Content warning: over 18s only

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

OVERVIEW REPORT

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

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Independent Chair

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1. PREFACE

1.1 This report of a Domestic Homicide Review and a Serious Case Review examines agency responses and support given to Tomas & Maria and their child Alex, who were residents of Surrey, prior to their death in January 2017.
The review will identify any agencies that were involved with the family, or which could have provided support. It will examine the past to identify any relevant behaviours towards or by any of the parties that may have impacted the homicide, whether support was accessed within the community, whether there are identified gaps in provision and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2 DHR: Domestic Homicide Reviews became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living within the same household.
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.

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

(a) Abuse or neglect of a child is known or suspected; and
(b) Either - (i) the child has died; or (ii) 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.

1.4 Time scales: The review will consider agencies' contact / involvement with Maria, Tomas and Alex from the birth of the child in 2010 although brief information will be assessed for relevance regarding the lives of the adults from the arrival in the UK of Tomas in 2003. The review began in July 2017 and concluded in June 2018, with submission to the Home Office in June 2018. The HO Quality Assurance Panel approved this report in January 2019 subject to some minor changes.

The Home Office confirmed an extension of the standard six-month deadline due to the need to contact family members in South America and the difficulty in gaining initial information about the family history.

1.5 Incident summary: The purpose of this review is to examine the circumstances surrounding the tragic deaths in a fire of Maria, Tomas and their child Alex[1] who lived in Surrey. The fire had been started deliberately from inside the bedroom of the cottage where they died but it was not possible to determine which of the adults was responsible. The child was deemed to have been unlawfully killed.

1.6 Confidentiality: Information is shared between partners under the following legislation:

- *Crime & Disorder Act 1998;*
- *Data Protection Act 1998;*

[1] Pseudonyms have been used for confidentiality purposes.

- *Human Rights Act 1998;*
- *Common Law Duty of Confidentiality;*
- *The revised Caldicott Principles 2018.*

The detailed findings of each review are confidential. Information is available only to participating officers / professionals and their line managers. A confidentiality agreement has been signed at each meeting of the DHR Panel

1.7 Dissemination: The Executive Summary and Recommendations have been redacted to ensure confidentiality and have been disseminated to the following groups:

- The local Community Safety Partnership
- The Leader of the local Council and relevant Portfolio Holders
- Surrey Adult and Surrey Children Safeguarding Boards
- Surrey Community Safety Board
- The Office of Surrey Police & Crime Commissioner (OPCC)
- The agencies involved in the review
- The families of Maria, Tomas and Alex.

The DHR/SCR panel members wish to thank the family, friends and colleagues who participated in the review. We understand what a difficult time this must be and offer our sincerest sympathies on their tragic loss.

2. DETAILS OF THE INCIDENT

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

2.2 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.

2.3 The police and fire investigations concluded that the fire had been deliberately started by one or both parents and that one or both parents were responsible for the death of Alex.

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

3. THE REVIEW

3.1 Surrey Police notified the local Community Safety Partnership concerning the deaths of Maria, Tomas and Alex in April 2017 and that either one or both parents deliberately started the fire causing the deaths of all three. The local CSP met in May 2017 and decided that the criteria for a DHR had been met. Liz Borthwick was appointed as independent chair, supported by Debbie Stitt as co-ordinator (see Section 5.5).

3.2 The DHR was commissioned by the local CSP in accordance with the revised Statutory Guidance for the conduct of Domestic Homicide Reviews[2] published by the Home Office in March 2016.

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

3.3 The Strategic Case Review Group (SCRG) of Surrey Safeguarding Children Board (SSCB) received a referral for a Serious Case Review (SCR) for Alex which it considered May 2017. It agreed that the case met the criteria for a proportionate SCR, in accordance with the Working Together 2015 Statutory Guidance[3].

3.4 It was agreed that both reviews would be combined (i.e. a joint DHR & SCR) to streamline information gathering and to reduce the emotional impact on family and friends being interviewed twice for the reviews. Ofsted[4] and the SCR National Panel were notified in July 2017

3.5 The Chair of the local CSP notified the Home Office in May 2017 that a combined DHR / SCR would be commencing. After identifying the complexities of gathering information from family and friends, including from South America, the Home Office agreed to extend the standard six-month deadline (confirmed in December 2017).

4. TERMS OF REFERENCE

4.1 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 One).

5. PARALLEL INVESTIGATIONS AND RELATED PROCESSES

5.1 Inquest

In early February 2018, HM Coroner for Surrey returned verdicts of unlawful killing in respect of Alex and an open verdict on Maria and Tomas.

5.2 Serious Case Review

The Surrey Safeguarding Children Board (SSCB) was represented on the DHR panel from the outset, which was renamed the DHR / SCR Panel to reflect its joint responsibilities. Alex was 6 at the time of death at the hands of his parent(s) Maria, Tomas or both. Every attempt has been made to include the voice of Alex within the process and discover any relevant learning. It was therefore agreed by the panel that the Terms of Reference for this review would include Maria, Tomas and Alex.

5.3 Criminal Trial and disciplinary action

No criminal trial took place. It was deemed that there was no third party involvement and both possible perpetrators died in the fire with their child.

Any information that demonstrates the need for a disciplinary hearing will be addressed by the relevant agency and is not part of the review. In this case, none was identified.

5.4 Panel Membership

The Panel consisted of senior representatives from the following agencies:

- Clinton Blackburn - Det Superintendent, 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

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

[4] The Office for Standards in Education, Children's Services and Skills

- Michelle Blunsom - Chief Executive, East Surrey Domestic Abuse Service
- Noreen Gurner - Specialist Nurse for Child Death Reviews, NHS Guildford and Waverley CCG
- Ben Murray - Senior Manager for Leisure and Regulation, The Borough Council
- Sarah Crosbie - Community Safety Officer, The Borough Council
- Hilary New - Tandridge Community Safety Manager, East Surrey Community Safety Partnership
- Dr Tara Jones - Surrey-wide designated GP for Safeguarding Children
- Paul Risbridger - Fire Investigation Officer, Surrey Fire and Rescue Service
- Liz Borthwick - Independent DHR / SCR Chair
- Debbie Stitt - DHR / SCR Coordinator
- Voluntary sector organisations: the local Citizens Advice Bureau, Community Debt Advice and Mental Health charities were invited to attend a Panel meeting to support the DHR / SCR and help develop the recommendations and actions.

The panel met five times during the period July 2017- April 2018.

5.5 Independence of Chair

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 conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has also been involved with a number of SCRs. Liz 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.

6. SUBJECTS OF THE REVIEW

The main subjects of this review are:

DHR subject	Year of birth	Date of death
Maria (female adult)	1976	Late January 2017
Tomas (male adult)	1986	Late January 2017
Alex (child)	2010	Late January 2017

7. METHODOLOGY

7.1 Contributors to the Review

Statutory Agencies:

Each involved Surrey agency submitted an Individual Management Review (IMR) in accordance with the statutory guidance. Authors were independent of the incident and the reports were Quality Assured by the organisation. As the review progressed, additional agencies were identified who had contact with the family members and they were requested to contribute.

The following agencies submitted IMRs

- Surrey Police
- Surrey and Sussex Healthcare NHS Trust (SASH)
- Children and Family Health Surrey (CFHS)
- Health (Surrey GPs)
- Alex's Primary School

The panel has given 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 the family had lived
- Local housing providers
- Surrey Children Services
- Surrey Adult Social Services
- Surrey & Borders Partnership NHS Trust
- National Probation Service
- Local domestic abuse outreach providers

Family, Friends, Work Colleagues, Neighbours and the wider Community:

Information has been supplemented through interviews / conversations with family, friends and employers in an attempt to understand the personal backgrounds of Maria, Tomas and Alex. These interviews were especially important as Maria and Tomas were South American and Portuguese respectively. Maria had no family living in the United Kingdom although Tomas had relatives nearby.

7.2 Research by the Independent Chair relating to Maria, Tomas and Alex took place through face-to-face meetings and telephone conversations as detailed below. Individuals were provided with the relevant Home Office leaflet (for family, friends, employers and colleagues) in advance. All those contributing were able to choose the medium they preferred.
The Chair made contact with members of Tomas's family who live in the United Kingdom. They initially declined to be involved; however a family member subsequently made telephone contact to try to assist, although found it very distressing and was still in great shock about what had happened.
The Chair also contacted Maria's relatives in South America via an email translated into Spanish, to gain some information about Maria's background**.** There was no response.
The family have been updated regularly throughout the Review, regardless of whether they chose to be involved in the process.
The family have been sent a copy of the draft report and given the opportunity to make any amendments but they chose not to respond.

i. Meetings
Tomas's employers
Tomas's close friend

ii By Telephone:
Head teacher at Alex's school
Clients of Maria who she worked for as a cleaner
Surrey and Borders NHS Foundation Trust

Local mental health and debt support charities, plus the Citizen's Advice Bureau
Surrey GP Services lead for Safeguarding Children

7.3 The Chair also asked the Head Teacher at Alex's school to enquire if any parents would be prepared to input to the Review, however there was no response.

7.4 The panel discussed whether contact should be made with any of Alex's school friends but it was felt that this was inappropriate due to their age and as they were very distressed over Alex's death.

8. EQUALITIES

8.1 Maria was South American, from Chile and was 41 years old at the time of her death. Tomas was Portuguese and was 31 years old when he died. Alex was born in the United Kingdom and was 6 years old at his death.

8.2 The nine protected characteristics of the Equality Act 2010 were considered (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). Only three of these are considered by the review to have had an impact – marriage, religion and race. These are considered later within this report.

9. OVERVIEW OF FAMILY LIFE

9.1 This section of the report provides information about Maria, Tomas and Alex prior to their deaths, gathered from a range of sources as listed above.

9.2 Tomas came to the United Kingdom from Portugal as a 16 year old in 2003 to live with a family member in Surrey, trained as a gardener and worked in a garden centre nearby. Tomas's family say that he was shy and had not had many girlfriends.

9.3 Maria lived originally in Chile. She married her first husband in Chile at the age of 16 as she was pregnant and she had a daughter. It is alleged that Maria's first marriage was not a happy one and they divorced. Maria moved to Spain and although Maria wanted to take her daughter with her, she felt that it would be better for the child to stay with her father. Maria lived in Spain for a year and then met her second husband. Maria and her husband moved to the United Kingdom but it is alleged that he became violent towards her and she left him. The police have been unable to find any further details and it is believed he is no longer in the country.

9.4 Maria started work in Surrey and lodged with Tomas's sister who she met whilst working at the same office. Tomas and Maria met through his sister and married quickly. Alex was born in 2010.

9.5 Tomas left the garden centre and moved to work on a large private estate in the area. The estate was sold and in 2012 the family moved to Essex where Tomas worked at a local Zoo, expecting accommodation to be part of the contract. As this was not the case, the family had to rent a one-bedroom flat which was difficult with a young child. After a year Tomas left the zoo and successfully gained a gardening position at a large country house in Surrey. The position included a cottage as part of the employment package.

9.6 In 2010, a few days before Maria's daughter's 16th birthday, the daughter committed suicide in Chile. Maria had said that her daughter suffered depression and was openly gay which was not acceptable in Chile, a devoutly Catholic country.

9.7 Maria never forgave herself for leaving her daughter and suffered depression herself following her death. Maria sought medical advice and support but she was also self-harming and allegedly tried to commit suicide.

9.8 Despite these issues by all accounts the family was happy and Alex was well cared for. Family and friends said that Maria and Tomas loved each other and they adored Alex. There is some anecdotal information that there may have been a few tensions between Maria and Tomas before their deaths but these were felt to be within the boundaries of normal family relationships.

9.9 Alex attended the local infant school where attendance was good. Alex's first language was Portuguese so at times struggled but was making good progress. The school highlighted that Alex won a teaching award and received a special badge. Maria and Tomas were very supportive parents, helping their child with reading and homework. Both parents attended parents' evenings. The school stated that Alex was a well-loved child.

10. VOICES OF THE VICTIMS

The inquest found that the fire had been started deliberately and that Alex had been unlawfully killed. An open verdict was returned on both Maria and Tomas.

10.1 Tomas: Speaking with family and friends, all agreed that the couple loved each other very much. Tomas mentioned to a family member that if anything happened to one of the family they would all go together such was their love for each other. According to all accounts Tomas was a delightful, caring person who was very good at his job.

10.2 Maria: People who met Maria said she was a very beautiful woman who cared about her looks. Whilst she suffered depression and isolation she appeared to have had support from Tomas's family and friends.

10.3 Alex: People who knew Alex said the child was energetic, playful, diligent and bright, who had grown in confidence as English skills progressed. The child was loved, well looked after and supported by both Maria and Tomas.

11. BACKGROUND INFORMATION - THE FACTS

11.1 The family had lived in the tied cottage in the grounds of the property where Tomas worked for four years. All three were found dead together within the main bedroom of this property following the fire. Alex was their only child and there was no-one else living in property. The family had two cats which were also found dead in the same bedroom.

11.2 In late January 2017, Tomas had received seven calls over four days to his mobile phone which had been from debt collectors and his bank, which he had not answered.

- **Late January 2017 (the day before the fire)**

11.3 According to Tomas's employer, he arrived as normal for work on the day before the fire. Tomas met with the employer's wife to run through the work programme for the week which was normal practice, and then went about his work as usual.

11.4 Maria worked as a cleaner and had a number of regular clients in the local area. The day before the fire was Maria's birthday. In the morning Maria phoned one of her clients to say she would not be cleaning that day as Alex was not well. Maria asked if she could come and clean the following day instead (the day of the fire). However teachers at Alex's School confirmed

that he had attended school that day and was collected by Maria as normal at 3pm. This was the last sighting of Maria and Alex together.

11.5 During the afternoon of her birthday, a close family friend visited Maria to give her a birthday card, flowers and some wine. The friend described Maria as being happy and behaving as normal. She asked her friend to stay for dinner but this was declined due to a prior commitment.

11.6 Tomas's family member tried unsuccessfully to call Maria around 19.00hrs. At 19.25 it appears that Maria texted another of Tomas's family who she had lodged with before marrying Tomas. The text said "I thought I was family? Thank you for my birthday wish". The family member was uncertain what this meant, as they had a family meal planned at the weekend to celebrate Maria's birthday.

- **Late January 2017 (the day of the fire)**

11.7 Early the next morning, a neighbour who lived a short distance away from the cottage (obscured by trees) was at home working late. He said he heard a 'boom' sound but did not think anything of it and did not go to investigate. It appears in hindsight that this was the sound of an explosion from the cottage when the window was blown out.

11.8 Later at 02.30 hours another neighbour living further way, stated he saw a red glow and smoke coming from the approximate location of the cottage. The neighbour was unable to see the cottage from his house and at the time forgot it was there so thought nothing of it.

11.9 The neighbours were not overly concerned about what they heard or saw as living in a rural area they often had people shooting game and setting up fires to burn rubbish. It was an extremely foggy night and visibility was poor. Neither neighbour felt the need to contact the emergency services.

11.10 At 11.08 hours on the day of the fire in January 2017, Surrey Police received a 999 call from Tomas's employer who reported that when he went to check on his gardener, (as he had unusually not arrived for work that morning), he found that the cottage was a smoking ruin and that the roof had been completely burned through.

11.11 The Fire Service and Surrey Police attended the cottage and discovered the remains of three bodies in one bedroom. The recovered bodies were unable to be visually identified and were later confirmed from DNA tests and dental records.

11.12 Fire Officers found that there would have been a large explosion in the bedroom prior to the fire starting which caused the bedroom window to be blown out and fall 4-5 metres from the cottage. There was no gas at the property and no reported issues with the electrics. There were storage heaters through the cottage and an open fire in the dining / sitting room but no evidence of other heating sources.

11.13 Crime scene and fire investigators found three areas within the bedroom that tested positive for petrol which had been used as an accelerant. The fire investigation proposed that fumes from the petrol built up within the bedroom before being ignited. The explosion occurred within the main bedroom and was instant. The fire investigator stated that whoever ignited the fire must have been in the bedroom and that no-one could have survived the subsequent explosion.

11.14 The Senior Investigating Officer (SIO) from Surrey Police, having reviewed all the evidence, believed no other parties were involved. The SIO was of a strong view that either Tomas or Maria, or both had started the fire and were responsible for the death of Alex. Anyone within the bedroom would have been killed and certainly would not have been able to leave the room. For these reasons he believed that there were no other parties involved in causing the explosion and subsequent fire.

- **Post Mortems**

11.15 Post mortem examinations found no evidence of a violent assault. Histopathy and toxicology examinations revealed the following:

i. **Tomas:** There were no common drugs or alcohol detected. He died from exposure to fire and smoke inhalation

ii. **Maria:** Several drugs were detected including
   - *Alprazolam* (used to treat short term anxiety - not prescribed on NHS)
   - *Citalopram,* (prescribed for treatment of depression and panic disorder)
   - *Codeine* (for pain relief over the counter)
   - *Pholcodine* (treatment for coughs available over the counter).

   None were in a sufficient high enough concentration to have rendered her unconscious or have been fatal. She died from exposure to fire and fire fumes.

iii. **Alex:** Died from exposure to fire and fire fumes.

12. ENGAGEMENT WITH OTHER AGENCIES AND IMR FEEDBACK

This section has been compiled from the Individual Management Reviews (IMRs) submitted by the agencies involved. The objective was to provide an accurate account of engagement with Maria, Tomas and Alex to the date of their deaths, evaluate their own agency's actions and identify improvements for the future. All IMRs have been challenged robustly by the panel and, where appropriate, have been subject to review and revision.

12.1 Surrey Police IMR

Surrey Police reviewed their local and national databases (PNC - *Police National Computer* and PND - *Police National Database)* for any involvement with the family, which would also show any incidents taking place in other Police Force areas. The Multi Agency Safeguarding Hub (MASH) records were also checked. The review showed that there had been no contact with Maria, Tomas and Alex prior to the tragic incident late January 2017.

Lessons learnt: *There had been no contact with the family and none had been required; no lessons to be learned.*

12.2 Health (Surrey GPs) IMR

12.2.1 During the period of the review, Maria, Tomas and Alex were registered with three practices, two in Surrey and one in Essex. Until 2012 the family were registered with Practice C; they then moved to Essex and returned to Surrey and registered with Practice R, which has since closed.

12.2.2 Maria's Health

Maria had contact with her GP for a number of issues – of note there was contact relating to her mental health.

i. Surrey Practice C

- In May 2010 she disclosed to her GP that she was devastated about the suicide of her 16 year old daughter; she had not seen her daughter for over 4 years but had kept in touch. Maria said she could not sleep but she had no thoughts of self-harm due to caring for Alex. Maria was given support details (counselling from Cruse Bereavement Care[5]) and a small amount of sleeping tablets. Tomas was noted as being present and supportive, helping with translation.
- In June 2010 Maria, accompanied by Tomas, visited the GP for a review. Maria said she was coping well, had no thoughts of self-harm. She had also been in contact with her ex-husband (the father of her deceased daughter) and was planning a Mass in the UK. Maria was given a small amount of sleeping tablets and contact details for SOBS[6] (Survivors of Bereavement by Suicide) support group. The GP advised a further review but Maria did not return until October 2010 when she visited as she was feeling tired and lethargic. Bloods were normal. There was no comment on the medical records about Maria's mood or the bereavement. She next returned in January 2013 with similar symptoms of tiredness and lethargy and was prescribed appropriate medication.

Maria, Tomas and Alex registered with Surrey Practice R in September 2013 (which has since closed) on the family's return from Essex.

ii. Surrey Practice R

- In the time she was registered at Practice R (early summer 2013 - late January 2017) she consulted on 6 occasions**, 4 of these were in relation to her mental health**. She also had 3 out-of-hours / Accident and Emergency attendances in this period, all for viral / respiratory illnesses. She last consulted at the practice on 5th August 2015, nearly 18 months before her death.
- In October 2014 Maria presented to her GP with anxiety and depression. She had been seeing a private psychologist for the past year and said her problems started when her daughter committed suicide. She was in a low mood, anxious and had disturbed sleep. Maria's PHQ 9[7] score of 21 indicated a major depression including a positive score for thoughts of being better off dead / thoughts of self- harming, although she stated she would not end her life because of her child Alex. Maria was prescribed anti-depressant medication (mirtazapine) with a review booked for 5th November 2014.
- She returned in November 2014 and stated she had been to Portugal on holiday and was feeling much better in herself. The GP noted that Maria was more cheerful and made good eye contact. Maria continued on her antidepressants and a further review was agreed for December 2014.
- At the December review, she stated she had been doing much better but had been upset by a call from her brother in Chile informing her that her mother was unwell and she was considering whether to visit. She continued on her antidepressant medication.
- At the next review in January 2015, she stated that she did not go to Chile but that she was feeling better in herself and presented as being happy and relaxed. The GP advised her to continue the medication with a further review in February 2015.
- Maria did not attend this February appointment and no further prescriptions were issued for her depression and anxiety.
- In August 2015 Maria attended the practice and was seen by another GP for an episode of tonsillitis and antibiotics were prescribed. The medical records also state that Maria was

[5] Cruse Bereavement Care https://www.cruse.org.uk/
[6] Survivors of Bereavement by Suicide https://uksobs.org/
[7] PHQ - Patient Health Questionnaire (PHQ-9) completed by the patient. It assesses levels of depression.

'stressed and not sleeping well, and was worried about her mother who was unwell.' The GP prescribed a short course of sleeping tablets. There appears to have been no mention of her previous treatment for depression

- *Maria had no further contact with a GP until her death nearly 18 months later*

12.2.3 Tomas's Health

- Tomas had extremely limited contact with Primary Care. In total he was seen three times and two of these were for new patient checks.
- Tomas had no records of any significant history.

12.2.4 Alex's Health

- Alex's contact with Primary Care (and other health services) falls into two distinct sections. As a baby, Alex had recurrent episodes of intussusception (a condition where a section of bowel telescopes in on itself, resulting in acute abdominal pain) which resulted in the child undergoing emergency abdominal surgery in May 2011.
- Following this, Alex was seen much less frequently. There were 9 attendances (early summer 2013 - last consultation April 2016) whilst the child was registered at Practice R excluding appointments for routine immunisations. There were also 3 A+E / out of hours contacts; all of these were for minor childhood illnesses.
- Alex received all routine childhood immunisations, and there did not seem to be any concerns after the child's early physical health problems.
- *Alex last saw a GP at Medical Practice R April 2016.*

Lessons learnt: *No actions identified from IMR and no lessons to be learnt.*

- The Independent author of the IMR interviewed the leading GP at Medical Practice R. The GP had been interviewed after the deaths as part of the Coroner's and Police enquiries and the Child Death Review process. The GP described Alex as happy, healthy and apparently well cared for. The GP regularly saw Maria during her episode of depression and anxiety in 2013 demonstrating good continuity of care and routinely booking up follow up appointments. The GP recalls no apparent problems with the marriage and the GP records state that Tomas was very supportive.
- The IMR stated that the GP did not ask about domestic abuse as the apparent trigger for the depression was the death of her daughter, illness of her mother and the isolation from them due to the geographical separation.
- The IMR identified that the GP Medical Practice R had a Safeguarding Policy which included the sharing of information and a lead Safeguarding GP. The staff at the Practice had undergone IRIS[8] domestic abuse training in 2016 but this was after the family's last contact with the Practice.
- IRIS (Identification and Referral to Improve Safety) is a general practice-based domestic violence and abuse training support and referral programme. Core areas are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It is aimed at identifying women who are experiencing domestic violence and abuse from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.

Actions: *None identified.*

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[8] IRIS: http://www.irisdomesticviolence.org.uk/iris/

12.3 Surrey and Sussex NHS Health Care Trust (SaSH)

- Alex was the only member of the family to have contact with SASH. The child presented in May 2013, March 2014 and February 2015 with abdominal pains linked to gastroenteritis and to constipation. There were no ongoing concerns.

Lessons Learnt: *The IMR stated that Surrey and Sussex NHS Trust followed all appropriate steps to ensure the safety and welfare of the patient, who was questioned during each presentation to the Emergency Department.*

Actions: *None identified*

12.4 Children and Family Health Surrey (CFHS)

- Alex was born by caesarean section in January 2010. Early contact was unremarkable. The Health Visitor recommended that the family receive a universal service after the first contact. The universal service at this time was limited to a New Birth contact with opportunities for the child to attend clinic in the first year.
- Alex was taken for regular monthly check ups at the health clinic from March to June 2010 but did not attend the 27 month review in May 2012. At this time there was no protocol for a missed appointment. An information request was received from the GP in Essex shortly after, as Alex was now registered in that area.
- The family returned to Surrey in 2013 and Alex came to the attention of CFHS again in 2014 when enrolling at the local primary school. A school entry questionnaire was sent to Maria and Tomas and there was no indication of any concern over Alex's health or development. Alex was seen by the school nurse in October 2014 for a Routine Entry Health Screen where it was noted that Alex was in neat school uniform, made good eye contact, cooperated well and was able to hold an appropriate conversation.
- There was no indication for any follow up after this contact and class teacher did not raise any concerns for Alex's health or development. Alex had received all required immunisations and was next seen in school at routine nasal flu vaccinations in the Autumn Terms of 2015 and 2016.
- Contact was made with the Essex Health Visiting Team to obtain any information they may have had about Alex and Maria and Tomas. Essex Health visiting team stated that a universal service had been offered and that there had been no identified Safeguarding concerns.

Lessons Learnt:

i. *CFHS highlighted in their IMR that there was opportunity to reflect on the value of quality interventions and recording assessments particularly the New Birth Contact:* A health needs assessment can offer a rich picture of a family functioning including relationships and points of conflict and stress. Often parents can be sign posted to different agencies and organisations for support. Health Visitors are now trained in the Solihull approach[9] to work with the families, to provide a family and child focussed approach to listening and responding to parents.

ii. *Routine enquiries regarding domestic abuse are made on face to face contact by the health visitor.* It appears that there was not an opportunity to see Maria alone and this continues to be an issue for the service. This issue is being considered by CFHS. Practitioners are encouraged to be sensitive and consider the safety of the individual and yet identify opportunities available to make enquiry. An audit took place in 2017 looking at contact with

[9] Solihull Approach: https://solihullapproachparenting.com/quick-guide-to-the-solihull-approach/

all one year olds, to track domestic abuse enquires. As predicted, the audit demonstrated that if there was no opportunity to enquire about domestic abuse at routine home contacts in the ante and post-natal periods, then it does not usually get addressed.

Actions

i. ***Domestic Abuse (DA) one-day training*** *has been made available to all within Mid Surrey 0 - 19 team from a DA lead and SSCB DA trainer.* Alternative training from SADA[10] is also encouraged. DA training compliance is recorded within training records.

ii. ***DA Routine enquiry audit completed in June 2017****.* All contact templates from antenatal periods now include routine enquiry of Domestic Abuse. There is current consultation to consider whether routine enquiry will include Nursery Nurses to broaden opportunities for discussion and this will include further DA training across CFHS.

iii. Alex was seen for routine health assessments at school entry which were well recorded. CFHS identified that there was a missed opportunity to request previous health records at this point and an assumption made that a universal service offer should continue based on the limited information available. Protocols will now ensure that as a minimum, a summary record is requested for all children transferring from a previous provider when a child is of school age, to ensure that assessments of need are based on all available information and the cooperation of partner health agencies. Work to combine all health records under CFHS will further facilitate information sharing at school age***. Update: This action has now been implemented.***

iv. ***Protocols and procedures are now in place to follow up missed opportunities****.* A missed appointment will provide an opportunity to make contact with a family and update information that may highlight any stress or conflict within the family. A missed 27 month appointment, as happened with Maria and Tomas and Alex, would now be followed up by CFHS according to the current protocol. The Health Needs Assessment across CFHS will be developed further to include employment, finances and mental health issues following the tragic death of Maria and Tomas and Alex. ***Update*****:** ***The Universal Health Needs Assessment across CFHS is under review*** and housing security, financial vulnerability and community integration will be recorded as part of routine questioning. Employment type allows free text within current HNA template. A Learning leaflet was distributed to encourage full exploration of these issues.

12.5 Alex's Primary School

- Alex had attended school for two years and there were no concerns raised by teaching staff; there were no reports of any concern in Alex's pupil file or the schools safeguarding records.
- Alex had good school attendance, always completed homework and was well supported by Maria and Tomas. They always attended parents' evening and were often seen after school in the playground talking to other parents. Alex had many school friends and would often have play dates with friends at home or a school friend's house.
- Following the deaths, a letter was sent to all parents giving information from the local authority about how their child could be supported in coping with the tragedy. A focal point in the school was established for the children and parents to leave flowers and toys to remember Alex and family. The toys were then taken to Portugal to place on Alex's grave.
- A remembrance day was held at the school for Alex with the children wearing Alex's favourite colour or character. The funds raised from the day enabled the school to buy a

[10] Surrey Against Domestic Abuse https://www.healthysurrey.org.uk/your-health/domestic-abuse

bench to celebrate and remember Alex. The inscription on the bench says 'Alex - Forever in our hearts' There was an event to unveil the bench with the family of Tomas attending.

Actions: *None*

12.6 Voluntary Organisations and Support Groups

The Independent Chair interviewed local debt advice services and local mental health support agencies including the Citizens Advice Bureau (CAB), Community Debt Advice (CDA), Surrey and Borders Partnership NHS Foundation Trust and Stepping Stones (a local mental health charity). A further range of mental health support services are provided by the local Clinical Commissioning Group (CCG) as listed in 12.6.3 below. Maria, and Tomas had no contact with any debt organisation. It is unknown if Maria accessed any of the NHS mental health support services.

12.6.1 **CAB:**

- The local branch is the main provider of universal debt advice in the area. The demand for their services is ever increasing especially relating to the introduction of Universal Credit. Two of the key issues relating to people being in debt are changes in circumstances e.g. work, break up of relationships and health issues, especially mental health.
- The debt advice services are provided via telephone or at local centres in the main areas of need.
- The CAB stated that rural areas (such as where the subjects lived) are not well provided for re debt advice; there are many farmworkers and land workers who are paid low wages who suffer debt problems in the local rural areas but they are often hidden due to the overall great wealth of the location.

12.6.2 **Debt Advice charity**

- The Debt Advice charity is a smaller debt advice organisation who deals with the very vulnerable. As an organisation they can be very flexible and offer individual support but they do not handle any of the clients' money.
- The charity agreed with the CAB that debt issues can be accompanied by mental health problems. They have seen a significant rise of debt cases over the past year.
- CDA have a website[11] to promote their services and are well known to the housing services in the area, the local domestic abuse outreach provider, Richmond Fellowship Trust and the local Councils.

The local debt agencies state they are inundated with requests for support and as such do not advertise their services but do have active websites. The services that the debt agencies provide are available in the large towns/villages in the area but in rural communities, residents may not be so aware of such services.

***12.6.3 Mental Health Support*:**

- **Surrey and Borders Partnership NHS Foundation Trust (SABP)**

SABP are one of the leading providers of mental health support, learning difficulties support and drug and alcohol services for adults in the south of England. SABP have a community hub in East Surrey (providing a range of services to the community including Community Mental Health Recovery Services. Many of the services are provided face to face or by phone. The services provided do not always require a referral by a GP with some being accessed directly by clients.

SABP also support Safe Haven in a local town, an evening and weekend service to support people experiencing mental health and their carers.

The mental health services provided or funded by SABP continue to be extensively used by the community. Services are promoted in GP practices and via the web.

- ***Stepping Stones***

Stepping Stones is a local small, well established mental health charity supporting people who live in the borough where the family lived. Its purpose is to provide a safe, social environment twice a week for people who have mental health issues aged 18 years and upwards. People who attend the group have been signposted. They also work with the local CAB to provide information about benefit entitlements.

A regular newsletter promotes the service and provides valuable information to its clients, although this is only provided in English due to the costs involved in translation. RSS also works with Richmond Fellowship and Safe Haven to support members of the community who are experiencing mental health issues including depression and anxiety. This collaborative working indicates a strong partnership between the charities providing mental health services to the local community.

- ***East Surrey Clinical Commissioning Group (ESCCG)***

ESCCG provides a leaflet for people who are experiencing mental health problems with links to the following support organisations

- ***Mind Matters***

Clinics in local towns provide support for depression (including post-natal) anxiety, stress and phobias

- ***iESO Digital Health***[12]

*P*rovides a telephone and online cognitive therapy service (CBT). Self-referral.

- ***Think Action***[13]

*S*upport for depression, generalised anxiety and phobias. Clinics in local town

- ***DHC (Local Healthcare)***[14]

Services include CBT, guided self-help and workshops.

13. ANALYSIS

13.1 This analysis is based on information provided in the IMRs. Where relevant this includes an assessment of appropriateness of actions taken (or opportunities missed), and offers recommendations to ensure lessons are learnt by relevant agencies. The Chair and Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight.

13.2 Maria, Tomas and Alex seemed a happy 'normal' family to most observers. Maria had alleged that she had suffered domestic abuse with her second husband. Following the suicide of her daughter in Chile, Maria suffered bouts of depression and was known to self- harm. Maria and Tomas were in debt and they appear to have been struggling to make the repayments to the bank.

[12] iESO Health: https://www.iesohealth.com/en-gb/patients/surrey
[13] Think Action: https://www.thinkaction.org.uk/contact-us/thinkaction-surrey/
[14] DHC Clinical http://www.dhcclinical.com/

13.3 *Issues to be considered*

a) Were there any barriers experienced by Maria and Tomas or their family / friends / colleagues in seeking support from professional service providers?

i. Language issues:

- Although English was not the first language of Maria and Tomas or indeed Alex, Tomas was a fluent speaker and had a better understanding of English than his wife. GP records at medical Practice C identified that Tomas helped with some translation issues at early GP visits; Maria then continued visiting on her own and there is no further mention of language being a barrier.
- The health services have explained that some providers e.g. 'Mind Matters' utilise Google Translate to provide information in different languages. Primary Care Services also use Google Translate and Language Line but noted that this approach is not always easy to organise. The debt advice services provide information in different languages but have commented that people who need the services do not always have the IT skills to find out how to translate the information. The debt advice services also have volunteers who speak two to three languages and if people can visit the centre then face to face help can be provided.
- Information from Alex's school indicates that the child struggled a little to make friends when first starting school, as Portuguese was the first language at home. This soon changed as the child's English developed. Alex was seen as a happy healthy pupil, fully integrated into school life.

ii. Debt Issues: Once the family moved back to Surrey in 2013, they lived in an isolated, rural part of the borough. The CAB has indicated that rural areas are not as well served with information about debt issues as towns. Tomas's family was totally unaware of the debts that the family had accumulated and stated that they would have helped if they had informed. It is not known whether the family of Tomas knew of agencies that could have helped the family resolve any debt issues either local organisations or national such as Step Change[15]

iii. Mental Health issues: Research has identified a number of voluntary support groups in the area who could have helped Maria. Friends highlighted that Maria did not initially drive and therefore may have found it more difficult to access such organisations. Maria's first language was not English and therefore she may have struggled to obtain information that she fully understood.

b) Were there opportunities for professionals that were missed to routinely enquire as to:

i. ***any domestic abuse experienced by either Maria or Tomas***
ii. ***any mental health issues or***
iii. ***other issues identified that should have been referred to specialist providers?***

- Maria visited her GP practices on several occasions with her husband Tomas. The number of visits was deemed to be average for a person of Maria's age. On the initial visits to the GP, Maria was accompanied by her husband. It was noted by the GP that Tomas was very supportive. As English was not Maria's first language, it was assumed by the GP that Tomas was also present to translate, as his understanding and speaking of English was a high standard. Maria subsequently visited the GP by herself but the records do not show

[15] https://www.stepchange.org/

whether there were any concerns raised or enquired about re current or past domestic abuse.

- The GP's view was that Maria's depression and anxiety related to the death of her daughter and that it was not appropriate to ask questions at that time about domestic abuse. A routine enquiry by the GP (professional curiosity) on the subject of domestic abuse with Maria may well have identified the alleged abuse by her previous husband which could have added to her anxiety and depression.

c) Awareness of the potential presence of coercive control and how this impacts on the behaviour of the victim and the perpetrator.

- The government's 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 personal gain, depriving them of the means needed for independence and escape and regulating their everyday behaviours. 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 victims.'
- It is not known who was the adult perpetrator or victim in this incident as the inquest returned an 'open verdict' on both adults. There are no direct examples that there was any controlling or coercive behaviour by either Maria or by Tomas. There are some anecdotal suggestions that Maria could have been encouraging Tomas to spend more money than they could afford;
  - *It was highlighted that Maria threatened to go back to Chile as she hated the English weather and therefore holidays to Portugal were seen as a necessity.*
  - *Maria was very conscious about her looks and had dental implants fitted privately which would have been expensive.*
  - *Concern was expressed in some of the interviews that the family did appear to live beyond their means. Mention was also made that Maria prevented Tomas from attending his mother's funeral but this has not been corroborated.*

d) Consideration of any equality and diversity issues that appears pertinent to the victim or perpetrator including support available in an appropriate language.

i. Language:

- Tomas came to the UK as a sixteen year old boy from Portugal. Family, friends and associates stated that Tomas had an excellent command of the English language. Tomas also had a network of family in the UK along with a range of friends.
- Maria came to the UK as a thirty year old woman. It would appear her command of English was reasonable although not as good as Tomas's. Friends and associates felt that due to this language issue, Maria did sometimes feel isolated. This isolation was compounded as Maria could not drive for a number of years. Whilst Alex was young this resulted in Maria being in a rural cottage, isolated from friends but more especially from family so far away. It does appear that Tomas helped Maria with any language difficulties during initial visits to her GP. The GP viewed that Tomas was acting in a supporting way and not a controlling way.
- The school commented that Alex was a little withdrawn on first arriving at the school but as his English improved, friendships with other children blossomed. Maria's circle of friends also grew due to Alex's attendance at school. Comments from friends and professionals was that this family were happy, always doing things together and with family and friends.

ii. Religion:

- Maria was Catholic and it appears that her religion played a part in framing her life. Her first marriage was at the young age of sixteen as she was pregnant and it was frowned upon in Catholic Chile to have a child out of wedlock. Chile was also a difficult environment in which to be gay, and it is thought that this contributed to her daughter's decision to take her own life.

***e) Investigation of support provided for debt management and bereavement support following suicide of a daughter*.**

Debt and ***depression*** may possibly have been the two key issues which drove Maria, Tomas or both to cause the fire and explosion which tragically killed the family.

i. Debt:

- Information gathered and from the inquest hearing suggests that one of the possible triggers for either Maria or Tomas (or both) to have started the fire could have been the repayment difficulties of the loans that the family had taken out over a number of years.
- On their deaths it was found that the family were £18,842 in debt due to outstanding payments on a bank loan and credit cards. A family friend was aware of this but not the family.
- Comments from clients, employers and friends indicate that the family had a good life style, often going out, on holidays and paid for expensive medical treatment and support. Tomas was a gardener and although he paid no rent for his accommodation, as in line with many rural employment positions, his wages were below the national average.
- A family friend who Tomas helped sometimes with his garden was very generous and gave a gift of money on a couple of occasions. Despite this Maria and Tomas remained in debt. It is obvious from a conversation with the family friend that Tomas was very concerned about their inability to repay the bank. The friend offered to help with the debt on an instalment basis. This support was not taken up as the tragedy took place a few days after the conversation.
- As identified previously, neither Maria nor Tomas were known to any of the local debt agencies.

ii. Mental Health:

- Maria felt very guilty about the suicide of her young daughter; she felt responsible for leaving her in Chile at a young age although at that time Maria felt her daughter would have a better life with her father.
- Maria did seek professional support which included advice about bereavement services in the area. It is not known whether Maria took up the opportunity of seeking help from such services as CRUSE.
- Maria was known to have had private counselling but there is no knowledge of how long this continued. The Surrey-wide designated lead GP for Safeguarding of children stated that it is unusual for health counselling services to contact a GP and provide any updates and as such health records may never be fully complete.
- GPs at Medical practice C and R said that Maria was good at booking and attending her follow up appointments. Nothing in Maria's presentation raised high levels of concern for her mental health and as such the GPs had no undue worries about her wellbeing. The consultation rate for Maria was within the yearly average of 5 per annum (2013-14 data).
- Maria's last medical appointment was 18 months before her death although it appears Maria was taking drugs for depression at the time of her death which were not prescribed on the NHS. It is assumed that they were obtained from another country.

- Information provided by clients of Maria was that she would talk to them about how depressed she felt, that she hated the English weather and she would regularly phone her clients to say she could not work as Alex was not well, despite the child actually being at school.
- Friends also highlighted that Maria was self-harming up until her death. Tomas told a friend he was concerned that 'Maria would do some serious damage to herself such as cutting deep into a vein'. A friend confirmed he had seen the scars on Maria's wrist. There is no indication why Maria stopped visiting her GP when it appears she was still suffering depression, anxiety and self-harming up until her death.

f) Agencies that had no contact will investigate whether helpful support could have been provided and if so why this was not accessed.

- Research and interviews with statutory and voluntary organisations identified that there is a wide range of agencies providing debt advice and mental health support in the area, which could have helped Maria and Tomas and Alex. The agencies contacted, especially the debt organisations said that they could not always support the demand and that services were stretched.
- Information about the services appears to be available through GPs (mental health services) and web sites e.g. CAB. Maria may have initially struggled with accessing such services if she had tried, as information may not be available in different languages.
- Many organisations now only promote their services using websites and there is an assumption that people have internet access. Living in a rural setting may mean that internet access is more difficult and access to libraries for information will also be restricted. *The family did not have internet access at home.*

g) Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.

- GP surgeries that have participated in IRIS[16] training have been identified; some surgeries utilise the IRIS system but not all do. It is currently only available in the areas covered by East Surrey CCG.
- Alex's school indicated that staff had regular Safeguarding training which includes the impact of domestic abuse. Future sessions need to include the wider definition of domestic abuse including controlling coercive behaviour and the consideration of triggers which could lead to abuse such as mental health, debt and isolation.
- The school also receives information through the Operation Encompass[17] scheme where a range of agencies with safeguarding responsibilities are notified when the police receive information about domestic abuse within the family over the previous 24 hours, in order to provide appropriate support for affected children.

h) Consider whether Alex's welfare was promoted and protected through timely and effective assessments including risk assessments and response to needs identified. (This includes application of thresholds, information sharing, use of assessment tools and timely interventions and recognition that those risks do not reduce at times of parental separation).

- Information from CFHS and Alex's school identifies that appropriate welfare checks were completed. Child Health Records show that Alex was registered with CFHS Surrey two

[16] IRIS: http://www.irisdomesticviolence.org.uk/iris/
[17] Operation Encompass: http://www.operationencompass.org/

periods, the first during the birth until the child's care transferred to Essex and secondly when Alex enrolled at Primary school.

- Within the School Nursing service, appropriate assessment of the child's health and immunisation took place within relevant timescales and in all instances consent and comments were sought from parents in the form of letters sent home via the child and returned by the parent. No specific needs were identified. The earlier assessment of family needs at New Birth contact in 2010 would be seen as inadequate in comparison with the assessment now undertaken in 2017. The impact of parental health and well-being on the welfare and development of a child would now be part of this review. In this case, there were insufficient details available about the outcome of the health needs assessment and enquiry with regards to any stresses relating to Maria or Tomas or current or past parental health concerns.
- Alex's school did identify that the child struggled a little when first attending the school due to difficulties with English. The school supported Alex and the child became fully integrated into school life together with Maria and Tomas.

i) Consider whether there is evidence that managers and supervisors understood the experience of children living with domestic abuse and the prevalence of the issue in the area.

- The key agencies involved with the family, GPs, CFHS and the school have identified through IMRs or discussion with the Independent Chair that they all have Domestic Abuse and Safeguarding training. The designated Surrey-wide lead GP for Safeguarding Children stated that the GP practices had training including IRIS. The GP practice also had a designated lead for safeguarding
- The Head teacher confirmed that the school has regular Safeguarding training which also includes issues relating to Domestic Abuse. What is not clear is to what extent controlling and coercive behaviour is considered as part of the above training.
- The Surrey Multi-Agency Safeguarding Hub (MASH) was one of the first to introduce 'Operation Encompass' to notify schools each morning about a child's exposure to domestic abuse (and in Surrey also when they have been reported missing). Each school day morning Surrey Police identify incidents that occurred within the previous 24 hours (or the entire weekend on a Monday) where a child under 18 was linked, involved in or a witness to domestic abuse. Surrey Police share this information and a short summary of the incident with the Education Safeguarding Team who, in turn, share it with the child's school or college. The aim is to inform the school by 9:30am so that timely support can be offered.

14. LESSONS LEARNT FROM THE REVIEW

When considering the 'lived experience' of Alex, the information provided indicates that Alex was a happy and well cared for child. There were no concerns highlighted in the review which suggested that Alex was at risk of harm until the night of the fire. Alex's tragic death as a result of the actions taken by one or both of parents could not have been predicted.

14.1 Equality Issues: Language

- It was very difficult to engage with the family members of Maria, who lived abroad and who did not speak English. Translation Services were required which was time-consuming and as there was no response from the person contacted, it is not known correspondence was received. The family would also not be aware and may have difficulty understanding the rationale and process of a statutory requirement to carry out a DHR / SCR under English law.

- Although Tomas had a thorough understanding of English it is not fully clear how well Maria spoke and read English. All the information relating to mental health support and debt is in English and although organisations do provide translation opportunities, finding the information in different languages appears to be challenging without a good understanding of English and reasonable IT skills.

14.2 Equality Issues: Mental Health

- Maria sought medical support for her depression, but the GPs involved did not use the opportunity to enquire about domestic abuse (*professional curiosity).* It was assumed that her depression and anxiety were related to the death of her daughter although it appears Maria may have suffered domestic abuse in a previous relationship, which may have contributed.
- It is also not known if there was any routine enquiry by the GP of any mental health issues within Maria's family e.g. mother/brother. Such an enquiry would help build up a holistic picture of Maria's mental health and anxiety issues.
- Maria chose to attend private counselling but it was not possible to obtain any information about who provided this, which may have added to the narrative of this DHR / SCR. There is no requirement for private counselling organisations to contact a client's GP with any health information and therefore medical records may well be incomplete.
- The use of a private counsellor by Maria may explain why she did not visit her own GP from August 2015 until her death, although it is apparent that she was still suffering from depression and was self-harming.
- There was no concern by the GP that Maria stopped visiting the GP practice. More than a third of GP consultations are related to mental health issues[18] of which many are related to moderate anxiety and depression. Maria due to her presentation was in in this category. The expectation would be that a GP would contact someone if they had high levels of concern for their mental health and they stopped attending the GP but not for mild / moderate concerns.

14.3 Equality Issues: Debt

- Although Maria and Tomas had debt issues, they did not seek any professional support through local organisations such as the CAB.
- Debt support agencies are struggling to cope with demand and information and advice centres are located in towns and areas of greatest need. However pockets of rural deprivation are less well supported and rely on access to the internet.
- The voluntary sector is very committed to try to support people who live in rural communities and whose first language is not English.

15. CONCLUSIONS

i. This review has highlighted the difficulty of predicting such a tragedy as happened in late January 2017.
ii. There is no evidence of any previous domestic abuse within Maria & Tomas's relationship but the Panel is mindful that this cannot be ruled out with certainty. It is alleged that Maria had experienced domestic abuse in a previous marriage.
iii. There is also no suggestion that Alex suffered any abuse at the hands of Maria and Tomas before being unlawfully killed. It has not been possible to conclude who was the adult perpetrator or the adult victim in this review. However, it was determined that Alex was a victim who was killed by one or both of his parents.

[18] https://www.england.nhs.uk/blog/ed-mitchell-3/

iv. The review has identified ways in which support, advice and practice could have helped the family.
v. There are local debt services available to support families in need although such services are much stretched. There is a willingness within this sector to review how they could promote their services to the wider rural community.
vi. Research and conversations with mental health service providers indicate that there is support available for people including those with depression and anxiety. There are also a number of private providers as used by Maria in this case. It is apparent that information is not always easily accessible, especially if the first language is not English, there is limited access to the internet or the person lives in an isolated community.

The DHR/SCR panel have welcomed the new policies adopted by CFHS which will follow up missed appointments as an opportunity to review the wider family situations such as debt and mental stress of family members.

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: Raise 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 are familiar with the referral pathways. This will include Family Service and Family Support Programme staff, Health & Wellbeing Advisors and Housing officers. *In this case, there is no suggestion that these services were aware of the family's debt crisis.*

  ii. Provide any necessary training for staff as required and encourage 'professional curiosity' in those staff, 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**

  i. To 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**

  i. ESCCG to expand their website information to include contact details for Debt advice services and the local domestic abuse service.

  Responsibility: East Surrey CCG

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

i. The local CSP Chair to write to all CCGs in Surrey and to Surrey CVS to encourage service providers to use free 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**

i. To increase the understanding and awareness of early help for families which will include the 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**

i. 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 &/or or past trauma.
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 Agencies to continue to implement the changes identified within their submitted IMRs.

GLOSSARY OF ABBREVIATIONS USED IN THIS REPORT

CAB	Citizens Advice Bureau
CDA	Community Debt Advice
CFHS	Children and Family Health Surrey
CVS	Councils for Voluntary Service
DHR	Domestic Homicide Review
ESCSP	East Surrey Community Safety Partnership
ICAD	Log of initial command and deployment
IMR	Individual Management Review
SASH	Surrey and Sussex Healthcare NHS Trust
SADA	Surrey Against Domestic Abuse www.healthysurrey.org.uk/your-health/domestic- abuse
SCA	Surrey Community Action
SCC	Surrey County Council
SCR	Serious Case Review
SIO	Senior Investigating Officer
SIRA	Serious Incident Requiring Investigation
SSAB	Surrey Safeguarding Adults Board
SSCB	Surrey Safeguarding Children Board

APPENDIX ONE

LOCAL CSP DOMESTIC HOMICIDE and SERIOUS CASE REVIEW PANEL MAY 2017

TERMS OF REFERENCE

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

2. This legislation places a statutory responsibility on organisations to securely share confidential information, which will remain confidential until the panel agrees the level of detail required in the final report for publication.

3. A Serious Case Review (SCR) will be incorporated into this process on behalf of the Surrey Safeguarding Children Board to ensure full consideration of all factors leading to the deaths in January 2017. As this Review will cover both the SCR and the DHR, the Panel will seek to work jointly with this process to avoid duplication of contact with, or requests for information from, agencies, family members, friends and colleagues.

4. The DHR will strictly follow the local CSP DHR protocol, which is based on Home Office guidance[19]

5. The statutory purpose of the DHR is to :

a) Establish what lessons can learned from the domestic homicide regarding how the local professionals and organisations worked individually and together to safeguard the victims of domestic abuse;

b) Identify clearly what those lessons are, both within and between agencies, how they will be acted on, and what will change as a result through a detailed Action Plan;

c) Apply these lessons to service responses including changes to policies and procedures as appropriate;

d) Prevent domestic homicides where possible in future through improved intra and inter-agency responses for all domestic abuse victims and their children.

6. The SCR will follow the statutory guidance from the SSCB:

a) establish what lessons are to be learned from the case about the way in which local professionals and organizations work individually and together to safeguard and promote the welfare of children;
b) 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; and
c) improve intra- and inter-agency working and better safeguard and promote the welfare of children

[19] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

7. The agreed timeframe for information to be secured and reviewed is from [redacted] the birth of the child, unless significant events are identified prior to this.

8. The DHR will not seek to apportion blame to individuals or agencies from the information it receives. However, it is recognised that other parallel procedures (e.g. SCR, IPCC referral, internal agency disciplinaries) may use information from the DHR process to support their investigations.

9. At present there is no indication that there will be criminal proceedings.

10. In addition the following areas will be addressed in the Individual Management Reviews (IMRs) and through wider enquiries:

a) Awareness of the potential presence of coercive control and how this impacts on the behaviour of the victim and perpetrator.

b) Consideration of any equality and diversity issues that appear pertinent to the victim or perpetrator[20] including support available in an appropriate language.

c) Investigation of support provided for debt management and bereavement support following suicide of daughter

d) Agencies that had no contact will investigate whether helpful support could have been provided and if so why this was not accessed.

e) Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.

f) Consider whether the children's welfare was promoted and protected through timely and effective assessment, including risk assessment and response to the needs identified. This includes application of thresholds, information sharing, use of assessment tools and timely intervention, and the recognition that risks do not reduce at times of parental separation.

g) Consider whether there is evidence that Managers and supervisors understood the experiences of children living with domestic abuse and the prevalence of the issue in the area.

11. The Panel will critically evaluate and approve the Overview Report, Executive Summary and Action Plan produced by the Independent Chair at the end of investigation prior to it being passed to the chair of ESCSP and the SSCB.

12. These Terms of Reference may be varied by the DHR Panel as new information emerges.

[20] e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.