SAFER BASILDON PARTNERSHIP

LEARNING REVIEW EXECUTIVE SUMMARY

Case of Georgia

Independent Chair and Report Author: Althea Cribb

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1. THE REVIEW PROCESS

1.1. This summary outlines the process undertaken by the Southend Essex and Thurrock Domestic Homicide Review Team and the Safer Basildon Partnership in reviewing the circumstances prior to the death of Georgia who was a resident in their area. Georgia was a woman aged in her 30s, of White British ethnicity.

1.2. The Southend Essex and Thurrock Domestic Homicide Review Core Group met in June 2019 and agreed, that a DHR would be established. Short Reports and chronologies were sought from those agencies involved in the case. A partnership workshop was held to consider the case and to capture key issues. Family and friends were approached for involvement (see below).

1.3. The Inquest has not been held. While police concluded Georgia had taken her own life, this has not been confirmed by the Coroner. The Review is called a Learning Review.

2. CONTRIBUTORS TO THE REVIEW

2.1. The following agencies contributed Short Reports to the Learning Review:

- Children's Social Care, Essex County Council
- Essex Police
- Integrated Children's Services, Kent County Council
- Georgia's General Practice (through East Kent Clinical Commissioning Group)
- Kent Police
- Porchlight Family Support Service, Kent
- Thinkaction East Kent (now named We Are With You)
- Victim Support

3. INVOLVEMENT OF FAMILY

3.1. The independent chair liaised with Advocacy After Fatal Domestic Abuse which was already supporting some family and friends; and contacted other individuals through the Coroner. Additional family or friends were contacted, or contacted the independent chair themselves, through those initial contacts.

3.2. All contact by the independent chair set out that involvement in the Review was voluntary, and could happen in a way and at a time of each person's choosing. The Home Office leaflet on Domestic Homicide Reviews was provided, along with information about the service provided by Advocacy After Fatal Domestic Abuse. The different means of being involved in the Review were outlined including face-to-face meetings, telephone conversations, written statements or other ways that could be discussed. The letter invited contact directly, or through a service or person who may be supporting someone.

3.3. The independent chair met or spoke on the telephone with eight of Georgia's family and friends. The Terms of Reference for the Review were discussed with them. Their contributions were incorporated into the workshop and the Review learning.

3.4. The report was shared with all family and friends who requested it, and their feedback was considered and incorporated as appropriate.

4. THE WORKSHOP

4.1. The review was conducted as a Learning Review via a multi-agency learning workshop. The independent chair gathered the available information from the relevant agencies, and from the family, and developed a multi-agency workshop from this information. Other DHRs and a thematic review completed in Essex, and other national reviews, were also used to inform the workshop.

4.2. A series of exercises were held with the participants to identify the learning. Participants were asked to review the timelines of agency contact for Georgia to identify good practice and comment on areas for learning.

5. AUTHOR OF THE OVERVIEW REPORT

5.1. The independent chair of the Review, and report author, was Althea Cribb. Althea has been carrying out Domestic Homicide Reviews for seven years and has completed more than twenty Reviews. Althea has worked in the domestic abuse sector for fourteen years.

5.2. Althea received Domestic Homicide Review Chair training from Standing Together Against Domestic Violence, a national charity bringing communities together to end domestic abuse. As an Associate of Standing Together Althea continues to deliver DHRs as part of their service and has the benefit of peer review and continuing professional development.

5.3. Althea Cribb has no connection with the Safer Basildon Partnership or Kent Community Safety Partnership or any of the organisations involved in the Review.

6. TERMS OF REFERENCE FOR THE REVIEW

6.1. Based on the information gathered during the setting up of the Review, the following issues were identified as areas for the independent chair, involved agencies and the workshop attendees to consider:

- responses to individuals who persistently present with 'low level' mental ill-health
- police responses to 'verbal only' non-crime domestic incidents
- responses to conflict that occurs following the end of intimate relationships

6.2. Agencies analysed their contact with Georgia with reference to the above issues in the Short Reports and at the workshop.

7. SUMMARY OF THE CASE

7.1. Georgia had contact with eight agencies (above). Most of her contact was in Kent, where she lived until three months before her death. For most agencies contact with Georgia was a one off, except for her GP with whom she had many, albeit sporadic, contacts.

7.2. The focus of Georgia's contact with her GP was her mental health. She experienced, at different times, anxiety and depression, with some suicidal thoughts but no plans. She was treated with medication, and provided with information about counselling services.

7.3. Georgia was also in contact with Kent Police, due to a past incident in an intimate relationship that led to no further action. As a result of this Georgia spoke with Kent County Council Integrated Children's Service, and accepted an offer of Early Help support, provided by Porchlight. Georgia moved to Essex prior to meeting with Porchlight and did not receive a service from them.

7.4. Following the move to Essex Georgia was in contact with Essex County Council Children's Social Care due to an incident in her family; she was given advice and information.

7.5. Essex Police attended Georgia's address following a call from a neighbour with concerns over a loud and long argument in Georgia's property. Georgia informed officers that everything was fine, and that she had instigated the argument. Georgia was recorded as the perpetrator of a domestic incident, and the other person (with whom Georgia was in an intimate relationship) was spoken to and recorded as the victim of the domestic incident. No offences were recorded.

7.6. Shortly before her death Georgia was reported missing to police, with concerns for her welfare. Essex Police responded and spoke with Georgia who confirmed she was well.

8. INFORMATION FROM FAMILY

8.1. Georgia's death is a tragedy for many people: her family, friends and loved ones. It came as a shock to all, and has changed the lives of those who knew her.

8.2. Georgia impacted many people in her life, and many of them wanted to contribute to this Learning Review in order to talk about the person they knew and had lost. Their contributions and feedback have informed the learning in this review.

8.3. Georgia was described as a lively, vivacious, fun and funny, beautiful woman. She was kind hearted and generous. She had a gift for making people feel at ease and important in her company. She was described as a loving mother whose children were her world.

9. KEY ISSUES FROM THE REVIEW AND LESSONS TO BE LEARNED

9.1. The Short Reports and workshop identified good practice from many agencies, as well as some areas of learning that are being acted upon.

9.2. Due to the nature of the workshop, a wider range of issues were discussed, that were prompted by Georgia's situation. Where such broader learning has been identified, this will be incorporated into the regular, ongoing dissemination of learning from Reviews.

9.3. *Visibility of Children when Organisations Respond to Adults*: There was a lack of attention to and focus on children. The General Practice, Kent Police and Essex Police missed opportunities to 'Think Family' and consider how an adult's situation may impact on their

children. The Short Report from Kent Police made a recommendation in relation to children, and that action should also to be taken by Essex Police (recommendation 1). In addition, the workshop highlighted the need to identify and respond to the needs of parents or children following parental separation. This issue is being addressed through the Southend Essex and Thurrock Domestic Abuse Strategy 2020-2025.

9.4. *Information Sharing*: During broader discussions, the issue of cross-border information sharing was raised along with the need for clarity of expectations in relation to notifications and referrals.

9.5. *'Non-Crime Domestic' Police Incidents*: The workshop discussed the incident in which Essex Police was called by a neighbour of Georgia's, and questioned why, when there were no offences, officers labelled Georgia as the 'perpetrator' based solely on the information that she instigated the argument that led to the police callout. Attendees asked: what was she the 'perpetrator' of, given that the incident involved a 'verbal only' argument and no controlling or coercive behaviour was identified? Essex Police have reviewed this and will continue to work on responses to such situations (recommendation (2). This Review welcomes the ongoing work but cautions that in many incidents, including non-crime domestics, it may still be clear to officers that there is a victim and perpetrator of domestic abuse/coercive control, even where there has been no offence. Officers should be alert to, and seek to rule out, controlling and coercive behaviour in all incidents.

9.6. *Understanding Relationships:* Feedback from family and friends, and discussions at the multi-agency workshop, highlighted the need for greater awareness for professionals and communities around the impacts of and issues relating to relationship breakdown, parental separation and understanding what healthy relationships look like. A recommendation (3) is made.

10. RECOMMENDATIONS FROM THE REVIEW

10.1. *Recommendation 1*: Essex Police and Kent Police to promote to officers the 'Think Family' approach when responding to adults. Both forces to be satisfied that, when children are mentioned during incident reports, their whereabouts and wellbeing are checked and documented.

10.2. *Recommendation 2*: Essex Police to address the learning in relation to categorisation in non-crime domestic incidents.

10.3. *Recommendation 3:* SETDAB and Kent Community Safety Partnership to integrate the learning from this Review into planning future awareness raising campaigns.