Language
CiN	Child in Need
CSP	Community Safety Partnership
DVC&V	Domestic Violence, Crime and Victims Act 2004
EHE	Elective Home Educating
IMR	Individual Management Review
KCH	King's College Hospital NHS Foundation Trust
LBB	London Borough of Bexley
LLR	Local Learning Review
LSCB	Local Safeguarding Children's Board
SISG	Serious incident Sub-Group of the LSCB

Appendix 4: Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
What is the over-arching recommendation?	*Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for the national level)*	*How exactly is the relevant agency going to make this recommendation happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this recommendation be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*