



The multi-agency response to children living with domestic abuse

Prevent, protect and repair

This report is about the second joint targeted area inspection programme, which began in September 2016 and which examined 'the multi-agency response to children living with domestic abuse'. The findings in this report consider the extent to which, in the six local authorities inspected, children's social care, health professionals, the police and probation officers were effective in safeguarding children who live with domestic abuse. The report calls for a national public service initiative to raise awareness of domestic abuse and violence. It also calls for a greater focus on perpetrators and better strategies for the prevention of domestic abuse.

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Background

1. The programme of joint targeted area inspections (JTAs) began in January 2016. The programme brings together inspectorates Ofsted, Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS), and HMI Probation (HMIP) to 'examine how well agencies are working together in a local area to help and protect children'. Each set of JTAs focus in depth on a particular issue. The first JTA programme, carried out in 2016, focused on child sexual exploitation and children missing from home, school or care.¹
2. This report is about the second JTA programme, which began in September 2016 and which examined 'the multi-agency response to children living with domestic abuse'. Under the Serious Crime Act 2015 (section 76), a new offence of 'controlling or coercive behaviour in an intimate family relationship' came into force in December 2015.

'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological; physical; sexual; financial; and emotional.'

3. Previously, the Adoption and Children Act 2002 (section 120) extended the definition of 'harm' as under the Children Act 1989 to include 'impairment suffered from seeing or hearing the ill-treatment of another'.² Therefore, children who are harmed through witnessing domestic abuse or violence at home are considered to be in need of help and protection from their local authority.
4. The findings in this report consider the extent to which, in the six local authorities inspected, children's social care, health professionals, the police and probation officers were effective in safeguarding children who live with domestic abuse. The findings review the practices of the individual agencies, as well as multi-agency working arrangements.
5. The inspectorates inspected six local areas: Bradford, Hampshire, Hounslow, Lincolnshire, Salford and Wiltshire.
6. In order to put the findings from inspections in context, we also:
 - conducted a literature review

¹ Joint inspections of the response to children living with domestic abuse: September 2016 to March 2017, Ofsted, Care Quality Commission, HM Inspectorate of Constabulary and HM Inspectorate of Probation www.gov.uk/government/publications/joint-inspections-of-the-response-to-children-living-with-domestic-abuse-september-2016-to-march-2017

² Section 31(9)

- considered relevant national data
- spoke to survivors of domestic abuse
- surveyed teachers in a small number of schools
- shared our findings with stakeholders from a range of organisations that work in the field of domestic abuse.

Executive summary

Professionals have made progress in dealing with the immediate challenges presented by the volume of cases of domestic abuse. However, domestic abuse is a widespread public health issue that needs a long-term strategy to reduce its prevalence.

The volume of activity that domestic abuse creates for agencies is so great that it requires sophisticated systems and well-coordinated processes. Inspectors saw significant differences in how well these systems worked in different local authority areas.

While agencies have overcome many of the problems associated with the volume of cases, the next step is for them to take a long-term approach towards the prevention and reduction of domestic abuse over time. This is more than a task for agencies individually, it requires a societal change in the conceptualisation of domestic abuse among professionals, and between individuals in the public domain.

Accepted practice in tackling social problems is to prevent, protect and repair. While much good work is being done to protect children and victims, far too little is being done to prevent domestic abuse and repair the damage that it does.

There needs to be a public service message aimed at reducing the prevalence of domestic abuse as part of a long-term strategy. The focus of this public service message needs to be on those perpetrators who have offended or might offend, and to communicate a better understanding of the behaviour and attitudes of those perpetrating abuse.

There is limited reliable research or evidence that enables agencies to select and deploy interventions they know are effective in changing the behaviour of perpetrators. There needs to be a focused effort across agencies to develop and test interventions. Once interventions are identified, they need to be made available for all levels of risk and need, particularly at the stage of early intervention.

Domestic abuse causes long-term suffering to partners/family members and children. More thought needs to be given to how local areas can collectively supply the emotional, psychological and practical support that is needed to help children and victims – or families that have stayed together – get safe, stay safe and move on to reach their full potential.

Work with families that we saw on inspection was often in reaction to individual crises. Agencies can be overwhelmed by the frequency of serious incidents, particularly higher risk ones. However, keeping children safe over time needs long-term solutions.

In higher-risk cases, we often saw an immediate response from agencies to prioritise the safety of children and adult victims. Some solutions, such as moving victims and children away from the perpetrator of the abuse, isolated the child from friends, family and school. This short-term view can make it harder for professionals to see the bigger picture and history of abuse within the family setting. It also makes it harder to see connections between isolated incidents. In high-risk cases of violence in particular, the lack of a longer-term response was a particular issue for the police.

The focus on the immediate crisis leads agencies to consider only those people and children at immediate, visible risk. As a result, agencies are not always looking at the right things, and in particular, not focusing enough on the perpetrator of the abuse.

A pattern emerged that suggests agencies focus on the victim as the only solution. In the worst cases, agencies placed an inappropriate attribution of responsibility on the mother to protect her children. The end of an abusive relationship was considered to reduce the risk to children, when in fact research tells us that separation can escalate risk.

Most agencies did not focus on the perpetrator of the abuse enough. Instead, they focused on removing the family from the perpetrator, leaving them to move on to another family and, potentially, a repeated pattern of abuse.

Inspectors saw many examples where some needs of children in the family were less well understood than others. For example, the needs of younger children and older children may be different, but were assumed to be the same.

Some adult-focused agencies, notably probation and adult mental health services, sometimes did not ask about children's welfare at all.

Some of the effective interventions included changing parents' perceptions about what family interactions can look like. In some cases, this meant recognising that in some communities, people have a shared view about what is acceptable in family life that needs to be challenged.

There is still a lack of clarity about how to navigate the complexities of information sharing. There needs to be greater consistency in the definition of harm, and in the understanding of whose rights to prioritise.

There needs to be a more consistent understanding of what information can be shared, with whom and when it should be shared. Then making sure that your systems are in place to do that.

There is still not a clear and consistent understanding about what information professionals can share within agencies and across agencies.

The Adoption and Children Act 2002 extended the definition of harm to include 'impairment suffered from seeing or hearing the ill-treatment of another'. However, this definition of harm does not appear to be fully taken into account in information-sharing practice between agencies.

Introductory findings

The strengths of domestic abuse services

7. Inspectors were positive about the range of services that address domestic abuse and its impact on victims and children.
8. Every local partnership visited was providing support for some of the individuals affected by domestic abuse. The main priority for professionals is to ensure the safety and well-being of children and victims of abuse. Inspectors observed that the ongoing support thereafter for victims, children or perpetrators, worked best when it was family-centred. The most successful interventions seen were multi-agency based. These were exemplified in Hounslow, Bradford and Hampshire.

In Hounslow, for example, inspectors praised the 'One Stop Shop' service for parents who are subject to domestic abuse. The service is open one morning a week. Parents can access a range of services, advice and support from various professionals including legal advice, support from an independent domestic violence adviser (IDVA), children's social care, the police, housing, substance misuse support, a refuge worker and an independent sexual violence adviser. Inspectors noted that:

'parents are gaining an understanding of the impact of living with domestic abuse, leading to their being better able to meet the needs of their children and keeping them safe'.

9. Midwifery was highlighted as a strength by inspectors in five out of six local authority areas. There was evidence that midwives were knowledgeable about the risks of domestic abuse and the additional risks to unborn children. Midwives generally engaged well with mothers and worked effectively with other agencies to protect children. In Salford, inspectors highlighted the emphasis on early intervention by midwives as an area of good practice. There was good information sharing between agencies, and good assessment and intervention with families. They used a family led approach, which supported good engagement. An outreach team supported couples with healthy relationship work when domestic abuse had been identified.

10. A lot of good work has been done by agencies to improve the understanding of domestic abuse. In every local authority, these improvements were seen as a strength. There was much more that could be done, however.
11. In a case study of good practice from Lincolnshire, inspectors noted the local authority's use of age-appropriate tools to understand the range of risks that children face. The local authority had also undertaken an impressive strategic overview of domestic abuse that enabled them to understand patterns and trends. As a result, there was good understanding of domestic abuse across a range of different agencies. Most of the local authorities used reviews and audits effectively to improve their services.
12. All the JTAs identified strengths where services were co-located.³ However, the benefits of co-location can be achieved without the need to locate professionals in the same building. Five out of six local authorities met daily with other agencies to improve communication and timeliness. For example, in Wiltshire, agencies used daily 'domestic abuse conference calls' to share information in a timely manner across multiple agencies.
13. Inspectors noted strengths in working with communities and minority groups in some local authorities. For example, inspectors highlighted good practice in Bradford where there was a provision of specialist domestic abuse services to male victims and LGBT groups.

The response to domestic abuse could achieve more

14. Our reports relating to individual local authorities recognised the significant achievements in each of the areas we inspected. Agencies that respond to domestic abuse perform a challenging role, and have made strides in addressing the daily pressures of this role. However, this national report still sets out a critique: *not because the system is failing, but because the system is ready to move on.*
15. Until now, the system-wide focus has been on managing the enormous volume of cases of domestic abuse. This was a necessary focus, and an important one. Failure to manage the huge flows of referrals and reports creates enormous risk to child and adult victims.
16. We have seen a great deal of practice that demonstrates how effectively a very large number of agencies have:
 - prioritised their response to domestic abuse

³ As we have previously stated, Ofsted does not advocate any particular front door model over another. See: Eleanor Schooling, 2016 at www.gov.uk/government/speeches/social-care-monthly-commentary-march-2017

- invested in designing sophisticated systems, processes and relationships to share and act on information about domestic abuse in their communities
 - built capability in many different workforces to respond in a timely and appropriate way.
17. However, the evidence from these inspections makes a convincing case that we need a widespread but subtle shift in the way we understand and respond to domestic abuse. The agencies we have inspected have gone a long way to address some very complex challenges – and so it is reasonable to believe that they can do it again, but they cannot do it alone.
18. Change must start with a more systematic focus on perpetrators' behaviour and preventing their abuse of their victims. By not taking this step forward, the cost to victims and children, and to the public purse, will remain high.
19. The main body of this paper explores the findings from the six inspections that took place, as well as findings from our focus groups with survivors, and information from teachers from our schools survey. We conclude with a discussion of what the next steps in tackling domestic abuse might be.

Section 1: An endemic challenge

Prevalence

20. The starting point for the joint inspectorates in committing to this programme of work was the prevalence of domestic abuse in all the services we inspect. Because the prevalence is high, it was a recurrent issue in our routine inspections and a priority in the sectors we inspect.
21. Domestic abuse is persistent and widespread. It is the most common factor in situations where children are at risk of serious harm in this country.⁴ It can have a detrimental and long-lasting impact on a child's health, development, ability to learn and well-being.
22. There are 6.5 million adults estimated to have directly experienced domestic abuse from the age of 16. If estimates included experience of domestic abuse in childhood, this number would be considerably higher.⁵
23. Women are more likely to be abused, to report abuse and to be killed by their partners. If we were to pick a random group of 16 mothers, there is likely to be one who experienced domestic abuse last year. For single mothers, it is much higher: one in four will have experienced domestic abuse. For fathers, it is one

⁴ Characteristics of children in need statistics, 2016–17 (Table C3). Available at: www.gov.uk/government/statistics/characteristics-of-children-in-need-2015-to-2016

⁵ Office for national statistics, 2016. Available at: www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseinenglandandwalesappendixtables

man out of 24.⁶ The evidence from the case tracking done as part of our inspections related entirely to female victims and male perpetrators.

24. The prevalence of domestic abuse means that there are many children who are also affected. We don't know exactly how many children this is, because the official source of self-reported data (the Office for National Statistics' Crime Survey) only gathers information about the experiences of adults.⁷ Domestic abuse has been estimated to affect around one in five children in some studies. However, the experience of children in relation to domestic abuse may go unrecorded unless they come to the attention of formal agencies, such as those in health, children's social care, the police or schools.

Demand from agencies

25. Domestic abuse-related crimes recorded by the police accounted for approximately one in 10 of all crimes in 2015–16.⁸
26. With the prevalence of domestic violence comes a high level of demand for help. The police recorded 1.03 million domestic abuse-related incidents and offences in the year ending March 2016. Following investigations, the police concluded that a domestic abuse-related criminal offence was committed in approximately four in every 10 (41%) of these incidents (421,000).⁹
27. Domestic abuse is the most commonly cited factor when children are assessed by children's social care services to determine whether they need support. In 2015-16, there were around 222,000 episodes where domestic violence was cited as a factor. This translates into around 28 new episodes every week in every local authority in the country.¹⁰
28. There is no regularly published data on the use of accident and emergency services as a result of domestic violence. However, The Crime Survey for England and Wales reports that 32% of victims in England and Wales experiencing partner abuse in the last year aged 16–59 sought medical assistance due to the abuse, equating to 486,720 victims. Of those, 13% (or 63,000 victims) sought medical assistance in a hospital or A&E.¹¹

⁶ See note four above.

⁷ See note five above.

⁸ See note five above.

⁹ See note five above.

¹⁰ See note four above.

¹¹ See note five above.

Section 2: The long term

29. The volume of domestic abuse incidents is so great that it requires very well-designed systems and processes to manage the load. However, the nature of domestic abuse is such that families may encounter one serious incident or crisis after another. This can result in professionals working in a short-term way that looks at the intervention needed to tackle the immediate risk at the expense of the longer-term outcome. This short-term crisis management can make it difficult for professionals to see the bigger picture, including the impact of coercive control.
30. Domestic abuse can involve multiple forms of abuse that need to be linked together to understand the extent of the impact on its victims. The hidden nature of domestic abuse means that by the time it comes to the attention of agencies there are likely to have been many incidents of abuse. In our inspections, we saw that professionals sometimes failed to connect isolated incidents and build a picture that would lead to a different conclusion about the level of risk. Domestic abuse can look different in different families. In some cases, it persists at a similar level for many years. In other cases, it escalates in severity and frequency. Professionals must understand the history of the abuse and the trajectory of its severity. The fact that domestic abuse can escalate means that in some cases it does result in murder. In 2015-16, 77 women and 28 men were killed by partners or ex-partners.¹²
31. Inspectors encountered cases where police officers assessed risk in isolation and concentrated on the incident they attended rather than taking a more holistic approach. This included grading domestic abuse incidents in isolation without taking full account of the history of the case or full account of the history of people involved in the case. For example, one case involved five separate incidents in one month before one incident occurred that posed a high level of risk to the rest of the family. The initial incidents should have been enough to raise concerns because of the nature of the threats that were made to the family, but no action was taken.
32. In high-risk situations, the response from police was often more assured. This included strong processes with quick arrests. The primary consideration was the initial safeguarding of the victim and children.

A child disclosed at school that they had been hit by Dad with a belt and that another child in the family was present at the time. There was a quick decision to conduct a section 47 investigation and the children and their mother were spoken to. The mother disclosed systematic domestic abuse over a period of years. The father was arrested and charged with assaults and child cruelty. He was later jailed by the court.

¹² See note four above.

33. Perpetrators often present a continued risk to their partners and children. If agencies fail to address the perpetrators' behaviour, the perpetrator can leave their home without any follow-up action and repeat the behaviours from afar or in a new relationship.
34. Agencies, particularly probation providers, may be missing the bigger picture around containment of the perpetrator and their behaviour. For example, sometimes, probation providers assumed that a perpetrator was contained when sentenced to custody. However, they can continue their abuse from prison. Probation providers also needed to respond better to new risks, such as when perpetrators entered a new relationship. In one case:

'an offender manager failed to recognise potential risks when an offender announced his intention, on release from custody, to spend time at the home of his new partner and baby. The reasoning given was that there had been no incidents of domestic violence reported to the police in respect of the couple. However, the history of domestic abuse perpetrated by the offender when he was in previous relationships was not taken into account. The offender manager was focused solely on working with the offender and not engaged with any other professionals or the family or new partner.'¹³

35. Professionals did not always recognise that, though not always, separation could escalate risk. They did not sometimes realise that the abuse does not end when people stop living together. For many victims and their children, violence can increase and escalate when the relationship ends. Some victims suffer persistent post-separation violence over long periods of time.¹⁴ Those perpetrators who go on to kill their victims are most likely to do so at the point of separation.¹⁵
36. Children sometimes feel as though they are to blame for the separation of their parents. Understanding the emotional impact, and the signs of the emotional impact, can be more challenging for professionals than identifying physical injury. As one of the survivors we spoke to in our focus groups said,

'Social services did not recognise the impact... they did not get to evaluate about what is going on underneath.'

37. Some professionals are attuned to this, for example, in one case, the impact of domestic abuse was clearly recognised on a child. She was noted as becoming quiet and withdrawn in school and reported to a family member that her

¹³ Joint targeted area inspection of the multi-agency response to abuse and neglect in Bradford, Ofsted, 2017; www.gov.uk/government/publications/joint-inspections-of-the-response-to-children-living-with-domestic-abuse-september-2016-to-march-2017

¹⁴ Harrison, C., 2008. Implacably hostile or appropriately protective? Women managing child contact in the context of domestic violence.

¹⁵ Saunders D., 1995. Prediction of wife assault.

stepfather shouted in her ears and she feared that her mother would be thrown down the stairs. The case was referred by an army welfare officer who clearly recognised the risks to the child's welfare.

38. In other cases, the wider implications of living with domestic abuse were not well understood. In one example, a mother was in distress due to living with domestic abuse and this was having a clear impact on the well-being of her child. Her child was seen in her home by a health visitor, she was naked, with food around her face. The home conditions were observed to be messy and the mother was reported to have made another suicide attempt. The conditions the child was living in were recorded in isolation. There was no evidence in the record that the practitioner considered the impact of domestic abuse on the well-being of the mother, and subsequently, her ability to care properly for her child.
39. Parents spoken to by inspectors were very positive about the 'Let's Talk' programme in Hounslow that supports children who have lived with domestic abuse. Creative work was undertaken with children to enable them to understand their experiences of living with domestic abuse. Work was also undertaken with adult victims, which enabled them to better support their children. However, not all agencies inspected were providing services to help respond to the emotional needs of children.
40. Lack of appropriate response to medical needs can also mean, in some cases, that children who do not need immediate medical attention for physical injuries can also go unnoticed by health practitioners. This lack of appropriate response is particularly so in accident and emergency departments. For example, in one Lincolnshire emergency department, we found that there were no specific safeguarding prompts that would alert practitioners to the needs of the child. Therefore, the system relied on individual practitioners to identify and escalate specific risks to children. In a hospital in Bradford, inspectors identified that professionals were not asking the necessary questions about children's welfare. They also identified cases where health practitioners did not follow the safeguarding procedures. In one case, the hospital failed to use the domestic abuse pathway nor did it ask questions about the child. The incident itself put the child at high risk, but the child was forgotten by practitioners. Had procedures and routine enquires been followed, these may have informed the assessment in the emergency department and the child would not have been forgotten.
41. On the other hand, where risk was lower, we saw some good work with families to improve longer-term outcomes. There was evidence of some effective work to support healthy relationships between parents. This included examples of therapy with children, support for mothers accessing volunteering and self-esteem raising groups, as well as a group for fathers who were the perpetrators of abuse.

42. Despite the need for specialist interventions, their availability was not guaranteed. These services are discretionary. Inspectors saw cases where commissioned services for supporting victims of domestic abuse faced the threat of closure, or were inaccessible, because of funding issues.

Recognising the family's context

43. Part of the long-term view involves interventions to change perceptions and behaviour. This has to be based on an understanding of the factors that are driving prevalence and that these may vary from one community to the other. Domestic abuse is not limited to any ethnicity, sexual orientation or segment of society. It occurs across a range of demographic divides, although it occurs more often against women than against men.
44. It was clear from our inspections that, in any given area, there were groups within the overall community where it was more difficult to prevent domestic abuse and where it was harder to protect victims and children. However, we found some examples of tenacious culturally sensitive work by partner agencies working together to challenge cultural norms or reach seldom-heard groups.

For example, in Bradford, agencies were engaging with specific diverse communities and groups including male victims and LGBT parents. In January 2017, the local domestic abuse partnership inspector held a meeting with dedicated LGBT support workers from Bradford Women's Aid and Staying Put, as well as a transgender support service in Bradford. The group discussed ways to improve the support services for LGBT victims, and raising awareness among frontline workers who deal with abuse in LGBT households.

45. Inspectors noted that more could be done by agencies across all six local authorities inspected to work through the risks associated with being a family that services do not as easily reach.
46. What was most effective was understanding the family and any family dynamics that were influenced by characteristics of attitudes within small social groups. By challenging those attitudes and reframing what it means to be in a healthy relationship, there was evidence of some very effective multi-agency work by professionals who were sensitive to families' contexts.

Section 3: Focusing on the right things

47. Achieving long-term impact is only possible if professionals are looking at the right things. Our inspections found a pattern where professionals focused on the victim, which in all the cases we saw was the mother. In the best case scenarios, this represented an understandable focus on the mother as a victim of crime and in need of protection. But, even in the best cases, there was often a lack of accountability or responsibility attributed to the perpetrator of the

abuse. Furthermore, in a minority of cases, there was an inappropriate attribution of responsibility on the mother to protect her children.

48. Taken across many cases, a focus mainly on the victim fails to address a range of important factors at play. These include the experience of the child, the root causes of violent behaviour displayed by the perpetrator, and the impact on other family members. Furthermore, without a focus on the perpetrator's mind-set and behaviour, there is a high risk of recurrence once the immediate crisis has passed. While we need to support victims to help them protect themselves and their children, we must not lose focus on the perpetrator, their behaviour, and their accountability for their actions.

Focus on the child

49. Focusing on the needs and experiences of children is critical. A failure to adequately focus on the experiences and needs of children means there is a high risk that the emotional and mental impact of domestic abuse will go unaddressed. Children and young people who have lived with domestic violence for several years frequently experience intense feelings of responsibility, guilt, anger and a sense of despair and powerlessness over their lives.
50. Children may experience high levels of anxiety and depression in response to living with domestic abuse.¹⁶ They may try to escape their difficult circumstances in different ways. Some focus on their education and do well at school.¹⁷ Others might be affected negatively because there may be a harmful impact on educational outcomes. The intensity of children's difficulties and their behavioural responses may find them in confrontational situations in schools. If underlying contributory factors are not obvious or understood, those children are likely to be labelled as problematic. In the words of a survivor:

'For kids it is daunting. They come into refuge, move schools and move again, and move schools again.'

51. Children affected by domestic abuse are more likely to be excluded from school or become homeless at a young age. They are at higher risk of offending.¹⁸
52. Children who witness domestic abuse can occasionally model their behaviour on their experiences. We found examples where children were taking on a 'parental role' and, in some cases, themselves becoming violent. However, it should be noted that children generally do not go on to abuse as a result of witnessing domestic violence.¹⁹

¹⁶ Roger A., 2002. The radiating impact of intimate partner violence.

¹⁷ Mullender A., 2002. Children's perspectives on domestic violence.

¹⁸ Hester, M., 2007. Making an impact: children and domestic violence: a reader.

¹⁹ Laing, 2000. Children, young people and domestic violence.

There was a long history of serious domestic abuse perpetrated by the father, who no longer lived in the home. Following a serious assault on the mother, the father was removed from the home. One of the children had also assaulted his mother and since his father's removal from the home was found to be taking on a 'parental' role with his brothers and sisters. At the time of inspection, it was not clear what risk he posed or whether he had been helped to address any of his problems. The inspector was concerned that he was also a child who was depressed, with poor school attendance, but all the focus has been on his abusive behaviours. The assessment of his needs was superficial and outcomes for the child had not improved.

53. Recognising a child's needs can also be done well, taking into account a wide range of factors. The context for the best work was where there was a management approach that made a focus on the child a priority. There are clearly many individuals who are listening to children and taking close account of their views. In some areas, however, this was only down to the efforts of individuals and not as part of a standard practice.
54. Worryingly, across the six areas we inspected there were some instances where children were forgotten about, missed, not spoken to or simply not considered.

Children and the police

55. We found that there were examples of very good police work in which there was an appropriate focus on the welfare of the child. However, there were also examples of work where there was no recorded focus on the child or their welfare.
56. Inspectors noted cases where police records did not show how officers engaged with children. In most of the reports of incidents of domestic abuse that were reviewed by inspectors, officers checked that the child was safe and well, put in place immediate safeguarding measures and notified relevant children's services. However, what the child said and their demeanour were not always recorded, either in the initial response to an incident by officers or in longer-term investigations. Inspectors noted that this critical information should be recorded more consistently to inform the initial risk assessment and shared as part of the police referral to children's social care services.
57. When police officers consistently engage with children during their attendance at each incident, they can build a relationship with children that will encourage them to engage with adults who can help them. As in the following example:

The officer engaged with a child regularly who was witnessing scenes of domestic abuse. Her parents were later involved in an incident while their daughter was present. The officer who attended spoke to the child to check she was OK and to ask her what happened. At a later date, she contacted the police to say she was scared and that her mum had been

hit. Inspectors commented that the fact that she contacted them herself may well be due to the trust that was beginning to build up between her and the police.

Children and Cafcass

58. Thorough and comprehensive analysis of risks of domestic abuse to the children and families was evidenced in a significant proportion of Cafcass cases. Recommendations made in the vast majority of private family law section 7 reports were appropriate and reflected a fair and balanced approach. Family court advisers used a good range of tools to assess risk of domestic abuse. Practice was appropriately proportionate to the role of Cafcass. This enabled children's needs to be identified and informed appropriate decision-making and advice to court. While tools were often used to comprehensively understand the risks to children, in a minority of cases this was not the case. When parents completed the 'Domestic Violence – What We Need to Know', which is a tool to gather parental concerns, they were used well and were really beneficial to the court's understanding of the family's experience of living with domestic abuse.
59. In a minority of Cafcass cases, there was insufficient gathering of children's views. These children would have benefited from further opportunities to share their wishes and feelings in order to inform decisions and recommendations to the court. There was not consistent evidence that the needs of the child were sufficiently taken into account when considering how their views should be gathered. Information-gathering from other relevant agencies was not consistently robust. There was also variation in family court advisers' level of understanding about the emotional impact of domestic abuse on children.

Children and health services

60. Children were not always considered by adult mental health professionals. In one area, inspectors noted that 'in most cases where adult mental health services were involved, the risks to children from adults was not evidenced as embedded in practice.' Inspectors identified that this was because adult mental health services worked in isolation and did not explore childcare responsibilities or contact with children. Both Ofsted and CQC have identified in many previous reports that this is a serious failing in the safeguarding of children and young people by adult mental health services and substance misuse services. Adult social care services need to prioritise the risks to children who live with adults with unmanaged mental health problems, substance misuse problems and, crucially, domestic abuse.²⁰
61. The focus of the needs of the adult patient was also sometimes a factor in children being missed by other health practitioners:

²⁰ 'Joint working between adult and children's services', Ofsted and CQC, 2013;
www.gov.uk/government/publications/joint-working-between-adult-and-childrens-services

For example, in one case, concerns about a father's presentation at contact and the possibility of substance misuse were not sufficiently followed through. There was no evidence of medical information being provided by the GP and the risks presented by possible substance misuse were not sufficiently assessed. Even though there were concerns about father being 'heavy handed' towards his son, these were not followed up with the child and no contact was made with the health visitor. Health practitioners were focused on the father and his problems, without consideration of their impact on his son.

62. The complexity of health services and health systems can make it hard for all children to be seen and their experiences fully taken into account. For example, inspectors found one child protection case involving three children in one family each supported by different health providers. Each had their own discrete record on the system and used different means of alerting staff to concerns. This meant that practitioners working with any of the children could not see the records about other children in the same family. This has wider ramifications in ensuring that a child's journey through different health services is understood. This lack of coordination and collaboration adversely affects continuity of care.

Children and social care

63. Inspectors saw many examples where the varying needs of individual children meant that some were less well understood than others. This means that attention was not always given to all brothers and sisters within the same family. In one case, a child had not been present at the time the social worker completed a session. That child's needs were then assumed to be the same as that of their brothers and sisters.
64. It is important that the perspective of very young children is also included. We found evidence that the voices of very young children was sometimes missing from assessments. This was sometimes because they were seen as too young to give a view. This can be addressed by observing very young children within their family, looking at the quality of their interactions and understanding what they should be able to expect from good enough parenting.

Focus on the perpetrator

65. Across the cases seen, there was a notable absence of attention given to the perpetrators of abuse, compared to the victim. Throughout the evidence, the complexity of coercive control and its role in the behaviour of abusers arose frequently.
66. The Serious Crime Act 2015 introduced coercive or controlling behaviour as an offence.²¹ The government defines coercive behaviour as 'an act or a pattern of

²¹ <http://www.legislation.gov.uk/ukpga/2015/9/contents>

acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'. Controlling behaviour is defined as 'a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour'.

67. There can be a lack of clarity from professionals about the impact of coercive control because it confounds usual interpretations of behaviour.
68. Victims themselves can appear to be manipulative, secretive or contradictory in their words and actions. It takes skill and insight to identify that untruths or attempts to distract or mislead may be a coping strategy. Effective engagement with such victims relies on the skills, insight and experience of professionals and their ability to move beyond a 'victim-blaming' response.
69. Some of the thinking and practice we saw with victims in contexts of coercive control were clearly inappropriate. This included the use of written agreements that placed responsibility for managing the risk to children with the victim. Written agreements are similar to written contracts, where social workers and parents agree a set of terms that the parents sign. The terms may include things like, the victim will not continue a relationship with her abusive partner, she will not allow him into the house, she will not be in contact with him, and so on.
70. The use of written agreements in two of the six local authorities was widespread. However, we saw no evidence that they are effective. Given that the focus of written agreements is often not the perpetrator who is the source of the abuse and therefore the risk, it is unsurprising that they are ineffective.
71. In our discussions with stakeholders, there was the view that children's social care can focus on the victim through a desire to be pragmatic, and that the victim is easier to engage with than the perpetrator. For example, inspectors were critical of a case where there was a written agreement that the stepdad would not argue with the mother during contact with the children. She would fully supervise contact and would stop it if an argument occurred. This placed the onus on the victim to police the situation. Children's social care decided that contact would take place in a public area, which was considered to be a protective factor. This expectation on the mother is unrealistic. Inspectors noted the relevance of at least one serious case review where a mother was murdered in a public place in front of her child by her ex-partner.
72. In another case, the emphasis within the written agreement was on the mother to ensure that her partner, who had been subjecting her to domestic abuse for 18 years, was not to have contact with the children. This did not take into account the coercive control she was likely to have been subjected to.

73. One local authority recognised that it needed to increase the skills and knowledge of its workforce, including changing attitudes of professionals about domestic abuse.

A father assaulted the mother in front of the children. The children were reported as being terrified. This was the first reported incident and good, swift protective action was taken by all agencies. The couple reconciled and a child protection conference was later called, which neither parent attended.

At the conference, the mother was described as very manipulative and dishonest to family and friends in resuming her relationship. This was despite it being recorded elsewhere that she presented as anxious and depressed. There was no consideration of potential coercive control.

Although the mother had undoubtedly deliberately misled agencies and the harm to her children was continuing, there was little empathy demonstrated towards her as a victim by agencies. Victims may take action that is not in line with agency recommendations as they may see this as the safest way to protect their children.

74. Domestic abuse is a complex area. It is hard for professionals/family members to know as much about the situation as the victim in any family. Coercive control is especially complex because the individual being controlled may be a victim of control in one area of their life, but may need to take responsibility in another. Drug and alcohol abuse, for example, was a common factor in a number of the cases reviewed. Alcohol may be used by victims as a coping strategy, linked to mental health problems associated with being abused, or forced on the victim by the perpetrator of the abuse. A person may be a victim of domestic abuse and not responsible for the risks to their children arising from that abusive relationship, but the risks to children as a result of alcohol or substance abuse are still paramount.
75. Some of the women we spoke to in our focus groups described how their abusers used their distress as evidence that they were unstable. Often the women believed they were regarded as having mental health conditions or of being emotionally incapable of caring for their children. In one case, this resulted in a mother being evicted from her home and her partner being given sole custody of her children, whom she did not see for several months. Eventually her abuser, who had a severe alcohol addiction, was evicted and custody returned to the mother.
76. Untangling this web and being consistent in identifying who needs to be held responsible, and for what, will always be challenges for professionals. We found instances of language being used that incorrectly held victims responsible for the risk of domestic abuse. For example, we saw reports that described an abusive situation as a 'lifestyle choice' and reports stating that victims had learnt to 'make better relationship choices'. We also found instances of

inappropriate practice, including a police log that had been updated to state that a safeguarding visit would not be completed because both parties were 'as bad as one another'.

77. A lack of focus on perpetrators can lead to a short-term view of risks. We saw examples of swift action being taken to secure the immediate safety of the victim and children, without any action being taken to address the root causes of the perpetrator's behaviour. In temporarily resolving the immediate incident, professionals can lose sight of the greater risks posed in future.
78. One survivor of domestic abuse told us:
- 'I called the police on him multiple times and they just kind of patted him on the back and said 'calm down son'. And I'm like, 'he's just thrown me down the goddamn stairs'.
79. We found significant gaps in the services available for adult perpetrators of domestic abuse. Gaps are especially acute for those perpetrators who have not received a criminal conviction through the courts. Inspectors also saw long waiting times. In one case, a perpetrator had been identified as needing to complete a programme to address his abusive behaviour, but this programme had not begun by the time the perpetrator left prison because of long waiting times. Inspectors found delays or waiting lists in relation to probation services in three of the local authorities inspected. In one area, this was the result of poor multi-agency working. In three areas, inspectors highlighted long waiting lists for domestic abuse interventions provided by the Community Rehabilitation Company (CRC). One inspector explained,
- 'The CRC's remit includes the provision of interventions to address domestic abuse. This includes Building Better Relationships, an accredited programme which can be imposed as part of a sentence. There are long waiting lists for Building Better Relationships.'
80. This means that while services may be provided for victims and children to address the impact of abuse, the work to prevent further abuse by perpetrators was absent in too many cases seen. This presents serious risks for those children who are subject to repeated domestic abuse or to other children as the perpetrator moves on to live with another family.
81. Not all domestic abuse includes coercive control, but it is accurately determining whether this is a factor which is instrumental in identifying support that works. The appropriate actions to take and what outcomes count as positive may well look very different from one family to another. We saw a good example of a family experiencing domestic abuse that had later been reunified following a managed series of steps to address past issues. This was possible because professionals were able to accurately identify that coercive control was not a factor in that case and amended their service and response accordingly.

82. In one Cafcass case, the perpetrator had mental health issues. The case was dealt with well because the family court adviser addressed the complexity of the relationship, including identifying coercive control and supporting the relationship while the perpetrator was under a restraining order. Sensitive direct work with the children and each parent involved good use of a range of effective tools, including specific domestic abuse tools. This supported a good analysis and understanding of risk and appropriate recommendations.

Section 4: About sharing information

83. Managing cases of domestic abuse effectively is only possible if the systems and processes surrounding professionals are a help and not a hindrance. To achieve an effective response to domestic violence, we need effective collaboration across different agencies and effective means of sharing information. The ability to share information quickly and effectively is critical to whether or not agencies are able to work together to spot risks, triangulate a picture of a problem and diagnose a solution.
84. Inspectors found many examples of very good systems and processes that enabled professionals to focus on the right things. However, there was variability across the six local authorities and across agencies in the consistency and effectiveness of information sharing systems and processes. Good information protocols, a skilled workforce that has confidence in making appropriate decisions, and well-designed information-sharing systems all help to support professionals in working together.

Information-sharing protocols

85. We found evidence of both good and poor information-sharing protocols between agencies. There was also a clear relationship between better protocols and better information-sharing. There is clearly an urgent need for clear information-sharing protocols to be developed and understood by all agencies. Protocols not being in place led to poor decision-making about when to share and when not to share information.
86. We saw some cases where there was a delay in sharing information between professionals due to agencies struggling to contact parents in order to gain consent to share. In some of these cases, inspectors' judgement was that due to the nature of the information in the referral or the history of the case, and that children were potentially at risk, sharing information should not have been delayed due to issues obtaining consent. An example was a case of a vulnerable young parent with two young children living in a situation of domestic abuse. Inspectors found some evidence of instances where insufficient information was shared with and by GPs. In this case, there were two occasions, these issues included confusion or difficulties with when information could be shared.

87. We found some clear misconceptions about what the law requires. This was particularly apparent within health services where staff did not have a consistent understanding of when information could be shared within health and with other agencies. There was a lack of consistent understanding of when agencies should share information quickly even where they have issues obtaining parental consent.

The DfE's seven golden rules to sharing information²²

Remember that the Data Protection Act 1998 and human rights law are not barriers to justified information-sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.

Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could, be shared and seek their agreement, unless it is unsafe or inappropriate to do so.

Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis on which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.

Consider safety and well-being: base your information-sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

Necessary, proportionate, relevant, adequate, accurate, timely and secure: ensure that: the information you share is necessary for the purpose for which you are sharing it; is shared only with those individuals who need to have it; it is accurate and up to date; it is shared in a timely fashion; and it is shared securely (see principles).

²² Information sharing, Advice for practitioners providing safeguarding services to children, young people, parents and carers, March 2015, DfE; www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, record what you have shared, with whom and for what purpose.

Skilled and confident workforce

88. Across the workforce, there were some examples of a lack of skill in identifying risk, which leads to information not being shared in a timely way. There was a tendency to see information in isolation, rather than the bigger picture, which meant professionals did not see the need to share the information. There were also weaknesses in recording information.
89. Managers often laboured under a dangerous assumption that, at key junctures, professionals were asking about domestic abuse. Inspectors found that professionals across health, social care, police and probation asked about domestic abuse when recording systems included prompts, but sometimes, even where there were prompts, considered they could be ignored. This was most often in health services. In one case, for example, school nurse assessment documentation did not prompt practitioners to ask direct questions and record answers in relation to domestic abuse. There was an overreliance by managers on staff professional curiosity to ask those questions. In the cases examined, we could not be assured that the appropriate questions were being asked.
90. Most of the survivors who told us their stories in the focus groups recalled how falling pregnant was a turning point in abuse – either where it began or it escalated. 'When I told him I fell pregnant – his attitude just changed'. In one local authority area, the use of an intelligently designed screening tool supported midwives to ask difficult questions at a crucial time – when they became pregnant. This helped midwives to create an appropriate environment and to phrase the questions in less a confrontational way, increasing the opportunities for a candid response. The completed screening tool is held on the woman's record so that all staff are clear about any risks in the future.

Well-designed systems

91. One of the most commonly identified issues, across many different agencies, was the ability of the partners to pull together all the relevant information. This is currently being hampered because of poorly designed forms or data collection systems or meetings that do not work as they need to.

A paper list, which staff refer to as the 'child protection register', was held in each of the two halves of the reception. This is a series of printed spreadsheets from each of the three boroughs served by the hospital. It contains names and details of children subject of a child protection plan and inspectors were told that it is refreshed weekly. This paper-based system is used in place of an effective means of alerting staff of risks through an electronic system. However, the lists held by both halves of

the reception do not correlate with each other and so either or both are inaccurate and there is a risk that clinicians are relying on inaccurate data.

The electronic recording system in one adult mental health service did not support the service sufficiently to be able to prioritise the safeguarding and protection of children and young people. Children's names and dates of birth did not form part of client demographics and details are, if known, simply recorded within the practitioner's progress notes. There is no routine use of alerts to ensure that practitioners and managers accessing the case record are immediately aware to a child at risk or subject to multi-agency working.

92. The complexity of the health service and of the systems across the health service are barriers to information-sharing. Multi-agency information on children was sometimes missing from school nurse records. School nurses did not always have access to important information from other agencies. This was sometimes due to school nurses not being represented at important meetings, such as children in need meetings. In two areas, inspectors found instances of school nurses not having access to information from other parts of the health service. Inspectors also noted that, in three areas, school nurse documentation did not always record domestic abuse information. This was sometimes due to a lack of formal procedures for doing so that meant that conversations about safeguarding issues were lost. In extreme cases, this lack of recording processes was part of a wider lack of safeguarding processes.
93. How meetings are planned and conducted makes a difference. Inspectors saw a good example of monthly safeguarding care meetings in a GP practice, which brought together a range of individuals including a community police officer, military welfare officer, community mental health, and troubled family work. In one area, inspectors highlighted a positive example of a partnership between a GP practice and a domestic abuse service that enabled people to book appointments with independent domestic violence advisers.
94. Nonetheless, not all GP practices have well-established meetings about vulnerable families where information on known or emerging vulnerabilities, including domestic abuse, can be shared between health visiting, school nursing and primary care. As a result, some GP practices may be less aware and less well sighted on families with children living with domestic abuse. In Wiltshire, inspectors found three instances of GPs not being asked to contribute to assessments completed by social workers.
95. There were also examples of meetings where recording of actions and outcomes was not fit for purpose. Inspectors also noted that agencies who are 'virtual' partners, such as the National Probation Service (NPS) and CRC, find communication more of a challenge. In two areas, there were concerns that the CRC was not always included appropriately, for example at strategy discussions or core group meetings. In one area, it was evident that the full implications of

the changes to CRC and NPS had not been fully understood and knowledge of the roles of the organisations was lacking.

Helping schools to support children and families

96. One of the issues raised by survivors of domestic abuse in our focus groups was the variable response their children received from schools:

‘It is getting schools to understand that children in refuges need a certain type of support they don’t always get it in schools. Some schools are brilliant, in some they are just classed as naughty kids.’

97. We did not inspect schools as part of this multi-agency inspection programme, but we did contact a number of schools about the topic of domestic abuse. We received a small number of responses from individual teachers. They told us that the following range of services were offered across their schools to help prevent, protect and repair the damage caused by domestic abuse:

- posters for Childline, Safer Schools and NSPCC and assemblies to raise awareness. Some schools also offer ‘Feel safe at home’ booklets.
- alongside visits from charities, some schools also had visits from local police officers to talk to children about domestic abuse and coercive control
- training for teachers and for the safeguarding team aimed at identifying and referring children who are living with domestic abuse to the appropriate agencies
- counsellors and play therapists to work with children who have suffered domestic abuse
- one-to-one learning mentors to help children build emotional resilience
- providing telephone numbers to parents who may need domestic abuse support services. One teacher gave an example where these can be disguised in keyrings or pens where the phone number looks like a bar code
- referrals for parents to mediation or counselling services, in some cases for free.

98. They also told us that there were some barriers that get in the way of preventing, protecting and repairing the damage done by domestic abuse:

- In a minority of cases, teachers’ concerns may not be shared with all of the appropriate professionals due to perceived barriers around ‘confidentiality’. One teacher felt that this ‘restricted a clear understanding of a child’s situation’ or involved leaving out a key piece of information.
- Conversely, teachers also felt that sometimes not enough information was shared with them by other agencies to help them protect or work with children living with domestic abuse. This included any historically significant information about the abuse, as opposed to just current incidents.

- Sporadic or limited resources are available across agencies, particularly for direct work with those children who have witnessed domestic abuse. There is more availability of services for young people who might become involved in an abusive relationship with a partner/peer
- Referrals relating to emotional harm to children are not always taken as seriously by children's social care as those relating to physical harm or neglect
- Not all schools covered domestic abuse in the home as part of their curriculum.

Agencies need to share information more readily and more efficiently with schools in order to protect children better. In some areas that we inspected, there has been work to make improvements in this area through the implementation of Operation Encompass, where police contact a school's 'key adult' by 9am if a child has been involved in an incident of domestic abuse. Key adults are given training on how to effectively respond to this information. However, the implementation needs to ensure that all professionals are clear about their roles and responsibilities, including information sharing and support to children. Schools need to ensure that appropriate information is given to parents about the school's involvement with Operation Encompass: through the school's website and prospectus. Providing information is managed securely and appropriately, Operation Encompass can be an effective information-sharing model.

What next?

99. The JTAs for this report drew out some common themes. There is a pattern of what has been described in a recent serious case review as 'incident-led' responses: short-term and focused on the immediate incident, not the bigger picture. Across these areas, the focus is often primarily on the victim, both in terms of keeping the victim safe and sometimes looking to the victim to manage the abusive situation.
100. We spoke to stakeholders to better understand the picture we were seeing and what it might take to do things better.

In the words of survivors:

'We are the ones that have gone through all of that crap, all of that stress. We are the ones who have to leave our homes, leave our families. We are the ones that have to change our lives completely and everything we do every day. We have to come and live in a house with other people. Your whole life is completely changed.'

'The person who put me here, he is living out there happy, still living in his house, getting to see his family and friends?'

'They have their own life – and we haven't. If you can't be around your family anymore you need more support – you feel like crap ... you feel like your independence has been stripped from you. Change whole life and lose absolutely everything – instead of saying what she needs they should ask her what they need.'

101. One stakeholder captured the problem as follows: the question that is still being asked is 'why doesn't she leave?' But the right question is 'why doesn't he stop?'
102. The implications of this mindset are far-reaching. We saw some good work at a local level where partnerships had invested in work with schools and children to educate them about relationships and abuse. But what was notable in its absence was a widespread public service message designed to shift behaviour on a large scale. Domestic abuse has an enormous impact on the workload of professionals in all the sectors we inspect. Yet accessible interventions – at different levels of intensity – that are designed to reduce the number of perpetrators now and in the future are simply not part of the system.
103. Stakeholders identified many public health and public safety interventions that are easily accessible by anyone who needs them: stopping smoking, reducing harmful alcohol use, road safety awareness, weight loss for example. By contrast, although domestic abuse is demonstrably harmful, not only to the individual but to everyone around them, help can be very hard to come by. Probation services can only mandate an intervention for a domestic abuser if their primary offence is related to domestic abuse. This is a high bar.
104. This lack of attention to prevention means that intervention is too late. The 'incident-led response' of many professionals is a response driven by 'blue-light' crises. A measured response driven by prevention would move upstream. When a universal service first recognises that domestic abuse may be a factor, the first line of action should be to give access to specialist support that will target the perpetrator's behaviour. GPs, midwives, teachers, nursery staff, health visitors and many more see children on a regular, if not daily basis. If we are to focus more on preventing abuse, and repairing the damage it has done after the fact, multi-agency working and coordination between these frontline professionals are crucial. Sophisticated and targeted information sharing processes and policies lie at the heart of this joined-up approach.
105. The pattern of domestic abuse is that it starts small. At this stage, the level of intervention needed to halt it becoming more serious is much less challenging for the perpetrator to engage with and much less costly for the public purse. The best long-term outcome for any child is that the abusive parent changes their behaviour. An abuser who stops abusing can have a safe relationship with that child, but also no longer poses a threat in any other future relationship. Moving children out of harm's way will always be needed in some cases, but if we have to move children out of harm's way after a serious incident, one or more opportunities to prevent or end abuse may have been missed.

106. Another implication of asking the wrong question is that there is an assumption that is built into the system that the victim should leave the abuser. Even though separation is highly dangerous, commissioners still build a requirement into contracts that services only be provided when the victim and perpetrator have separated. This can be disastrous for children. It leads to a series of bad assumptions: that it is the victim and children who must leave, with the associated enormous disruption to children's lives that that entails. It means that arrangements to leave cannot be made until after the separation takes place, making it less likely that separation will happen, as the victim has no assurance that her children can be cared for without housing, benefits, school places or other essential needs. The new system transformation planning in health is an opportunity to commission differently. We will be interested to see how this develops.
107. The role of schools is an important one for children. Teachers see children day to day more than any other service and, therefore, have a good chance of being the universal service that can spot a pattern and initiate a process of de-escalation. Children also learn to socialise with their peers at school, and the school environment can have a big impact on how children understand all sorts of relationships. Schools also have an essential role in educating children about domestic abuse. Education for children about healthy relationships is already part of the curriculum, but it is often not part of the curriculum that is prioritised by schools.
108. Education and intervention would improve if we understood better what works. When the emphasis is on managing the crisis, there is no incentive to test interventions to change behaviour in the long term. One of the things that was striking from our inspections was the lack of evidence about what works to stop abuse and violence. Recent analysis of the research base that underpins work to tackle domestic abuse found that: 'Evidence on intervention programmes for perpetrators of domestic abuse tends to show limited effects in changing perpetrator behaviour. This is an area where new models are being developed, although evidence of effectiveness is at an early stage.'²³ Clearly more needs to be done to develop an evidence base that is extensive and rigorous enough to justify investment.
109. Developing practices could be helpfully borrowed from parallel areas of work. Having recently completed a JTAI on child sexual exploitation, the contrast between the practices in this area and domestic abuse is stark. Most practice in preventing child sexual exploitation is now intently focused on the perpetrators of this abuse. Local areas build perpetrator profiles and they focus on disruption. Where are the profiles of domestic abuse perpetrators? We have heard there may be some disruption practice in some areas, but we did not see it in these inspections and it is not widespread.

²³ Improving the Effectiveness of the Child Protection System, Early Intervention Foundation, 2017; www.eif.org.uk/publication/improving-the-effectiveness-of-the-child-protection-system-overview

110. As inspectorates, it is not our role to direct policy, nor have our inspections provided solid evidence of practice that we can advocate that would deliver the sea-change we believe is required. What these inspections have shown, however, is that the pattern of practice has served its time. We think the system is ready to evolve. Domestic abuse may be endemic, but it is not inevitable and it is possible for prevalence to decline. There has been a pattern of reported decline in all violent crime since the mid-90s and reported intimate partner violence has followed this trend.²⁴
111. There are few people in public service who don't agree that prevention is better than cure. Yet, this seems to have taken hold more securely in some areas of public service than others. Domestic abuse is incredibly harmful to children and it poses an enormous cost to the public purse to deal with the repercussions.

²⁴ Office for national statistics, 2015. Available at:
www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2015/chapter1overviewofviolentcrimeandsexualoffences

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