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Domestic Abuse in Greenwich - Scrutiny report for GSCP

1. Introduction

As part of the annual independent scrutiny programme for the Greenwich Safeguarding Children's Partnership (GSCP) it was agreed that the next area for the Independent Scrutineer to focus was domestic abuse. This area has been selected due to the reported rise in domestic abuse (DA) nationally and locally during lockdown as a result of COVID 19 and the implications for safeguarding children.

The scope of this work was to focus on how agencies provide domestic abuse services and would be considered at various levels, both operationally and strategically. Initially to consider how well agencies are responding and working together including police, children's services, health, probation, community safety and how agencies are providing support and interventions to children and families, including voluntary sector organisations. The review also considers the interface and use of Multi Agency Risk Assessment Conference (MARAC) and Child Protection Plans to address domestic abuse and family conflict in families with children. The review also considers the strategic coordination of domestic abuse, including the interface between the Community Safety Partnership, Safeguarding Adult's Board and GSCP and consider how enforcement and safeguarding are being addressed. The report focuses on how well partners are working together but only briefly covers outcomes and impact of the work of agencies and how agencies can reduce and prevent domestic abuse.

To undertake this work, I (virtually) met with police officers responsible for domestic abuse work across the South East Borough Command Unit (BCU), a reference group of social workers and managers, who worked in the Multi-agency Safeguarding Hub (MASH) and the longer term children and families teams who worked with families on Child Protection and Children in Need plans. I was able to meet with key workers across the health trusts and primary care who have specific responsibilities for domestic abuse. I also met with officers from the Community Safety team who are responsible for Violence Against Women (VAWG) Strategy and support MARAC, the manager of SafeCORE and the HER Centre. Through the HER Centre I was also able to meet with a group of service users who shared their lived experience of domestic abuse and the services they had received.

I would like to thank all the individuals who took part in this review for their open, honest appraisal of services and their commitment to making things better for families and children affected by domestic abuse.

2. Context/ Research

Domestic abuse is a significant social issue, requiring specialist support for those victimised. Over the course of their lifetime, it is estimated that one in four women and one in six men will have experienced some form of domestic abuse. In the Domestic Abuse Act 2021, domestic abuse is defined in the following way:

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.

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.

e) psychological, emotional or other abuse.

It does not matter whether the behaviour consists of a single incident or a 'course of conduct'.

The Domestic Abuse Act received Royal assent on 29 April during the writing of this review and new guidance has been issued for consultation. The Government have also issued a new Violence against women and girls strategy. From this it is clear that there is a need to have separate domestic abuse strategy. It is significant as it was amended to recognise children as victims of domestic abuse in their own right. The Domestic Abuse Act (Home Office, 2021) acknowledges the substantial impact on children, which includes '[harm] to emotional and psychological wellbeing as well as effects on education, relationships, risky and harmful behaviour and housing and accommodation' (Wedlock & Molina, 2020). A child is now considered a victim of domestic abuse when they witness, hear or experience the effects of domestic abuse and are related to the victim or perpetrator of the abuse. This is a positive step forward, as legal recognition of children as victims of domestic abuse will:

- give children greater protection through domestic abuse protection orders
- enable professionals to take action to protect children at risk of domestic abuse
- help authorities ensure there are specialist domestic abuse support services for children and young people.

I used the terms victim and perpetrator throughout the report, some studies use the term survivor to acknowledge the impact of domestic abuse but appreciate that the terms are nuanced and need to be gender neutral. The police recorded a total of 1,288,018 domestic abuse-related incidents and crimes in England and Wales (excluding Greater Manchester Police) in the year ending March 2020. This is an increase of 4% from the previous year. 1.6 million women experience domestic abuse each year and in 90% of domestic abuse cases there is a child present. In Greenwich the MARAC data shows 58.8% of cases had children involved for 20-21, 50.7% in 19/20 and 58.6% the year before.

Research from the National Society for the Prevention of Cruelty to Children (NSPCC) has found that around one in five children have been exposed to domestic abuse, and that one third of children witnessing domestic abuse also experience another form of abuse. 75% of children on Child Protection plans live in households with domestic abuse. In 2019/20, 32% of Children in Need assessments reported parental domestic violence (up 6% from 2019) and 12% reported child domestic violence (up 3% from 2018/19) as a factor identified that contributed to the child being in need (Department for Education, 2021d). However, research has shown that as few as 3.4% of referrals to Independent Domestic Violence Advocacy (IDVA) services, and 3.2% of MARAC referrals, come from Children's Social Care (SafeLives, 2020) but in Greenwich this number is higher with 13.9% of referrals to MARAC for 20-21 from Children's services. In Greenwich the number of referrals to Children's services from police (Merlins) with a factor of Domestic Violence was 389 in 2019/20 and ??? for 2020/21.

The new Domestic Abuse Act in section 3 now defines children as victims of Domestic abuse specifically and 'sees or hears, or experiences the effect of the abuse.' The Act is clear when describing 'teenage' relationships that abuse in relationships between those under the age of 18 years will be treated as child abuse and child safeguarding procedures should be followed. Abuse involving perpetrators and victims aged between 16 and 18 could be both child and domestic abuse. It is important to remember that abuse perpetrated by someone over the age of 18 against someone under the age of 18 also constitutes child abuse. It also covers abusive relationships between family members as well as child to parent.

Domestic abuse disproportionately affects women, with data supplied from 28 police forces for the year ending March 2020 showing the victim was female in just under three-quarters (74%) of domestic abuse-related crimes recorded by the police. Nonetheless, one in six men will experience domestic abuse and they are nearly three times less likely to tell anyone, compared to a female victim. Common barriers to seeking help for men include: fear of disclosure, challenge to masculinity, commitment to relationship, diminished confidence/despondency and invisibility/perception of services.

The lockdown has had a significant impact on families and there has been an increase in domestic abuse reporting. According to the Office for National Statistics (ONS) the police recorded 758,941 domestic abuse related crimes in England and Wales in the year to March 2020, up 9% in a year. But successful prosecutions fell by 225 from 78,6224 to 61,169. During the first lockdown, Refuge experienced a rise of around 50% in calls to the National Domestic Abuse Helpline and traffic to the helpline's website rose by around 300%.

ONS figures show that two women a week are killed by a current of former partner in England and Wales. From the recent Annual Report 2020 from the Child Safeguarding Practice Review panel (often known as the National panel) domestic abuse featured in 41% of fatal child deaths. Domestic abuse was also a feature of 42.6% of incidents involving serious harm to a child reported to the National panel. This predominantly involved the father as a perpetrator and mother as a victim (74%). Other patterns, including the mother as perpetrator, both parents as perpetrators and young person to adult abuse in the household, were also recognised in the report. Their report highlighted the factor of parental domestic abuse is children have poorer outcomes in education, are more likely to come to the attention of the police and have poorer employment history. Parental domestic abuse is the single most predictive factor for a child's future mental health.

Research published by the Home Office has estimated the social and economic costs of domestic abuse in the region of £66 billion for the victims identified in England and Wales within the year

2016/17. The biggest component of the estimated cost is the physical and emotional harms incurred by victims (£47 billion), particularly the emotional harms (the fear, anxiety and depression experienced by victims as a result of domestic abuse), which account for the overwhelming majority of the overall costs. The cost to the economy is also considerable, with an estimated £14 billion arising from lost output due to time off work and reduced productivity as a consequence of domestic abuse.

3. Multiagency working

Theory to Practice

Research strongly suggests that the sort of response a family experiencing domestic abuse receives from professionals depends on the sector those professionals are working in. Marianne Hester (2011) describes the areas of domestic abuse, child protection work and child contact work as 'three planets', each 'with their own separate histories, culture, laws, and populations (sets of professionals)'. What this means is that each "planet" looks at the problem in a different way, and in turn their responses differ from one another's. Hester describes 'how, bouncing between these planets, are women and children who find inconsistency and contradictions; just the type of environment in which perpetrators can hide and abuse' (Eaton-Harris, 2019). According to Hester, stopping families falling into this 'black hole' between planets requires much closer and coherent practices across the three areas of work, with understanding of professional assumptions and practices and those of other professional groups. For children's services, it means taking into account not just that work on domestic violence requires intervention with victims, children and perpetrators, but that the most effective way of doing this is to team up with practitioners on the 'domestic violence planet', who have extensive experience of work with both domestic victims and perpetrators, and with practitioners on the 'child contact planet' to integrate further a common response to women and children's safety.

Multi agency processes

Existing multi-agency processes, such as Multi-Agency Risk Assessment Conferences (MARAC) and Local Safeguarding Children's Partnerships(LSCPs), can often be situated 'within' planets rather than 'across' planets, meaning further work is needed to establish and maintain the most effective way of joining up the approaches of the three 'planets', in relation to keeping victims of domestic abuse safe.

Child Safeguarding Practice Reviews

Domestic abuse is a key feature in the case sample for the Child Safeguarding Practice Review Panel's national thematic review of Non-Accidental Injury (NAI) in children under one, which is still underway. It was found that Domestic Abuse, Stalking and Harassment (DASH) assessments and other risk tools tended to focus more on risks to adults rather than children. In some cases, there was insufficient co-ordination between Multi Agency Risk Assessment Conference (MARAC) processes and children in need planning. A multi-agency audit by the former GSCB looked at risk assessment tools for domestic abuse a number of years ago and found disparity between agencies in completion and which model was use. There was also challenge several years ago by the Independent Chair about Children's services engagement in and referral to MARAC – this is reportedly improved significantly since that time.

The National panel review found that there was a high degree of variation in the types of programmes commissioned by local authorities and safeguarding partnerships to address domestic

abuse. They found responses to incidents of domestic abuse were most effective where there was a robust analysis of risks to the victim and support for them; swift action to ensure safety of the children and provide on-going support in recognition of emotional abuse; and purposeful work with the perpetrator, which was followed up to monitor the extent of sustained engagement and positive outcomes. They found that Domestic Violence Prevention Orders or Notices (DVPO/DVPN) had limited impact where they were not accompanied by a robust support plan. They also noted that there is currently no national system to track males who have previously had domestic abuse/violence convictions and later move in with other partners. Women can find out for themselves if their partner has a violent past under the domestic violence disclosure scheme, Clare's law, introduced in 2014 after Clare Wood was killed by her ex-boyfriend in 2009. Last year 7,252 women applied for information and 55 succeeded in getting the information. I understand if there is no information then this is recorded as a non disclosure which may explain the discrepancy.

This scrutiny review undertaken in Greenwich will look at a number of ways that agencies worked together and how these 'planets' aligned or were disparate. I have tried to take the 'lens' of the safeguarding children's perspective when addressing this issue but clearly this cannot always be uncoupled from that of the non-abusing parent who is suffering the domestic abuse.

4. Individual agencies response – 'Safeguarding planet'

Police in Greenwich are arranged around the Basic Command Unit model (BCU) covering Lewisham, Greenwich and Bexley, domestic abuse teams coming under the Safeguarding command which includes other services for vulnerable children, with the expectation that this provides better join up and information sharing. There has been a reported 5-8% increase in domestic abuse call outs in Greenwich over the pandemic, with 10-12 % increase generally across London with a continuing annual trend upwards. Where children are involved or present in household in a domestic abuse incident, officers always send Merlins (notification of involvement of police) to Children's services whether children are present in the household or not. All Merlins are managed through the MASH process and rag rated There were a few cases raised by children's social workers where a Merlin had not been received and information shared by officers following a domestic abuse incident. These cases, which were followed up by police colleagues, were individual situations where information had not been shared but it did not appear to be a systemic issue – police followed up these with learning from the individual cases. Considerable training has been undertaken by MASH officers around domestic abuse with frontline police officers It is important that this is regularly repeated in order to keep up with turnover of staff.. Social workers and their managers spoke highly of the police staff in MASH who were their 'go to' to find out contact details of officers involved and support the multiagency working. One mother I talked with also spoke highly of the two police officers involved in her situation, who were proactive and signposted her to support services (the HER Centre) via the MARAC process.

Good practice identified by police were the independent domestic violence advisors (IDVA)s in the service and how these posts supported individual victims – these posts were seen as crucial but were stretched. Also highlighted as good practice was Operation Encompass which is the process of sharing Domestic abuse notifications with schools by police, which continued to operate even during lockdown. There has been significant sign up by schools in Greenwich, who really appreciate the information sharing and ability to be able to offer support to children that this information sharing affords.

A frustration expressed by a number of agencies was the rapid turnover in more senior officers in the police who had responsibility for domestic abuse, this had been a particular issue since

introduction of the BCU. I understand there have been eight officers undertaking chairing MARAC since 2019. This had impacted on consistent chairing of meetings and developing good professional working relationships. Agencies felt this had impacted on officers gaining specific expertise of the subject area in short timescales and conversely loss of expertise once those officers moved on. This was slightly negated for children's social care, by the good working relationships in MASH where police officers were visible and supported agencies in problem solving, where it involved police.

MASH process

Once a Merlin is received by MASH, police in MASH triaged it, to ensure rag rating is applied correctly. The MASH social care manager will review the notification / contact and decide whether threshold is met for assessment by children's social care and what action will be taken or pass to early help; MASH are able to pass referrals directly on to SafeCORE where service criteria appear to be met. If the case is known to other teams in children's services, the information is passed quickly to them on FWi and an alert through email.

Two mothers mentioned issues of 'threshold 'in their feedback. Mothers had contacted Children's Social Care themselves to request help, both practical and emotional support. But in both cases, as they had protected their children by leaving the perpetrator, they were therefore seen to have been proactive and safeguarded their children, and therefore did not meet 'threshold' for intervention by children's social care. Those who had experienced service from Early Help indicated they were given a 'list' of agencies for them to contact themselves. It was suggested that onward referral to services maybe more effective and supportive in these circumstances.

The quality of Merlins reporting domestic abuse was said to be generally satisfactory but there were often problems trying to get hold of investigating officers to clarify or provide missing information. It was often found that new officers showed inconsistency of response and quality of Merlins. There is additional pressure on MASH team police officers to support this, chase detail and provide training. An issue raised during this review by the team was a new directive about welfare check visit, (when social care asks police to call to check whereabout or welfare of child or family) the police have been informed that they do not have to feedback on a Merlin, and it has been difficult on occasion to get information back.

It is acknowledged by the MASH team that they 'process' a lot of families who have experienced domestic abuse through the notification from police. A general concern expressed by social care staff was that some families can minimise domestic abuse and the impact on their children; if it is a one-off incident, they often remain in the relationship, with others it is trying to work together with the family in order to minimise the impact of domestic abuse on the children or support the non-abusing family to leave an abusive relationship. Clearly during the pandemic where most contact has been conducted with families over the phone or virtually, one of the considerations was risk and understanding whether the perpetrator was in the home or could hear the call. In this situation it was described how the social workerwould often text in advance to ensure that it was safe to talk.

There were issues about finding the appropriate support and help for victims, for example it was felt that there was a high-level threshold to get support from an IDVA and had to be through referral to MARAC. There is a commitment that all MARAC cases are offered the IDVA service, and the high number of those cases means there is very little capacity for medium & low risk cases, though there is some additional resource through the Her Centre. Social workers expressed frustration that meeting the criteria for SafeCORE can also problematic because of the issue of consent and agreement to take part in the programme – the comment 'we can't always use them in the way we

want to.' Social workers referred to the HER centre most frequently. There were also waiting times for the Freedom programme. Male victims could be refereed to Victim Support for services, but this was not widely known by workers. There was frustration felt that there were no services for perpetrators available to MASH, these had to be accessed through MARAC or probation (on an order) The Children's Services representative at the MARAC participates in collective identification of which perpetrators to refer. Social workers expressed good working relationship and information sharing with Probation officers.

If a victim needed rehousing due to domestic abuse, workers found housing services responsive and had good working relationships with them. It was acknowledged there was a housing policy to help victims escape domestic abuse. However, there were rehousing problems with NRPF (Nil recourse to public funds) and resistance by victims to relocate especially outside RBG/ London, which was often the only accommodation available. Families understandably wanted to remain close to children's schools and their own support networks, extended families and significant others .

Social workers felt that most agencies worked well together to address DOMESTIC ABUSE, but the one thing that was felt needed to change was court's responses. Concerns were raised about the application of non-molestation orders, though police responded, arrested and took to court for breach of these orders, the courts did not seem to perceive this as serious and address the behaviour of the perpetrator. It was felt that there had to be consequences for breaches of these orders otherwise mother maybe 'punished' as a result, there needed to be stronger response to perpetrators that breached their order – the view expressed was that should mean imprisonment.

The MASH team felt it would add to the support they could offer if there was a dedicated domestic abuse resource based in the MASH (ie IDVA), so that early intervention could be offered from the MASH team at the first DV incident.

<u>SafeCORE</u>

In 2018 there was a successful bid for innovation money from the DfE with a particular area of practice testing out working with families that did not meet criteria for continuing social care involvement, being aware that there was often a revolving door and repeat Merlins for domestic abuse . SafeCORE was set up as Greenwich has a high rate of repeat contacts, referrals and child and family assessments where Domestic violence and abuse is a presenting factor. The SafeCORE practice model uses a 'whole-family' systemic approach, working in small units & adopting a set of tools & techniques derived from Compassion Focused Therapy. The approach acknowledges that in many situations of domestic violence, a couple choose to remain in a relationship but may lack the capability to avert escalation of arguments into harmful conflict or violence. SafeCORE works with the whole family to enhance capability to regulate emotional responses, whilst also seeking to address contextual challenges (e.g., mental ill-health, substance misuse, employment, housing, access to community resources etc). It has a particular focus on engaging fathers in their work. In 2019 there was an expansion of the programme as there was a tested practice model, based on learning through the first year and the criteria was extended to include child to parent violence or aggression. As SafeCORE entered year 3 and the Covid-19 pandemic took effect, SafeCORE continued their work engaging with family members using remote platforms. Further funding was secured and SafeCORE began to test out working alongside Child Protection plans, typified by a higher level of concern in relation to domestic violence.

There is a limit to the scope of work as it is based on a therapeutic model; there needs to be scope for change and consent is needed. SafeCORE main focus is on situational parental conflict not

coercive control. It recognised the practical limitations for families of separating and is realistic that couples may remain together for contextual reasons, housing, financial, children etc. SafeCORE always seek the voice of the child in their systemic working with whole families. SafeCORE continues to be subject to evaluation that will include cost-benefit analysis which will consider potential cost-savings linked to future reduction in use of acute level services (Evaluation report by Anna Freud) This evaluation found improved outcomes for children and reduced impact on acute levels of domestic abuse across the spectrum of parental couple violence.

The service currently operates as 3 units comprising an experienced C&F SW as Practice Lead, a Childrens SW practitioner, an adult practitioner (YOS /Probation practitioner), a Family Support Worker, and a Unit Co Ordinator. Units are supported by a clinician who provides consultation and clinical expertise to support the work of the Unit. The Unit model allows flexible working with family members, whereby workers can be paired up to work with families and all unit members are involved in discussion, reflection and planning undertaken at a weekly Unit Meeting.

A model of Compassionate Mind Training has been offered to other SW teams in Greenwich by SafeCORE , as well as being offered to foster carers. Its emphasis is of building awareness of emotional flow, intervening to correct and regulate behaviour, with a particular emphasis on identifying and receiving compassion.

As of January 2020, SafeCORE had worked with 179 families with 248 children. There has not been an increase in referrals during lockdown, but there has been an increase in child to parent violence; however there has been a steady flow of referrals.

SafeCORE is located within the Royal Greenwich Children's Safeguarding division, promoting close links and referral pathways with teams best placed to refer and work alongside the service. SafeCORE's status continues as a research project subject to evaluation and, funded until the end of the current financial year. Dependant on evaluation outcomes and future funding, it will be valuable to build greater links with community-based services. There is a different focus on women's' safety as opposed to dealing with whole family conflict- 'different planets.'

There has not been an increase in referrals during lockdown, but there has been an increase in child to parent violence; however there has been a steady flow of referrals to SafeCORE. What would SafeCORE become when grant funding ends? Located in safeguarding services, they believe their current governance though where service is located. There is an acknowledgement that relationships with other services such as Community services has not really been built upon, with a different focus of services.

<u>Health</u>

I was able to meet with several individuals from health who had different roles and responsibilities within the hospitals, provider services and primary care.

There are two IDVAs based in hospital settings employed by Victim Support, which covers the Greenwich and Lewisham Health Trust. Referrals from A&E and maternity services would go to the IDVAs as well as through to Children's services. Because of this route IDVAs could feel on the periphery, as communication was back to refer and they were not always aware of any response or additional services being provided to the victim. They experienced some difficulties with communication from and to services. Trying to ascertain the correct contact details, as victims in hospital could present from anyway in London or Kent, for MASH or MARAC, frustration that can be referring or contacting other Local Authorities, as email are not the same in every area. A suggestion

for all LAs to have a standard email address ie MASH@london.borough.gov.uk. There is also not a standard form for referral to MARAC. The IDVA's experience of MARAC sitting through all cases, was that it worked better during pandemic as you could dial in and out, and get on with other things when cases were discussed where you were not involved.

Concern was expressed that focus is on preventing revictimization and responsibility placed on victim rather than holding perpetrators to account. In the IDVA's experience police involvement can be hit and miss - in terms of application of breach processes, often it needed to be a serious breach which was violent or physical, rather than continuous repeat of lower-level breeches. It was felt there needed to be consistency, she felt courts were improving in their response, but there was still work to be done. Concerns were also expressed about services/provision for NRPF, LBGT+, people with a disability and child to parents and a view that services rely too heavily on voluntary sector to provide.

Due to changes in the commissioning and delivery of health visiting and school nurse services initially from Oxlease to Startwell and then to Bromley Healthcare, the responsibility for Domestic abuse is not clear in this service area. The dedicated lead post for Domestic Abuse in the previous Oxlease structure has not been replaced. Previously this role provided a strategic link and engagement with VAGW /domestic abuse services and to provide information, advice and support to staff with domestic abuse cases. It provided support to HVs going into refuges, training on domestic abuse, support and training for SN and training for Bromley (not in contract). As part of this role a level 3 on domestic abuse training package was developed with the intention that it would be rolled out across the Trust. I believe following the reorganisation there was no satisfactory lead for MARAC, MASH or safeguarding and that this has temporarily been contracted to Essex to support. Because the record keeping system has changed, MARAC could not be provided with information from health system until very recently.

The Domestic Abuse Act suggests a pathfinder to support access to healthcare for victims of domestic abuse. It is recommended that this lead role is urgently reviewed for Greenwich. I understand that focus on domestic abuse and its links to safeguarding was also raised in the recent CQC inspection. It is suggested that there should be an across the trust a lead for domestic abuse that is based in the safeguarding team, which can provide an across trust lead for health not just HV/SN and oversee all MARACs. This role could also support staff undertaking domestic abuse SH risk assessments, improve standards of safety plans and ensure that the very small numbers referred from health to MARAC was increased by promotion and training.

The two refuges in Greenwich have particular issues with information being shared with health, as families move in and out. It was reported that there have been problems with one individual in the refuge, who does not recognise or understand the safeguarding remit of HVs, this has been appropriately escalated. Health no longer receive Merlins so may not know that there is domestic abuse in a family. GPs may also not know about domestic abuse incidents or that it has been referred. Information is only shared from hospital. Is there an extension of Operation Encompass to share Merlin information with health so there is a record on the system for HV/SN and GPs? The CHIS system allows information for children who are LAC or on CP plans to be shared, is this extended to the same health wide ta system?

I met with the GPs who have the clinical lead responsible for rolling out training on domestic abuse for all GP practices across Greenwich through the IRIS system, which is a partnership with the Her centre who provide education / domestic abuse advisors to train alongside the GP leads. This is a programme which originated in Bristol; they run 2x2 sessions for clinicians, every practice 80 % staff

are trained. There is also a templates available which prompts clinicians about domestic abuse. They hold bimonthly steering group meetings with the advocates/advisors to look at quality of referrals (to the Her centre). There is some training for GPs prior to qualifying on DOMESTIC ABUSE but the IRIS trainers have also offered training on domestic abuse to trainees GPs across Greenwich. The clinical leads have had good feedback from other GPs practices about the training and the use of the domestic abuse advisor/educators.

General information sharing with other agencies was mixed and was recognised as a two way system. The GPs felt that they did not get feedback or know if a case was know to MARAC or other services. They felt there was greater opportunity at the GPs clinical meetings for greater input from other professionals.

5 .Community safety – 'public safety planet'

The Safer Greenwich Partnership is the overarching Community Safety Partnership (CSP) for Royal Borough of Greenwich (RBG), the VAWG strategy (Violence against Women and Girls) explains the CSP response to harm, which includes Domestic Abuse. There are two dedicated officers in the Safer Communities team who drive this agenda and support the MARAC process, by providing support, progress cases and pulling together bids for support services. They monitor attendance of agencies and observe the quality of action planning on cases. These officers have provided continuity and challenge in the MARAC process as they have the experience, skills and continuity that is necessary, and are highly regarded by colleagues. One of the officers provides training in relation to domestic abuse and this will now need to be extended due to the new legislation. There is a need for join up between this training provided by CSC and any training provided by the GSCP on domestic abuse and the impact on children. It was recognised that there needs to be a better understanding by all practitioners of perpetrators use of coercive control and greater understanding of familial abuse – older children to adult.

The Safer Communities team often find the cut off at 18 problematics as victims are often within a cycle of abuse. There was frustration felt that adult safeguarding do not see domestic abuse as a vulnerability under the Care Act and therefore are unable to engage if there is no evidence of care needs, this can act as a boundary to access resources for victims if there are no children in the family. Because of lack of resources ACS (Adult Care Services) have not until recently been able to attend MARAC but sent information, which is limited to what is available on FWi. The Safer communities team felt that Children's services had moved on from decisions just based on thresholds and conversations are had to ensure support was provide, based on need.

The Safer Communities Team sit within the same directorate within the council which is also responsible for providing housing and tenancy support for victims of domestic abuse through the domestic abuse H (Alliance) accreditation and this has been identified as best practice. Refuge services are provided by the council through the GDVA, proving 30 refuge bed spaces. A phone helpline is also provided and well used. Council also funds floating support / phone, and the lower risk Freedom programme, separately commissioned by CS team. Housing is losing some of its funding support and there is a constant cycle of having to make short term bids for money, which is often not secure for long periods of time. One of the frustrations experienced was security of funding for projects and posts going forward. Bids are often long and complicated, with unrealistic expectations/ explanations from government to get additional funding.

Safer Communities team has also bid for additional funds and commission services from a number of voluntary organisations. Victim support is available for male victims from MOPAC across all 32

boroughs, HER Centre is a women's only provision in the borough who provide IDVA support, 2 IDVA from other funding streams, also one stop shop legal advice for victims and basic English classes for those who have English as a second language. Her Centre links to the Migrant Hub, run at Woolwich Common Community Centre, providing a gateway to support. The Migrant hub covers nil recourse rights and access to immigration advice. Her Centre offer support against other issues such as modern slavery, forced marriage, FGM, Honour based Violence, and Stalking and support for GPs through the IRIS project. (see above) A Perpetrator fund from the Home Office has given opportunity to set up domestic abuse perpetrators project for highest prolific offenders. Most authorities have no perpetrator intervention service and Greenwich is only been able to introduce one after successfully bidding for Home Office funding. It is limited to MARAC cases because it is aimed at the highest harm perpetrators (evidenced by repeat victimisation and/or highest levels of harm) This will be run directly by the Safer Communities team. Previously the council funded 2 additional police officers to work closely with high-risk perpetrators – the Perpetrators Intervention Team (enforcement and support). It ended at the same time the BCU was introduced so there has been a gap for about 2.5 years.

The Safer communities team also raised issues about the difficulties enforcing of breeches of non-molestation orders through courts and Judges' responses. Concerns were expressed that the Judiciary will be able to implement new legislation.

It was recognised that following the new structure of the GSCP that Community Safety were no longer represented at the strategic level and did not feel they had a voice representing them, which was felt to be a loss by Safer Communities Officers but recognised that officers were invited to attend subgroups of the GSCP. There had always been supportive and constructive dialog and challenge between the two governance arrangements and currently partner agencies attend the Safer Greenwich partnership. As part of this review and the new legislation the GSCP may want to reconsider this decision. It was felt that this still worked effectively at an operational level, but the strategic join up was not as strong. SafeCORE are present at VAWG Strategic Partnership Group board, but CSO felt there was little links to their work, as CS focussing on high risk and SafeCORE address family conflict in order to help them to stay together safely or to separate safely. The Safer communities team view was that they rarely hear any feedback or how they work as there is little dialog with them 'it sit outside 'our' world' , it was felt there would be benefits for more join up , perhaps sharing performance information.

The Safer Communities team were also responsible for commissioning Domestic Homicide reviews when there was a death caused by Domestic violence. It was important that learning from these reviews were shared and understood by the GSCP and the GSAB too. There were some similar issues arising from Childrens LSCPR and 2 DHRs regarding parental mental health particularly during the lockdown period and provision of services from Oxleas

Some of the particular areas that were raised as issues which resonated with the issues raised by Children's services were supporting victims who had no recourse to public funds and spousal visas. The other issue raised by Safer Communities team was the issues of contact and Private law. See section below.

There is a need for a full briefing on the new Domestic abuse Act and the implications for agencies which should be shared with all statutory boards ie ASB, GSCP and the Safer Greenwich Partnership and the implications for service delivery reconsidered and as a result development of a standalone Domestic abuse strategy which is agreed by all Partnerships.

MARAC

Individual borough-based MARACs continue to be chaired by police, who see high volumes of cases being referring into MARAC and good multi agency engagement and response. Police chairs felt it would be useful to have more consistency across MARACs as they felt the framework for MARACs was not applied consistently both national and particularly across the Met, as there were 32 different Community Safety Partnerships across London and different local authorities to work with; some MARACs meeting weekly most monthly. In RBG, the MARAC meets fortnightly, it may be held over several days because of volume of cases being discussed: an average of 27 cases a fortnight. The fortnightly agenda is now done over two meetings on consecutive days that each last several hours; it was adapted from the previous single meeting (that was almost all-day) when Covid necessitated switching to virtual format, which proved unsustainable for such a long period in one go. There is a quarterly steering group and a quarterly practitioners' forum. There is a pressure on meeting as by its nature MARAC deals with high level of risk and enough time needs to be given to ensure information is shared and appropriate actions taken to protect victims.

There is a dedicated MASH worker who represents children's services at MARAC who will research cases being presented for information, consult with SWs and ascertain what support is needed for a family and then present this to the meeting. This was then fed back to SW and into the child's plan (CP or CiN) plan. It was felt to be a useful multi-agency approach to high-risk cases of domestic abuse. There is some duplication of process between a CP and CiN plan and actions may be repeated across these two 'planets ' but the MARAC meeting often had different agencies or services available ie housing or IDVA intervention at MARAC. The focus of children's plan is the child(ren) the MARAC is the victim, usually the mother – will this change following the domestic abuse A and the expectation that the child is also recognised as a victim in their own right?

There is good multiagency attendance from statutory agencies, including from adult drug and alcohol services, with the HER centre representing the IDVA voluntary service. Safer communities staff also sit on the MARAC and act as the 'glue' in ensuring that the administration and actions are progressed. They have provided continuity over time. A senior Children's Social care manager attends the strategic MARAC steering group. The steering group is chaired by the senior manager for the Safer Communities team, who attends the MARAC periodically to observe and to monitor the quality and efficiency of its process, which is then reported to the steering group with recommendations for any issues noted.

The Her Centre provides a Children's IDVA, funded by Children's Safeguarding, with referrals filtered through a senior safeguarding team leader. All referrals must be under a CIN or CP plan. The service receives limited referrals and Her Centre and Community Safety have asked that more referrals of vulnerable children from MARAC cases can be referred through to the specialist worker.

Probation

I met with the CRC service who are the main 'probation' service dealing with convicted domestic abuse perpetrators, as the National Probation service deal with the more serious offenders. During the pandemic they operated an extra ordinary delivery model which was based on risk /need and tried to maintain face to face contact with users with a history of domestic abuse or concerns regarding safeguarding arrangements. However, because of the social distancing requirements they could not keep the same staffing ratios in offices, for RBG there were 3 officers in the office, which was a quarterly of normal staffing, which provided a challenge to seeing users at required levels. There was some planned phone contact, where domestic abuse was known but acknowledge that

this response was reactive. The ability to do home visits /doorstep visits was not well utilised and therefore visibility was lost in a number of cases. The technology available to the CRC service also was limited - the MoJ would not agree to the use of virtual visits and there was limited access to Teams for frontline staff. It took a long time to get this operational and it was not until July that it could be used for managers to take part in partnership meetings such as MARAC. The National probation service have the IT and made use of the service.

The lack of the technology and ability to respond in a virtual way, has had a major impact on the delivery of services meaning that CRC have had to stand down on unpaid work, accredited programmes and had to suspended Building Better Relationships (a programme for domestic abuse perpetrators– offence focussed work). This ran again from July following the first lockdown suspension and then from December onwards, though numbers were limited to 4 service users rather than 12. There were also restrictions on how they could be delivered as they could not be delivered virtually. This then pushes work onto the 1:1 offender manager, who could not deliver this work either. It is also important to note that the intervention programme ended when the order ended – a number ran out during the pandemic, therefore there are a number of perpetrators that did not complete the required programme as required by the court as part of their order. There is a women's safety officer attached to this programme, who works with the victims alongside the perpetrators while they undertake the programme. This support also could not be offered, for example if victim furloughed at home and with the perpetrator, it was not appropriate to undertake the work. There was also no engagement with unpaid work programs and therefore limited ability to intervene. It is of concern that CRC were not supported by MoJ to use virtual visits to undertake their work as it was one way of maintaining some contact, appreciating that face to face and home visits enable a more rounded assessment of risk. It is also of concern that the limited programmes /provision for perpetrators were not running during the pandemic and many would not have had this intervention.

The impact of courts not working during the early lockdowns meant that numbers attending court dropped during first wave by 10/12 % during closure of courts, and they were not hearing breaches. As part of a risk management exercise this was believed to be by the summer a backlog of 250 cases. Caseloads are gradually increasing again; courts are now prioritised those cases pleading guilty. It is of concern to note the delay that this has caused in processing cases and protecting victims through Orders or processing breaches.

CRC struggled with the frequency of MARAC meetings especially with increased length of meeting and during the pandemic managing the administration and information sharing into meetings with the constraints with technology. The CRC acknowledged the ability to share information and demand often placed them in a reactive/ firefighting mode, making it difficult to deliver partnership expectations. The National changes happening across the probation service will mean by June 2021 a shift into a unified service with 3 probation delivery units to deliver a 'challenge /continuity /transformation /change programme' which has been a year in making and acknowledge there will be disruptions but believe there will also be benefits. Opportunities coming with unification with increase in visibility such as MASH.

Good practice – CRC consider that information sharing works well and working collaboratively across the partnership; an example given of this was RESET with interconnectedness on the ground and utilising resources, and as a result there were good personal relationships and increase in meaningful conversations. It was acknowledged that CRC staff sometimes struggle with some areas especially dealing with children and safeguarding, as their focus is on the adult. There is often some dislocation from family, and a need to ensure information sharing, gathering with a holistic view

/family focus which has proved difficult for some staff and considering the impact of offence on family/ child.

All participants were asked what one change would they make –CRC felt that the supply chain providers, and support trauma informed trained with women manging women and more working with victims , as an example the HER centre commitment offering a dynamic framework which is bespoke to women. Concern that this will lose momentum during the pandemic.

Her Centre

The Her Centre provides services for female victims of domestic abuse, based in Greenwich . The centre provides wider sexual violence advocacy to Bexley and Lewisham. However, most of the focus is on services for Greenwich who provide a number of grants, HER centre has secured other sources for grant funding to double the local provision. The main council funding is from Community Safety funding two full time IDVA posts. The grant from Children's services provides advocacy funding for a full-time children's IDVA and counselling funding. Her Centre is also funded by Public Health to provide IRIS, a training programme for GP surgeries about domestic abuse. The big lottery funds a Young Person's IDVA whose focus is on peer-on-peer abuse and sexual assaults. There is also a Sexual violence advocate who deals with adult victims, and a housing outreach IDVA supporting women with tenancy issues who are experiencing abuse. During the pandemic services were initially dealt with on phones lines only, but face to face was arranged for exceptional cases, and resumed in May with the one stop shop and courses being run in person. The weekly One stop shop provides access to a Family solicitor to provide legal advice at the HER centre. There is follow up outreach service and courses that provide basis English, parenting, IT training and a back to work programme. Many of these additional services are provided by charities such as the City Bridge Trust, Charles Hayward, Brook Trust and other charities; there are 20 fund raising streams. The main work of the centre is at point of crisis for women at high risk of harm or death. The centre also works with the Westminster drug project if there is substance misuse. The HER centre also works closely with other Voluntary organisations, such as victim support and Refuge. There is school's engagement, the HER centre works in partnership with a theatre production charity called 'Little Fish Theatre' which goes into school running training around domestic abuse. From 900 referrals, around 600 women will be engaged by the HER centre.

The CEO and services manager attends the MARAC steering group to ensure women are keep safe and works closely with community support team and the Police representatives and is part of the VAWG strategic group. With Children's services there are good individual relationships. Links with the SW who attends MARAC, who follows up and acts as a gatekeeper, tighter accountability and follow up on actions are areas where there could be improvements. The adult representative on MARAC was not seen as proactive. If there are safeguarding concerns HER centre will refer to MASH but they are sometimes frustrated by the response, as focussed on children not the victim. When asked about links with SafeCORE the response was it was felt to be a bit of a mystery. The programme appeared very expensive and question on reach. There had only been one report to VAWG partnership board on the service – it was dealing with conflict does not work where there is physical abuse and focuses keeping families together, working with lower risk rather than higher risk . Differences about how families are worked with, occasional happens that families feel coerced into working with fear that 'that kids will be taken away' – keeping a SW 'off their back' they will go along with SafeCORE when they would rather not. There was a view that there was a lack of coordination, minimal links by SafeCORE with other services.

The HER centre reiterates previous concerns about courts not taking sufficient action against perpetrators. Another area for concern was child contact, with particularly CAFCASS writing reports, they believed through feedback from mothers that they were often too taken in by father and manipulated, which left children unsafe. This was reiterated by the user group, who had experienced this first-hand. The areas to be considered were uncertainty about funding, also wanting recognition that murder by somebody they know less likely to get media attention.

6. Contact 'planet'

Issues about contact with abusive fathers was a major concern raised by the mothers in the user group. Important insights into the impact of domestic abuse and the response to it are provided in the Ministry of Justice report, *'Assessing Risk of Harm to Children and Parents in Private Law Children Cases'* published in June 2020 alongside the *Domestic abuse and private law children cases - A literature review by the MOJ.* (links below)

Contact is enshrined in the Children Act 1989 and is well established in case law, with an assumption that the involvement of both parents in a child's life will usually further the child's welfare and that compelling reasons must be demonstrated for the court to suspend contact. Article 8 of the ECHR also reiterates this right to family life. 'Family life 'can include the relationship between a parent and a child, and the court should not interfere with this right, for example by making an order for no contact, unless it is necessary and proportionate to do so. A barrier to the courts addressing domestic abuse effectively, is the priority placed by the family justice system on ensuring that contact between the child and non-resident parent will occur. The review of the research material by the MoJ reviewed the previous literature which identified the 'pro-contact culture' of the family courts and adopted this terminology as appropriate to capture the systemic and deep-seated nature of the courts' commitment to maintaining contact between children and non-resident parent. The Children Act 1989 was amended to set out that the court was to presume, unless the contrary is shown, that involvement of each parent in the life of the child concerned will further the child's welfare. It is perceived the dominance of contact as excluding other welfare considerations, including the child's need for protection from abuse, or the child's wishes and feelings. The research found that there is a pro-contact culture which results in a pattern of minimisation and disbelief of allegations of domestic abuse and child sexual abuse.

There is also an adversarial approach to decision-making, as well as resource limitations in relation to private law proceedings (Legal aid) and the family court working in a silo, which can lead to court processes that are unsatisfactory and outcomes that are potentially unsafe for children and adults. A review of the presumption of parental involvement in s.1(2A) of the Children Act 1989 is needed urgently in order to address its detrimental effects. In May 2019 the MoJ announced a public call for evidence steered by a panel of experts from across family justice, to gather evidence on how the family courts protect children and parents in private law children cases concerning domestic abuse and other serious offences. To assist the inquiry, the MoJ commissioned a review of the available literature on the risks to children and parents involved in private law children cases of domestic abuse, and how these risks are managed by the family courts

Findings and estimates from predominantly quantitative studies based in England and Wales indicate that the prevalence of domestic abuse in private law children cases is considerably higher than in the general population, with allegations or findings of domestic abuse in samples of child arrangements/contact cases ranging from 49% to 62%. That domestic abuse is harmful to children is recognised by statute (Section 31(9) Children Act 1989). The literature review shows that children are directly involved and affected by domestic abuse in a variety of interlinked and co-existing ways.

Many studies found a high incidence of physical, sexual and emotional abuse, and a greater risk of child homicide, in the context of domestic abuse. A wide range of studies revealed the physical, psychological, behavioural, developmental and emotional problems, disorders and traumas sustained by children experiencing domestic abuse, which can carry through to mental and physical health difficulties in adult life. Qualitative studies found that living with coercive control can have the same cumulative impact on children as it does on adult victim/survivors, which may contribute to emotional and behavioural problems in children. While some children may have more intrinsic resilience to the impact of domestic abuse than others, a supportive relationship with a caring adult, particularly the non-abusive parent, has been found to be the key protective factor for children. The literature reviewed found that ongoing abuse after parental separation can leave victim/survivors in a continued state of fear and can substantially impede women's recovery and ability to regain their confidence and parenting capacities and support their children's recovery.

Child contact was highlighted by numerous studies as the key site for the perpetration of continued, potentially more serious, abuse, including homicide, of mothers. Children can be exposed to the physical, psychological and sexual abuse and coercive control of their mother during contact. Additionally, contact could be used by perpetrators as a site to undermine mothers including criticising, denigrating and degrading them in front of or to the children, getting children to pass on abusive or threatening messages to their mothers, and manipulating children to provide information about their mothers. A wide range of predominantly qualitative studies found that children's continued involvement with a parent who perpetrates domestic abuse carries the risks of maintaining controlling, dominant or bullying relationships, and of children being physically, sexually and emotionally abused, neglected and abducted, children witnessing the abuse of their mothers, being co-opted into the abuse of their mothers, and at worst, children being killed. Qualitative and quantitative studies found that the effects on, and outcomes for children are poorest when post-separation contact is the site for continuing domestic abuse. Children can, however, recover from the impact of domestic abuse when they are in a safer environment, but ongoing contact with the abusive parent can create difficulties for children's ability to recover and sustain recovery (Katz, 2016). Qualitative and quantitative studies revealed that children have widely varied, conflicted, mixed and ambivalent feelings and views about their fathers and contact. The studies reviewed reveal that the priority for nearly all children, even those who do want a relationship with their fathers, is safety, for themselves, their mothers and the rest of their families.

In England and Wales and in many other jurisdictions the family courts strongly promote ongoing relationships between children and both their parents following separation, even in circumstances of domestic abuse. Numerous qualitative and quantitative studies have identified how a strong presumption of contact has led to domestic abuse being marginalised, misunderstood, and downgraded within private law children proceedings, which may conflict with a focus on protecting children from harm.

These studies revealed a widespread view among courts and professionals that mothers who opposed or sought to restrict contact or even raised concerns about it were 'implacably hostile' or, more recently, 'alienating', which has led to an increasing perception among courts and professionals that mothers raise false allegations of domestic abuse. However, empirical case file analyses found that cases of 'implacable hostility' were very rare, and qualitative studies found that the majority of mothers, including those who had experienced domestic abuse, were supportive of post-separation contact.

A consistent theme that emerged from the research literature was that a 'selective approach' was taken to children's views in court proceedings. Children's views were taken seriously and were even

determinative if they wanted contact with non-resident fathers, but their views were also more likely to be disregarded and discounted, and treated as problematic, when they were opposed to contact – even if children had experienced domestic abuse. One of the service users spoken to as part of this review , offered a similar experience where her daughter was not listened to about ceasing contact.

Qualitative studies revealed that women experienced the promotion of contact by the family courts and professionals as highly problematic in the context of domestic abuse. Mothers felt that domestic abuse was not taken seriously and minimised by courts and professionals, and that the dynamics and impact of domestic abuse were not understood. Women participating in a number of studies were dismayed to find themselves labelled unreasonable, over-anxious, and obstructive of contact by professionals if they raised concerns about contact with violent fathers. The disbelief expressed by courts and professionals, including their own lawyers, when women raised concerns about domestic abuse, left them vulnerable and unsupported. However, where women did feel listened to and believed by judges and professionals, they felt supported rather than undermined, and more confident that the impact of abuse on themselves and the children would be factored into contact decisions. Qualitative and quantitative studies report mothers experiencing considerable pressure from courts and professionals, including their own lawyers, to agree contact arrangements or attend mediation, in some cases without any assessment of child welfare concerns or without obtaining children's views.

Numerous research studies undertaken in England and Wales and in other jurisdictions have revealed how perpetrators of domestic abuse may use continuous and protracted litigation as part of an ongoing pattern of control and harassment, which many women found as bad as, or worse than the abuse itself.

Court directives still have not changed courts and judge's behaviour. Statistics and qualitative and quantitative research studies revealed that some form of direct contact between children and perpetrators of domestic abuse was ordered in the great majority of all private law cases. Orders for no contact were consistently found to represent less than 1% of total contact orders. Qualitative studies found that only recent, extremely serious physical violence could lead to no contact being ordered. Quantitative case file analyses and qualitative studies found that the most common outcomes of cases involving allegations of domestic abuse were orders for direct, unsupervised contact which could be achieved by an incremental or 'stepped' approach towards the end goal of unsupervised, preferably staying, contact.

<u>Assessing Risk of Harm to Children and Parents in Private Law Children Cases - findings.</u>

Submissions highlighted a feeling that abuse is systematically minimised, ranging from children's voices not being heard, allegations being ignored, dismissed or disbelieved, to inadequate assessment of risk, traumatic court processes, perceived unsafe child arrangements, and abusers exercising continued control through repeat litigation and the threat of repeat litigation. The panel found these issues were underpinned by the following key themes in the evidence that was reviewed:

• Resource constraints; resources available have been inadequate to keep up with increasing demand in private law children proceedings, and more parties are coming to court unrepresented.

• The pro-contact culture; respondents felt that courts placed undue priority on ensuring contact with the non-resident parent, which resulted in systemic minimisation of allegations of domestic abuse.

• Working in silos; submissions highlighted differences in approaches and culture between criminal justice, child protection (public law) and private law children proceedings, and lack of communication and coordination between family courts and other courts and agencies working with families, which led to contradictory decisions and confusion.

• An adversarial system; with parents placed in opposition on what is often not a level playing field in cases involving domestic abuse, child sexual abuse and self-representation, with little or no involvement of the child.

Respondents felt that orders made by the court had enabled the continued control of children and adult victims of domestic abuse by alleged abusers, as well as the continued abuse of victims and children. Many submissions detailed the long-term impacts of this abuse manifesting in physical, emotional, psychological, financial and educational harm and harm to children's current and future relationships. Many parents felt that the level of abuse they and their children experienced worsened following proceedings in the family court. There were concerns these efforts to report continuing abuse were treated dismissively by criminal justice and child welfare agencies because of the family court orders. Many mothers also highlighted the negative impacts felt by children who were compelled to have contact with abusive parents, and the burden placed on mothers and children to comply with contact orders compared to minimal expectations on perpetrators of abuse to change their behaviour. Many respondents felt that negative long-term impacts to children's wellbeing from continued contact with an abusive parent vastly outweighed the value of an ongoing relationship with that parent.

This viewpoint was also made strongly by the group of service users I spoke to from the HER centre. They felt that SWs often did not listen to their views and often did not listen or hear the views of their children. It is important that when SWs are undertaking s 37 reports for courts, they are aware of the research(above) and need to take into account the risk and impact of domestic violence on the children opposed to the need for maintaining a relationship with the abusing parent. Though there have been a number of directives to courts the attitudes to contact have persisted. We need to challenge these assumptions, as CAFCASS are no longer attending GSCP meetings, we may want to hold them to account through the PQA as to the steps being taken to implement this review and the recommendations arising from it, as well as through Family court liaison meetings with civil courts and judges.

7. Conclusion

There is much good work happening across RBG and working together to address domestic abuse. However, this could be improved by considering how the links between the three 'planets' can join up more constructively to address some of the issues raised, further work is needed to establish and maintain the most effective way of joining up the approaches to keeping victims of domestic abuse safe. The Domestic Abuse Act gives the opportunity to review delivery and how we as agencies and across strategic partnership can address the growing issue of domestic abuse through the development of a domestic abuse strategy that straddles agencies and partnerships and pulls together the recommendations and requirements of the Domestic Abuse Act and national VAWG strategy . This will need to outline how agencies will reduce and prevent domestic abuse and focus on the impact and outcomes for victims.

8. Recommendations /suggestions for improvement

- Briefing on new Domestic Abuse Act for all partnership boards and consider implications for practice and service delivery, especially children now being recognised as victims.

- Develop a stand alone Domestic Abuse strategy which is agreed by all the partnership boards.
- Keep under review the quality of Merlins. The Met Police also to consider the concerns raised by partners of impact of churn of officers on working relationships. Consider how information from Merlins can be shared with health
- Consideration to be given to an IDVA or domestic abuse worker being able to be accessed via MASH to provide support at an early stage.
- There is a need for join up between training provided by Safer Greenwich and any training provided by the GSCP on domestic abuse and the impact on children. This should be training for all agencies services, which includes the use of coercive control and including complexity of working with children and families. Training of SWs should also reflect the research of the impact of domestic abuse on contact arrangements.
- CCG / RBG to consider strategic health post responsible for domestic abuse that co ordinates training , response to MARAC, and provides advice and guidance on domestic abuse, which should be located within core safeguarding services.
- Consider the links between the Partnership Boards (GSCP, GSAB and Safer Greenwich) including information sharing and participation especially in regard to key points such as MARAC and DHRs.
- Work across London(London procedures group/ALDCS) at developing consistent email accounts for MASH and MARAC to provide consistency for referring agencies.
- SafeCORE – consider remit and use of resources and how this resource is aligned with other service provision .
- Consideration for different models of working for Children's services, for example Family Safeguarding model where there are workers specialising in working with adults(domestic abuse, MH, substance misuse) in multiagency teams working alongside children's social workers.
- Use the Domestic Abuse Act as an opportunity to work with police and judiciary to understand the impact of response to breaches of non- molestation orders in criminal courts.
- Work with civil courts and CAFCASS to understand issues of domestic abuse and implications for contact with children.

Nicky Pace GSCP Independent scrutineer

May 2021

Links

Assessing Risk of Harm to Children and Parents in Private Law Children Cases- Ministry of Justice

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/895173/assessing-risk-harm-children-parents-pl-childrens-cases-report_.pdf

Domestic abuse and private law children cases - A literature review by the MOJ.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/895175/domestic-abuse-private-law-children-cases-literature-review.pdf

Domestic Abuse Act statutory guidance - GOV.UK

https://www.gov.uk/government/consultations/domestic-abuse-act-statutory-guidance

Tackling violence against women and girls strategy

https://www.gov.uk/government/news/tackling-violence-against-women-and-girls-strategy-launched?utm_medium=email&utm_campaign=govuk-notifications&utm_source=6067a9db-09a0-4073-8ae7-2834a0ff0578&utm_content=daily