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The following document contains material of a highly sensitive nature (including references to death, violence, and abuse) and may be upsetting for some individuals.

EXECUTIVE SUMMARY

of the

Domestic Homicide Review and Serious Case Review

relating to the deaths of Maria, Tomas and their child Alex in January 2017

on behalf of:

A SURREY LOCAL COMMUNITY SAFETY PARTNERSHIP

Report author: **Liz Borthwick**
Independent Chair

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1. INTRODUCTION

This Executive Summary outlines the process and findings of a joint Domestic Homicide and Serious Case Review undertaken by East Surrey Community Safety Partnership and Surrey Safeguarding Children Board into the tragic deaths of Maria, Tomas and Alex. The identity of those involved has been anonymised for the purpose of confidentiality.

2. OUTLINE OF THE INCIDENT

i. In late January 2017, Surrey Police received a 999 call from Tomas's employer who had been to check the whereabouts of Tomas as unusually he had not arrived for work that morning. On approaching the nearby cottage where Maria, Tomas and Alex lived, he found it in smoking ruins with the roof completely burned out.

ii. When the Emergency Services attended the cottage, they found the badly burned remains of three bodies, subsequently identified through DNA and dental records to be Maria, Tomas and Alex.

iii. The police and fire investigations concluded that the fire had been deliberately started by one or both parents and that this was the cause of the death of Alex.

iv. In early February 2018 HM Coroner for Surrey returned a verdict of unlawful killing of Alex and an open verdict as to the cause of death for Maria and Tomas as the person starting the fire was unknown.

The panel would like to express its sincere condolences to the family and friends of Maria and Tomas and Alex for their losses in this very tragic incident.

3. DOMESTIC HOMICIDE REVIEW

The review considered the issues identified in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (DHRs), issued under section 9(3) of the Domestic Violence, Crime and Victims Act (2004) and aims in particular to:

a. Establish what lessons are to be learned from the domestic homicide regarding how effectively local professionals and organisations work individually and together to safeguard victims;
b. Identify clearly what those lessons are, how and within what timescales they will be acted upon, and what is expected to change as a result;
c. Apply these lessons to service responses including changes to policies and procedures as appropriate; and
d. Prevent future domestic violence homicides wherever possible, through intra and inter agency working.

4. SERIOUS CASE REVIEW

Serious Case Reviews are commissioned by the Independent Chair of the Local Safeguarding Children Board where:

i. Abuse or neglect of a child is known or suspected; and

ii. Either (a) the child has died; or (b) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The Strategic Case Review Group of the Surrey Safeguarding Children Board agreed that the case met the criteria for a proportionate Serious Case Review (SCR) in accordance with Working Together 2015 Statutory Guidance. The Independent Chair agreed a joint DHR / SCR process for this case.

5. TERMS OF REFERENCE

Terms of Reference were agreed by the DHR / SCR Panel in August 2017 and were regularly reviewed and amended as further details of the incident emerged (see Appendix Two).

6. INDEPENDENCE

The Chair and author of the review is Liz Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council. Liz has a wide range of expertise including services for vulnerable adults and children, housing and domestic violence. She has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has also been involved with a number of SCRs chaired several Domestic Homicide Reviews and has no connection with the local Borough or any of the agencies in this case.

Liz was supported in this review by Debbie Stitt as DHR / SCR Co-ordinator. Debbie has worked in Community Safety for many years and has a thorough understanding and knowledge of domestic abuse and the processes involved in DHRs. Debbie has attended Home Office training in the running and delivery of DHRs.

7. PARALLEL AND RELATED PROCESSES

The inquest took place in February 2018 and the Coroner returned verdicts of unlawful killing in respect of Alex and an open verdict on Maria and Tomas.

8. METHODOLOGY

The Chair requested Individual Management Reviews (IMRs) from those potentially having contact with Maria, Tomas and Alex. The chronological period for any engagement was from the birth of Alex in 2010 until the fire in January 2017 unless there was anything of note prior to this.

In particular they were asked to feedback on the following:

- Awareness of the potential presence of coercive and controlling behaviour and how this impacted on the behaviour of the mother and father.
- Consideration of any equality and diversity issues that appeared pertinent to the mother, father and child, including support available in an appropriate language.
- Investigation of support provided for debt management and bereavement support following the suicide of Maria's daughter.
- Agencies that had no contact were asked to assess whether helpful support would have been available and to identify any barriers in accessing it e.g. language, lack of internet provision or skills.

- Assessment of any training or awareness-raising input that would ensure a greater knowledge and understanding of the impact of domestic abuse and the availability of support services.
- Consideration of whether the child's welfare was promoted and protected through effective assessment (including risks) and the response to the needs identified

9. CONTRIBUTORS TO THE REVIEW

Five agencies submitted IMRs detailing their contact with Maria, Tomas and Alex:

- Surrey Police (no knowledge or contact prior to incident in January 2017)
- Surrey and Sussex Healthcare NHS Trust (SASH)
- Children and Family Health Surrey (CFHS)
- Health (Surrey GPs)
- Alex's Primary School

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

The panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.

The following agencies and voluntary groups were contacted and confirmed that they had no relevant engagement with the family:

- The local authorities where they had lived
- The local authority housing in those areas
- Surrey Children Services
- Surrey Adult Social Services
- Surrey & Borders Partnership NHS Trust
- National Probation Service
- Local Domestic Abuse Outreach providers.

The Independent Chair also spoke with a number of voluntary and statutory agencies providing services in the area, to gain an understanding of the support available to people who suffer from depression and anxiety and debt issues.

10. PANEL MEMBERSHIP

The Panel consisted of senior representatives from the following agencies:

Clinton Blackburn	Det. Superintendent Public Protection Unit	Surrey Police
Bridie Anderson	Force Domestic Abuse Advisor	Surrey Police
Amanda Quincey	Manager	Surrey Safeguarding Children Board
Siobhan Burns	Head of Safeguarding	Surrey County Council Children Services
Fiona Crimmins	Adult Safeguarding Lead	Surrey and Sussex Healthcare Trust
Michelle Blunsom	Chief Executive	Local Domestic Abuse Outreach Service
Noreen Gurner	Specialist Nurse for Child Death Reviews	NHS Guildford and Waverley CCG

Ben Murray	Senior Manager for Leisure and Regulation	Local Council
Sarah Crosbie	Community Safety Officer	Local Council
Hilary New	Community Safety Manager	Local Community Safety Partnership
Dr Tara Jones	Surrey-wide Designated GP for Safeguarding Children	Designated GP
Paul Risbridger	Fire Investigation & Community Risk Reduction Officer	Surrey Fire & Rescue Service
Liz Borthwick	DHR / SCR Chair	Independent
Debbie Stitt	DHR / SCR Coordinator	Independent

11. CONTACT WITH FAMILY AND FRIENDS

The chair sought contact with the family of Tomas by letter and through the Investigating Officer in this case. The family of Maria who lived in Chile were also contacted by letter translated into Spanish, without a response.

The review was supplemented by a number of interviews / conversations by the Independent Chair, with employers, the head teacher and friends in an attempt to understand the personal backgrounds of Maria, Tomas and Alex and to identify if there had been any previous concerns about domestic violence or the safety of Alex. These interviews were especially important as Maria was from Chile and had no family in this country and Tomas was Portuguese and although he had some family who lived nearby, they chose not to be fully engaged with the DHR / SCR process.

The panel discussed whether contact should be made with any of Alex's schools friends but it was felt that it was not appropriate as they were so young and were very distressed over the death of Alex.

12. SUMMARY OF THE CASE

The DHR / SCR Panel acknowledge that it has been difficult to source extensive details about Maria, Tomas and Alex. The family of Tomas only engaged with the Chair briefly as they were so upset and could not comprehend how and why the tragedy had happened. Maria's family, who live oversees did not engage although they were contacted in their native language. The information has been built up from a family friend, employers and the very few agencies that the family had contact with. The lack of direct information from the family should be borne in mind when drawing conclusions.

Tomas came from Europe as a 16 year old, lived with a family member and was employed as a gardener.

Maria lived in South America and married her first husband at 16 as she was pregnant. The marriage ended in divorce after a few years and Maria moved to Europe but left her daughter with her ex-husband in South America as she felt it would be better for the child to stay with her father. She stated to friends that she always felt guilty about this. Maria met her second husband and they moved to the United Kingdom. It was alleged that Maria's second husband became violent towards her and she left him.

Tomas subsequently met Maria through his sister; they married quickly and had Alex. The family lived in Surrey for a while before moving to Essex for employment. However accommodation was difficult and Tomas was successful in getting a gardener's role back in Surrey with a rent free cottage included as part of the employment package.

Just before Maria's daughter's 16th birthday, the daughter committed suicide in South America. Maria never forgave herself for leaving her daughter and she sought medical help for depression. She was self- harming and it is alleged she tried to commit suicide.

Comments received from friends and those who knew the family described them as happy family. Tomas and Maria loved each other and both adored Alex. Comments indicate that Alex was bright, energetic, making good progress at school and had a number of school friends.

13. EVENTS LEADING TO THE DEATHS IN JANUARY 2017

A few days before the fire, Tomas had received a number of calls from debt collectors and his bank, which he did not answer.

The day before the fire, the family was reported as going about its normal business. It was Maria's birthday and a friend visited with a gift. Tomas's family had arranged a family meal to celebrate her birthday a few days later. A friend of Alex had been invited over to play the following day.

Early the following morning, distant neighbours heard a loud sound and saw smoke coming from the approximate location of the cottage but thought nothing of it.

Later that morning the employer went to the cottage as Tomas had, unusually, not turned up for work. He found the cottage in smoking ruins and phoned the police.

The emergency services found three bodies in one bedroom which were later identified through DNA as Maria, Tomas and Alex. Fire officers found that there had been a large explosion in the bedroom which caused the fire. There was neither gas in the house nor any reported issues with the electrics.

Crime scene and fire investigators found petrol in the bedroom which had been used as an accelerant. It was not possible to determine who may have done this. The fire investigator said that no one would have survived the explosion.

The police reviewed the evidence and confirmed that no other parties were involved. The Coroner at the inquest agreed with the police findings and recorded an open verdict for Maria and Tomas and the unlawful killing of Alex.

14. KEY ISSUES ARISING FROM THE REVIEW

The review identified a number of possible key triggers which *may have* led to the tragic event in which the family died, including;

- *Language issues and isolation*
- *Mental Health, including depression, anxiety and self-harm*
- *Debt*

i. Language Issues

Although Tomas had a thorough understanding of English, it was not fully clear how well Maria spoke and read English. Whilst there is a lot of information and advice available for debt issues and mental health support in the community, it is in English and / or access to the internet is required. Although there are translation opportunities on line, reasonable IT skills are required. Tomas & Maria did not have access to the internet in the cottage and mobile phone signal coverage is patchy in this rural area.

ii. Mental Health

Maria did seek medical support for her depression but it would appear that there was no enquiry around domestic abuse, either present or historic (it is alleged that Maria's second marriage had been abusive). There was no enquiry around any history of mental health issues within the wider family or relating to debt. The assumption was made that Maria's depression and anxiety were related to the death of her daughter.

iii. Debt

Maria and Tomas were in debt which they kept from their families who may have been able to help. Tomas shared this information with a family friend who had previously helped them financially but he did not seek professional support through organisations such as the CAB. The review identified that debt agencies are struggling to cope with demand and that although services are available in towns the rural communities are less well supported.

15. CONCLUSION

i. This review has highlighted the difficulty of predicting such a tragedy as happened in January 2017 where there was little or no engagement with local agencies.
ii. There is no evidence of any previous domestic abuse within Maria and Tomas relationship, although it was alleged that Maria had suffered domestic abuse in a previous marriage. There is no evidence at all that Alex was subject to any abuse before the tragic event in January 2017. From most accounts, the family was devoted to each other. It has not been possible to identify the adult perpetrator or the adult victim in this review. What is known is that Alex was a victim and the perpetrator was one or both of the parents.
iii. The review has identified ways in which support, information and advice around debt and mental health issues could have helped the family. There are many professionals who, with the right tools, would be able to identify or sign post families who may have debt or mental health issues.
iv. The review has also identified the limited availability of information in different languages and that professionals should understand what tools are available to translate such information.

16. RECOMMENDATIONS

Four key areas of learning were identified in the Review; Debt, Mental Health, Language translation services and 'professional curiosity', particularly in relation to Domestic Abuse. The below recommendations highlight ways in which support in these areas can be improved

❖ Recommendation One: Raising Awareness of support for Debt

i. Ensure that frontline service staff, particularly those involved in conducting family assessments, are fully aware of the debt advice services available and how to refer. This will include Family Service and Family Support Programme staff, Health & Wellbeing Being Advisors and Housing officers.

ii. Provide any necessary training for staff as required and encourage 'professional curiosity', to ensure questions around debt are routinely asked of all clients seen.
Responsibility: The local CSP

- **Recommendation Two: Support people in rural communities to access Debt and Mental Health advice**

  Encourage debt and mental health services to provide information about their services to community organisations in rural communities, e.g. through churches, schools and other rural community hubs.
  Responsibility: The local CSP

- **Recommendation Three: Improve availability of information in East Surrey relating to Debt and Mental Health**

  ESCCG to expand information on its Mental Health Service leaflet to include Debt Services (CAB and Debt Advice charities) and the local Domestic Abuse Outreach Service.
  Responsibility: East Surrey CCG

- **Recommendation Four: Raise awareness of Language translation services**

  The local CSP Chair to write to all CCGs in Surrey and to Surrey CVS to encourage service providers to use translation tools e.g. Google Translate, Collins Translate to provide information about services in different languages.
  Responsibility: The local CSP

- **Recommendation Five: Early Help and Emerging Need**

  To increase the understanding and awareness of early help for families which will include the understanding and review of whether a family is able to supports its basic needs; to be promoted via training and relevant newsletters, e.g. Surrey Safeguarding Children Board. This will include health and social care, housing and family support professionals.
  Responsibility: Surrey Safeguarding Adult and Children Boards.

- **Recommendation Six: Domestic Abuse Safeguarding Training**

  Surrey Safeguarding Adults and Children Boards to review their Safeguarding training to ensure that it encourages 'professional curiosity' to explore Domestic Abuse, inclusive of Controlling Coercive Behaviour (CCB) and the impact of historic DA
  Responsibility: Surrey Safeguarding Adult and Children Boards

- **Recommendation Seven: Promote the value of IRIS to NHS England**

  The Chairs of Surrey Adult and Children Safeguarding Boards to write to NHS England to highlight the importance of IRIS in local safeguarding.
  Responsibility: Surrey Safeguarding Adult and Children Boards

- **Recommendation Eight: Individual Agency Actions**

  For partner agencies to continue to implement the changes identified within their submitted IMRs.