City of York
Safeguarding Children Partnership

Briefing of our learning (June 2025)

Joint Targeted Area Inspection on our multi-agency response to Domestic Abuse

Background

Joint Targeted Area Inspections are carried out under Section 20 of the Children Act, 2004.

They are thematic and are an inspection of multi-agency arrangements for:

- the response to all forms of child abuse, neglect and exploitation at the point of identification
- the quality and impact of assessment, planning and decision making in response to notifications and referrals
- protecting children and young people at risk of a specific type (or types) of harm, or the support and care of children looked after and/or care leavers (evaluated through a deep dive investigation into the experiences of these children)
- the leadership and management of this work
- the effectiveness of local safeguarding arrangements in relation to this work

The most recent theme announced in September 2024 was regarding Domestic Abuse. To support our partnership Inspection preparation, we agreed that we would undertake a multi-agency audit on this theme. The audit day took place in October 2024 and was chaired by one of our statutory safeguarding partners (Police).

This audit focused on the multi-agency response to children who are victims of domestic abuse following the implementation of the Domestic Abuse Act (2021) where it recognises that children are victims of domestic abuse in their own right if they have seen, heard or experienced the effect of the abuse.

Other themes which featured within the cases considered as part of the audit as follows:

- Drugs and alcohol
- Suicidal Ideation/Attempted suicides
- Mental health and Wellbeing
- Homelessness
- Language barrier
- No recourse to public funds

(this audit reviewed six children's case files and the findings are reflective of this sample cohort)

What areas of good practice was highlighted?

- When the Police become aware of incidents which involve Domestic Abuse, these are internally reviewed by the Domestic Abuse Officers. The Domestic Abuse Officers complete a Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH) risk assessment and appropriate support is put in place including referrals to Independent Domestic Abuse Service (IDAS) and also consideration of incidents been discussed at a Multi-Agency Risk Assessment Conference (MARAC) and appropriate flagging on ICT systems is undertaken.

- In some instances where cases were considered at Multi-Agency Risk Assessment Conference (MARAC), there was evidence of the process working well and there was good evidence of multi-agency sharing of information at the meetings. Health (Mental Health Provider and York Hospital) agencies receive Multi-Agency Risk Assessment Conference (MARAC) invites and minutes. Health (Mental Health Provider, York Hospital and Primary Care) also ensure that their ICT systems have appropriate flagging in place.

- There was good evidence shared at the audit of the Police Domestic Abuse Officers working well with Independent Domestic Abuse Service. In addition, there was also good liaison between Independent Domestic Abuse Service and Children's Social Care.

- Where there are Domestic Abuse incidents, the Independent Domestic Abuse Service routinely receive referrals from the Police for support to be put in place. The referrals are often detailed and contain information regarding children with family groups and also voice of the child.

- Police routinely share Public Protection Notices of expectant mothers with the hospital where there are concerns of Domestic Abuse or risks/vulnerabilities of an unborn child.

- Referrals into the Multi-Agency Safeguarding Hub (MASH) are overall of a good standard which are detailed, specific about behaviours and provide high quality information to enable threshold decision to be made quickly. However, in one case it was noted that the referral outcome was not shared with the agency who had made the referral.

- There was evidence of good multi-agency working including undertaking of joint visits, exploring family networks at the earliest opportunity, ensuring relevant agencies including health (hospital) are invited to strategy meetings.

- There was good evidence of information sharing and communications in all of the cases for this audit. Where Probation are involved with the family there was evidence of good information sharing and in some cases there was evidence of safety planning linked to impact of this on the children.

- The hospital's Emergency Department coding enables safeguarding reviews and ensures that relevant information is shared and actions undertaken including flagging on ICT systems.

- For one family where mental health was a feature, the mental health practitioner used the Potentiality for the Adult's Mental Ill Health to Impact on the Child (PAMIC) tool to assess the impact of fathers' mental health on their child.

- In one case an appropriate referral was made to the Local Authority Designated Officer (LADO) due to the suspected perpetrator working with children and young people.

- At the point of when multi-agency partners became involved with each family, appropriate support was put in place, including safety planning which meant that no repeat incidents happened which could suggest that the multi-agency interventions were good.

- There was also evidence of routine enquiry being asked in Midwifery (where appropriate and safe to do so) and there was good liaison between hospital midwifery and the Health Child Service (Health Visitor).

Key Learning Points

Learning Point 1

Where it was identified that the Independent Domestic Abuse Service (IDAS) were working with a family, they were not routinely invited to strategy meetings. Audit partners felt that the joint working with the Independent Domestic Abuse Service (IDAS) could be strengthened as the Independent Domestic Abuse Service (IDAS) provide valuable information and also should be considered as part of wider professional network.

Learning Point 2

Where a child is open on a Child in Need Plan, not all relevant paperwork (minutes, assessments, plans) is routinely shared with partners (Healthy Child Service, Education, Primary Care, IDAS). It is acknowledged that when a child is on a Child in Need Plan the lead practitioner/social worker does not have any business support, therefore responsibility is on individual workers to share this information. However, as a partnership this is something we need to improve upon.

Learning Point 3

When Probation are working with perpetrators, consideration of the wider family must be given. For example, in one case the Probation partner who attended the audit acknowledged that the risk assessment and referral recording was not as robust as it could have been and therefore lacked analysis of the wider impact of this for the child/young person in the family.

Learning Point 4

Not all safety plans are joined up – some agencies such as the Independent Domestic Abuse Service (IDAS) and Children's Social Care have their own safety plans. It was acknowledged that these would benefit from being multi-agency.

Learning Point 5

Family and household relationships were not routinely recorded or linked in GP systems, and family members may be registered at different practices. This limits the visibility of safeguarding risks across households.

Learning Point 6

Where routine health information is required for assessments, the GP and other health agencies such as Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) should be routinely asked to share information. In one of the cases this did not happen.

Learning Point 7

Where there are school aged children, they are routinely seen on a daily basis by professionals and therefore any information/disclosures of Domestic Abuse can be acted on. However, at the audit day we considered that those children who are not school age could benefit with furtherwork being undertaken within the Early Years sector regarding pre-school children and consideration should be given as to how we can capture their views and voice.

Learning Point 8

Further work needs to be undertaken with partners to ensure that where it is recognised that further support may be required with adults within the families due to additional vulnerabilities; consideration of Adult Social Care may be required.

Learning Point 9

For one family, they had no recourse to public funds (an individual, often someone subject to immigration control, is ineligible to access certain government benefits and housing assistance) professionals need to work creatively to support families.

In this case, the family were also made homeless staying with another parent from the children's school whilst trying to secure accommodation through the local authority. Subsequently, further discussions between, Housing, Children's Social care, the Independent Domestic Abuse Service and the Partnership were undertaken following the audit to resolve some of issues identified within this specific case regarding the families housing need and to ensure they could secure accommodation.

Learning Point 10

Not all children's plans are SMART and have multi-agency input/actions. Where drug/alcohol is featured consideration of referrals to support services should be made.

Learning Point 11

When working with families consideration should be given to support victims of Domestic Abuse where there are parallel processes underway such as family arrangements through the courts.

Useful resources and further reading

Independent Domestic Abuse Service (IDAS)

City of York Council Adult Social Care

City of York Council Housing

City of York Council Domestic Abuse webpage

City of York Council Domestic Abuse Resident and Tenant Policy 2025 to 2028

Change Grow Live (York's Drug and Alcohol Service)

Joint targeted area inspection of the multi-agency response to children who are victims of domestic abuse

Where do I go for further information?

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