Ofsted Care Quality Commission HM Inspectorate of Constabulary and Fire & Rescue Services

His Majesty's Inspectorate of Probation

Research and analysis

The multi-agency response to children who are victims of domestic abuse

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Contents

Acknowledgements

We would like to express our gratitude to the women and men who chose to share their experience with us, via our survey and focus groups.

Thanks also to our colleagues at the office of the Domestic Abuse Commissioner, especially Jacqueline Gilbank, and to Althea Cribb, for helping us hear the important voices of domestic abuse survivors.

Executive summary

This report sets out our findings from 6 joint targeted area inspections (JTAIs) carried out between October 2024 and June 2025. JTAIs are carried out by Ofsted, the Care Quality Commission (CQC), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Probation (HMI Probation).

Together, we looked at how local partnerships and services respond to children who are at risk of, or who have been victims of, domestic abuse. The scope of this JTAI theme reflected the definition of domestic abuse in the Domestic Abuse Act 2021, which makes clear that children are victims of domestic abuse in their own right if they have seen, heard or experienced the effect of the abuse.

We decided to focus on the unborn children and children aged 0 to 7 years who are victims of domestic abuse, in recognition of the vulnerabilities of very young children. However, our evaluation of strategic arrangements in the local area took a broader look and considered children of all ages, including how local partners have implemented the changes set out in legislation.

We considered the work of individual agencies as well as multi-agency working arrangements between children's social care, health services, police, youth justice services and schools. In this report we use the term 'multi-agency' to describe arrangements between these agencies.

Our inspections focused on 4 themes:

- responding to children who are victims of domestic abuse, at the point of identification
- assessment, planning and decision-making in response to notifications and referrals of children who are victims of domestic abuse
- protecting, supporting and caring for children who are at risk of, or who have been victims of, domestic abuse
- preventing children from becoming victims of domestic abuse

We sampled and tracked the experiences of hundreds of children across these inspections. Most of the findings refer to this large sample. From this, we selected a smaller sample of 36 children whose experiences we tracked in detail.[footnote 1]

To help us understand the multi-agency response to children who are at risk from, or are victims of, domestic abuse, and to help us write this report, we also:

- carried out a literature review of current research
- held 2 focus groups for each area we inspected with the multi-agency inspection teams that were involved in the inspections; when we could not hold a focus group with all necessary inspectors, we received written feedback
- consulted stakeholders from organisations that work in the field of domestic abuse throughout the project, to help us develop the methodology and advise on our report

The 6 local areas inspected were:

- Hertfordshire
- Hillingdon
- Norfolk

- North Yorkshire
- Reading
- Redcar and Cleveland

As part of our inspections, we spoke to children who were victims of domestic abuse and their families. We also worked with the office of the Domestic Abuse Commissioner to hear the voices of survivors and parents through a survey and focus groups. Although these parents do not necessarily live in the areas that we inspected, their testimonies about the help and support they received were extremely valuable. The findings from this separate engagement did not feed into any of the inspection findings from any of the areas visited. They are used purely to add context from the survivor's point of view about many of the things we saw across the JTAI visits. We are grateful for their time and contribution, which will better inform our collective understanding of the experiences of families.

This report shares the most significant findings from these inspections. It aims to help improve practice, knowledge and understanding for local areas, partners and agencies working in domestic abuse. The report is not a summary of all the inspection findings. These are available in the letters that we published after each inspection.

We have changed children's names and personal information in the case studies included in the report. We withheld some details to protect identities.

Summary of main findings

We saw some very good practice at a strategic and practice level. Some excellent work, undertaken by individual practitioners, helped, protected and supported children. However, what was striking was the inconsistent experience of children.

Effective multi-agency strategic responses to children who were victims of domestic abuse were characterised by engagement and commitment from all partners, including the voluntary, community, faith and social enterprise sectors. These responses worked well when they included partnership boards responsible for responding to domestic abuse that were clear about their roles, and that worked and communicated well between strategic boards and with other agencies and practitioners. When strategic responses were effective, there was a strong understanding of children's needs in the local area accompanied by an effective strategy and plan. Critically, domestic abuse was seen as a priority and there was a golden thread between strategy and practice. However, we saw examples where

some of these key elements were not in place, which impacted negatively on the response that children and their families received.

In some areas there was a focus on practitioners developing strong and trusting relationships with children and family members where safe to do so. The importance of building trusting relationships with children and non-abusing parents was recognised at a strategic level. This makes a significant difference in ensuring that the child's experiences are understood, and that this leads to effective multi-agency action which helps to ensure that the child is safer.

We saw strong practice in relation to unborn babies from midwives who showed professional curiosity, and both awareness and knowledge of the potential risk of domestic abuse and the needs of the child and their mother. We saw how they ensured that, in every contact with the family, they made routine enquires about domestic abuse. Good early identification of potential risks to unborn children from perpetrators of domestic abuse was evident in the majority of partnerships, as were effective multi-agency responses to keep them safe.

Schools and early years play a critical role in supporting and protecting children from domestic abuse. The schools involved in the inspections generally know their children well and respond effectively to changes in the child's presentation. We saw good examples of schools and early years providers being involved at a strategic level. Effective support and training for early years providers and schools enhances their ability to identify domestic abuse, understand children's needs and any risks, and then use effective pathways to support and protect those children. Operation Encompass works well in strengthening schools' capacity to support and safeguard children.[footnote 2]

Children are not consistently recognised as victims of domestic abuse in their own right. Despite the changes in legislation through the Domestic Abuse Act 2021, strategic leaders do not fully recognise the needs of children who are victims. This affects how children are supported and leads to ineffective commissioning of services to meet their needs. Practice across the different agencies in some local areas remains focused on adults' needs and risks, and insufficiently focused on risks and needs of children. Some of the children's plans we saw during the

inspection relied too much on the role of non-abusing parents, mostly mothers, in protecting children. Non-abusing parents are being expected to protect their children from perpetrators (over whom they have no control) and this means the risk to children is insufficiently recognised.

We did see good practice where children were recognised as victims in their own right. This led to an effective assessment of the child's experience, risks and needs, and to a timely and effective child-centred response. A child-centred approach within a whole-family focus needs to be at the centre of multi-agency responses to children who are victims of domestic abuse.

Domestic abuse was not always identified or understood, including coercive control. When practitioners do not recognise or understand controlling or coercive behaviours, they do not always directly connect perpetrators' behaviours with harm to children. A lack of effective identification of risk for children who are victims of domestic abuse meant that children did not always get the right help and protection at the right time. Early help for children at risk of domestic abuse was not consistently prioritised. Where there were services and responses in place, these made a significant difference.

We also saw a lack of focus on children's needs for help and protection in some key multi-agency forums such as multi-agency risk assessment conferences (MARACs) and multi-agency public protection arrangements (MAPPA), as well as in some responses to individual children and their families. We saw some mitigation through other processes such as child protection planning, which had a greater focus on children.

We saw significant variation in how well the voices and experiences of individual children who are victims of domestic abuse are listened to, understood and captured by agencies and practitioners. This needs greater focus. There are examples of strong practice that should provide a platform for improvement. However, children's voices were not consistently represented at a strategic level in all areas.

Practice overall is too inconsistent. While we did see some excellent child-centred work that was based on developing strong relationships with families and led to children being safer, we also saw some poor practice. For example, some practitioners were over-optimistic and lacked the professional curiosity needed to better understand and recognise the impact of domestic abuse on children. When practitioners raised concerns

about risks to children from domestic abuse and did not get the required response, they did not consistently challenge and escalate those concerns. In other examples where professionals challenged the quality of planning and decision-making for children, the challenge was not always responded to. Assessments were not always holistic, did not fully take into account all aspects of children's lives, and did not always recognise cumulative risk to children.

There were not always robust systems in place for sharing information between agencies. For some children this means critical information is not being shared, and their needs and the risks to them are not always fully understood. Practitioners involved with supporting children and families are not always invited to meetings, or informed about outcomes of meetings, changes relating to other practitioners, or changes in family circumstances. Agencies experience challenges in accessing records from other services that use different systems. Multi-agency meetings and forums are not always attended by the right agencies and practitioners. This undermines effective information sharing and joint decision-making.

There are variations in how well the risk posed by domestic abuse perpetrators is understood and managed by the children's services, police and probation services. While there has been an overall improvement in how they use their respective powers to protect children from domestic abuse compared with findings from our report The multi-agency response to domestic abuse: prevent, protect and repair (published September 2017), we saw examples where this work was not effective. The police do have processes in place for sharing domestic abuse referrals with children's social care. But they often fail to communicate to other agencies involved with the children/families the action they have taken with regard to perpetrators, such as domestic violence protection orders (DVPOs), domestic violence protection notices (DVPNs) and bail conditions. This undermines their effectiveness in protecting victims. And probation services are not consistently realistic about what can be – and is being – delivered. For example, they sometimes tell the partnership that domestic abuse interventions will take place, even when these interventions are not available.

There are some delays in protecting children from domestic abuse. There are various reasons for this, including information-sharing between partners that is not effective or timely, and risk to children not being fully identified. These all result in a lack of timely and robust decision-making. We did see some strong practice, as highlighted through the report. The need is for

effective systems and oversight to enable a more consistent, impactful and timely response.

Introduction

In September 2017, we published our report The multi-agency response to domestic abuse: prevent, protect and repair. This was an overview of findings from JTAIs in 6 local areas that examined the multi-agency response to children living with domestic abuse. These are the main findings set out in that report:

- Professionals have made progress in dealing with the immediate challenges presented by the volume of cases of domestic abuse.
- Domestic abuse is a widespread public health issue that needs a long-term strategy to reduce its prevalence.
- Too little is being done to prevent domestic abuse and repair the damage that it does.
- Work with families was often in reaction to individual crises rather than preventative.
- Keeping children safe over time needs long-term solutions.
- Agencies do not always focus enough on the perpetrator of the abuse.
- There is still not a clear and consistent understanding about what information professionals can share within agencies and across agencies.

Since we published this report, the government has introduced the Domestic Abuse Act 2021 and updated guidance for local safeguarding partners and their multi-agency safeguarding arrangements (MASA). We have also experienced a pandemic and a cost-of-living crisis, which have resulted in societal changes that have increased the pressures on families. Both have also had an impact on the scale and nature of domestic abuse.[footnote 3] More recently, the Child Safeguarding Practice Review Panel published a paper on multi-agency safeguarding and domestic abuse. It sets out their findings from a thematic analysis of rapid reviews and local child safeguarding practice reviews where domestic abuse featured. Given these developments, the inspectorates agreed that 2025 was the right time to revisit the multi-agency response to domestic abuse.

The scope of this JTAI theme reflected the definition of domestic abuse in the Domestic Abuse Act 2021, which makes clear that children are victims of domestic abuse in their own right if they have seen, heard or experienced the effect of the abuse.

Following discussions with stakeholders, we decided to focus on unborn children and children aged 0 to 7 years who are victims of domestic abuse, in recognition

of the vulnerabilities of very young children as highlighted in the Child Safeguarding Practice Review Panel's findings.[footnote 4] Our evaluation of strategic arrangements in the local area took a broader look and considered children of all ages, including how local partners have implemented the changes set out in legislation.

The agencies in the scope of this inspection are the police, children's social care, probation services and relevant health services. We also looked at how local agencies work with education and early years providers to identify and respond to children who are victims of domestic abuse.

Context

Domestic abuse is a pervasive and deeply entrenched issue affecting children across the UK, with 1 in 7 estimated to have lived with domestic abuse at some stage in their lives.[footnote 5] It is the most significant factor in child safeguarding, appearing in the majority of child protection plans and care applications.[footnote 6] Research shows that, despite its prevalence, prevention and early intervention efforts remain underfunded and deprioritised, even though evidence shows that early help can positively impact children's wellbeing and safety.[footnote 7]

Younger and unborn children are particularly vulnerable, yet the Domestic Abuse Commissioner's research found that women who are pregnant are not consistently asked about domestic abuse, and early years settings are often excluded from protective measures like Operation Encompass. In addition, although children are now legally recognised as victims in their own right under the Domestic Abuse Act 2021, frontline practice and statutory guidance are not clear enough, which results in opportunities to hear and support children being missed.[footnote 8] This is compounded by systemic gaps in how healthcare services, police and children's social care engage with children, especially those from ethnic minority communities, who face additional barriers and risks such as 'adultification' and cultural insensitivity.[footnote 9] The Domestic Abuse Commissioner also heard that perpetrators sometimes evade accountability. This can be due to professionals' limited confidence in working with perpetrators, their limited overall understanding of domestic abuse (especially coercive and controlling behaviours) and a lack of tailored interventions.

The impact of domestic abuse on children varies, but it can result in a wide range of adverse outcomes, including emotional, psychological, behavioural and social challenges. The Domestic Abuse Commissioner's report emphasises the importance of listening to children's voices and tailoring responses to their unique needs.[footnote 10]

Exposure to domestic violence is linked to increased risks of anxiety and depression, with protective factors such as maternal warmth, emotional intelligence and participation in extracurricular activities helping to mitigate these

effects.[footnote 11] Recent UK research highlights a concerning link between childhood exposure to domestic abuse and increased risks of exploitation. The Victims' Commissioner found that children who experience domestic abuse are more vulnerable to criminal exploitation and serious youth violence.[footnote 12]

The government has pledged reforms and investment to promote prevention and strengthen multi-agency working, for example through the Children's Wellbeing and Schools Bill, the Families First Partnership programme and the cross-government freedom from violence and abuse strategy.[footnote 13]

Protecting and supporting children at risk of abuse are a priority for the government, but significant challenges remain in ensuring all children receive the protection and support they deserve.[footnote 14]

The government response to the Domestic Abuse Commissioner report in early 2025 also highlights the importance of updating the relationships, sex and health education (RSHE) curriculum, to equip children with the knowledge and skills they need to build positive relationships and to recognise abusive behaviour, which they highlight as being crucial in the prevention of domestic abuse.

What we found

Strategic leadership and governance

Our inspections highlighted the importance of strong strategic oversight by the local partnership, coherent governance structures, and leadership commitment to tackling domestic abuse. Where leadership is well-developed and collaborative, services are more coordinated and responsive, leading to more consistent and effective help, support and protection.

In Norfolk, for example, domestic abuse is seen as a 'priority for everyone'. Relationships between agencies and strategic leaders are embedded and allow for constructive mutual challenge and problem-solving.

> **Good practice**
>
> Norfolk's domestic abuse strategy focuses on tackling the causes of domestic abuse and supporting all victims of domestic abuse. There is an evident synergy between partners and there are coherent governance arrangements for providing and overseeing the multi-agency response to domestic abuse at all levels.

This strategic response to domestic abuse affecting children was not always

evident. Several partnerships lacked a coherent domestic abuse strategy which sufficiently addressed the needs of, and risks for, children. Sometimes strategies were underdeveloped, or they were not yet embedded. Strategic oversight was sometimes fragmented, or insufficiently focused on children. With limited alignment across different boards, there was insufficient use of data to inform service development and the multi-agency response.

Some areas need to significantly strengthen their focus on domestic abuse and introduce a partnership approach to more fully understand need. They also need to make sure that specific support is available for children who are victims of domestic abuse.

Using partnership data intelligently, auditing, and taking into account the voices of children and families gives the local partnership an in-depth understanding of the needs of children and families at risk from domestic abuse in Norfolk. It also helps the local partnership understand the impact of the services that support them.

We saw instances where local needs assessments of children at risk of or experiencing domestic abuse were either absent or ineffective. Even when these assessments existed, they were not always consistently used to inform commissioning decisions. Some services were not effectively evaluated to better understand the impact they were having for children and their families, limiting the ability to measure effectiveness and improve outcomes.

Health data is often not shared with safeguarding partnerships, which limits the strategic understanding of the prevalence and impact of domestic abuse on children. Health services hold valuable data, yet this is not routinely included in multi-agency dashboards or strategic planning. This contributes to a lack of child-focused commissioning and oversight.

Access to services for children and families varies widely depending on location. Some areas have well-established commissioned services and integrated support, while in other areas, children and families face gaps in provision, long waiting lists, or lack of services for younger children. Commissioning decisions, for example in health settings, are not always based on a robust understanding of local needs, and data relating to children's needs is not always accurate. Services for children – especially younger children – are often underdeveloped or not tailored to their specific needs. Waiting lists and gaps in provision are evident, and commissioning efforts tend to prioritise adult victims over children.

Commissioned services such as independent domestic violence advisers (IDVAs), refuges and therapeutic support, where they are available, are valued. Our inspections found that children and families who used these services experienced positive impacts. However, they are not always available and are not always tailored to meet the needs of young children.

> **Good practice**
>
> There are strong governance arrangements in place in North Yorkshire. This

includes a well-considered, streamlined governance structure focused on the response to domestic abuse, which serves North Yorkshire well. The domestic abuse local partnership board reports directly to the children's safeguarding partnership, ensuring that adult services and the wider community are actively involved at a strategic level.

Representation of community groups, 'experts by experience' and commissioned services at a strategic level, alongside statutory partners, is well embedded in North Yorkshire. This invites both challenge and a multi-agency perspective on problem profiling in the county at both a local and strategic level. Contributions and involvement in identifying, monitoring and informing services are well-informed by learning from local and national reviews and policy changes. This extends to vibrant sub-groups that shape practice and learning across the partnerships.

Knowledge of practitioners, learning and training

In our inspections, we saw that where creative and well-structured training is in place, it leads to improved practitioner confidence and consistency. For example, in Hillingdon, targeted training has improved practitioners' ability to identify and support children affected by domestic abuse. In Redcar and Cleveland, virtual reality training is used effectively to raise awareness of the impact of domestic abuse on unborn children.

MASAs that include effective case auditing, with learning translated into timely, tracked action plans shared across agencies, lead to measurable improvements in the multi-agency response to children.

In some local areas there is insufficient single- and multi-agency training on domestic abuse and its impact on children, which is limiting practitioners' understanding of domestic abuse. This leads to inconsistent responses and missed opportunities to identify risk and provide timely support for some children. In particular, the understanding of coercive control is still limited. Where there is training, low attendance and weak evaluation of its quality undermine its impact.

One of the survivors who responded to our separate survey said:

> "I think services may have some training but it's clear to me from the response I had that they just don't understand. Domestic abuse training needs real investment and thorough training, including [involving] those with lived experience, that is vital. Coercive control must be at the heart of this, alongside [an understanding of] misogyny."
>
> (Female survey respondent)

Participants in the focus groups (which we ran separately from the inspections) described feeling that they were trapped in a vicious circle where seeking help led to being judged as a 'bad' parent who was failing to protect their children, while not seeking help resulted in being seen as neglecting their children's safety. This contributed to a perception that they 'can't win' with services. Another survivor discussed the staff skills and actions that had been beneficial to them:

> "What was helpful [was] trained staff who were DV [domestic violence] trauma informed and able to apply good communication skills. They were able to ask very good questions and assess the situation accurately. They were aware of other agencies [and] resources that would be helpful."
>
> (Female survey respondent)

Suitable accommodation for children and families at risk of domestic abuse

The Domestic Abuse Act 2021 created a new duty for local authorities in England to assess the need for, and provide, domestic abuse support in safe accommodation for victims and their children. A key part of this duty is that local authorities must now provide homeless people fleeing domestic abuse with priority need status for accommodation, removing the previous requirement for them to be assessed as vulnerable to qualify for assistance. The act also requires authorities to develop and publish strategies for providing this support, and makes it clear that victims should not be placed in unsuitable accommodation. We have seen progress in some areas in improving the range and type of suitable accommodation.

> **Good practice**
>
> Hillingdon continues to expand the housing stock through purchasing properties. There is strong local provision with a range of options to suit people's needs, including self-contained units for leasing, and refuges. There is specific IDVA support in the housing team.
>
> In Norfolk, there is a good range of quality-assured, suitable accommodation in place to meet need, including 'sanctuary support' to help parents and their children to live safely in their own homes. Children and parents living in safe accommodation are well supported by a range of skilled and experienced support workers and volunteers. Families are helped to achieve their next steps, with careful thought given to their move-on plan.
>
> In Hertfordshire, an array of in-house, commissioned, voluntary, community, faith and social enterprise services are providing children with the help they

> need to support their recovery. This includes the provision of safe accommodation and high-quality support for children who are living in this accommodation.
>
> Also, alongside other agencies, the local authority family safeguarding service provides specialist support to children, adult survivors and perpetrators. It is achieving very positive outcomes for many children and their families in tackling the root causes of domestic abuse, and in reducing risk.

Focus on children as victims in their own right

A consistent finding across most of the areas is the lack of recognition of children aged 0 to 7 as victims of domestic abuse in their own right. This lack of oversight significantly affects how their needs are assessed and addressed, often resulting in delayed or inadequate support and protection.

In many areas, responses to domestic abuse are insufficiently focused on children's needs. Children are sometimes seen as passive witnesses rather than individuals directly experiencing harm. The emphasis tends to be on non-abusive parents needing to take actions to protect children, while there is a lack of attention on the perpetrator, which can lead to ineffective safeguarding of children. We saw examples where this meant that assessment, planning and service delivery were primarily focused on adults' needs rather than having a child-centred approach within a whole family focus which addressed the specific needs of children. For example, some children are being described as 'indirect victims' by probation services or 'caught in the crossfire'. This language minimises children's experiences and highlights the need for a shift in professional understanding and language.

Failing to fully understand the risk to children can result in delayed referrals and delays in child protection strategy meetings, when children may be at risk of significant harm. There is not always a comprehensive understanding of children's lived experiences of domestic abuse, which results in limited recognition of both the impact on the child and their current level of risk. A strong focus on single- and multi-agency training can support practitioners in their knowledge, identification and response to children as victims of domestic abuse.

Professionals' lack of understanding was also evident in our separate engagement work with parents. When asked whether they felt that their children were recognised as victims of domestic abuse, only a small proportion (8%) of survey respondents said this was fully the case. The majority reported that their children were either only partly recognised (39%) or not recognised at all (53%). Some survey respondents told us that their children had been recognised as victims of domestic abuse by domestic abuse support services but not by other services:

> “The only services that recognise my son as a victim of domestic abuse are those that are specific in domestic abuse.”
>
> (Female survey respondent)

> “My child has witnessed multiple incidents of my ex-partner abusing me, yet none of the services have ever recognised this or provided her with any support… children’s voices don’t seem to matter to these people and the services which should be there to protect them, fail them miserably.”
>
> (Female survey respondent)

Some parents described ongoing effects of their children’s abuse, and the lack of support, such as their child dropping out of school because of mental health issues.

A child-centred approach within a whole family focus means that there should be an effective approach to holding perpetrators to account for the impact they have on both adults and children in the family. Probation services often focus on adult victims and perpetrators, and give insufficient attention to the risks posed to children. In several areas, assessments failed to consider the full impact of domestic abuse on children. This narrow view leads to harm being underestimated and safeguarding opportunities being missed.

The importance of understanding the voice of the child and direct work

Listening to, and responding to, the voice of the child is essential to understanding their lived experience of domestic abuse. Strong practice includes creative and tailored direct work, especially with younger children and those with special educational needs and/or disabilities (SEND).

We saw some examples of strong practice in the quality of relationships that practitioners build with children and families, supported by creative, child-centred direct work. Tailored approaches – particularly for very young or non-verbal children – help practitioners better understand children’s lived experiences.

> **Good practice**
>
> In Hillingdon, visual tools were being used very effectively to capture children’s experiences of domestic abuse, demonstrating the value of innovative engagement methods.

> In Hertfordshire, we saw evidence of strong practice in children's social care and health services. The wishes and feelings of children aged 0 to 7, including disabled children, are well recorded and used to inform next steps and to identify risks. Practitioners use observations and play to understand children's experiences and learn what their wishes are. For some children, using the child's own words in records is helping adults in the family to really hear and understand the child's experiences.
>
> In North Yorkshire, early help professionals and social workers carry out particularly impressive work to engage children in difficult conversations, regardless of their age and learning ability. They use a wide variety of tools which help them to understand children's views and wishes. For example, they skilfully identify 'circles of safety' for children and explore what makes them feel afraid using bears and buttons, stories and senses.
>
> This direct work is used effectively to ensure that social work remains child-centred and that children's experiences inform planning and intervention.

Health practitioners use creative methods to engage children, especially those with SEND or communication needs. However, there is a lack of consistency across the partnerships in recording and incorporating children's voices into health records and safeguarding decisions. This inconsistency disproportionately affects younger children, those with additional needs and those from diverse backgrounds.

Mothers in our focus groups told us that, in several cases, professionals declined to speak with or interview children about their experiences of domestic abuse – including related abuse such as child sexual abuse – citing concerns about causing trauma. As a result, children's voices were not heard, the impact of abuse was not recognised, and no action was taken. This left children in ongoing contact with perpetrator-parents, and at continued risk of harm.

Children's voices are rarely captured in probation assessments or case records. This lack of child-centred engagement contributes to weak analysis of risk and undermines multi-agency planning.

Across all areas, police officers do not consistently capture or reflect the voice of the child in their reports or safeguarding referrals. While some forces have made improvements, such as using child-focused prompts, the child's lived experience is often absent from police documentation. In agencies where this has been captured well, good practice is not always shared. This limits the ability of other agencies to understand the full impact of domestic abuse on children.

> **Good practice**
>
> In Norfolk, the voices and experiences of children and families are central to needs analysis and service development, and co-design and co-production with children are a strength for the partnership. Children contribute to the

development of strategic plans, which are written in a way that they can understand. Children have been instrumental in designing specific services to support them as victims of domestic abuse. Leaders regularly hear from children to learn from their experiences to help improve domestic abuse support and services even further. For example, leaders have advocated powerfully about the need for self-help resources and have contributed to the production of a mindfulness guide and anxiety handbook.

Having IDVAs embedded in hospitals and health services is a significant strength. They provide timely support to adult victims and contribute to safeguarding unborn and young children. The presence of IDVAs improves information-sharing, safety planning and multi-agency coordination. Embedding them in key settings like hospitals and social care teams helps to ensure timely, expert support.

Good practice

In Norfolk, IDVAs are also based in acute hospitals, which means that practitioners have an improved understanding of domestic abuse and offer prompt support. The IDVA in Hillingdon Hospital is highly respected and plays a valued role, contributing to improved safety planning and victim support.

Some participants in the focus group said that they initially had positive engagement but that this was not sustained, leaving them without ongoing support and unsure where to turn.

"…early years was absolutely fantastic and they're the ones that actually worked with us for about a year. And when I was stronger, pointed out that it was a domestic abuse relationship and now that I was stronger, I would need to take action… and they supported me through that. And then the worker's role changed and it seems to have all fallen apart then. So that initial support was really there, police were there… school were on board and 6 years later [it's gone] and my children have been taken."

(Focus group participant)

During these inspections, we found that some fathers do not feature strongly enough in multi-agency work with their children. We saw stronger practice in Norfolk, where the partnership is committed to including fathers. Its assessments include resident and non-resident fathers whenever possible and its frontline practice includes a range of innovative programmes designed by fathers for fathers.

Good practice

> In Hertfordshire, a referral was made for a 2-year-old child by health services, following a significant injury to a parent during a domestic abuse incident. The child witnessed the incident. This was not the first domestic abuse incident in the home and there had been a pattern of parental separations and reconciliation, as well as previous concerns about domestic abuse in previous relationships for the non-abusing parent. Police issued a DVPN as a protective measure. The protective parent was considered a high-risk domestic abuse victim and appropriate support was provided to them and reviewed in a MARAC. Partners across early years, health, children's services, police, and probation and housing services worked effectively to address the changing needs and risks to the child and protective parent.
>
> Appropriate and timely decision-making and robust safety planning helped the child and their parent to remain safe. Alternative accommodation was identified to help them to safely rebuild their lives. The child was clearly seen by some practitioners as a victim of domestic abuse and received intensive trauma-informed psychological support to help them to understand their experience and to make sense of their separation from the abusing parent. The protective parent has benefited from the support of specialist practitioners in the family safeguarding service, alongside the IDVA and housing support. The child protection plan was stepped down to a child-in-need plan to reflect the progress being made. The risk of further emotional and physical harm to the child is central to practitioners' planning. Practitioners are good at recognising and being aware that domestic abuse can continue after parents are separated; they know that the likelihood of reconciliation with an abusive partner cannot be minimised.

Early help, schools and preventative services

The purpose of early intervention is to 'reduce risk and escalation of harm, reduce repeat referrals and reported incidents, increase confidence for child and adult victims and survivors and lessen the potential for immediate harms to result in longer term impact.'[footnote 15]

The Domestic Abuse Commissioner outlines a broad range of prevention activity that can help to build a culture of equality and respect across a community and stop abuse happening before it occurs. These include:

- universal communications campaigns
- social-emotional development programmes for children and young people
- prevention programmes for men and boys
- community outreach programmes and peer groups for marginalised communities

However, for early intervention to work effectively, universal and frontline services

must recognise their role in providing early identification opportunities.

In our inspections, we found that early intervention through family hubs, health visitors and community services plays a role in reducing harm and preventing escalation.

In Hillingdon, for example, family hubs located in local communities provide a calm and welcoming environment for children and their families, who can access a comprehensive range of multi-agency early and targeted help support services. This supports developing effective relationships and therefore identification of domestic abuse.

Early years providers and schools in Hillingdon build open and trusting relationships with young children and their families and engage well in multi-agency planning for vulnerable children. Regular safeguarding audits in early years settings are helping to raise awareness and practice responses to domestic abuse.

> **Good practice**
>
> In Norfolk, referrals are taken over the phone by consultant social workers, who work to the principle of 'never do nothing'. These rich and detailed conversations quickly help to identify the level of need and risk for children and what interventions and support are needed to help safeguard and support children as early as possible. This ethos of collaborative conversations, together with early help support, is providing an effective response to children experiencing domestic abuse and is helping to improve their lives.
>
> In Hertfordshire, inspectors met parents who were incredibly positive about their involvement in a programme aimed at preventing the escalation of domestic abuse. One parent described the impact of the group work as 'life changing'.
>
> Children's centres based in local communities in Reading provide a valued multidisciplinary response for vulnerable children and their families who are, or may be, victims of domestic abuse. Parents are offered a range of universal and targeted group programmes, as well as one-to-one work programmes that parents, including new fathers, value. This work has a positive impact and reduces risks for many children at this early point of intervention. The One Reading Partnership Hub provides a safe space for families who are victims of domestic abuse to seek advice about how they can be best supported. The partnership hub offers consultation and facilitates multi-agency meetings which help practitioners to be reflective and curious about historic and cumulative risk, in order to reduce the impact of domestic abuse. This impacts positively on outcomes for children.

Despite these examples, good practice was not consistent enough across all partnerships.

Feedback from our survey highlighted the critical role played by the voluntary and community sector, alongside specialist domestic abuse services. These were consistently identified as the most helpful sources of support. GPs and mental health services were also viewed positively. In contrast, statutory agencies were often perceived as less helpful, underscoring the importance of the voluntary sector in meeting survivors' needs (see Table 1 in Annex B).

Multi-agency working and information sharing

Effective safeguarding depends on timely, consistent information-sharing between key agencies such as police, health, probation and social care. However, we saw inconsistencies and gaps in communication leading to delays in assessing risk and providing support to children. Information held by different agencies about children, adult victims and perpetrators is not always systematically shared or drawn together by the network of professionals involved with children, limiting their ability to form a complete picture of risk. There are a range of reasons for this, including a lack of effective systems to share information, and agencies not equipping practitioners and managers with knowledge about when to share information. This reflects an inconsistent understanding nationally about when information about safeguarding children should be shared.

Our findings from inspection were also reflected in our focus groups with parents. Focus group participants described services as fragmented and disjointed. We heard that agencies did not communicate effectively, worked in silos, and sometimes operated in ways that conflicted with one another. This lack of coordination contributed to inconsistent and ineffective support:

> "I feel like I've spent the last near-7 years since I left this relationship being bounced from one place to another, no one wants to assume responsibility or help… help you in any way, shape or form."
>
> (Focus group participant)

In a family, the risk of domestic abuse to all children is not always considered. For example, some children, especially those not directly involved in incidents (such as half-siblings or children in other households), are sometimes overlooked in multi-agency discussions, leading to missed safeguarding opportunities.

We saw some examples of complex strategy meetings, but in one area these were not taking place when offenders posed a potential risk to a number of children who lived in different households and across different local authorities. These are missed opportunities to share information, to track and assess the risk perpetrators pose, and therefore to have a holistic assessment of risk for all relevant children.

The probation service contribution to the multi-agency approach is variable. While some areas show improvement, such as probation representation in the multi-agency safeguarding hub (MASH) or proactive safeguarding referrals, contributions remain inconsistent. Strategic links between probation and safeguarding partnerships are still underdeveloped, and operational engagement in multi-agency meetings is variable. Improvements are underway, but not yet embedded. Insufficient coordination between probation and the partnership means that children are not always effectively protected.

Police forces overall were using legal powers (like the Domestic Violence Disclosure Scheme, known as Clare's Law, or DVPNs) more effectively to help prevent escalation and protect victims than we found in our previous JTAI. In Hillingdon, police have allocated dedicated resources to managing perpetrators, and officers can request a dedicated arrest team.

Police forces across the areas inspected do have systems to share referrals about domestic abuse. However, these mechanisms are often underused when it comes to sharing other critical information. As a result, information-sharing between police and partner agencies is often inconsistent and subject to delays. In several areas, police do not routinely share key data such as records of previous incidents, bail conditions, or the outcomes of Clare's Law disclosures. This lack of systematic sharing undermines multi-agency risk assessments and safety planning, especially when children are involved.

In all areas, police lead on Clare's Law, overseeing both the 'right to ask' and 'right to know' processes. While this is appropriate, risks are not always shared with partner agencies. As a result, other professionals may remain unaware of critical risks to children and adult victims. This lack of coordinated information-sharing undermines the effectiveness of multi-agency safeguarding efforts. It was not evident that all professionals from other agencies were aware that they can request the right to know under Clare's Law on behalf of an adult who is at risk of domestic abuse.

Operation Encompass is widely recognised as a valuable safeguarding initiative, helping schools and early years settings provide support to children following domestic abuse incidents. While Operation Encompass generally has a positive impact, it can be less effective in some areas due to delays in police notifications and a lack of detail in the information shared. This hinders the ability of education staff to deliver timely and tailored support for children who may be in distress.

Operation Encompass is well established in Redcar and Cleveland where referrals are received by schools, early years providers and health services.

In most areas, police officers and staff co-located in a MASH have access to social care systems; this supports timely decision-making and information-sharing. This arrangement is a strength, helping police contribute meaningfully to safeguarding discussions and enabling better coordination with children's services.

Engagement in multi-agency meetings is inconsistent across services, with limited

participation from some key partners such as probation officers and adult mental health professionals. We did not see inclusion of general practitioners (GPs) at multi-agency meetings in any of the areas we visited. This limited the effective sharing of information and therefore the ability to ensure there was a full understanding of the child's experience.

When professionals from different agencies were co-located in integrated MASHs, this enabled timely, informed decision-making.

> **Good practice**
>
> In North Yorkshire, daily multi-agency domestic abuse screening meetings in the multi-agency safeguarding team (MAST) encourage professional challenge and reflection on the best way to support families. Similarly, multi-agency daily group discussions about more complex situations and families minimise the need for parents and children in crisis to repeat their story unnecessarily. This helps to inform decisions about risk to children, including whether escalation to a strategy discussion is required.

We saw good examples of professional curiosity. Some health professionals – especially midwives, health visitors and emergency responders – demonstrated particularly strong professional curiosity in their practice.

> **Good practice**
>
> In Redcar and Cleveland, ambulance call handlers and crews show high levels of professional curiosity. They use enhanced alerts and safeguarding flags to inform their responses. Practitioners in the emergency operation centre and ambulance crews ensure that children are appropriately referred to safeguarding teams.
>
> Ambulance practitioners are often the first service to respond when children are experiencing domestic abuse in their home. Call handlers in the emergency operation centre have received additional training to help them be professionally curious and remain alert to signs of domestic abuse involving children. The ambulance service has enhanced systems which include police and probation alerts on its records, linked to people and addresses. These alerts notify both call handlers and clinical practitioners of known victims and perpetrators of domestic abuse. There are also safeguarding alerts on the patient records of children who are subject to child protection plans or are in care.
>
> This effective multi-agency information-sharing ensures that ambulance practitioners are well informed and equipped to respond appropriately when dealing with emergency callouts. For one young child, the risk of domestic abuse was identified early. The call handler listened carefully to the background noise while recording details of the emergency. She noted the

> presence of a verbally abusive and highly agitated adult alongside a distressed young child. Swift action ensured that both an ambulance and police were dispatched to the address. The use of a sensitive and detailed approach by the ambulance crew on scene provided further detailed information about the child's emotional and physical presentation, the family dynamics and the home environment. For this child, the multi-agency information gathering and assessment of risk resulted in effective decisions and response from children's services.

However, this is not consistent across all health settings. In some cases where health services have concerns about domestic abuse, assessments are primarily focused on adult victims, and opportunities to explore the child's experience are missed. Primary care and probation-linked health services often show the greatest variability, which means risks to children are not effectively identified and shared.

> **Good practice**
>
> There was good joint working with the substance misuse service in Redcar and Cleveland. 'We Are With You' (WAWY) drugs and alcohol rehabilitation services are members of the Thrive partnership, which is an integrated domestic abuse, drug and alcohol service consisting of key delivery partners, plus Redcar and Cleveland Borough Council's vulnerabilities and housing advice and information teams. Co-located WAWY staff work jointly with social workers, conducting home visits, and are part of children's reviews and core groups. This means that parents with substance misuse issues benefit from simultaneous support in relation to domestic abuse as well as their addiction.

Multi-agency risk assessment conferences (MARAC) and multi-agency public protection arrangements (MAPPA)

The quality and consistency of the multi-agency approach to managing high-risk domestic abuse is variable, and there is sometimes an insufficient focus on the risk to children from domestic abuse, which leads to insufficient safety planning for some children. MARAC and MAPPA are key multi-agency forums to manage significant risk to victims of domestic abuse. These processes are not always sufficiently integrated into the wider multi-agency system to support and protect children, which can result in missed opportunities to protect children.

The oversight and effectiveness of MARACs is inconsistent across areas, with variable engagement from key partners. Discussions sometimes focus primarily on adult victims and specific incidents, with insufficient consideration of patterns of behaviour and the consequent risks and impact of domestic abuse on children. In some areas, practitioners lack clarity on how to refer cases to the MARAC, nor

do they understand its purpose, leading to underutilisation. Additionally, outcomes from MARAC meetings are not consistently shared with relevant professionals, limiting their ability to contribute to effective safety planning for children.

When MARAC arrangements worked well, we saw how this made a significant difference for children. Effective information-sharing resulted in the early identification of risk, which enabled child protection processes and other safety arrangements to be put in place. For example, supplying doorbells with built-in security cameras to families experiencing domestic abuse and monitoring data from them as part of safety plans helped to increase feelings of safety, including for children.

> **Good practice**
>
> For one child in Hertfordshire, agencies worked together effectively through strong information-sharing. The MARAC was well attended by a range of agencies. This led to good information-sharing through MARAC and child protection processes, which enabled the identification of the level of risk that the perpetrator posed to the child. Effective multi-agency planning, including the participation of probation services in MARAC and child protection processes, supported appropriate action to safeguard the child.
>
> This reflects the importance of professionals being clear about the role of MARAC and child protection processes. They need to understand the responsibility and decision-making processes of each forum, and the importance of joining up rather than working in isolation.

Risk assessment and safety planning

Effective safety planning and risk assessment are essential to protect children from domestic abuse. We saw a good example in North Yorkshire of prevention and early support, which, alongside good use of legal remedies including non-molestation orders, DVPOs and anti-stalking legislation, both support victims and hold perpetrators to account.

> **Good practice**
>
> In Redcar and Cleveland, the police force control room staff consistently use the ‘threat, harm, risk, investigation, vulnerability, engagement’ (THRIVE) risk assessment model to determine the appropriate level of response to domestic abuse incidents. This tool helps police determine the level of threat, harm and risk, while also taking into account the victim’s specific needs and vulnerabilities. When responses are delayed, incidents are systematically reassessed to ensure risks are managed effectively in order to provide a quicker response to non-emergency domestic abuse.

However, in other areas we saw examples of delays, a lack of holistic assessments, and an over-reliance on non-abusing parents – typically mothers – without sufficient accountability for perpetrators. Risk assessments do not always capture the cumulative impact of domestic abuse well enough. When safety planning is not adhered to, this is not always robustly challenged. This allows some harmful parental behaviours to continue.

Probation services are not consistently realistic about the delivery of interventions for perpetrators. For example, they sometimes state that domestic abuse interventions will be delivered when, in reality, delays or capacity issues prevent this. This undermines assessment, planning and intervention by safeguarding partners, who assume work to reduce risk is underway when it is not. However, when perpetrators access effective interventions, this can make a significant difference.

On one inspection, the importance of accessing the right intervention was highlighted. When inspectors met with a group of victims and survivors, they spoke positively about how completing a specialist domestic abuse programme had helped them to understand the powerful impact of domestic abuse on themselves and their children.

Safety plans sometimes rely on non-abusing parents (usually mothers) being held responsible for protecting their children without holding perpetrators accountable. Mothers that we spoke to in our focus groups felt that the responsibility to protect their children – while also ensuring their own safety – was placed solely on them. One participant reflected:

> “[The SEND officer] sat in the review meeting and told me that it was my responsibility to make sure that my ex-husband understands his children and treats them right. She literally said that to my face… and that’s the attitude… it is the woman’s responsibility that her ex-partner, the dad, whoever it is – the other parent – treats them [the children] right, and it’s not OK.”
>
> (Focus group participant)

The inherent risks to non-abusing parents, and their ability to protect themselves and their children, is not always appropriately assessed and understood, particularly the impact of coercive control and the recognition that adult victims are not responsible for, or able to control, perpetrators’ behaviour. When good safety planning that supports the non-abusing parent does take place, this can be undermined by these plans not being shared with other agencies and practitioners, who are therefore not aware of the actions that need to be taken to keep children and adult victims safe.

Operational practice varies significantly, with some practitioners demonstrating

strong awareness of the needs of children, and others lacking consistency in applying thresholds, sharing information and engaging with children. This variability affects the quality and timeliness of support.

Cultural competence also varies widely. Understanding families' cultural, religious and linguistic backgrounds is critical to protecting and supporting children and improves engagement and safety planning. While some areas, such as Hillingdon, show strong understanding of how culture, ethnicity and religion intersect with vulnerability and resilience, in others, children's unique identities are not sufficiently reflected in assessments or plans. A lack of understanding of the individual culture and experiences of families can hinder engagement and effective safety planning.

> **Good practice**
>
> In North Yorkshire, police officers and staff demonstrate a strong understanding of the importance of completing public protection notices for children, due to their extensive training.
>
> The force also benefits from a specialist stalking prevention team which plays a key role in arresting prolific perpetrators of both online and in-person stalking and harassment – particularly in the critical window after victims have left their abusers. When victims feel unable to proceed with a prosecution, the police proactively seek evidence-led prosecutions or apply for DVPNs to protect children and reduce ongoing risk.

> **Good practice**
>
> In Reading, we saw successful assessment practice and work within the family help service. Practitioners across the partnership work well together through multi-agency meetings, in which they discuss how to support children and their families to transition from statutory involvement to family support. This includes how partners can provide support, for example pastoral support in schools or referral to voluntary sector organisations for various programmes to prevent domestic abuse.
>
> Family help assessments are timely. They report comprehensively on risks children face from domestic abuse. Family help workers have received training on domestic abuse assessment, MARAC and domestic abuse, as well as trauma-informed approaches.
>
> Practitioners use a variety of approaches and tools to understand children's experiences and seek their views. Observations of very young children inform assessments when they are too young to express themselves verbally.

The impact of a lack of effective risk assessment, insufficient challenge by professionals and agencies, and overoptimism that change had already been

achieved has led to poor decision-making in some cases, including inappropriately ending a child protection plan. This can have the unintended consequence of increasing risk. Under the national approach to managing probation workloads, which was in place at the time of the inspection, probation contact with the perpetrator and involvement in multi-agency working for the child may end in some cases once a child protection plan is no longer in place. This potentially leaves gaps in oversight of perpetrators and safeguarding of children.

> **Good practice**
>
> In Norfolk, practitioners work closely with children and their families to develop multi-agency safety plans at an early stage. These help to mitigate risk and ensure children and families understand and agree with plans that help to keep them safe. These are developed through sensitive direct work with children, which helps them develop and understand their own age-appropriate safety plan. Often, these plans draw on the family's 'natural network' (supportive people around them like family and friends) to support children and to sustain the progress made.

The impact of coercive control on children is not always sufficiently explored. In one case we saw, practitioners did not fully consider the full range of protective measures that could be used by probation services to manage the risk posed by a high-risk domestic abuse perpetrator. While several practitioners in the multi-agency network did not agree with the decision to end the child protection plan, they did not formally escalate their concerns. This decision was exacerbated by probation services withdrawing once the case was stepped down in line with guidance that was in place at the time of the incident to manage capacity.

Unborn babies

Most areas have mechanisms to identify risks to unborn children, such as pre-birth panels or specialist teams. However, access to specialist support is not always equitable; in one area, only first-time mothers or those who had previously had children removed receive specialist support, leaving others without the same levels of support. Midwifery teams play a critical role in the multi-agency response, showing professional curiosity, using screening tools effectively, and providing tailored support to pregnant women. However, their reach and integration with other services can vary, limiting opportunities to protect unborn children from domestic abuse.

Early intervention with unborn children and their families is an effective approach to identifying and reducing risks before birth. In Norfolk, practice around unborn children at risk of domestic abuse is a particular strength. Practitioners undertake early safety planning, and families receive timely access to appropriate services and support.

Good practice

In Redcar and Cleveland, effective work by the 'Indigo' midwifery team and the social care pre-birth team demonstrate strong multi-agency collaboration, ensuring prompt information-sharing and interventions that are focused on the needs of the unborn children.

In Reading, the multi-agency 'vulnerable people pre-birth panel' identifies risks to unborn children and offers early protective interventions and assessments before birth. Regular review of these unborn babies' circumstances allows the partnership to give early support and consider interventions to reduce risks. This includes a valued specialist midwifery team, which provides additional support to families before and after birth.

In North Yorkshire, a midwife raised concerns about domestic abuse for one child, who was unborn at the time of our inspection. An immediate referral was made early in the pregnancy, enabling timely information-sharing and a comprehensive risk assessment. Practitioners, including social workers and midwives, built a trusting relationship with the family, underpinned by a strong understanding of their specific cultural needs.

A multi-agency approach was adopted, involving a specialist safeguarding midwife, health visitor, a commissioned domestic abuse support service, and a targeted education programme for the child's father.

Joint planning, analysis and evaluation, ensured that the desired changes had been made before the baby was born. In parallel, in-depth, culturally sensitive, pre-birth assessments identified support within the family that created a sense of safety for both parents and helped the mother grow in confidence.

As a result, the family is now in a strong position to apply what they have learned.

Conclusion

It is important to recognise the good work that practitioners, the voluntary and community sector, statutory agencies and local partnerships are doing. In addition, the government's focus on domestic abuse through the Domestic Abuse Act 2021 and its freedom from violence and abuse strategy is a very positive step forward. However, there is still a need for more emphasis on providing support so that children can stay safely in their family, or, where necessary, on acting swiftly to protect children from significant harm. The findings of this report need to be seen in the broader context of the financial and other challenges that public services currently face. To embed improvements and sustain effective practice, long-term multi-agency investment is needed in directly delivered and commissioned

services responding to local and national needs analysis.

The most striking finding in our JTAIs was the wide variability between local areas in relation to the multi-agency response experienced by children who are victims of domestic abuse and their families. Following our previous JTAI report The multi-agency response to children living with domestic abuse: protect, prevent and repair, and despite the implementation of the Domestic Abuse Act 2021, there have not been the consistent improvements in all areas that we hoped to find. Some of the same themes for improvement remain since the last JTAI and seem hard to shift.

Although the Domestic Abuse Act 2021 recognises children as victims of domestic abuse if they have seen, heard or experienced the effect of the abuse, there is an insufficient understanding at a strategic level across local partnerships about what it means for children to be victims of domestic abuse. Consequently, we saw too many instances in practice where children were not recognised as victims in their own right. This needs urgent action. It is important to 'think family, but think child too'.[footnote 16] As stated in Working together to safeguard children, what is needed is a child-centred approach within a whole family focus.

Government and agencies need to do more to ensure the intention of the Domestic Abuse Act 2021 is realised in the experience of children and their families. It is critical that government and agencies work together to ensure they are sufficiently focused on the child's needs, and that at a strategic level and practice level children are both seen and responded to as victims in their own right.

Supporting and protecting children from domestic abuse cannot be achieved by single agencies alone. To reduce the suffering of children from domestic abuse, agencies need to work effectively together and with their communities. This requires a collective commitment from all agencies working with their communities and provision of robust oversight through effective multi-agency working. The system for protecting children needs to be more integrated; for example, MARAC needs to be integrated into the wider system to help and protect children.

What works well in terms of a multi-agency response to children should be further disseminated to relevant agencies, so that the goals of the Domestic Abuse Act 2021 in this regard can be fully implemented. There needs to be a relentless focus on the child's voice and experience, and the good practice cited in this report needs to be more consistently demonstrated across and within local areas. The 'postcode lottery' for children needs to be addressed. Commissioning needs to be informed by children's views and experiences alongside robust needs assessment and evaluation of practice and services. There needs to be a greater focus on timely help and protection for children.

It is good to see an increased focus on perpetrator management in some areas, although more work needs to be done to achieve this fully. It is critical that perpetrators have access to timely, good quality interventions and this needs urgent attention.

Information sharing remains a challenge, as our JTAIs have consistently highlighted. Information held by different agencies about children, adult victims and perpetrators is not always systematically shared or drawn together by the network of professionals involved with children, limiting professionals' ability to form a complete picture of risk. We need to grasp the opportunity created through the Children's Wellbeing and Schools Bill, alongside the government's focus on ensuring that there is clarity across agencies and systems, and that processes support effective information sharing.

Cultural competence also varies within local areas. Understanding families' cultural, religious and linguistic backgrounds is critical to protecting and supporting children. It is clear that a cultural shift is required in how all agencies understand and view the impact and risk to children who are victims of domestic abuse, putting more emphasis on children's voices and lived experience. There also needs to be increased focus on prevention and early help, and good practice in this area needs to be further disseminated.

Domestic abuse needs to be viewed as a public health issue. The government needs to do more in its messaging to promote zero tolerance of domestic abuse in all relationships, and to challenge negative and misogynistic views of girls and women in society, as domestic abuse is predominately a gender-based issue. At the same time there needs to be a recognition that domestic abuse can happen in all relationships so that boys and men can also receive the help and protection they need.

At the time of writing this report the government has published Freedom from violence and abuse: a cross-government strategy. The aims of the strategy address our findings effectively and we welcome the ambition and priority given to tackling violence and abuse.

In the executive summary, it states: "Ending violence against women and girls (VAWG) is a moral mission for our whole society and it will require a whole of society effort to achieve it. Our mission prioritises prevention, focused on addressing root causes, the relentless pursuit of perpetrators, and comprehensive support for victims and survivors. The cultural norms and misogynistic attitudes that enable and inspire this violence permeate every part of our country – from family homes, schools and workplaces to our streets, sports clubs and local communities."[footnote 17]

We strongly support the emphasis on prevention, holding perpetrators to account and supporting victims, and we endorse the 'whole society' approach. Government and agencies need to cultivate an even greater sense of urgency and make it a priority to build on these positive developments towards helping and protecting children who are victims of domestic abuse. There should be a relentless focus on recognising children as victims in their own right and on aligning this work in the wider multi-agency work of supporting children to stay safely in their families and, where necessary, taking swift action to protect them from harm.

How to get help

We understand that the contents of this report may be upsetting for some readers. If you would like to talk to someone or feel you need help or advice about domestic abuse, you can access support and helplines:

- I need help – Domestic Abuse Commissioner
- National Domestic Abuse Helpline – a freephone, 24-hour helpline: 0808 2000 247
- Domestic abuse: how to get help

Annex A: detailed research methods

Research questions

The overarching question guiding this JTAI and thematic report was:

How effective is the multi-agency response to children who are victims of domestic abuse?

The JTAI inspections and research activity aimed to understand:

- the strategic response to children who are victims of domestic abuse at the point of identification
- the assessment, planning and decision-making in response to notifications and referrals of children who are victims of domestic abuse
- the protection, support and care for children who are at risk or have been victims of domestic abuse
- the work to prevent children becoming victims of domestic abuse
- how much are children treated as victims in their own right and given effective support
- what progress there has been since the previous JTAI on this topic

Data collection

To help us answer our questions, we held focus groups with lead inspectors and team inspectors from each of the 6 inspections. We held 2 focus groups per area:

- lead inspectors from each inspectorate to cover the strategic and leadership arrangements
- inspectors who were involved in tracking individual children's cases to cover details of the child's experience

Focus groups included inspectors from Ofsted's school and social care remits, as well as those from HMICFRS, HMI Probation and CQC.

Where it was not possible to meet with all inspectors, we sought written feedback via Microsoft Forms.

Data from focus groups was analysed thematically alongside other inspection information (for example, inspector notes) using MaxQDA software.

Terminology

There are so many organisations and agencies that have a part to play in responding and supporting victims of domestic abuse. We have therefore referred to partnerships, or partners, to describe the local multi-agency working between the local authority, police, healthcare services, probation services, and so on.

Limitations

Domestic abuse is a broad topic and these inspections could not cover all aspects of it. For example, child-to-parent abuse and teenage relationship abuse (between teenagers under the age of 16) are not covered by the definition in the Domestic Abuse Act 2021, so were not in the scope of these JTAIs.

Given the younger age range that we focused on, we evaluated the role of probation services in relation to the multi-agency response to children who are victims of domestic abuse, but we did not evaluate the role of youth justice services.

Findings are based on inspections in 6 local authority areas; this sample was not nationally representative. And because we focused specifically on younger children, we recognise that our findings are not representative of all children who experience domestic abuse.

The DAC's Voices panel, through which we found survey and focus group participants, is a group of domestic abuse survivors who have put themselves

forward to be involved in policy and research opportunities. As such, they are not necessarily representative of all survivors.

Annex B: engagement with survivors of domestic abuse

Although we spoke to survivors of domestic abuse in the course of our inspections, we wanted to make sure that we heard about a range of experiences to help us put our findings into context. This included understanding the lived experiences of children experiencing domestic abuse through the voice of their parents.

The Domestic Abuse Commissioner (DAC) published a report on their research with children, 'Victims in their own right?', in May 2025.[footnote 18] This research covered children's experiences of agencies, including the police and social services.

We therefore decided not to commission any further work directly with children as it would be unethical to engage with children on this sensitive issue when there was current and newly published data available. We worked closely with the DAC research team who developed their report and have drawn on the findings throughout.

For further insight, we worked with the DAC's office to engage with adult domestic abuse survivors, to hear about their experiences of engaging with services and how their children were supported. This engagement had 2 elements. The findings from this separate engagement did not feed into any of the inspection findings from any of the areas visited. They are used purely to add context from a survivor's point of view about many of the things we saw across the JTAI visits.

Survey of adult survivors

We used the DAC's VOICES at the DAC panel to identify and survey a broad group of survivors. We received responses from 81 participants, the majority of whom (67%) were parents. Although these survivors do not necessarily live in the areas that we inspected, their experiences of multi-agency responses were extremely valuable.

The respondents, primarily women, shared information about which agencies had been helpful, what kind of support they had received, and whether agencies treated their children as victims in their own right.

Of the 81 survivors who responded to the survey:

- the majority were women (63 females, 10 males)
- 69% were of White British ethnicity
- the majority had children aged 8 or older; a smaller proportion had children aged 7 or younger
- over half reported physical or mental health conditions (ADHD, PTSD, anxiety, depression, and so on)

The services that most respondents found useful were specific domestic abuse services (83%), other charities (66%) and GPs (61%):

Table 1: Helpfulness of services contacted or received support from in the last 2 years

Service	Helpful (N)	Helpful (%)	Unhelpful (N)	Unhelpful (%)
Police	20	30%	44	67%
GPs	39	61%	17	27%
Mental health services	33	56%	21	36%
Social services	8	17%	33	70%
Domestic abuse services	55	83%	10	15%
Other charities (non-domestic abuse – specific support)	31	66%	10	21%
Schools	16	33%	25	51%

Many parents described inconsistent experiences with services. While some reported receiving effective support, others described the same services as patchy or unhelpful in different circumstances. This variability suggests a need for greater consistency in service delivery and trauma-informed practice.

The men we heard from in our survey reflected on the lack of services for male survivors of domestic abuse:

> “Men’s services are desperately lacking… with massive under-reporting and huge under-funding, with staggering male suicide figures… a lot needs to be done… When new initiatives and strategies are being planned there has to be provision for men and women.”
>
> (Father)

Figures suggest that women make up a large majority of victims of domestic abuse.[footnote 19] This was reflected in our inspections: we heard primarily about the experiences of mothers and their children. Although this is a gendered issue, it is not clear-cut that victims are always women and perpetrators are always men. The experiences of men, especially fathers, as well as those who are LGBTQ+ or who have SEND, should not be forgotten when services are planned and designed.

Focus groups with survivors who were mothers

We asked survey respondents if they would be willing to speak to us and commissioned an external expert in violence against women and girls to help us run 2 focus groups. In these, we spoke with 10 mothers who had experienced domestic abuse, to better understand their interactions with services and the impact on their children.

As the number of women we spoke to was small, the findings are not representative of all mothers who have experienced domestic abuse. They were not recruited from the areas visited as part of the JTAI, so findings from the groups cannot be directly compared with what we found in these areas. However, their experiences provide a useful insight into some of situations faced by domestic abuse victims and their children.

The women represented a range of ethnic backgrounds, ages and experiences, including differences in the age of their youngest child and whether they had special SEND.

Our focus groups included only mothers for a few reasons:

- The sensitive nature of the topic, and the fact that the women we heard from had largely experienced traumatic experiences due to men, meant it would not have been ethical to have both women and men talking together.
- As fewer men responded to the survey, the number who volunteered to talk to us was very low.
- The experiences of men were different to those of women and warranted separate discussion. For example, men experienced different expectations and engagement with services, such as police or the courts. They also reflected on the sensitivities around being a male victim of domestic abuse and the stigma surrounding this.
- As male victims did not come up as a theme in our inspections, we decided to concentrate on findings that could help contextualise what we heard on inspection.

Although we did not speak to male survivors for this project, further research or analysis focusing on male domestic abuse victims' experiences of services would be beneficial, as there is little research in this area.

1. We reviewed a wide sample of children in each local area. We then selected 6 children from each of the 6 local authorities for the purpose of tracking their experiences. A range of children were included in this sample, for whom the local authority and partner agencies believed that domestic abuse was a current or significant factor. Some had child in need status, some were on child protection plans, and some were looked-after children. ↩
2. Operation Encompass is a police and education early information safeguarding partnership in which police inform a school of domestic abuse incidents involving their children, enabling educational settings to offer immediate support to children experiencing domestic abuse. ↩
3. Domestic violence during COVID-2019: evidence from a systematic review and meta-analysis, Council for Criminal Justice, February 2021;

   Cost of living and the impact on survivors of domestic abuse, Women's Aid, August 2022. ↩
4. Multi-agency safeguarding and domestic abuse paper, Child Safeguarding Practice Review Panel, September 2022. ↩
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