THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Multi-agency safeguarding and domestic abuse

Panel Briefing 2

September 2022

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This briefing from the Child Safeguarding Practice Review Panel is part of an ongoing series of publications to share information arising from work undertaken by the Panel with safeguarding partners and those working in child protection.

This paper sets out key findings from a thematic analysis of rapid reviews and local child safeguarding practice reviews where domestic abuse featured. It summarises the most common themes that emerged in relation to multi-agency safeguarding for children who are victims of domestic abuse, and includes examples of practice and recommendations.

Background

The Child Safeguarding Practice Review Panel (the Panel) reviews cases where children have died or been seriously harmed, and abuse or neglect is known or suspected. In 2020, domestic abuse was a factor in over 40% of cases notified to the Panel, and its annual report highlighted this as a key area of work. Therefore, the Panel commissioned Althea Cribb and Sarah Lawrence to carry out an analysis of reviews where domestic abuse was mentioned to understand the implications of domestic abuse for child protection practice.

Subsequently, the Panel's national review into the murders of Arthur Labinjo-Hughes and Star Hobson demonstrated the prominence of domestic abuse as a factor in child harm. Learning from the analysis was integrated into that national review.

The Panel's aims and objectives for the commissioned analysis were to:

- understand the effectiveness of multi-agency practice in safeguarding children where domestic abuse has contributed to the serious incidents notified to the Panel.
- understand, from recent research and evidence, what works in response to protecting children from domestic abuse.
- understand how services and practice might be improved to support children as victims of domestic abuse.

The methodology for the commissioned analysis comprised of:

- a case review comprised of 50 rapid reviews, 13 serious case reviews (SCRs), 7 local child safeguarding practice reviews (LCSPRs), 1 serious youth violence review, and 1 joint SCR and domestic homicide review (DHR). (72 total)
- a light-touch literature review of recent research and evidence

- meetings with, and a call for evidence from, key stakeholders including the Domestic Abuse Commissioner, specialist domestic abuse charities and children's charities
- a national survey issued to all local safeguarding children partnerships to call for evidence of developing practice (94 responses)
- local area 'visits', where local partnerships were invited to virtual meetings, requests for a template to be completed, or answered specific questions from the reviewers

Introduction

Section 1 of the Domestic Abuse Act 2021 defines domestic abuse for the purposes of the Act as:

- "(2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if— (a) A and B are each aged 16 or over and are personally connected to each other, and (b) the behaviour is abusive.
- (3) Behaviour is "abusive" if it consists of any of the following:
- (a) physical or sexual abuse;
- (b) violent or threatening behaviour;
- (c) controlling or coercive behaviour;
- (d) economic abuse (see subsection (4));
- (e) psychological, emotional or other abuse;
- and it does not matter whether the behaviour consists of a single incident or a course of conduct."

Further, the Domestic Abuse Act 2021 sets out that children are victims of domestic abuse that is perpetrated against their parent or carer. We do not yet know what the criminal justice impacts of this change in legislation will be. While the Domestic Abuse Act 2021 introduces a statutory definition of domestic abuse which encompasses single incidents and courses of conduct, for the purposes of this work we understand controlling and coercive behaviours to be core to 'domestic abuse', separate from non-controlling 'conflict'.

A light-touch literature review of the considerable amount of research in relation to domestic abuse and child protection was conducted alongside the case analysis. It highlighted a range of resources (the detailed bibliography is available on request), but also revealed a lack of research on the lasting impact of domestic abuse on children and young people. This includes a lack of focus on how children and young people are able to recover from the abuse they have experienced, and the support they need to do this.

Reviewing multi-agency safeguarding practice when there is domestic abuse has been challenging. Every stakeholder we spoke with welcomed the review, and there was a consensus that the safeguarding system is not currently 'getting it right' in this area.

Despite the challenges, many organisations, local areas and practitioners are working hard to develop improved responses to children, young people, adults and families. It is not possible to say with confidence 'what works' in response to domestic abuse, and evaluations of interventions and projects are often not robust or do not measure the same outcomes which could enable comparison. Local areas choose from a range of different types of interventions, but they will all have resource implications and may only respond to the experiences of some children, such as those in a specific age group.

We have included examples of different interventions that we have been made aware of, to exemplify the range of activity happening in practice. Through looking at these examples, speaking with stakeholders and safeguarding partners, and analysing what happened to individual children, we have developed four core principles. We think that these principles should underpin practice with children and young people, their families and communities affected by domestic abuse. The Panel believes that applying these principles and reflecting on the recommendations for local safeguarding partners, will help local areas develop effective responses to the impact of domestic abuse on serious child safeguarding cases.

Key findings

The following key findings highlight patterns in practice evident in the case reviews, which were also evidenced within the literature review and in responses from stakeholders and local partnerships.

Multi-agency join-up in safeguarding children when there is domestic abuse

In this case sample of reviews received by the Panel, there was no evidence of a coordinated multi-agency response to domestic abuse. Notably, very few specialist domestic abuse services, for adults or children, were referenced in the reviews, and none appeared as members of review panels. This makes it difficult to determine if they had been involved in the case.

Lack of understanding of domestic abuse

The Panel's review of cases found that most practitioners (and subsequently those writing rapid reviews and local child safeguarding practice reviews) use the term 'domestic abuse' without full exploration, assessment or understanding of the nature of the abuse and its impact on the child and family. This was evident within multi agency meetings, plans and case records. There appeared to be an assumption that simply naming 'domestic abuse' as a concern for a child is enough for all practitioners to understand the situation and respond appropriately. This is an overly simplistic, optimistic and, at times, dangerous assumption that leads to potentially avoidable harm to children and non-abusing parents.

> A teenage child took their own life following many years of being a victim of domestic abuse and coercive and controlling behaviour perpetrated by their father. The level of risk posed by the father to the mother had been deemed as 'high' and the case had been previously discussed at a multi-agency risk assessment conference. The child's mother and father had separated, and the mother was subsequently experiencing high-risk domestic abuse from her current partner. The child had regularly demonstrated their fear of their father and had clearly stated this to practitioners. The risk to the child regarding domestic abuse was seen by safeguarding practitioners as of most concern in relation to the mother's recent partner, and the child was subsequently placed with their father shortly before their death.

While domestic abuse was referenced in all 72 of the reviewed cases, the nature and extent of it was rarely explored. Only 35 of the reviews described the type of abuse being perpetrated.

No 'whole system' response

Multi-agency working was evident only in cases deemed as 'high risk', where practitioners had used the risk identification checklist known as the DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence risk identification checklist). 13 out of 72 reviews referenced multi-agency risk assessment conferences (MARAC). These were used primarily as designed, in response to only the adult victims/survivors. Their ability to co-ordinate and ensure responses to children was not evident. Where a need for specialist domestic abuse support was referenced in cases, this was in the context of 'signposting' adult victims/survivors to the specialist services. Those services were not involved in ongoing multi-agency child safeguarding arrangements.

> A father was convicted of killing his three-month-old baby and of controlling and coercive behaviours against the baby's mother. Despite three separate reports to police made by the mother and by neighbours, separate notifications to the local authority children's social care front door, and police holding information that the father had been abusive to three previous partners, no assessment was initiated. The three notifications were responded to separately by a practitioner (not a social worker). A referral to a specialist domestic abuse service was not offered.

Distinguishing domestic abuse from ‘parental conflict’

The review analysis found an overemphasis on physical violence as the primary indicator of domestic abuse and as a means to assess the level of risk posed by the abuser. This reflects a lack of recognition, understanding or response to abusers’ use of controlling and coercive behaviours.

An overemphasis on physical violence meant that non-physical incidents of domestic abuse were viewed as ‘low level’ and therefore not responded to appropriately. For example, in some cases, first-known incidents or incidents without physical violence reported did not lead to any response for either child or adult victims. In other cases, it was not clear who was using abusive behaviours and who was the victim, leading to responses that inappropriately made the mother, or both parents, equally responsible for risk. While situations where both parents/carers pose a risk occur, they are relatively rare, and professionals have a responsibility to identify the dynamics of the situation and thoroughly understand the risks to children.

These ‘low level’ incidents of domestic abuse were often conflated with the term ‘parental conflict’. Parental conflict and domestic abuse are evidently distinct and require different types of intervention and action from services. It is therefore essential that practitioners are able to distinguish and differentiate the two in order to correctly manage risk in the household.

> Due to both the mother and the father calling the police, both were, at different times, identified as the ‘victim’ and the ‘perpetrator’ of domestic abuse and offered support from the specialist domestic abuse service (which they declined). The reviewer of the case could not identify if this was a case of ‘parental conflict’ or controlling and coercive behaviour – and if the latter, who the primary perpetrator was, and what this meant for the children.

Children as victims of domestic abuse

The Domestic Abuse Act 2021 sets out that children are victims of domestic abuse in their own right, when it is perpetrated against their parent or carer. The Panel sought to understand the implications of this for safeguarding practice. The review analysis found that concerns for children were often categorised as ‘emotional harm’ or ‘neglect’ rather than direct abuse. Actions focused on the mother changing her parenting or protecting the children from the behaviour of the perpetrator, rather than identifying that the children were being directly harmed by the abuser and targeting attention on these concerns as a result.

The Panel issued a survey to all local safeguarding children partnerships as part of this analysis. A survey question asked how partnerships are responding to the change in the Domestic Abuse Act 2021 to recognise children as victims. Notably, responses were varied. Some partnerships said they could not answer the question because they were waiting for further national guidance. Others said they had always considered children to be direct victims of domestic abuse, and that this shaped their whole response.

This shows that there may be tension between seeing the change as both a legal issue which requires further guidance to implement – what this change in legal status means for the criminal justice process – and a cultural issue – what the change in legal status means for how practitioners understand children's experiences. The following key themes reflect that tension.

Impact of abusers' behaviours on children and young people

The case review of rapid reviews, local child safeguarding practice reviews and serious case reviews where domestic abuse was mentioned demonstrated different types of harm to children depending on their age and stage of development.

- **Pre-birth and babies:** nearly all these cases involved death or serious injury to the child through deliberate harm/physical abuse or accidental harm (for example, through co-sleeping).
- **Pre-school age:** impacts were similar to those concerning babies, but this sample also included cases of non-fatal neglect.
- **Primary school age:** co-occurring issues included sexual abuse of the child by family members, and the child demonstrating communication and learning difficulties.
- **Adolescents:** five cases involved the child taking their own life. Co-occurring issues included gang involvement, knife crime, criminal exploitation, sexual abuse and exploitation, teenage pregnancy, child/adolescent to parent violence, including one case of murder.

Extensive research has been done to demonstrate the negative short-term impacts on children and young people of living with an abuser. These include emotional, psychological, behavioural impacts, impacts on their relationships, education, sense of isolation and the losses they experienced, and the risk of physical harm.

The lasting impact on children and young people is not as well researched, and the case review and stakeholder feedback reflected a lack of focus on how they are able to recover from the abuse they have experienced. Lack of funding can drive a focus on crisis support, with services ending at the point the family are deemed to be 'safe'. In the case review, those concerning adolescents consistently saw the domestic abuse as 'in the past', with practitioners unable to see how these early traumatic experiences were potentially still impacting on them.

Practitioners should reflect on and be aware of the varying impacts of domestic abuse on children of different ages, including long-term impacts, and the need for ongoing support.

Children's voices and their experiences of services

Despite widespread recognition that children and young people can experience multiple negative impacts on their lives due to being victims of abuse, there was a notable absence of children's voices in the reviews that were considered.

Nearly all the cases considered showed involvement of the family, at some point, with children's social care (90%) and police (81%). In some cases, the children were seen by practitioners, in particular the police, but not spoken with directly. This is in part due to the perception that they 'seemed well', which we infer to mean that they were calm and not in obvious distress.

In examples where practitioners engaged directly with children in a supportive way and considered their wellbeing beyond appearances, they had a significant positive impact on children's wellbeing.

> An 18-month-old baby was believed to have been shaken so badly that their injuries will lead to lifelong disabilities. The mother had recently started a relationship with a known high-harm domestic abuse perpetrator. When attending a previous domestic abuse incident, the children were seen by police, who recorded they "seem well". The review highlighted that it is not possible to understand how this impression was formed: the children were not spoken with; they were observed sitting quietly and watching television.

The impact of COVID-19 lockdowns

The impact of COVID-19 restrictions was present in several of the cases reviewed, specifically in terms of 'enabling' further controlling and coercive behaviour by perpetrators and exacerbating risks for children. Regarding practitioner responses, remote meetings were possible but professionals could not know who was in the background while the call took place, or whether the abused parent and child could speak freely.

> A male perpetrator of domestic abuse, with a history of sexual abuse of children, was found by police holding a knife to the throat of his female partner, after the victim witnessed him sexually abusing her child. The child subsequently disclosed multiple occasions of abuse by this perpetrator. He had a history of sexual abuse allegations against him and was previously known to safeguarding partners. In the lead-up to the incident, COVID-19 was described as a reason for not allowing professionals into the home or the children to return to school; enabling the perpetrator to further isolate the children and mother from wider family and support services.

The needs of children, young people and families from diverse backgrounds

There was a significant lack of recording and therefore meaningful analysis of, demographic information about children, siblings, parents and carers in both the rapid reviews and local child safeguarding practice reviews analysed. Some characteristics, such as religion, gender identity and sexual orientation, were missing completely. Others, such as ethnicity, physical or learning disabilities, were sparse and under-recorded.

Ethnicity: A third of reviews did not record any ethnicity information for the child who was the focus of the review. Fewer separately recorded the ethnicity of the parents or other siblings. Where it was recorded, the data suggests an over-representation of Black/Black British, mixed, and ethnic minority groups in the sample of cases when compared with England and Wales population data. Reviewers identified only one learning review in the sample that contained any analysis of the ethnicity of the family. As a result, the case review was unable to draw conclusions on practice learning in this area. The literature review and meetings with stakeholders made clear that this notable and concerning absence of ethnicity data and analysis in reviews reflects a lack of understanding from partnerships and services of the needs of children and families from black and minoritized ethnicities. The lack of 'by and for' specialist domestic abuse services that can appropriately meet the needs of families and children was also apparent.

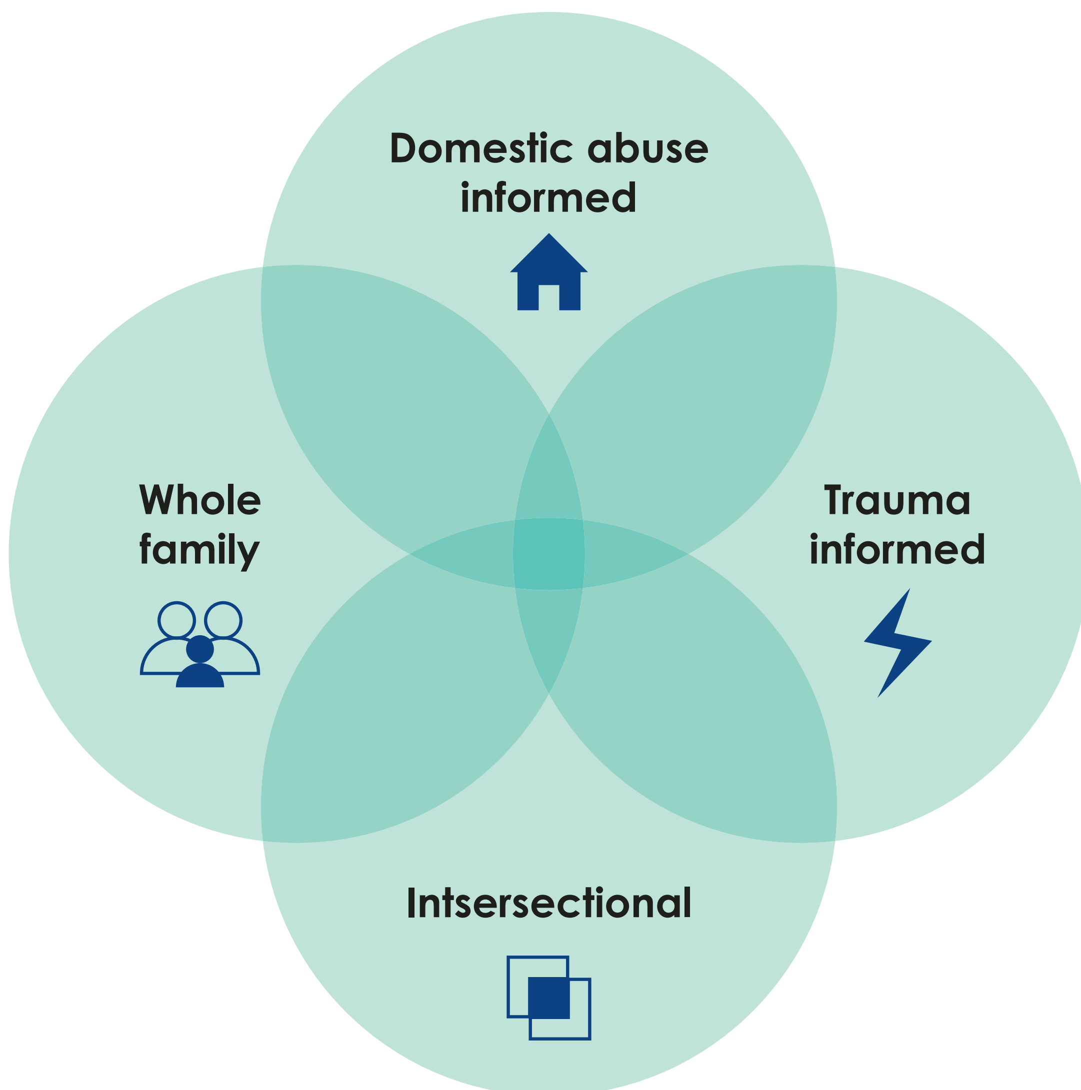
Gender: Another important aspect of this review was the gendered nature of domestic abuse. Gender and gendered expectations are still essential to our understanding of, and response to, domestic abuse. In nearly all cases reviewed in this analysis (92%), mothers were the victims of domestic abuse from the children's father, the children's stepfather or a male partner. Yet there is a lack of response to those who cause harm, and the myth that men and fathers are 'invisible' endures, despite their consistent presence in the lives of children.

Disability: Two of the cases identified that the child had a learning disability. No cases recorded either disability or learning disability of the parents/carers. Research is lacking both within the domestic abuse field (which has not considered the experiences of disabled victims) and the disability research field (which has not focused on experiences of domestic abuse). The literature review highlighted evidence that disabled adults are more likely to experience domestic abuse and to have increased barriers to accessing support. More work is needed in this area, involving 'by and for' services working with child and adult victims/survivors, to understand their experiences and support needs.

Immigration status: Insecure immigration status and no recourse to public funds are significant barriers to safety for adult and child victims of domestic abuse. Stakeholders informed the review that victims they work with (often mothers) fear that statutory services will remove their children because the state has a duty to support the child, but not the adult. This leads to victims not reporting their experiences. They also fear that their children will be placed with perpetrators who have secure immigration status. Services report that, as soon as women with insecure immigration status disclose domestic abuse, they become an 'immigration case' rather than being responded to as a victim/survivor of abuse.

Four core practice principles

The analysis identified four core practice principles that should underpin practice approaches when working with children and young people, their parents, wider families and networks in relation to domestic abuse. These principles are described below; they are not prescriptive about how services or practitioners work but aim, instead, to provide a common approach. They are not to be seen as separate, but interlinked and interdependent.



Domestic abuse-informed

Domestic abuse can take many forms and involves a range of abusive and coercive behaviours that can occur in all types of relationships. Statutory and voluntary sector services working with children and adults require detailed understanding of abusers' use of controlling and coercive behaviours, and the consequent generalised and pervasive fear for adult and child victims. Services must understand these components as central to domestic abuse, and how to distinguish between this and parental conflict. A domestic abuse-informed response names the source of the harm and describes the behaviours of the abuser and the impact on adults and children, seeing both as direct victims who are entitled to support.

Interventions are focused on holding abusers accountable and offering them support to change. This approach means all services understand and account for all risks, not just physical violence, and risk assessments incorporate information from children and about abusers as well as information from non-abusing parents. Being domestic abuse-informed means not taking an incident-based approach, but focusing on the continuous patterns of behaviour by the person causing the harm.

Trauma-informed

Children and adults who have experienced domestic abuse are likely to be traumatised. We recognise the term 'trauma-informed' is used to mean different things to different people but in this context, we refer to a trauma-informed approach as one characterised by a recognition that people who come to the attention of services have histories, experiences and contexts that are relevant to and impact on their current circumstances. Being trauma-informed means responding to individuals and families in a non-judgemental, non-blaming and strengths-based way that prioritises building trusting relationships and avoids re-traumatisation. Services that are trauma-informed emphasise safety (physical and emotional), trust, transparency, peer support and collaboration (working with, not doing to). They promote empowerment and choice, and recognise cultural, historical and gender differences (SAMHSA, 2014). In relation to those who harm, a trauma-informed approach ensures that the whole person is responded to, but without collusion around their abusive behaviours. Trauma-informed organisations will want to promote a non-blaming culture in relation to staff, and provide clinical and reflective supervision, and support for staff to enable them to work with individuals and families in a trauma-informed way.

Intersectional

An intersectional approach is more than simply recognising the diverse characteristics and identities of children and adults. It is essential to understanding how these intersect and lead to discrimination and oppression. An intersectional approach to domestic abuse means services must seek to understand the unique experiences of each family, including their histories, characteristics, and current context, and to see these in the context of unequal societal structures including racism, sexism, and poverty. It requires practitioners to be aware of their own values, biases, and judgements, have safe spaces to reflect, and receive support to separate these from work with families.

Whole family

Children do not come to services alone: they are part of families. They have relationships with their parents, grandparents and wider networks, as well as with siblings and stepsiblings who they might not live with. Responses must gain an understanding of what 'family' means for each child. Children are likely to have strong or complicated feelings about their abusive parent and their non-abusing parent, and they may be traumatised by the abuse and living in a state of permanent fear and anxiety. A whole-family approach does not separate the abusive behaviours of the parent from the impact on children. It considers the parenting of the abuser, as well as the impact of their abuse on the non-abusing parent and their care for the children. Work with the whole family provides direct and specialist holistic support to adult and child victims, alongside specialist holistic support to those causing harm that challenges their abusive behaviours and focuses on behaviour change, while prioritising the safety of child and adult victims/survivors.

Practice and interventions

This section outlines some of the common and emerging practice and interventions that safeguard children where there is domestic abuse, including those that enable children's concerns to be better addressed.

While details are provided here for different examples of local areas with developing practice on child safeguarding and domestic abuse, this is not intended to suggest that they are the only current interventions. These areas of work have not been independently evaluated as effective, as currently there are challenges in measuring and evaluating the outcomes of interventions to tackle domestic abuse.

Common practice and processes within the safeguarding system

Multi-agency safeguarding hubs

The most evident multi-agency response bringing together child safeguarding and domestic abuse in local areas (presented to the reviewers) was within multi-agency safeguarding hubs (MASH) or equivalent 'front door' arrangements for processing referrals and notifications to children's services. Most seemed to be using the 'front door' to manage the high volume of police notifications of domestic abuse incidents within households containing children.

Stakeholders often cited the multi-agency safeguarding hubs as evidence of effective multi-agency working in response to domestic abuse because it is a means of bringing separate systems (local authority, health, and police) together to share information and notify services about what is happening in and with families. However, there can be an unspoken hierarchy in these processes, with the local authority as the key decision maker, rather than a sense of truly shared responsibility. This is particularly evident in areas that told us that a domestic abuse specialist was present within the process, but on further probing, they were there for safeguarding practitioners to 'consult' with, not necessarily as an equal partner.

The multi-agency risk assessment conference was also frequently cited as an example of effective multi-agency working. Stakeholders said it can be an effective place for information sharing around adult victims, but that it faces challenges with information sharing around those who harm, and around children.

Therefore, the Panel's recommendations to safeguarding partners suggest that they should look at local safeguarding systems and responses to domestic abuse more systematically, rather than solely focussing on the 'front door'. This would help practitioners to move beyond 'managing demand' caused by domestic abuse notifications and develop a more effective and child-centred response. Additionally, specialist domestic abuse services, as well as adults and children with lived experience, should be included in the development of strategies and local responses, including commissioning, service design and delivery.

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Operation Encompass

Operation Encompass[1] enables police to provide notifications to schools when domestic abuse is reported and there are children in the household. The purpose of sharing, in theory, is for designated safeguarding leads in schools to be aware of what is happening at home for that child and provide support if needed, but not necessarily to intervene.

This process was referred to frequently in reviews as an area of good practice, but reviews did not explore what the expectations were on schools to respond to children and young people. The information regarding expectations on schools is available from the Operation Encompass website. Some local areas reflected that more work was required to understand the impact Operation Encompass can have in responding to children and young people experiencing domestic abuse.

Domestic abuse partnerships and boards

In response to the call for evidence for this review, it was evident that domestic abuse partnerships and boards report to community safety partnerships, and that domestic abuse leads tend to be located within community safety departments. A 'dotted line' link to safeguarding children partnerships and safeguarding adults boards exists for reporting, usually annually, but mutual accountability for domestic abuse and children who are victims in these connections varies greatly across England.

1 www.operationencompass.org

For example, a domestic abuse team or lead may have been trying to develop relationships with education to promote prevention work with children and young people, or to enhance schools' responses to Operation Encompass notifications. However, this may not then involve the safeguarding children partnership, which is likely to have strong connections with education.

Child and family domestic abuse projects

The review identified several promising interventions that have some evidence of improving outcomes for children and families experiencing domestic abuse. On a local level, these seem able to influence system responses, but implementation levels vary across the country and are dependent on leaders' passion and commitment to tackle domestic abuse. Below we outline the projects and interventions that were most frequently referred to in the review. We are not intending to suggest that they are the only, or best, interventions or models on offer. We are also aware that local specialist services have developed their own ways of working with children, young people and adults that may have equally positive findings.

Opening Closed Doors

Barnardo's Opening Closed Doors[2] in Southeast Wales works with adult and child victims of domestic abuse, and the adult using abusive behaviours, in a whole-family approach. Each person in the family has their own worker, and a combination of one-to-one and group work is delivered.

An evaluation of Opening Closed Doors (IPC, 2021) showed that demand for the programme had been high, with 521 families referred in two years. 253 children accessed the children and young people's domestic abuse programme, and 131 adults participated in the perpetrator programme.

The evaluation looked at 29 case files for children within the intervention, and 79% of these outlined that the children were living in safer and more stable home environments. Reasons included that the perpetrator's behaviour had changed, or that they had moved out, or were practicing strategies to manage their emotional responses; the child had developed their own safety plan or parents understood the impact of abuse on children.

2 www.barnardos.org.uk/what-we-do/services/opening-closed-doors

For Baby's Sake

For Baby's Sake[3] is a whole-family programme, integrating work with fathers and giving them a voice within the safeguarding system that otherwise may not be sought or heard. For Baby's Sake strategic and operational leads told the review about working with families. An evaluation led by King's College London (Trevillion et al, 2020) concluded it is the first intervention to "address existing limitations of whole-family interventions, as it works with both parents from pregnancy and combines evidence-based treatments for domestic abuse, trauma and adult mental health alongside parenting interventions focused on infant mental health and parent-infant attachment". The evaluation found that "successful embedding of For Baby's Sake … [local] programme[s] received referrals, particularly from children's social care, and attracted both co-parents to engage, demonstrating the feasibility of this novel aspect of the model, and sustained this engagement".

The Drive Project

The Drive Project[4] focuses on high-harm, high-risk and serial perpetrators of domestic abuse to prevent their abusive behaviour and protect victims. These are perpetrators who have been assessed as posing a risk of serious harm or murder to people with whom they are in intimate or family relationships. It aims to implement a whole-system approach using intensive case management and one-to-one interventions, including behaviour change and diversionary support for those using abusive behaviours, and activities to disrupt their ability to abuse.

Harbour – Salford

Salford commissions a partnership project called Harbour[5]. This is a trauma-informed service and is designed to support children and young people who have witnessed, been victim or have portrayed behaviours deemed to be harmful to others, under the definition of domestic abuse. The service supports children who live or work in the Salford area. Both intervention and prevention services are available in the form of safety planning, one-to-one emotional support, counselling, group engagement and education. The service works in partnership with other voluntary organisations to support families affected by domestic abuse. Their social impact report shows that 50% of children felt less anxious or stressed after accessing the service. Similar types of interventions are offered across other areas.

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3 www.forbabyssake.org.uk

4 www.driveproject.org.uk

5 www.talklistenchange.org.uk/project/harbour

Tools and guidance

Safe and Together model

The Safe and Together model[6] differs from those already referred to in this section. It is not an intervention or referral point for safeguarding practitioners, but instead aims to change the culture of the safeguarding system. Training, practitioner tools and systems consultations aim to ensure the system responds to domestic abuse through an emphasis on keeping children and non-abusing parents 'safe and together' through practitioners focussing on the behaviours of the abusive parent, how these impact on children and the non-abusive parent's relationship with the children.

Women's Aid good practice guide

Women's Aid has published a Working with Children and Young People Good Practice Guide[7] to bring together promising practice from their members (2021). They make recommendations aimed at improving responses to children and young people, including that the Domestic Abuse Act 2021 translates into meaningful action to ensure children and young people have access to the right support at the right time, and for the length of time they need it.

Local child safeguarding partnership responses

The reviewers issued a national survey to all local safeguarding children partnerships to call for evidence of developing practice. The following examples demonstrate the type of responses received that refer to domestic abuse at a partnership or system level.

Bath and North East Somerset

Bath and North East Somerset has established a community safety and safeguarding partnership with the joint purpose of protecting children, adults, families and communities. All strategic, operational, and sub-groups within the structure of the partnership, including the domestic abuse partnership sub-group, take a holistic, all-age approach to these work areas. The work of each sub-group is shared quarterly. Performance data is gathered and reviewed by the domestic abuse partnership. A young person's focus group is in place, and volunteers who have been service users help with reviewing and developing provision.

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6 www.safeandtogetherinstitute.com

7 www.womensaid.org.uk/information-support/downloads-and-resources/children-young-people

North Yorkshire

North Yorkshire has an established domestic abuse joint commissioning group. It is chaired by the commissioning and partnerships manager from the Office of the Police, Fire and Crime Commissioner and includes representatives from North Yorkshire Police Safeguarding Unit, Community Safety, Public Health England, North Yorkshire County Council and City of York Council. A joint needs and demand assessment of domestic abuse has been produced, and a single shared performance and outcomes monitoring framework. A collaborative commissioning agreement is in place, setting out each organisation's role, responsibilities and financial contributions as part of a joint procurement process. The joint commissioning group provides quarterly reports to the North Yorkshire and the City of York domestic abuse local partnership boards and the safeguarding boards/partnerships.

Hammersmith and Fulham, Kensington and Chelsea and Westminster

The London Borough of Hammersmith and Fulham, together with the City of Westminster and Royal Borough of Kensington and Chelsea, have a long-established sub-group of the violence against women and girls (VAWG) strategic partnership, the Children and Young People's Operational Group that brings all stakeholders together to ensure child victims of domestic abuse receive due attention in strategic and operational responses. The group, alongside the local safeguarding children partnership, has been a driver in the initial roll out of the Safe and Together model training across all three boroughs. Stakeholders informed the review that this group benefits from the passion and dedication of the chair, and the co-ordinator role which is jointly commissioned by public health in all three boroughs and provided by Standing Together Against Domestic Abuse.

Recommendations for safeguarding partners

The following recommendations are not mandates, but suggestions based on the analysis, which the Panel believes would help local areas develop effective responses to the impact of domestic abuse on serious child safeguarding cases.

- Reflecting the priority in the new Domestic Abuse Plan[8] (published 30 March 2022) to bring national government departments together in a whole-system response, child safeguarding partners should recognise their central role in the local response to domestic abuse. They should connect closely with the community safety partnership or domestic abuse board to ensure priorities and work plans align, including commissioning and budget priorities, with clear accountability mechanisms.
- Local child safeguarding and domestic abuse partnerships should involve specialist domestic abuse services and experts by experience (children, young people and adults) in the development of strategies and local responses, including commissioning, service design and delivery. Specialist services, including those working with minoritized and disadvantaged victims and their families, should be appropriately recognised and resourced for this work.
- Local partnerships should look at local safeguarding systems and responses as a whole, focusing not only on the 'front door', and move beyond the need to 'manage demand' resulting from domestic abuse notifications.
- Training should be embedded across all safeguarding partners for all practitioners to ensure they provide a domestic abuse-informed response, and for this to be supported within supervision and reflective practice opportunities.
- Rapid reviews and local child safeguarding practice reviews should involve local specialist domestic abuse services in every review where domestic abuse is mentioned, whether the domestic abuse is perceived to be current or historic. Specialist services should be appropriately recognised and resourced for this work.
- Rapid reviews and local child safeguarding practice reviews should identify and record the protected characteristics of each family member, along with details of the whole family, to ensure that families' diverse needs, experiences and wider family networks are identified and analysed appropriately.

8 www.gov.uk/government/publications/tackling-domestic-abuse-plan

- Safeguarding partners should read recommendation eight in the national review into the murders of Arthur Labinjo-Hughes and Star Hobson, which relates to specific practice improvements in relation to domestic abuse. They should consider these alongside the above, including:
  - Safeguarding partners to improve how they work with specialist domestic abuse services by establishing stronger working relationships and clear information sharing protocols.
  - Safeguarding partners must be committed to, and fully invested in, the commissioning of domestic abuse services and ensure all staff have a robust understanding of what the domestic abuse support offer is in their area.
  - Appropriate responses to domestic abuse should feature clearly in any new proposed National Child Protection Practice Framework as recommended by the national review into what happened to these children. Training should be embedded across all safeguarding partners for all practitioners to ensure they provide a domestic abuse informed response.

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PRACTICE REVIEW PANEL