# Impact of Domestic Abuse on children

## Independent Scrutiny Report

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## 2 INTRODUCTION

The review was commissioned by the Kingston and Richmond Local Safeguarding Children Partnership (KRLSCP) as part of the work to undertake independent scrutiny of the work in Kingston and Richmond to enable the statutory partners to gain assurance of the effectiveness of the safeguarding arrangements in the two boroughs and to identify any learning for improvement.

Wood (2021) suggested that there has been a wide variety of scrutiny work since the inception of the Local Safeguarding Children Partnerships in 2019.

*"Is scrutiny a review of an activity or services or is it a diagnostic analysis of what impact a service is having? Is something being scrutinised because it is 'next in line' or because there is a question about its effectiveness? Can scrutiny trace a line between decisions taken by safeguarding partners and outcomes for children and improvements in multi-agency practice?"*

The reason domestic abuse was chosen within Kingston and Richmond was due to it being a priority of the LSCP and a desire to check the effectiveness of the services dealing with the issue.

The Independent Scrutineer was asked to consider and report around domestic abuse on a strategic level; for example, liaising with practitioners to consider:

- Are there effective working relationships between related oversight, for example between the KRSCP, Safeguarding Adult Boards (SABs) and Community Safety Partnerships (CSPs) in each of the boroughs?
- Is learning from Domestic Homicide Reviews (DHRs), Local Learning, and Child Safeguarding Practice Reviews (CSPRs), relating to domestic abuse, being effectively disseminated and embedded, good practice from Domestic Abuse Bill (signed into law as the Domestic Abuse Act 2021, on 29 April 2021)?
- Does the KRSCP have appropriate policies and training in place to support partners' practice, including consideration of disproportionality?
- Independent scrutineer to test with multi-agency frontline practitioners.
- Does the partnership have adequate intelligence to support agencies understanding and respond to Domestic Abuse?
- Review learning and recommendations from multi agency audit held in May 2021
- Produce a scrutiny report into this deep dive theme with findings and recommendations
- Meeting with Senior Leadership Group (SLG) to present draft scrutiny report findings
- Participate and present the finding in the virtual learning event to be held on June 22

A wide range of documents and conversations have been included within this review. The aim has been a diagnostic analysis to look at the impact of the arrangements for addressing DA in the two boroughs. This has not always been possible to elicit but that, in itself, brings to the attention of the LSCP the need to have more of a focus on impact and outcome.

In terms of the line between the decisions of the safeguarding partners and outcomes for children, there is evidence of a commitment to listen, good use of

resources and positive response to professional differences when raised with leaders.

# 3 METHODOLOGY

## 3.1 DOCUMENT REVIEW

### 3.1.1 Kingston and Richmond Local Safeguarding Children Partnership (KRLSCP) Website

The KRLSCP website is easy to navigate and signposts what local and national support is available for families. It highlights the impact of domestic abuse on children.

For professionals it provides definitions of domestic abuse, including 16/17-year-old young people. There is information for schools. Additionally, there is guidance for how to work with young parents and Covid-19 updates to show the support still in place.

For children and young people, there are details of where to get local or national support and teenage focuses websites.

However, there is limited information for male victims, although does include this for children and young people. Nevertheless, the link to the CSP takes to more resources which does include the recognition of male victims.

### 3.1.2 Annual report 2019-20

The report recognises the impact of domestic abuse as a priority for the partnership. It notes that, in Richmond 5.74% of children are affected by domestic abuse, in Kingston there are 6.14% affected.

The report states that child protection planning is stronger in identifying children under 5 years as being at risk of physical abuse from domestic incidents. There was an increase in MARAC referrals in Kingston, including 16/17 year old young people.

As the report covered the first stages of the Covid-19 pandemic, it was able to demonstrate the work done in Kingston during the first lockdown to get communications out to the community in different languages. This led to an increase in referrals to police and MARAC.

The report also showed how half of the schools in the boroughs were involved in Operation Encompass.

### 3.1.3 London CP Procedures

The KRLSCP directs practitioners to the London procedures. These are extensive and include safety planning with mothers and children and the Domestic Violence Risk Identification Matrix (DRIM). However, they are probably too vast for

practitioners when they need some fast, brief, guidance, although the DRIM remains a useful tool for practitioners to think through the risks to children living in households where there is domestic abuse reported.

### 3.1.4 Kingston Domestic or Sexual Violence (DSV) Prevention Partnership / Safer Kingston Partnership

- Commissioning DV hubs/complex needs
- Review of DHRs
- Translating leaflets
- DA Bill
- MARAC data – includes number of repeat cases involving children

### 3.1.5 Domestic Homicide Reviews

DHRs were reviewed and discussed during conversations. The most recent review did not involve services as the family had only been in the country for a short period.

### 3.1.6 Richmond VAWG

- Voice of survivors
- Commissioning of Independent Domestic Violence Advocate (IDVA)
- Perpetrator management
- Multi Agency Risk Assessment Conference (MARAC) data- rise in cases during pandemic

### 3.1.7 Standing Together Review 2016 (Richmond)

- Commitment but not shared objectives across DAOG
- Leadership in silos, not everyone involved
- No clearly specified framework used – so individuals do what they think
- BAME % survivors are higher than the % population who are BAME

### 3.1.8 2019 audits

- DVA immersed in child neglect and abuse or drugs/alcohol
- Difficulties in engaging mothers
- Survivor and perpetrator wanting to remain in relationship
- Engagement/non engagement = stepdown/step back up to CP
- Reduction in pre-birth plans

### 3.1.9 Domestic abuse Newsletters

Include partner perspectives.

### 3.1.10 Young people you tube sessions

Useful and constructive conversations with young people, male and female. These were very powerful in showing how young people reflect on positive relationships and what they should expect of each other. There was also some insight into the impact on young women who have been raised by survivors of domestic abuse.

### 3.2 QUESTIONS FOR CONVERSATIONS

The key lines of enquiry were developed from the Joint Targeted Area Inspections Themed: Children Living with Domestic Abuse (2018) which considered the following areas:

- Early and effective help to address needs of child, non-abusive parent, perpetrator
- Right help / protection through appropriate thresholds, effective information sharing, timely intervention
- School systems to identify timely referrals and to provide additional support
- Risks reduced through identification and assessment of risks perpetrators pose leading to targeted intervention
- Child welfare promoted and protected through timely identified assessment and response to risks to and needs of adult victim
- MARACs have effective action plans
- Evidence based approaches
- Police investigate
- Children and families feel their views are heard
- LSCP actively monitors, promotes, coordinates, and evaluates the work of partner agencies to help protect children at risk, including working effectively with other multi-agency groups for DA

These were formulated into a framework covering:

- *Identification* of domestic abuse
- *Response* by those who first identify the abuse
- *Right help*: what help provided and when
- *Reduction of risk*: how services work with perpetrators to reduce the risk of harm to the adult and child victims
- *Working Together* to identify and respond effectively, as well as efforts to prevent abuse
- *Listening to children and families* in relation to the way services address domestic abuse
- *Impact*: what difference work is having on safeguarding children from domestic abuse and what barriers there are to doing this

### 3.3 CONVERSATIONS HELD

- Refuge Kingston
- Refuge Richmond
- Strengthening Families
- Midwives (Kingston Hospital)
- LSCP Strategic Partners
- AfC professionals including those working children and those working with perpetrators
- Metropolitan Police
- LSCP Manager
- LSCP Training and Development Manager
- Designated Safeguarding Leads (K&R, Primary, Secondary and Independent)
- Richmond CSP Team

- South West London and St George's Mental Health Trust (MARAC leads)
- Kingston MARAC Coordinator

### 3.4 GAPS AND LIMITATIONS

It was not possible to speak directly to children and young people, although the you tube podcasts provided a sense of the perspectives of older adolescents. Additionally, survivor or perpetrator groups were not included due to the Covid restrictions. However, Refuge in both boroughs provided a strong view of the experience of victims/survivors of abuse, whilst the Strengthening Families team working with perpetrators presented a good picture of the outcomes of one to one and group work.

The analysis has been limited due to the speed of the review and so has been confined to intimate partner abuse within the home rather than young people relationship abuse, child to parent or wider family members.

The Scrutineer has attempted to focus on Richmond and Kingston separately, but this has not been consistently successful. Where issues have been raised that specifically relate to one borough this has been noted, otherwise the learning is more generalised.

## 4 FINDINGS

### 4.1 AUDIT REVIEW (THIS WAS THE DRAFT AND MIGHT BE SUBJECT TO CHANGE)

The audit of pre-birth cases involving domestic abuse was undertaken by the KRLSCP in May 2021 and the draft report was shared with the scrutineer on 11 May 2021.

The audit highlighted that there was good:

- Multi-agency communication and relationship-based working was key to working with mothers.
- Importance of understanding the family narratives and history
- Use of Clare's Law and routine enquiry

The audit considered some grey areas:

- Timeliness of post-natal information sharing
- How to respond to victim retractions of allegations
- Cross boundary working and IT
- Absent fathers (being looked at by the National Panel)
- Supporting mothers when infants are removed from their care
- Listening to different accounts, critical thinking, and risk assessment

The audit set out areas for development:

- Understanding MARAC/ Child Protection thresholds
- Co-location of IDVAs
- Ensuring Child Protection Plans that include domestic abuse for young children have the category of risk of physical abuse?

- Multi-agency attendance for key case level meetings
- The importance of the role of GPs at the centre of the spider's web.

| **Scrutineer review of audit findings** | | | |
|---|---|---|---|
| **Key points** | **Kingston** | **Richmond** | **Scrutineer Comments** |
| MARAC | 50% rise in referrals to MARAC since March 2020. | 25-30% rise in referrals to MARAC since March 2020. | *What plans are there for increased resources for interventions to match the increase in high risk referrals?* |
| Complex needs | Non DA issues regarding mother lead to focus being on her rather than father. Children not in care of parents. | Care and support needs of mothers who misuse substance | *When there are substance misuse or mental health issues for woman who is pregnant, how are adult services utilised to address care and support needs? Child removed but what will impact of future pregnancies be?* |
| History | Maternity services not knowing about extent of previous concerns. Previous CP due to DA | Mother's childhood experience of DA Previous concerns from another borough not known due to booking at hospital | *Women not disclosing DA due to previous experience of CP* |
| Follow through by adult victim | • Mother refused for police to take forward DA allegations<br>• CP stepped down to CiN<br>• Mother did not agree to see the SW face to face | Lack of transparency of information shared by mother | *Language used, worker experience, trust* |
| Communication | • Police not informed of birth immediately<br>• Police and GP kept up to date | Late notification of DA concerns to maternity Coordination and safety planning for baby | *Information sharing – when, how, who* |
| Cross borough | • Joint supervision for | Transient families Sharing information picks | *Use of networks. How does LSCP work with neighbours* |

| | | | |
|---|---|---|---|
| | SW teams (Surrey) | up issues not being shared by mother | *regarding professional disputes?* |
| Impact on the child | • Delays in CP<br>• CiN not CP<br>• | Delays in CP<br>Need to 'think family'<br>CP Physical abuse for assault during pregnancy<br>Assault of older child | *Professional conversations*<br>*Trusting relationships for child, victim, perpetrator* |
| Social media harrassment | • Threshold for concerns | | *How is this included within practice?* |
| Involvement of father | • Father asked to leave labour ward<br>• New partner engaging well (HBV) | Delays in involving father | *Understanding of risks within the CP system* |

## 4.2 STRATEGIC ISSUES (FROM REVIEW SCOPING)

**4.2.1 Are there effective working relationships between related oversight, for example between the KRSCP, SABs and CSPs in each of the boroughs?**

There was evidence of mutual understanding between strategic partnerships. Community Safety Partnerships focus on issues affecting children. However, there needs to be more done to:

- Recognise and explore the long-term harm to children
- Consider the needs of young people, who have lived experience of domestic abuse, in how they can safely move into adulthood.

This requires clearer structures, accountability, and responsibility agreements between the strategic partnerships.

**4.2.2 Is learning from Domestic Homicide Reviews, Local Learning, and Child Safeguarding Practice Reviews, relating to domestic abuse, being effectively disseminated and embedded, good practice from Domestic Abuse Bill (DA Act 2021)?**

There was good understanding of the local reviews completed and the learning seemed to have been disseminated widely. There was also evidence of planning for development work following the Domestic Abuse Act 2021 becoming law.

In relation to children, of particular note, the Act will:

- create a statutory definition of domestic abuse that widens it beyond physical, but can also be emotional, coercive or controlling, and economic abuse. As part of this definition, children will be explicitly recognised as victims if they see, hear or otherwise experience the effects of abuse

- extending the controlling or coercive behaviour offence to cover post-separation abuse
- place a duty on local authorities in England to provide support to victims of domestic abuse and their children in refuges and other safe accommodation
- place the guidance supporting the Domestic Violence Disclosure Scheme ("Clare's law") on a statutory footing
- ensure that when local authorities rehouse victims of domestic abuse, they do not lose a secure lifetime or assured tenancy
- provide that all eligible homeless victims of domestic abuse automatically have 'priority need' for homelessness assistance
- stop vexatious family proceedings that can further traumatise victims by clarifying the circumstances in which a court may make a barring order under section 91(14) of the Children Act 1989

(Home Office, 2021)

Much of this work is already embedded within Kingston and Richmond, such as the use of 'Clare's Law' and some examples of good practice in relation to keeping emergency housing open, for a period, for a survivor who changed their mind and returned home to the perpetrator.

This provides a good basis on which to plan for the future. It is suggested that there is particular joined up work on:

- The capacity of housing for victims and their children
- What support there will be for children as victims- how will this link with the child protection system?
- Understanding whether situations of parental conflict and separation are viewed as domestic abuse. This is significant in light of the 'vexatious' family proceedings

**4.2.3 Does the KRSCP have appropriate policies and training in place to support partners' practice, including consideration of disproportionality?**

The KRSCP has an excellent website that is easily navigated to take practitioners through to policies that are related to domestic abuse. This includes the London Child Protection Procedures which are quite extensive. Training commissioned by the LSCP focuses on the local picture, definitions, barriers to disclosure, impact, safety planning and services. Well attended by voluntary services, social workers, health and schools but police have had bespoke training. The difference the training has made has been reported as:

- Increase in awareness of DA
- Increase in awareness of child vulnerability from DA
- Increase in talking to each other
- Increased knowledge of resources

This has improved during pandemic as sessions have been virtual.

Refuge Kingston also provides DA training, and this is being accessed more by children's professionals. The training includes use of language and relationship development. However, the two routes of training are not aligned.

In the Standing Together review (2016: Richmond) there was a conclusion that there was no clearly specified framework for domestic abuse. There is a perception that this is still the case. The policies and training are sound in helping professionals to recognise and take an appropriate, initial, response to domestic abuse. However, there is variation in how professionals take forward their work with adult victims which can lead to difficulty in establishing trusting relationships.

It is recommended that there is more exploration of how to develop relationship-based practice for domestic abuse where there are children in the home. The use of multi-agency reflective practice sessions or group supervision regarding complex cases could aid this work.

**4.2.4 Does the partnership have adequate intelligence to support agencies understanding and respond to Domestic Abuse?**

The MARAC data was considered as part of the review. In Kingston this includes number of cases involving children both as first referrals and repeats. When tested with the frontline practitioners from AfC, they reported that it was likely that they already knew most of the children recorded in the 'repeats' section.

Given that MARAC is supposed to be for the highest risk cases, those 'tip of the iceberg', then a question is whether services are keeping children safe if there are repeat MARAC referrals?

In Richmond, there is recording of children involved in MARAC cases. At the start of the pandemic data was used to review all cases to enable checks to be made as to the safety of victims and their children.

The data between agencies has been reported as 'not matching'. It is recommended that there is some mapping of MARAC child data on the Child protection/ Child in Need data to examine what difference the response to domestic abuse has on the outcomes for children.

The KRSCP dataset was reviewed which provides data on the relevant areas relating to domestic abuse. This shows that, in Kingston, during 2020/21 there were between 37% -41.4 % of the children assessed within AfC for whom domestic abuse was a factor, compared to 35.7%-41% in Richmond. It is noted on the dataset that nationally, in 2018/19, the percentage was 50%. Given the awareness of the rise in domestic abuse during the pandemic, it would be beneficial to explore this data further and map against the MARAC data and school data to ensure that children are not being missed, particularly in light of the increase in the number of children being electively home educated in Kingston specifically (208 for Q3 2020/21 compared to 143 end of year 2019/20.

It would be of benefit to do further mapping for both boroughs in relation to cases not reaching MARAC, to compare with school data regarding reports of children in families where there is parental conflict. This could be done through looking at the Early Help Assessments that featured domestic abuse and considering the origin of the referral and how both parents were involved in the assessment.

## 4.3 CONVERSATIONS (USING FRAMEWORK FROM 3.2)

### 4.3.1 Identification

There was evidence of some proactive work in identifying domestic abuse within both boroughs. There seemed to be a good range of agencies alert to the potential for abuse and knowing where to seek advice and support from.

Examples in Kingston:

- There are referrals to the DV hub from a range of agencies. There has been an increase in MARAC referrals during pandemic and increase in repeat referrals (36% from 20%) (Safe lives state that there should be 30-35% repeats.)
- Emergency MARACs work in identifying high risk offenders who have moved boroughs and living in Kingston with new partner and her children
- Improved DA referrals by GPs who have attended awareness raising sessions
- There is a sense that there are more referrals via the police for ethnic minorities and this would indicate need for earlier support and a BAME specific worker.

Richmond examples:

- Funding provided for the Identification and Referral to Improve Safety Programme (IRIS) across 23 practices for Richmond GPs
- Of concern, that if a victim retaliates then they can be referred to MARAC as the perpetrator

General issues:

- The perception was that the majority of referrals to children's services tend to be DA, but alongside mental health or substance misuse. However, over the past 12-15 months, there referrals have become more about family breakdown and child mental health, but DA is still a significant issue.
- DA shifting to peer on peer abuse and child on parent abuse.
- The data focus is on MARAC but this is just the 'tip of the iceberg'. Need to look at all contacts where threshold met for Children's services.
- When a woman presents for antenatal care will be asked about other children. She can say they are at home and midwives will not know the children are not in the care of the mother until much later. All depends on what woman wants to disclose and whether she feel she will be supported if she discloses. (suggestion from midwives for national spine flag for women who have had children removed) some women change their date of birth.
- There needs to be recognition that men can also be victims and be the primary carer for the children

### 4.3.2 Response

General:

- Dependent on the worker rather than service. Works best when there has been a MARAC referral as the panel work together well as accountable – including housing, education, children's services.
- Outside of MARAC no one is accountable: language used – 'why not leave?'
- Refuge is client led. This means that they can stay in the relationship if they want to which means they are more accessible and can be more honest. This can be difficult for other agencies to deal with.
- IDVA and advocacy risk assess clients, varied caseloads re demographics. Increased awareness raising during pandemic.
- Responses can be very adult focussed rather than taking a child trauma informed approach.
- When adult victim needs hospital treatment then children might be taken into police protection. This can mean a long wait in a cold room for the child whilst waiting for Children's Services. Often this will be out of hours and so Children services lack capacity. Impact of the delay for the children. If women and children taken to refuges, then this can help them to adjust.
- Metropolitan Police have positive action policy so have to do something when there is a DA incident. Use of IDVAs with Police is helpful to support victims to move forward in thinking about criminal proceedings. It is difficult when victims want the abuse to stop but do not want to progress with criminal proceedings; it is difficult to police the private space of homes. There is a need to prioritise DA by harm caused, e.g., intimate partner abuse rather than focus on sibling-to-sibling arguments. Currently, Police have to investigate all DA to the same extent, e.g., sibling arguments take time away from high-risk intimate partner abuse.
- Schools notice changes in the behaviour of a child e.g., withdrawn and becomes 'victim' or 'acts out and dominates'. Parents often totally deny problems but in the end the mother might disclose. Contact made with the Single Point of Access (SPA) for advice pre disclosure and referral to Children's services but can take 9 referrals before there is a s47 and social worker assigned.
- Definition of DA needs to be clarified as safeguarding referrals can include parental conflict or separation, adult led issues -particular issue in wealthier families
- AfC respond by trying to build trusting relationships with the family, e.g., via family coach
- MARAC very good as not just looking at score but professional judgement counts.
- Strengthening families focus on children, victims, and perpetrators. Victims also have IDVAs.
- Local demographics showing mutual couple violence leading to child emotional difficulties and Child in Need (CiN)/Child Protection (CP)/Public Law Outline (PLO). There is also growing DA between teenagers.

Kingston:

- CP Plans – Kingston is all about the mother having to change. Sometimes perpetrator and victim in same room.
- Agencies are quick to withdraw if someone else is working with the family. There can be incidences of delays on waiting lists for therapeutic work with children who have witnessed abuse. This can have an impact on the adult survivor, who struggles then to parent the child with extreme reactions to the domestic abuse, by then returning to the perpetrator. This can be the result in families where the children are subject to child protection plans. The children needing mental health support are too young to meet criteria for some services. The outcome is that Refuge workers pick up more than their capacity or skills and work with schools.
- Need more hands-on mental health work for children. If mother has mental health issues, then she needs help to understand the impact of the abuse on their child.

Richmond:

- Children Centres worked well for mothers to access support and advice. Co-location works, enables face to face work or three-way meetings with other professionals.
- There are a lot of safeguarding referrals but varied outcomes, cases have different issues. Can refer in to safeguarding thinking that the threshold is met but the response is that it does not, whilst other cases are a lower threshold but end up as cp plans.
- Split conferences, now, as had to escalate concerns to AfC as refuge could not attend if perpetrator there. Has not been a problem since.
- Good working with AfC b8ut depends on individuals and personalities. Nevertheless, onus is on mother to change.

### 4.3.3 Right help

Kingston:

- Kingston Refuge are commissioned to do play work but do more than that.
- Housing in Kingston is poor for victims of DA and their children. Some housing officers try their best but there are limited resources. Others are judgemental and do not put themselves in shoes of the women. They need more empathy and better language which would improve relationships. A VAWG officer is being recruited who will work with housing and refuge.
- Some very good, individual, professionals but not consistent.
- Lack of therapeutic support for under 8’s and under 5’s has been identified through QA processes.

Richmond:
One stop shop changed during pandemic, not face to face but other options were available. 25% increase in requests for advocacy.

General:

- IDVAs are well used in hospital and able to see women in antenatal clinics or postnatal wards. Opportunity for the 'reachable moment' for women to accept the support to enable them to move forward.
- Evidence of some good practice where multi agency network have supported mother and children, from being away from perpetrator to returning but housing keeping emergency housing open for a couple of months in case woman changes her mind.
- Schools use nurturing groups and Emotional Literacy Support Assistant (ELSA) for the children in primary schools who have experience of domestic abuse, but some need more therapeutic support, which is not resourced, as shown in Kingston. Schools used to find Safe Space was good for children, but this has gone and now can be 6-7 months wait for external support. Social Workers see the children as part of CP plans, but the children need more psychological support outside of the CP plan. Some SWs are good and approach CAMHS, but threshold for CAMHS not always met. Those parents who can afford it sometimes pay for therapy.
- Housing is an issue as stock of emergency homes tends to be in Croydon or Hounslow which are different environments to Richmond/Kingston and survivors do not feel safe.
- Safer spaces stopped which is a loss. Some thought that this is now covered by Strengthening Families but not enough to meet the needs.

### 4.3.4 Reduction of risk

- The previous audit in 2019 showed how issue of when couples want to remain in relationship and there is step down as they engage, despite not engaging previously, leading to escalation within months as the couple disengage again. This has the suggestion of potential coercion and control of an adult 'victim' who is then unable to put child first.
- If agencies work together and enable survivor choice then they are able to have the space to leave or to return, knowing they have support. However, there is a need for more accessible support from housing and GPs etc (Richmond)
- Focus needs to be on the offending intervention, not just arrest, to work towards stopping the abuse, both physical and the increasing social media harassment.

Response from Schools:

- Parents can change schools to avoid the 'safeguarding file'
- Referral made but then mum says everything is ok so case closed
- DA between siblings not addressed
- Coercive control- perpetrator tries to control the school staff, need to keep staff safe but need multiple safeguarding referrals before recognised.
- Splitting of professionals
- Family court delays

- Litigation threats by families lead to services backing away
- Frequent changes of SW can be a problem if a child cannot trust adults
- Safety plans do not reduce the exposure of harm for the child and do not consider the mental and emotional support for a child

In Richmond there was a Council DA roundtable which showed the recognition that need to improve response, housing and Children's services need to show more compassion in their language towards survivors.

Generally, Children's Services victim and perpetrator workers seen as good in taking a whole family approach with risk assessment of the perpetrator rather than removal of the children.

### 4.3.5 Working Together

- There is representation at LSCP groups by DA services.
- Schools are very good in pushing for support for the mother.
- Richmond International Women's Day Conference had good feedback and involved a wide range of professionals.
- Kingston – MARAC working well in identifying risk and which agencies not referring in which has led to being able to address this with the agencies concerned.
- IDVAs information sharing protocol with Kingston MARAC which supports in women being able to talk to police with support of IDVA. How statutory services work with the independent sector requires trust.
- Strategic working across the different partnerships is not joined up, although there are conversations and representation. Operationally multi agency work is joined up and some individuals have developed networks across the agencies. However, need a more strategic approach.
- Pre-birth, midwives do not know about DA if women do not disclose. Routine enquiry used but women can choose not to say, might be due to mistrust of professionals during previous pregnancies or fear of police intervention. Significant issue cross boroughs and also need GPs to inform. When a woman self refers for antenatal care, an email is sent to the GP but often they do not respond or miss out the DA information.
- Cross borough work, when safeguarding issues are flagged in maternity then midwives do check with previous hospitals and are able to gather information. When risks are flagged, there is a good network across London. If midwives have 'gut feeling' then they will ask about women at the maternity concerns meeting where health visitors, social workers are present.

It is important to note that **Operation Encompass is not viewed as being delivered effectively.** Schools across both boroughs reporting that they are not hearing from police which is diminishing the impact that this system could have in working together to reduce the risks of domestic abuse.

### 4.3.6 Listening to Children and Families

The conclusion is that there is room for improvement. Feedback from survivors to DA services is that they do not feel believed by non-DA agencies.

Use of language – 'just coercive behaviour' is not recognised as serious as physical abuse even though it has the biggest impact on the family and the children. Some social workers see through the 'manipulation', others do not. If listened to then the adults are more likely to engage with services.

Voice of survivor heard by IDVAs rather than the voices of the children, but this should change with the DA Act 2021 recognising children as victims. In refuges there are children's workers.

Police call outs, some officers ensure focus on the children in the home. Sometimes victims can be reluctant to mention that there are children there. Good practice- even in a non- violent call out checking in on the child and talking to them and can provide reassurance for the adult victim that their children are alright.

*'engage with victim, engage with children, be human'*

*'get a feel for how their lives are'*

There are **c**oncerns about how victims in different communities are listened to and supported. They can be very isolated and not know that DA is unacceptable in the UK. Professionals can be seen as powerful rather than a support due to the language used and cultural belief systems. This has been part of learning from a DHR but there is insufficient evidence to demonstrate whether a significant difference has been made yet.

### 4.3.7 Impact

- Covid -19 Pandemic

Impact of pandemic on health visiting and support groups meant that as there was an increase in referrals for babies and under 2's, along with an increase in adolescent issues, health visitors were not doing routine face to face visits, NCT, family networks were not there. There was an increase in non-accidental injuries in babies and unsafe sleeping deaths. Some of this might not be a direct impact of domestic abuse but demonstrates the increased vulnerability of families where there are young children.

- Multi-agency working

Some services only involved time limited and then do not know the rest of the journey for the family. This makes it difficult to recognise the impact of their work, e.g. midwives, police.

- Intelligence and Data

The data monitoring needs to be more granular to focus on local areas, ethnicity, age, housing and mapping across agencies as the police data does not match that of support services.

- Children

Young carers are silent carers

Legacy work – relationships as young people and then adults, parent history

- Strategic changes

E.g health landscape

# 5 LEARNING POINTS

## 5.1 THEME 1: CHILDHOOD TRAUMA

The most significant issue raised within the conversations across both boroughs was that of the need for therapeutic intervention for children who have had experience of domestic abuse. The description of examples of changes in behaviour or emotional impact has been described by those working in universal and specialist services, children's workers or those focused on the adults but 'thinking family'.

Brandon et al (2020) discussed how complex issues and cumulative harm to children can occur. This can be when domestic abuse is dominating the family, with the issues of the perpetrator and the non-abusing adult as continued victim or survivor trying to move forward. The experience in Kingston and Richmond reflects that of the research.

**Recommendation 1**
Consider how often the following is explored with the adults in the home, be it within the child protection, child in need, early help processes, or through survivor and perpetrator work:
*'How has the domestic abuse affected the child?'*
*'What do you need to do as the adult in the home to help the child recover?'*

Brandon et al (2020) found that out of the serious case reviews during the period of 3 years, domestic abuse was noted to be a feature in 64% of the families, alongside a significant level of other complex issues facing the adults such as mental health issues or alcohol misuse. These issues were seen to contribute to the neglect of the child. Whereas, in the Kingston and Richmond audit there seems to be more consideration of physical or emotional abuse.

**Recommendation 2**
Consider the cumulative harm to which the child is subjected, not just a risk of an incident of abuse but the long term neglect of their mental and emotional health.
*What resources are there for long term planning for access to therapeutic support?*

In some of the conversations there were concerns that not all situations were actually domestic abuse but, rather, parental conflict or separation, which can also have a negative impact on the child's emotional wellbeing. Cleaver et al. (2011) state that where parents' lives are 'complicated and complex' this can lead to inconsistent and ineffective parenting. Brandon et al (2020) suggest that the complexity of families' situations and the large volumes of information held, when there is complexity, can get in the way of identifying the risks faced by children.

**Recommendation 3**
Explore, through case audits, in relation to children between 5-10 years:
*To what extent do practitioners seek to understand the experience of the child when there has been domestic abuse?*

'*Effective protective practice requires an ability to contextualise the lives of vulnerable children, understand the experience and perspectives of their parents or carers and engage with them through meaningful interactions and relationships with the professionals that are involved in their lives*.' Brandon et al (2020)

**Recommendation 4**
Consider:
*What opportunities are there for professionals to reflect on their approach towards parents involved in domestic abuse – language and relationships?*

*What multi-agency reflective practice sessions are there to provide challenge and mutual understanding of the impact of domestic abuse on children?*

There is evidence that the recognition and response in relation to the childhood trauma caused by witnessing domestic abuse needs to be strengthened across Kingston and Richmond. The view that not enough is done to support the under 8's is a valid one. Therefore, this is a real opportunity to develop a multi-agency network around/within the school so that teaching staff are not left in isolation in trying to tackle the impact of the domestic abuse or the early identification of abuse.

**Recommendation 5**
Review how specialist services work within schools to provide the right help, at the right time for children and support school workers to assess the level of need of the children.

### 5.2 THEME 2: LANGUAGE

There seemed to be a disconnect between the language used by domestic abuse services and those working in other services. This is the dilemma faced when trying to address such an adult issue that impacts on children. The DA Act might lead to more guidance on this as children will be legally seen as victims. It is difficult for children's workers to see non abusing parents wanting to return to the perpetrator or not to leave, given the impact on the child. Meanwhile, it is difficult for victim focused workers trying to support the adult to move forward with or without the perpetrator, whilst other workers have expectations on the victim to make changes. Additionally, there are concerns about the routine use of the word 'perpetrator' in cases where there is relationship discord rather than definitive abuse.

**Recommendation 6**
The LSCP should work with the other partnerships to explore what language is used for domestic abuse and parental relationship difficulties. This could be achieved through reflective practice or group supervision sessions across the multi-agency networks

### 5.3 THEME 3: RELATIONSHIPS

*"A critical moment was the new birth visit as both parents were present, so it was an opportunity to form a relationship with the family. The health visitor focused on the new baby rather than the previous history. This approach proved beneficial as the family listened to advice given…" (Kingston audit)*

*"By having a midwife who is providing continuity of care this has enabled a positive and trusting relationship to be built up with the mother and has meant that she has been able to be open and honest and has accepted referrals and happy to work with other services."(Richmond audit)*

There is evidence that there some professionals utilise good skills in developing trusting relationships with families. To achieve this, professionals need to have the confidence to manage potentially risky situations and to actively listen to all members of the family. This requires robust supervision for the workers to ensure that they are able to reflect on the family dynamics. This can be particularly challenging when faced with parents who choose to remain together, e.g., there is the risk that there is coercive control at play leading to the victim not being able to make an independent decision, or manipulation of the worker by the perpetrator. In other situations, there might have been a separation but a fear by a survivor due to holding a legacy of violence in their life, of children being removed, not being believed, or having witnessed domestic abuse in their own childhood, which leads to them not disclosing any current domestic abuse. Additionally, there needs to be enough capacity to work with perpetrators to ensure that they can acknowledge their accountability and responsibility for their actions.

**Recommendation 7**
Review how reflective supervision is used across agencies working with domestic abuse where children are in the home.

### 5.4 THEME 4: COMPLEX NEEDS

The pre-birth audit and the conversations held highlighted the complexities in families where there is domestic abuse. There was evidence of parents who had mental health problems, substance, or alcohol misuse. This evidence reflects that found by Brandon et al (2020). More recently the National Panel work (DFE 2021) has shown that a combination of domestic violence and substance misuse appears particularly strong, accounting for 24% of all serious incidents reviewed. The Panel urge the need for families to be considered in the specific circumstances of a household including parental age, quality of housing, employment status and identity factors, such as ethnicity, rather than in terms of DA/Substance Misuse/Mental Illness (DFE 2021). This enables professionals to actively listen, and hear, the child's voice rather than become preoccupied with the parents' issues.

Within the conversations there was concern that adult services need to 'jump through hoops' to get all services working with a family together to discuss the risks. Also, there was a comment that, in Wandsworth, there is dual diagnosis worker commissioned which can reduce need to remove children from the survivor's care.

**Recommendation 8**
The LSCP should work with the SAB to review the effectiveness of risk assessments between children and adult services, as well as the long-term planning to promote the best outcomes for the child, so that families are not left in isolation once the perpetrator is out of the picture.

### 5.5 THEME 5: WORKING TOGETHER

There was some evidence in the audit of some good practice of services working together.

*"The telephone call from the social worker to the health visitor, highlighting the domestic abuse facilitated the early antenatal contact to mother."(Richmond audit)*

*"The professional network was described to really pull together to support mother, and to gain contact with mother to support the plans put in place." (Kingston audit)*

The views of MARAC were also consistently that of a panel that works together well. There did not seem to be any significant concerns in either borough as learning had already happened where there had been gaps identified, e.g., GPs being notified of MARAC.

However, from the review of the pre-birth audit and the thresholds document, there are questions regarding how strong the lens is focused on the child when considering domestic abuse within families. Certainly, there needs to be a clear expectation of the changes to be made by the perpetrator, to reduce risk, and support for the survivor. However, more assessment of the actual impact on the child and what the child needs (see recommendation 4)

Several views were raised about how well some individual professionals work with families, however, there was a lack of consistency across agencies and between those working with adults and those focused on the children.

The work of IDVAs and that of the Strengthening Families Team were highly praised.

A key issue of concern that Operation Encompass was perceived, by schools, not to be working.

**Recommendation 9**
Consider what framework is used that can be 'owned' by the local agencies to enable a more consistent approach to the long-term response to domestic abuse, i.e. aligned to the programme developed by the Strengthening Families Team.

**Recommendation 10**
Ensure that there are clear pathways of communication and addressing professional differences with neighbouring boroughs, including Surrey.

**Recommendation 11**
Review how Operation Encompass is working with schools across the two boroughs.

### 5.6 THEME 6: PATHWAYS FOR SUPPORT FROM SERVICES

There were concerns that there can be blocks to effective support for adult survivors, and workers, who are trying to navigate their way. A particular example of this was in relation to housing in Richmond. There were comments that the emergency housing tended to be in other boroughs which meant that survivors had difficulties in then accessing other support such as therapeutic support for their children. Added to this, housing was seen to be away from the protective networks that survivors could call on for themselves and the children. Basically, this means that life beyond the actual abuse is not restorative for the survivor or the child, which can lead to the impact of the harm being long term.

**Recommendation 12**
Review how housing pathways work for victims of domestic abuse in light of the DA Act 2021 setting out that children are actual victims.

### 5.7 THEME 7: RISK ASSESSMENT

There is a need for robust, ongoing, risk assessments for families where domestic abuse has been identified. There is evidence that there is variable practice within Kingston and Richmond services.

The National Panel (DFE, 2021) are undertaking a thematic review of Non-Accidental Injury (NAI) in children under one. Current findings include:

- Some of the tools currently used widely such as Domestic Abuse, Stalking and Harassment (DASH) assessments tend to focus more on risks to adults rather than children
- Insufficient co-ordination between Multiagency Risk Assessment Conference (MARAC) processes and children in need planning
- Variation in the types of programmes commissioned by local authorities and safeguarding partnerships to address domestic abuse.

The National Panel report that '*responses to incidents of domestic abuse were most effective where there was a robust analysis of risks to the victim and support for them; swift action to ensure safety of the children and provide on-going support in recognition of emotional abuse; and purposeful work with the perpetrator, followed up to monitor the extent of sustained engagement and positive outcomes'*. (DFE, 2021).

Within the Kingston and Richmond review, there was clear indication that the DASH was being used. However, there was little evidence of the use of the DRIM which is part of the London Child Protection Procedures.

**Recommendation 13**
Review how DASH and DVRIM are used in identifying domestic abuse and the impact on the child. Consider how the DVRIM, or a different child focused tool, can be used to complement the DASH, and when it should be used.

# 6 CONCLUSION

There is an ambition to create generational change and to prevent 'revolving door' situations across Kingston and Richmond in terms of domestic abuse. There is some strong work in place with good networks and commitment to improve.

However, there is more work to do in relation to reducing the legacy of violence for children and their parents. There is an absolute need to improve the relationships made between professionals which will, in turn, enable more trust between services working with adults and ensure that the children have adults in their lives who they can trust.

The priority area for consideration must be that of ensuring that children are given the support to recover from the abuse to enable them to move forward safely.

# 7 APPENDICES

## 7.1 REFERENCES

Brandon et al. (2020) *Complexity and challenge: a triennial analysis of SCRs 2014-2017 Final report*. DFE.

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