SAFER BASILDON PARTNERSHIP

LEARNING REVIEW REPORT

Case of Georgia

Independent Chair and Report Author: Althea Cribb

Final Version: October 2020

Preface

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 closest to her. We give our condolences to all those affected by her death.

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.

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 by everyone as a loving mother whose children were her world.

This has been a complex review involving many different and differing narratives from the people who knew Georgia. It is not the role of this Learning Review to judge these personal stories or to draw firm conclusions on the nature of Georgia's life, particularly in the months prior to her death. Georgia is the only subject of this Learning Review; but inevitably her family and friends talked about the people in her life. For confidentiality purposes this information cannot be shared in this report, but it has been fully considered by the independent chair and workshop attendees in the development of lessons to be learnt.

Contents

Introduction

1.1. This report of a Domestic Homicide Review (the Review) examines agency responses and support given to Georgia, a resident of Basildon, prior to the point of her death in 2018. Georgia was a woman aged in her 30s, of White British ethnicity.

1.2. In addition to agency involvement the Review will examine the past to identify any relevant background for Georgia, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3. The key purpose for undertaking Reviews is to enable lessons to be learned. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.4. The Review considered agency contact or involvement with Georgia from January 2009 up to the time of her death. This timeframe was selected following brief information provided by services which established these dates as the start of Georgia's involvement with them. Georgia previously lived in Kent; Kent services and the Community Safety Partnership were therefore involved in the Review.

1.5. This review began in September 2019 and was concluded in July 2020. Reviews should be completed, where possible, within six months of commencement. The Review was completed as quickly as possible while allowing time for family and friends to read and comment on the report. Some delays were experienced due to agencies being required to divert resources to respond to Covid-19 pandemic.

Confidentiality

1.6. The findings of every Domestic Homicide Review are confidential until such time as a Review is published. Information is available only to participating

officers/professionals and their senior managers. Information shared by organisations or individuals with the Review remains the property of those organisations and individuals.

Methodology

1.7. The Southend Essex and Thurrock Domestic Homicide Review Core Group met to discuss the case. Initial scoping did not suggest cause for concern that would meet the requirement for a Domestic Homicide Review. A request was made by a member of Georgia's family to reconsider and in June 2019 the Core Group agreed that a Domestic Homicide Review at Level 3 (see below) would be established. The Inquest has not been held, and while police reports stated Georgia had taken her own life, this has not been confirmed by the Coroner. The Review is referred to as a Learning Review.

1.8. These Reviews are framed by the 2016 Home Office Domestic Homicide Review Statutory Guidance, in which a review should be undertaken when there are circumstances of concern prior to the individual's death.

1.9. A Level 3 Domestic Homicide Review (DHR) is a single or twin agency review, or for cases where there is limited relevant information held by agencies. A partnership event is held to consider the case and to capture key issues to be written up in the DHR Report. Regardless of the Level of DHR, the involvement of family and friends is a high priority (see section five).

1.10. The independent chair agreed the Terms of Reference for the Review with the Southend Essex and Thurrock Domestic Homicide Review Team and the Safer Basildon Partnership. The key issues identified were:

- 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

1.11. Due to the brevity of contact by the agencies, Short Reports and chronologies were sought from agencies involved in the case (see section six). Agencies analysed their contact with Georgia with reference to the above issues.

1.12. A partnership workshop was held (see section six below) to consider the case and to capture key issues to be written up in this Report. As a Level 3 Review this also involved a number of agencies who could input to the learning in addition to those who had contact.

1.13. The Report was shared with the workshop attendees for comment and feedback. Comments and amendments were incorporated. Further discussions took place between the chair, involved agencies and the Southend Essex and Thurrock Domestic Abuse Team to agree the learning and recommendations to finalise the Review.

Involvement of Family and Friends

1.14. The independent chair sought to contact Georgia's family members and friends to gain an understanding of who Georgia was as a person, and anything that could have made a difference for her prior to her death.

1.15. 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.

1.16. 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 any service or person who may be supporting someone. All contact made clear the remit of the Review was restricted to Georgia, prior to her death.

1.17. 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.

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

Contributors to the Review

1.19. The following agencies contributed to this Review through submitting a chronology and short report:

- 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

1.20. Chronologies and Short Reports were produced by individuals who were independent of the case and of line management of those involved with Georgia.

The Workshop

1.21. The review was conducted as a Learning Review via a multi-agency learning workshop, and therefore no Review Panel Meetings were held following this. The independent chair gathered information from relevant agencies, family and friends to develop a multi-agency learning workshop. Other Reviews, a thematic review completed in Essex and national reviews and research were also used to inform the workshop.

1.22. Workshop attendees were:

Job Title	Organisation
Deputy Designated Nurse, Safeguarding Adults	(East Kent) Clinical Commissioning Group
Quality and Patient Safety Manager, Safeguarding Adults	(Basildon) Clinical Commissioning Group
Community Safety Manager & Safeguarding Lead	Basildon Borough Council, Safer Basildon Partnership
Independent Domestic Violence Advocate & Independent Stalking Advocate Caseworker	Changing Pathways
Clinical Specialist Safeguarding	Essex Partnership University Trust
Domestic Abuse Practice Lead	Essex County Council, Children's Social Care
Domestic Abuse Support Officer	Southend, Essex & Thurrock Domestic Abuse Board
Domestic Abuse Support Coordinator	Southend, Essex & Thurrock Domestic Abuse Board
Development Support Officer	Essex Police
Strategic Centre Supervisor	Essex Police
Community Safety Officer	Kent County Council, Community Safety Partnership
Service Manager, Quality Assurance & Safeguarding	Kent County Council, Children's Social Care
Case Review Officer	Kent Police
Safeguarding Lead	Porchlight
Senior Caseworker	Victim Support

1.23. Workshop attendees demonstrated an appropriate level of expertise throughout the Review and were independent of the case and line management of the case.

1.24. The Chair of the Review wishes to thank everyone who contributed their time, patience and co-operation to this review.

Chair of the Review and Author of the Overview Report

1.25. The independent chair of the Review and report writer was Althea Cribb. Althea has been carrying out Domestic Homicide Reviews for over six years and has completed more than twenty Reviews to date. Althea has worked in the domestic abuse sector for fourteen years in a range of roles.

1.26. 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 Domestic Homicide Reviews as part of their service; and has the benefit of peer review and continuing professional development.

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

Parallel Reviews

1.28. The Coroner's Inquest is scheduled to take place following the Review. The Terms of Reference for the Review were provided to the Coroner's Office. The independent chair maintained communication with the Coroner's Office.

1.29. There was no criminal trial or other parallel reviews during this Review process.

Equality and Diversity

1.30. The nine protected characteristics in the Equality Act 2010 were assessed for relevance to the Review. The following characteristics were not felt to be relevant: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sexual orientation.

1.31. The characteristic seen as relevant to the analysis of the case was Georgia's sex. While the Inquest had not concluded the case of Georgia's death, initial police reports had concluded she had taken her own life. Research shows that

women are less at risk of death by suicide than men[1] making this characteristic potentially relevant. This Review follows legislation for Domestic Homicide Reviews, and research shows that women are more likely to be subject to domestic abuse, and controlling and coercive behaviours, and the Review was mindful of this fact. It is essential that this Review does not draw conclusions as to the nature or cause of Georgia's death, which is the role of the inquest.

Dissemination

1.32. The following have reviewed the report in draft form, and/or will receive a copy (or notification) of publication:

- Family and friends of Georgia
- Workshop attendees
- Safer Basildon Partnership
- Kent Community Safety Partnership
- Southend Essex and Thurrock Domestic Abuse Strategic Board
- Essex Police Fire and Crime Commissioner

Summary of the Case

1.33. Due to the nature of this DHR, there are some elements of Georgia's life that cannot be described fully. This is because they would identify people in Georgia's life, and therefore breach their confidentiality.

1.34. In the terms of reference timeframe Georgia had contact with eight agencies (above). Most of her contact was in Kent, where she lived until three months before her death.

1.35. For most agencies contact with Georgia was a one off, except for her GP with whom she had many, albeit sporadic, contacts.

1.36. From 2009 to June 2018 Georgia only had contact with her GP. She first attended in 2009 with regard to depression, for which she was prescribed

[1] ONS (2019) Suicides in the UK: 2018 Registrations www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations [accessed 29 January 2019]

medication. Georgia was in contact with the GP twice for anxiety in 2015 (face to face), three times in 2016 (telephone) and four times in 2017 (face to face and telephone). The GP noted that Georgia did not have depression nor suicidal thoughts. Georgia was prescribed medication, and changes were made to prescriptions to better address her needs. Georgia was encouraged to contact a counselling service, Thinkaction.

1.37. In 2018 Georgia spoke on the telephone to the GP four times and attended one face to face appointment. In the first contact, May 2018, she was recorded as having anxiety with depression and had stopped the previous medication. Georgia reported thoughts of 'ending it all' but would not harm herself, and the GP recorded that Georgia's children were a protective factor for her, and her mum was supportive. The GP recorded a plan for Georgia to contact them if the suicidal thoughts worsened, and that the medication would be reviewed. This was done in June 2018; Georgia reported that she had a supportive partner and would self-refer to Thinkaction[2]. That service recorded an online self-referral from Georgia at the end of June 2018. She was contacted and a telephone assessment was booked for July; she did not respond to that booked call. Following repeated attempts to contact her, a text message was sent stating Georgia could contact the service again, and provided other sources support such as Samaritans.

1.38. Also in June 2018, Kent Police officers responded to a contact from Georgia concerning a past incident in her previous intimate relationship. She stated she was not in fear, did not make a statement and did not wish to pursue the case (just to have it recorded) and so no further action could be taken. Officers notified Kent County Council Integrated Children's Services, referred Georgia to Victim Support (she declined support) and made a notification to Kent and Medway NHS and Social Care Partnership Trust (KMPT, mental health) in response to Georgia stating she was experiencing anxiety/depression.

[2] Now named We Are With You; provider of the IAPT (Improving Access to Psychological Therapies) service offering brief psychological therapy to people with moderate to severe anxiety disorders and/or depression.

1.39. KMPT has no record of receiving the notification and had no contact with Georgia.

1.40. Kent County Council Integrated Children's Service received the notification from Kent Police (made following the above report). The Early Help service contacted Georgia to offer support but could not reach her, and so a letter was sent. The Service then received a notification (treated as a referral) from KMPT to Social Care (which at the time was a separate pathway to Early Help). The information was a copy of the police notification to their service; no additional or further information was provided or requested. Social Care contacted Georgia and following a discussion with her concluded that Early Help support was the appropriate pathway. Georgia accepted the support, to be provided by Porchlight.

1.41. A Porchlight worker contacted Georgia to offer support for her and her children. Georgia accepted and a meeting was arranged. Before the meeting took place, Georgia contacted the worker in July 2018 to cancel the meeting and decline the support because she was moving to Essex and things had 'calmed down'. The worker attempted to contact Georgia following this to offer any further support, but was unable to reach her and did not have a forwarding address in Essex.

1.42. Georgia's last contact with the GP (telephone) was in July 2018. She reported being stressed by the move to Essex, but her mood had improved and she had no suicidal thoughts.

1.43. Georgia was next in contact with an agency at the beginning of October 2018 when Essex County Council Children's Social Care spoke with Georgia following a police report about her and her family, and offered information and advice about her situation.

1.44. Later in October 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.

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

Conclusions and Key Issues Arising from the Review

1.46. The workshop identified good practice through this Review. Kent Police were proactive in making referrals to key agencies that could support Georgia. On receiving a referral for Georgia, Kent County Council Integrated Children's Services offered her an appropriate level of support. Porchlight, the provider of that support, were proactive in trying to meet with Georgia. Georgia's General Practice responded to her need for mental health support through medication, which was her stated wish, and was responsive when she asked to change medications due to side effects. While Georgia consistently stated that she did not want counselling, this continued to be offered, in recognition that her needs and wishes may change.

1.47. In addition to learning that is outlined in section thirteen below, agencies identified the following in their Short Reports:

1.48. *East Kent Clinical Commissioning Group (General Practice)*: The following recommendations are made to address the learning in the Short Report: (a) Provide an education update into management of chronic low-level anxiety and how to manage and monitor the infrequent attender and advice on how to ensure medication courses are complied with. (b) Provide training on professional curiosity to all primary care staff to include the value of routine enquiry in all cases of depression and anxiety and during antenatal, post-natal and contraception reviews. (c) Provide training to primary care around the Think Family agenda and the offering of early help support to parents with emotional issues.

1.49. *Essex Police*: While good practice was shown in the response to concerns over Georgia's welfare in November 2018, officers should have spoken with the

Street Triage Team in line with policy; a recommendation has been made to address this.

1.50. *Kent County Council Integrated Children's Services*: It is important to triangulate information received by the service, and essential for practitioners to remain curious and cautious in their contact with families Prompt allocation of cases. At the time of Georgia's contact, Social Care and Early Help were separate parts of the service which could have been confusing for Georgia when they contacted her. They have now been integrated. The following updates and recommendations are made: (a) Kent implemented training during the summer of 2019 to assist the recent integration of Social Work services with Early Help. This training addressed the importance of triangulating all evidence available when making decisions about interventions, case progression and closure. The Quality Assurance Framework was reviewed in July 2019 to reflect the integration of services whilst identifying the importance of triangulating evidence using the various databases whilst ensuring information from different agencies is also considered. (b) Reasons for non-engagement with families should be reviewed and should inform decisions about next steps at all stages of an intervention. The training during the summer of 2019 also addressed professional curiosity and an individual's capacity to change. (c) Kent is currently reviewing how allocations are made within the Early Help framework to support greater consistency in the timing of allocations.

1.51. *Kent Police*: While the Review showed that the referral was received by the mental health service, it was not possible to demonstrate on Police systems that it had been sent. A recommendation is made to address this. A recommendation is also made to continue to promote voice of the child opportunities across the service.

1.52. *Porchlight*: The Short Report identified that more information should have been sought in addition to what had been provided on the notification (from Police to Children's Integrated Services, see 12.8), and a recommendation is made to address this.

1.53. *Thinkaction*: Appropriate policy and procedure was followed in the service's contact with Georgia, except that a letter should have been sent to Georgia's General Practice informing them of her self-referral and subsequent discharge. Recommendations are made to address this learning.

Lessons to be Learned

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.

Visibility of Children when Organisations Respond to Adults

1.54. 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 to consider how an adult's situation may be impacting on their children.

1.55. NSPCC research into Serious Case Reviews (2018) in which parental mental health was a factor argued the following: "Children should never be considered a protective factor for parents who feel suicidal. In some cases, professionals inappropriately viewed the child as a protective element who could help to reduce the parent's risk of self-harm." In some cases a person's family will be a protective factor, but it is important not to assume that this will continue to be the case, and for practitioners to question what may occur if someone's stated protective factor is no longer present for them.

1.56. 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).

1.57. The multi-agency workshop discussed how agencies identify and respond to the needs of parents or children following parental separation. Attendees identified a need for professionals to 'look behind' presenting issues and what is being stated to ensure they work to try to identify any additional issues or needs that need response or onward referral. In particular it is important for families to understand how early help interventions can support them.

1.58. The Southend Essex and Thurrock Domestic Abuse Strategy 2020-2025 recognises that there is conflict in relationships that may or may not be abuse, but still requires a response from specialist and universal services[3]. This is a positive step to support professionals in recognising the range of situations that occur, and how best to support those in need of, or accessing services.

Information Sharing

1.59. In recognition that movement is common for people, particularly between local authority areas, workshop attendees discussed the need for agencies to ensure that information is appropriately shared across boundaries. For some agencies this will involve ensuring that consent has been provided by the individual concerned; for others this would be overridden in response to a concern for the individual or the family. When agencies share information through a notification or a referral, clarity is required by that agency over what was expected from the organisation they are sending the information to.

'Non-Crime Domestic' Police Incidents

1.60. 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?

1.61. This review cannot draw any conclusions on what happened. But research, data and professional experience tell us that women are more likely to be victims of domestic abuse and coercive and controlling behaviours. While this should not lead to assumptions of this being the case in all situations, it should lead officers to remain professionally curious when responding to incidents in which a woman claims to have 'instigated' the argument or altercation. An initial recommendation was made for Essex Police to review the automatic labelling

[3] p15, https://setdab.org/wp-content/uploads/2020/06/SETDAB-Strategy-Report-Final-2020-2025.pdf

of individuals as ‘victim’ and ‘perpetrator’ in non-crime domestic incidents in which the situation and context are not clear. Essex Police responded promptly with an internal review.

1.62. Following this review by Essex Police, with oversight from the Force's Chief Superintendent Domestic Abuse lead, the Force agree with the DHR lesson learnt that when no offence has been committed individuals concerned should not automatically be categorised as victims or offenders. Their review has identified a need to evaluate opportunities in Force systems to avoid such labels being applied and provide clarity for officers and staff in order to standardise behaviours and move away from routine categorisation in non-crime domestic incidents. Essex Police are committed to working to improve this position with key partnership insight and engagement. A recommendation (2) is made to ensure this ongoing work is captured in the action plan. This Review welcomes the ongoing review but cautions that, in many incidents, including non-crime domestics, it may still be clear to officers that there is a victim and a 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.

1.63. Additionally, Essex Police informed the Review that an Assessment Team is now in place that researches any known history, and risk assesses incidents being reported, in real time, actively helping to safeguard victims at the earliest opportunity, this includes any domestic abuse incidents. Their research assists the call takers and attending officers to make informed decisions to support an appropriate response for attendance. Essex Police has also invested in an Audit and Inspection Team to carry out audit and inspections as directed through the Force's audit plan or as required by Chief Officers or Heads of Departments. This includes a wide variety of inspections across all areas of policing focusing on force priorities, including domestic related incidents, in order to provide an additional layer of scrutiny to ensure compliance against policy and procedure including qualitative reviews of the police response and investigations by examining Force systems to identify areas of risk, non-compliance or weakness.

Since October 2019, the Audit and Inspection Team have conducted two inspections into Domestic Abuse, as a result, findings and any associated actions for improvement are fed through the Force's Domestic Abuse Governance Board chaired and monitored by the Chief Superintendent Domestic Abuse lead. The Review welcomes these developments to ensure procedure is followed and enable opportunities for learning.

Understanding Relationships

1.64. 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.

Recommendations from the Review

1.65. *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.

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

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