women's aid
until women & children are safe

NINETEEN MORE CHILD HOMICIDES

safe child contact **saves lives**

women's aid

Authors

Phoebe Nicholson-Pallett and Simran Kaur

Women's Aid

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Women's Aid is the national charity working to end domestic abuse against women and children. For 50 years, Women's Aid has been at the forefront of shaping and coordinating responses to domestic abuse through practice, research and policy. We empower survivors by keeping their voices at the heart of our work, working with and for women and children by listening to them and responding to their needs.

We are a federation of 183 organisations which provide over 300 local lifesaving services to women and children across the country. We provide expert training, qualifications and consultancy to a range of agencies and professionals working with survivors or commissioning domestic abuse services and award a National Quality Mark for services which meet our quality standards.

We hold the largest national data set on domestic abuse and use research and evidence to inform all our work. Our campaigns achieve change in policy, practice and awareness, encouraging healthy relationships and helping to build a future where domestic abuse is no longer tolerated.

Our support services, which include our Email Service, the Survivors' Forum, the No Woman Turned Away Project, the Survivor's Handbook, Love Respect (our dedicated website for young people), the national Women's Aid Directory and our advocacy projects, help thousands of women and children every year.

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Foreword

This report should never have had to be written.

Almost ten years ago, Women's Aid produced a report identifying **19 children who had been killed because of statutory or legislative failures** in the context of the family courts.

Five years ago, the Ministry of Justice (MoJ) published its Harm Panel report which included a set of recommendations to improve the safety of women and children in the family justice system.

Four years ago, children's experiences were legally recognised within the statutory definition of domestic abuse in the Domestic Abuse Act 2021.

Yet today – nearly a decade on from the publication of our *Nineteen Child Homicides* report in 2016 – we have found that the same number of children have been killed in circumstances that could have been avoided, should there have been the political and judicial will to do so.

The MoJ's Harm Panel's Report "*unveiled deep-seated and systemic problems with how the family courts identify, assess and manage risk to children and adults*". The findings **confirmed what survivors had been telling Women's Aid for decades** about their experiences in the family courts. Women's Aid has been monitoring closely the progress of the Harm Panel's recommendations and published further research which highlighted that the optimism and hope many survivors had felt after this publication had been lost, **with the lack of progress on actioning the report's findings leaving them disillusioned and disappointed**.

Whilst *Nineteen Child Homicides* was also a report that should not have needed to be written, this report should have been enough, and survivors should have been listened to. We did not expect to need to make a further call to government, statutory agencies and family court professionals to prevent further avoidable child homicides.

In 2016 we identified 12 families where 19 children had been killed, and **sadly this report today identifies 18 families where 19 children have been killed**. Whilst we should show caution when comparing reviews over time,[1] it is concerning to see a 50% increase in families affected in this report. More families have been impacted by this devastating crime, and more lives lost – and we are clear that **every case is one case too many**.

Despite the lack of progress when starting this further investigation, we had not anticipated that we would be giving this report the same title as 10 years previously. The reality of women and child survivors' ongoing experiences in the family courts, and this report's findings could not be bleaker.

It is clear that within the family court system there remains inequality, injustice, fear and oppression. This report sadly highlights that still all too often perpetrators are shielded by a system that does not prioritise the safety of adult and child survivors, and the current system is facilitating efforts by perpetrators to prey on the vulnerability of survivors which is unseen or ignored by

1 The data from both our reports are dependent upon the publication dates of serious case reviews/ child safeguarding practice reviews, rather than the dates of the homicides. Therefore, even though the time frames for the case reviews were the same (ten years), statistical comparison is not possible. Nonetheless, the increase is concerning because it suggests an increase in the number of families affected during this most recent period.

professionals. Statutory agencies continue to operate inconsistently and with no meaningful join-up, with adult and child survivors falling through the gaps. There also remains a disproportionate regard for the rights of the perpetrator in the family court system, often at the expense of the rights of the child.

This report identifies many of the same themes as 2016, however it also explores the impact of changes over time, with financial hardship forcing parents to live together with dangerous informal contact arrangements and agencies failing to respond appropriately to risks from perpetrators. The findings also raise the importance of considering the wider harms experienced by children in contact arrangements with parents who are also perpetrators of domestic abuse, including the mental health impacts, sexual violence and physical harm.

As noted, we have previously evidenced the lack of progress on implementing the Harm Panel report's recommendations. A key example of this is the long overdue publication of the MoJ's review of the presumption of parental involvement, which was deemed 'urgent' and started in 2020. Despite this, in June 2025 we are still awaiting the publication of this review, and governments have missed key legislative opportunities to address this issue. We are concerned that personal experiences of family court proceedings may be deterring policymakers and representatives within the judiciary from taking the decisive action that is needed in this space. As this report highlights, the impact of **too much individual interpretation of policy and guidance is then left to play out in the statutory and courts response**.

This report brings back to the fore what is truly at stake because of a lack of action or will to address this – children's lives. Children must not pay the price for this.

We are clear that a breadth of change is needed, from enhancing the voice of children to improving communication, coordination, and consistency. For example, mechanisms must be in place at national and local levels between statutory agencies, with an emphasis on detailed logging of both the survivors' and perpetrators' histories. It is also clear that professionals such as social workers should be accredited and reviewed as part of their career progression by domestic abuse specialists to help ensure the requisite knowledge and skills are sufficiently assessed. Of course, it must be an urgent focus for government, statutory agencies and family court professionals to truly commit to the **full implementation of the Harm Panel's recommendations and to repeal the presumption of parental involvement**.

Women's Aid, sector experts and countless survivors, including our Child First ambassador Claire Throssell MBE, have continuously stressed the urgent need for this change. We have made clear what needs to happen and why – the evidence is there.

Enough is enough. If as a society we want to address the epidemic of domestic abuse and other forms of violence against women and girls - or at a minimum, comply with the legal recognition of children as victims in their own right in the 2021 Domestic Abuse Act - government, statutory agencies and family court professionals will put words into action and put an end to avoidable child homicides. If not, then we need answers as to why these issues are being ignored and why the lives of and safety of women and child survivors are not being prioritised.

Farah Nazeer
CEO
Women's Aid

Executive Summary

Nineteen More Child Homicides tells the stories of 19 children who were killed by a parent who was also a perpetrator of domestic abuse, in circumstances relating to child contact (formally or informally arranged). Our focus is on children but, in some of these cases, women were also killed. This report details the further 19 children's lives that have been lost in the subsequent decade through child contact with a parent who is a perpetrator of domestic abuse since the publication of our *Nineteen Child Homicides* report in 2016. Building upon our findings from this previous report, we have also included three case studies which detail some of the further harms that have come to children through continued contact with a perpetrator of domestic abuse.

Clearly, the responsibility for these killings lies with the perpetrators. Nonetheless we have identified common failings in these cases that must be addressed to ensure that agencies such as the family courts, Child and Family Courts Advisory and Support Service (Cafcass), children's social work, the police, education and health work together to minimise the possibility of further harm to women and children.

This study reviewed relevant serious case reviews and child safeguarding practice reviews for England and Wales, published between September 2015 to September 2024 (inclusive). It uncovered details of 19 children in 18 families who were killed by perpetrators of domestic abuse. Seventeen out of 18 perpetrators were men and fathers to the children they killed, apart from in two cases where they were fathers to the siblings of children they killed. One of the perpetrators was female and a mother to the child she killed. All of the perpetrators had access to their children through formal or informal child contact arrangements.

Key themes

This research identified five key themes in these 18 case reviews where improvements could be made to better protect children and survivors around child contact with a perpetrator of domestic abuse. If these factors are better understood and addressed through our recommendations, we could see the prevention of further avoidable child deaths through child contact.

These key themes are:

1. **Recognising children's experiences**
2. **Professional understandings of coercive and controlling behaviour**
3. **Understanding child contact as a tool to manipulate professionals**
4. **Agency separation as a risk factor**
5. **Supporting non-abusive parents as survivors**

Recommendations

This report makes some clear recommendations for each of these key themes, but there are some overarching recommendations that the Government, family court judiciary and Cafcass must urgently act upon. These include:

- Through urgent legislation to be brought forwards by government, repeal the presumption of parental involvement.
- Commit to full implementation of the Harm Panel's recommendations in the upcoming VAWG Strategy.
- Following the initial findings of the Pathfinder project, explore options for hearing from and providing advocacy, representation and support for children as a central consideration for social care workers, including in Child Impact Reports.
- Conduct a rapid evidence review of the experiences of children bereaved by domestic abuse, including a review of the statutory and voluntary sector provision available to them.
- Put in place functioning mechanisms for communication, coordination, continuity and consistency at national and local levels between statutory agencies, which includes more detailed logging of both the survivors' and perpetrators' histories.
- Ensure that social workers undertaking assessments for private law children's proceedings are not only accredited, but reviewed as part of their career progression by domestic abuse specialists to help ensure the requisite knowledge and skills are sufficiently assessed.

Introduction

In 2004, Women's Aid published *Twenty-nine Child Homicides*, documenting the homicides of 29 children in 13 families by abusive fathers between 1994 and 2004 (Women's Aid, 2004). The second report, *Nineteen Child Homicides*, detailed 19 children in 12 families who had been killed by abusive fathers between 2005 and 2015 (Women's Aid, 2016). All these homicides took place through informal and formal contact arrangements, including those that had come about through private law child arrangement applications. There were a higher proportion of cases in this report compared to previously where the child/ren had been killed through circumstances relating to informal contact rather than formal contact through the family court. We know that only a minority of parents arrange child contact through the family courts, and that domestic abuse is a feature in a high proportion of these cases (Women's Aid, 2017; Cusworth, et al. 2021).

In our Nineteen Child Homicides report we wrote, 'In another ten years, we must not yet again be repeating the same investigation, with the same findings.' Whilst the same number of children have been killed in this subsequent period, there has been a notable increase in the number of families involved, with 18 compared to 12 in the previous report. Last time 12 perpetrators killed 19 children, this time 18 perpetrators were implicated for the deaths of 19 children. Whilst it may appear that these families had less children than the families in the previous report, close analysis revealed a total of 44 children[2] attributed to the mothers and fathers in these 18 cases.

Through these homicides, 25 children lost a sibling, eight lost a parent, and six children lost both a parent and a sibling. The impact on those left behind must not be under-estimated. As shown throughout this report, it is often the entire family which is subject to the coercive and controlling tactics of the perpetrator. It is without doubt that other members of the household would have experienced the effects, even if the actions associated with the perpetrator's behaviour were not directly towards them. The long-term impact that this has upon children is something that we have highlighted previously, including through our campaigning on the Domestic Abuse bill.[3] The failure to fully recognise the experiences of children and respond to their needs through funding specialist support for children and young people is one that warrants further investigation. Therefore, we have explored the detrimental impact of limited specialist domestic abuse support within a context of ongoing coercive and controlling behaviour on children in the case study of Alex.[4]

It is also worth noting that five out of the 18 cases included covered the period of the national UK Covid-19 restrictions, which restricted survivors' ability to leave their homes and statutory agencies ability to engage with the families. However, the themes identified demonstrate that there are common lessons to be learnt across all cases, preceding and succeeding the UK Covid-19 restrictions. Nonetheless, the findings indicate a continued breakdown of join up between criminal courts and family courts; a continued lack of understanding of the duality of risks for both the mother and child post separation; and a continued assumption that the perpetrator can be a 'good enough father' to have supervised and/or unsupervised contact.

2 43 of which were biological.

3 Women's Aid (2021) *Joint briefing on key elements for a quality response to children's domestic abuse-related needs*.

4 Pseudonym

Seventeen out of 18 of the perpetrators in this report were fathers and one was a mother. This is the first time in this research that we have identified a mother who is a perpetrator of domestic abuse killing a child through formal or informal contact arrangements. Nevertheless, this is still in-keeping with the gendered nature of domestic abuse, which is disproportionately perpetrated by men onto women (ONS, 2024). To best reflect the majority of cases in this report we have often used the term "mother" to refer to the non-abusive parent. This is not to detract from the seriousness of case six where the mother was the perpetrator, where the same key themes were still identified. When referring to this case we have tried our best to be explicit that the mother was the perpetrator, and the father was the non-abusive parent.

To avoid causing any further distress to the families involved in these cases we have removed any identifying data, such as serious case review report titles, publication and crime dates, the sex and ages of individual children, place names or people's names (although the latter are usually already redacted in public serious case review reports). In the case studies we have chosen unisex pseudonyms to conceal the children's sex and have used terms such as 'they' and 'their' as opposed to 'he/she' and 'his/her.' We have attached a 'Case Number' to each serious case review to help structure our research and report-writing. These numbers are randomly assigned and do not relate to the chronology of the reports.[5]

Women's Aid Child First campaign

Upon the publication of our *Nineteen Child Homicides* report in 2016, we launched Women's Aid Child First: safe child contact saves lives campaign. Through this we have been calling on the government and all family court agencies to make the family court process safer for women and child survivors of domestic abuse.

We want an end to child deaths as a result of unsafe child contact with dangerous perpetrators of domestic abuse. For this to happen, domestic abuse must be taken seriously, and survivors must receive the right response. Nine years on the campaign has seen some critical changes. These include a further review of the Practice Direction 12J, a previous government leading an expert review on domestic abuse and the family courts, as well as crucial provisions brought in through the Domestic Abuse Act 2021. However, we caution that much of this progress has been met with setbacks[6] in conjunction with delays to progress, which has led to the stalling and prevention of much needed and evidenced change to bring about safe child contact. These issues demonstrate that wider culture change continues to be needed in the family courts, including agencies involved in the process to bring about improvements in the response to domestic abuse.

5 These case reviews are all publicly available through the NSPCC repository and we are happy to make our data available to the Government for their confidential use.

6 Such as the emergence of a so called 'parental alienation industry' between 2016 and 2019. A review of child arrangement cases in England and Wales found evidence of increased allegations of so called 'parental alienation' coinciding with renewed attention on domestic abuse in family courts. The review identified a pattern of so called 'parental alienation being raised in family proceedings in response to concerns about and measures to address domestic abuse.' (Barnett, 2020a).

Progress since Nineteen Child Homicides

2017 Review of Practice Direction 2J

In October 2017 a revised version of Practice Direction 12J came into force with many welcome developments.[7]

2020 Ministry of Justice's Harm Panel report

Three years on from the launch of our Child First campaign, the Ministry of Justice announced that an expert panel would be set up to assess the risk of harm to children and parents in private law children's cases. This panel was made up of experts from the judiciary, academics, children's social work and domestic abuse sector organisations, including Women's Aid. The aim was to understand how those involved in proceedings experience the process and identify any systemic issues to build a robust evidence base to inform best practice improvements. It identified four key issues impacting the family courts response to domestic abuse, including:

- Resource constraints affecting all aspects of private law proceedings.
- The pro-contact culture in the courts and the minimisation of abuse.
- The problem of siloed working and a lack of coordination between the courts and other agencies and organisations dealing with domestic abuse.
- The problem of an adversarial system.

The Harm Report made several key recommendations that offered the potential to transform private law child arrangements proceedings to prioritise the needs and wishes of children, as well as recognise and respond appropriately to domestic abuse. Since this publication there have been some welcome developments, including the launch of the Pathfinder pilots in Devon and North Wales. The aim of these pilots is to improve the experiences of families in child arrangements proceedings, reduce the re-traumatisation of survivors of domestic abuse, reduce the amount of time families spent in court and improve coordination between agencies. Initial evaluation of these pilot sites suggests some that the model has brought much needed improvements compared to the child arrangement proceedings model. This includes a focus on enhancing the voice of the child, reduced re-traumatisation for both adult and child survivors, and improved information gathering and collaboration across agencies. However, there are also some challenges relating to resourcing and staff capacity, particularly for domestic abuse support services, which were found to play a vital role in reducing the re-traumatisation for both adult and child survivors. Furthermore, the pathfinder pilots are yet to roll out nationally and evaluation is yet to investigate, record, and analyse the experiences of adult and child survivors directly involved (Ministry of Justice, 2025).

7 The most fundamental changes include but are not limited to: the presumption of contact can now (explicitly) be displaced; the court must be satisfied any contact ordered does not expose to the 'other parent' and/or the child to risk of harm, rather than considering the risk just to the child; and a presumption against making interim contact orders where there are disputed allegations of domestic abuse. The revised direction also requires the court to give reasons if (i) it finds domestic abuse proved and makes an order for contact with the perpetrator and (ii) why it takes the view the order made will not expose the child to risk of harm. In cases where a risk assessment has concluded that a parent poses a risk to the child or to the other parent, supported contact either by a supported contact centre or by a parent or relative is not deemed appropriate.

2021 Domestic Abuse Act

The Domestic Abuse Act received Royal Assent on 29th April 2021 and includes a number of provisions that have implications for private family law proceedings relating to child contact. Firstly, children who see, hear, or experience the effects of domestic abuse, are now explicitly recognised as victims in their own right. Secondly, it implements a new section into the Children Act (1989), clarifying how barring orders should be used; to prevent perpetrators of domestic abuse from persistently taking survivors back to court over child contact. The legislation also implemented the provision of special measures for all survivors of domestic abuse in the family courts and prohibits the cross-examination of survivors by their perpetrators in family court proceedings (Foster, 2021). An amendment to the controlling or coercive behaviour offence was also made as part of law, removing the cohabitation requirement to ensure that post-separation abuse and familial domestic abuse is provided for when the survivor and perpetrator do not live together (Home Office, 2024). An investigation into safeguarding processes in child contact centres in England was also commissioned by the Ministry of Justice as required as part of the Domestic Abuse Act 2021 (Ministry of Justice, 2023).

Evidence of stalling

Whilst we have witnessed some welcome developments to promote safe child contact as a result of our Child First campaign, it is crucial that this does not obscure the setbacks that have also taken place. As discussed in our Two years too long report (2022), not enough has been done to implement the transformed system that the Harm Panel recommended, and in some instances, there is evidence of progress stalling[8], a lack of transparency and shift away from the original intentions of the Panel's recommendations.

Practice Direction 12J

As highlighted, Practice Direction 12J has now been substantially revised and it continues to be mandatory in family proceedings involving child arrangements orders and where there are allegations of domestic abuse. However, findings from The Harm Report (Ministry of Justice, 2020) drew attention towards a continued lack of understanding around the ongoing impact of abuse on children. We also continue to hear from survivors of instances in which the Practice Direction 12J is not considered in proceedings (Women's Aid, 2022). This links to wider issues relating to culture within the family courts, including evidence of a 'pro-contact culture' amongst the courts and professionals involved.

The acceptance of counter-allegations without robust scrutiny

Evidence of a pro-contact culture equated to the systematic minimisation or disbelief of abuse, and the acceptance of counter-allegations without thorough investigation, including allegations of so-called 'parental alienation'. At Women's Aid, we have continuously drawn attention to the dangerous and harmful concept of so-called 'parental alienation' (Women's Aid, 2020; Women's Aid, 2021a), for which there is no commonly

8 A Court of Appeal judgment in the case of K and K published in April 2022 is an example of evidence of stalling. Despite allegations of domestic abuse, including rape and coercive control, being upheld by the finding of fact hearing, the judgement states that the parties should first have participated in a mediation, information and assessment meeting (MIAM) before going to court. However, MIAMs have been established as not appropriate in cases involving allegations of domestic abuse. K and K [2022] EWCA Civ 468.

accepted definition, robust empirical studies to back up the concept, or reliable data on its prevalence (Doughty, et al. 2018).

Despite this, over recent years it is evident that the concept of so called 'parental alienation' has occupied the resources of public sector bodies, including the Family Justice Council (Family Justice Council, 2024). As a result of this and to uphold our commitment to women and child survivors, we have had to spend significant time contesting a concept which has been internationally deemed unsuitable for use in any psychotherapeutic practice (European Association for Psychotherapy, 2018). However, evidence from survivors continues to indicate that counter-allegations of so called 'parental alienation' are taken more seriously than those of domestic abuse (Domestic Abuse Commissioner, 2023). This highlights the need for a wider culture shift in the response to domestic abuse for all professionals involved in child contact arrangements. A study into private family law child arrangement cases in England and Wales noted how increased allegations of this kind often coincided with renewed attention on domestic abuse in family courts. The years between 2016 and 2019 were noted as a key time where 'parental alienation suddenly leapt into the spotlight,' involving the emergence of a 'parental alienation industry' consisting of experts, lawyers, and therapists specialising in this area (Barnett, 2020a: 6). This coincides with the launch of our Child First campaign in 2016. The concept of so called 'parental alienation' has been deemed 'more powerful than any other in silencing the voices of women and children resisting contact with abusive men' in the family courts (Barnett, 2020a: 10). Moreover, the concept steers the conversation away from what is at stake, which is a child's life being at risk through unsafe child contact with a dangerous perpetrator of domestic abuse.

Safety in court

The Domestic Abuse Act 2021 brought about provisions to make survivors of domestic abuse automatically eligible for special measures in the family courts. Whilst the experiences of some survivors suggest that there is some better practice happening around this area, we continue to hear that this is not always the case (Women's Aid, 2022; Domestic Abuse Commissioner, 2023). Until we see evidence that the courts are always proactively considering and offering special measures in family court proceedings involving domestic abuse, it is clear that a wider culture shift is still needed in the response to domestic abuse in the family courts.

Methodology

In this study, Women's Aid aimed to identify cases where a child had been killed by a perpetrator of domestic abuse in circumstances relating to child contact (formally or informally arranged) in the period from 2015 to 2024. In reviewing the relevant Serious Case Reviews (SCRs) and Child Safeguarding Practice Reviews (CSPRs)[9], we aimed to identify the key barriers to establishing safe child contact. This included exploring the courts and other statutory agencies' roles in minimising the risk of further harm to adult and child survivors of domestic abuse. Building on our findings from our previous child homicide reports we have included three case studies regarding the further harms that children experience through ongoing contact with parents who are perpetrators of domestic abuse.

Women's Aid Experts by Experience

Women's Aid Experts by Experience group was assembled in 2019 and contains a diverse network of survivors knowledgeable about the response to domestic abuse by their own lived experience. We incorporate their expertise and understanding into our work to ensure it remains survivor centred. Throughout this research process we consulted Women's Aid Experts by Experience Family Justice Subgroup to gather their feedback into the project.

Data collection and analysis

We used the online search engine in the NSPCC National Case Review Repository[10] to identify SCRs and CSPRs relevant to our research. Our review period was September 2015 to September 2024 (inclusive). This period relates to the dates when the reports were published, rather than the dates that children were killed or harmed. We used the following search terms to find relevant reports:

- "Domestic Abuse"
- "Child Homicide"
- "Child Arrangement Order"
- "CAFCASS"
- "Family Violence"
- "Partner Violence"

9 As of 2018 Serious Case Reviews became known as Child Safeguarding Practice Reviews.

10 NSPCC National Case Review Repository.

Through this initial sift, 115 possible relevant cases were identified for further analysis. Through this analysis the following information was captured and recorded:

- If a child had been killed
- If a child had been harmed
- If an adult survivor had been killed
- If an adult survivor had been harmed
- If the perpetrator was the parent of child/ children in the review
- If the perpetrator had committed domestic abuse against the other parent
- If child contact was involved

This second stage of analysis led to the identification of 22 cases which related to domestic abuse, child contact, and homicide.

Four of these cases were excluded from the final 18 cases for reasons outlined in the excluded cases section. A further 30 cases were identified that may have related to other harms that possibly occurred through formal or informal child contact arrangements where the parent was a perpetrator of domestic abuse. However, it was not possible to quantify the exact number of cases that relate to further harms caused to children through formal or informal contact arrangements with a perpetrator of domestic abuse within the 10-year period. Doing so would have required undertaking an in-depth analysis of these 30 cases and this was not possible within the remit of this study. However, we have included three case studies of these further harms within our report that specifically relate to our thematic findings of the 18 homicide cases.

Limitations of the methodology

Our study is limited in that we only have access to publicly available redacted documents through the NSPCC repository. It must be noted that SCRs and CSPRs panels do not have access to family court records, and it is not their role to review court proceedings, although they do work with and receive information from Cafcass where the family courts are involved. It is possible that there may have been some relevant cases that were not revealed by the search terms used or that there were some very recent reports not yet in the NSPCC repository. Additionally, SCRs and CSPRs are only undertaken when a child dies or is seriously harmed, and abuse or neglect is known or suspected. Therefore, the true extent of harms that occur through formal or informal contact arrangements with a parent who is a perpetrator of domestic abuse cannot be known. Lastly, we know that unfortunately many more children will have been killed through domestic abuse by a parent within this time frame, however, this report only looks at child homicides which occurred through formal or informal child contact arrangements.

Summary of cases

18 families

19 children killed

4 women killed

three of whom were mothers of the children[11]

2 children seriously harmed

one through attempted murder, the other through inflicting grievous bodily harm with intent at the time of child homicide

2 dogs killed

3 perpetrators dead by suicide

two fathers and one mother

11 Case sixteen, perpetrator killed another girlfriend before being caught.

CASE 1

- **One child and mother killed by the father.**
- Father found guilty of their murder.

Informal unsupervised contact became inevitable when the couple were forced to stay living together for financial reasons despite leading separate lives.

CASE 2

- **One child killed and another harmed by the father.**
- Father found guilty of murder and inflicting grievous bodily harm with intent.

Contact was informally arranged following the expiration of a six-month Supervision Order that stated child must live solely with mother.

CASE 3

- **One child killed by the father.**
- Father found guilty of manslaughter.

Child lived with mother and contact was informally arranged.

CASE 4

- **One child killed by the father.**
- Father found guilty of murder.

Children thought to have had informal contact with father (not clear whether the killing happened during a contact visit).

CASE 5

- **One child killed by the father.**
- Father found guilty of murder.

Children lived with mother and contact was informally arranged.

CASE 6

- **One child killed by the mother.**
- Mother committed suicide.

Children lived with father as arranged through a Child Arrangement Order and unsupervised contact arranged through family court.

CASE 7

- **One child and mother killed by the father.**
- Father committed suicide.

Children lived with mother and the family court had ordered supervised and indirect contact only (through the exchange of letters, cards, etc.).

CASE 8

- **One child and two dogs killed by the father.**
- Father committed suicide.

Child lived with mother and contact was informally arranged.

CASE 9

- **One child killed by the father.**
- Father found guilty of murder.

Children lived with mother and contact was informally arranged.

CASE 10

- **One child and mother killed by the father.**
- Father found guilty of their murder.

Perpetrator had moved back into the family home despite the couple being separated.

CASE 11

- **One child killed by the father.**
- Father found guilty of manslaughter.

Despite being separated, the mother was forced to move back into the shared home due to unresolved housing and joint mortgage difficulties.

CASE 12

- **One child killed by the father.**
- Father found guilty of murder.

Father and mother lived together despite being separated. Homicide took place whilst child was in the sole care of father.

CASE 13

- **One child killed by the father.**
- Father found guilty of murder.

Children lived with mother and contact was informally arranged.

CASE 14

- **One child killed by the father.**
- Father found guilty of murder.

Despite being separated, the father had moved back into the shared home and so unsupervised contact became inevitable.

CASE 15

- **One child killed by the father.**
- Father found guilty of manslaughter.

A pre-birth assessment was undertaken, and a child's plan was put in place that father would live separately but no restrictions were placed on contact which was arranged informally.

CASE 16

- **Two children killed and another seriously harmed (attempted murder) by the father.**

Social care had temporarily arranged for child to live with father under supervision of another adult following an allegation made by the father about the mother.

Father found guilty of both children's murders, attempted murder of harmed child, and murder of a subsequent girlfriend. These three homicide incidents (including attempted murder) took place separately.

CASE 17

- **One child killed and mother killed by the father of mother's other child.**
- Perpetrator found guilty of their murders.

Both children lived with the mother. Perpetrator was on bail at the time of killing for assaulting the mother. Unclear how contact was arranged.

CASE 18

- **One child killed by the father of guardian's other child.**
- Perpetrator found guilty of their murders.

Child was placed with guardian by the family courts under a Special Guardianship Order (SGO) and had informal contact with perpetrator.

Key findings

Our review uncovered details of 19 children killed in 18 families by perpetrators of domestic abuse in circumstances relating to child contact (formally or informally arranged). In addition, two other children were seriously harmed at the time of these homicides, four women were killed, and two dogs were also killed. These homicides took place in England and Wales and were described in Serious Case Reviews (SCRs) and Child Safeguarding Practice Reviews (CSPRs) published between September 2015 to September 2024 (inclusive).

In 18 families 19 children were killed by perpetrators of domestic abuse who had access to these children through formal or informal contact arrangements.

Seventeen of the 18 perpetrators were men, and 15 out of these 17 men were the fathers to the children that were killed. The remaining two men were fathers to other children in the family and killed these children through formal or informal contact arrangements which were in place through their biological children who lived with the child/ren they killed. In one case the perpetrator was female and mother to the child who was killed.

28
DEATHS

There were 28 deaths in total, 27 of which occurred in the 18 families: 19, children, three mothers, two dogs, and three perpetrators who committed suicide. Another female survivor was also killed by one of the perpetrators after he had already killed two of his children and attempted to kill another.

43
CHILDREN

There were at least[12] 44[13] children of the mothers and fathers in these 18 case studies.[14] This means that through these homicides, 24 children lost a sibling, and six children lost both a parent and a sibling.

12
MURDER

In 12 cases, the perpetrator was found guilty of murder. In the three cases where the perpetrator was found guilty of manslaughter, the children had died because of the perpetrator's violent physical abuse, and in two of these cases the original charge had been murder.[15]

12 In one case the father told at least one agency he had children from a previous relationship; however, this was not known for certain.

13 43 were biological.

14 Including both maternal and paternal half-siblings.

15 In the case where the original charge and final conviction was manslaughter, the father was a known perpetrator of 'significant domestic violence' to the police. There was a non-molestation order in place to prevent this man from contacting a previous partner and the child they had together. When he breached this order, he told agencies that his actions were solely in relation to the mother preventing him from having contact with his child. He repeated these same arguments to the reviewers in relation to his subsequent partner and the child he killed.

5

In five of the cases the perpetrator either committed suicide or attempted suicide at the time of the homicides. Three committed suicide, and two attempted to commit suicide.

Out of the 18 perpetrators, 13 were known to statutory agencies as perpetrators of domestic abuse, and 12 of these were known for this by the police.

In five cases it was stated that the perpetrators were not known to statutory agencies as perpetrators of domestic abuse, however, there were clear and acknowledged failed opportunities to ask or follow up concerns regarding domestic abuse.[16]

Two more children were seriously harmed in these 18 case studies; one through attempted murder, and the other through grievous bodily harm during the same incident where another child was killed.

4
WOMEN KILLED

Four women were also killed by the perpetrators, three at the time of the child homicides.[17] In the three cases where the woman was the mother[18] a DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) risk assessment had been completed and was scored as medium risk. In one case this assessment was subsequently regraded as high risk after applying professional judgment to the contextual information regarding the domestic abuse.

In three of the cases, the perpetrator had other children where he either had only supervised contact with these children or no contact at all. In one of these cases the family courts had granted the father supervised contact only with his other child/ren, in another case there was a non-molestation order in place to prevent the father from contacting his ex-partner and their child/ren. In one case it was not known why the father had no contact with his other child/ren.

In five of the cases, the couple appeared to be living together despite being separated. In three of these cases, the reviews stated that this was for financial reasons. This links to the findings of a recent report by the Association of Directors of Children's Services (ADCS, 2025), which cited poverty and lack of adequate housing against the backdrop of a cost-of-living crisis as adding pressure to children's services. In the two remaining cases the perpetrator moving back in appeared to form part of the perpetrator's controlling behaviour and financial abuse.

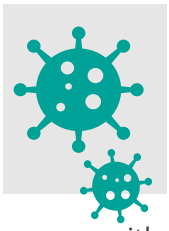
16 Including failure to complete routine domestic abuse questionnaire, failure to ask questions about injuries without presence of perpetrator, failure to provide interpreter.

17 Three of these were mother to relevant children in the case study, one was a subsequent girlfriend of the perpetrator.

18 It was not clear from the review whether a DASH assessment had been completed in the case where the woman killed was not a mother to the children.

8 Excluding the five cases where the parents were living together but separated, contact was arranged informally in eight of the cases. These informal arrangements included one case where a supervision order[19] had expired; one where family courts had granted supervised contact only to the perpetrator's other child; one where both a restraining order and non-molestation order had been put in place to prevent the perpetrator from having contact with a previous partner and their child, along with a pre-birth assessment undertaken by social care prohibiting the father from having residency with his subsequent child but placing no restrictions on contact. In the case where it was unclear how contact was arranged or whether killing happened during child contact, there were bail conditions in place to prevent the perpetrator from contacting the mother or entering the area she lived and requiring child contact to be arranged through a third party.

2 In two of the cases, the perpetrators had a history of committing child sexual abuse, including child sexual exploitation. In one of these cases the victim was the mother of one of the children killed and agencies had failed to respond appropriately to this concern at the time. She had been exploited as a child by the same perpetrator with whom she shared a child with as an adult/ when she became an adult.



In the five cases where the period of review covered the Covid-19 national restrictions it was acknowledged that the lockdown had restricted survivors' ability to leave their homes and statutory agency's ability to engage with the family. In three of these cases the perpetrator appeared to have utilised the Covid-19 restrictions to exercise more control over the family.

Four of the cases involved the family courts. This includes two involving private family law arrangements where the non-abusive parent had residency, and in one case the perpetrator had been granted unsupervised contact and in the other the perpetrator had been granted supervised and indirect contact only. Attempts to safeguard the child in the latter case through supervised and indirect contact only were undermined by evidence of three occasions where details of the family address were shared with the perpetrator in error[20]. When the mother reported this to the police it was accidentally passed to the wrong neighbourhood team where it was closed without further action. Another case involved a Special Guardianship Order (SGO)[21] following the breakdown of a previous Child Arrangement Order. In the final case social care had temporarily arranged for the child to live with the perpetrator under supervision of another adult as an interim measure after he had made an allegation about the mother.

The types of controlling and coercive behaviours committed by the perpetrator towards the child/ren and non-abusive parent (before and after separation) include but is not limited to: stalking and harassment, threats to kill, isolating them from informal support networks, preventing them from accessing support and medical treatment, monitoring and controlling what they eat, threats to commit suicide, threats of deportation.

19 Under the Children Act 1989, local authorities can ask a court to make a child the subject of a care or supervision order if a child has suffered or is likely to suffer significant harm (Children Act 1989, s.31).

20 Including by a bank, Child Support Agency, and the mother's solicitor.

21 A SGO is a family court order that places a child or young person in long-term care with someone other than their parent(s) (Child Act 1989, s.41).

Demographics

Children

- The children's ages at the time of their death ranged from just over three weeks old to 11 years old.
- Of the 14 cases where the children's ethnicity was known, eight were recorded as White British, five were of Mixed Heritage, and one was African Caribbean. In the four remaining cases the ethnicities of the five children were not recorded in the case reviews.
- Four out of the 19 children were recorded as having a condition that constituted a disability. Two had a learning disability and another two had a long-term health condition.

Non-abusive parents

- The age range for the non-abusive parent at the time of the child(ren)'s death (and in three cases their own) was from 19 to 45. However, the age of the non-abusive parent was not recorded in 10 of 18 the cases.
- Of the 14 cases where the non-abusive parent's ethnicity was known, nine were recorded as White British, one as African Caribbean, one as Indian, one as Russian, one as South-East Asian, and one as White Eastern European. In the four remaining cases the non-abusive parent's ethnicity was not recorded in the cases.
- None of the non-abusive parents were recorded as having a disability.
- Six of the 18 non-abusive parents were described as having mental health problems.
- One of mothers was known to use drugs, however, it was unclear whether she had support needs around this.

Perpetrators

- The age range of the perpetrator at the time of the child(ren)'s death (and in three cases their own) was from 26 to 55. However, the age of the perpetrator was not recorded in six of the 18 cases.
- Of the 14 cases where the perpetrator's ethnicity was known, 11 were recorded as White British, one as African Caribbean, one as Arabic, and one as Lithuanian. In the four remaining cases the perpetrator's ethnicity was not recorded.
- None of the perpetrators were recorded as having a disability.
- Ten of the 18 perpetrators were known to have mental health problems.
- Nine of the 18 perpetrators were known to have problematic alcohol or drug use.

Excluded reports

Amongst the excluded reports, there were four reports that included domestic abuse, child contact, and homicide, and therefore were significant to our central themes in our study but did not meet our final review criteria:

1: One report details the case of a mother murdered by her former partner through a Child Arrangement Order. The mother was a vulnerable woman whose child had been removed from her care at birth and placed with the perpetrator and his then partner under a Child Arrangement Order (CAO). The review stated that the perpetrator was known to have perpetrated domestic abuse in several intimate and familial relationships but at the time the CAO was granted, he had not come to the notice of the police due to domestic abuse for several years. Under the terms of the CAO, the mother's contact with the child was supervised by the perpetrator and his then partner. During the review, family and friends disclosed that the perpetrator had exploited the placement of the child with him to manipulate, control and possibly coerce the mother to have sex with him. They felt that she had been unwilling to report this abusive behaviour because she thought she would not be believed, given the fact that the child had been removed from her care at birth. This case was excluded because our methodology requires cases where a child had been killed by a perpetrator of domestic abuse through child contact.

As we solely searched for cases through the NSPCC repository, and not the Domestic Homicide Review (DHR) library, it may be that there were other cases like number one on this list, where an adult survivor was killed through formal or informal child contact. Whilst both the NSPCC repository and the Domestic Homicide Review (DHR) library address safeguarding and domestic abuse, their focuses differ in that one is focused on child protection, and one is specifically focused on the deaths of adults aged 16 or over due to domestic abuse. It may well be that other non-abusive parents have been killed in this way through formal or informal contact but that these were recorded in the DHR library, rather than the NSPCC repository.

2: One report detailed the case of a mother who had murdered her child and child's father and seriously harmed another child. The review acknowledged that the mother had been experiencing domestic abuse and was suffering an acute psychotic episode at the time of the event. While these deaths were the result of the mother's extreme mental illness and not an act of domestic abuse, it is a fact that this feature of the relationship was a significant factor in mother's mental health deteriorating. In this case, there were a number of calls to the police, including by the mother's mother, who reported to police that her daughter was in an abusive relationship. The mother pleaded insanity for the murders, which was accepted by the prosecution, obviating the need for a full trial. This case was excluded because our methodology requires cases where the killer was a perpetrator of domestic abuse.

> *"While these deaths were as a result of [mother's] extreme mental illness and not as an act of domestic abuse it is a fact that the nature of the relationship was a significant factor in [mother's] mental health deteriorating. It is notable in the review that no agency conducted a domestic abuse risk assessment when domestic abuse was a feature throughout. The rationale for this by the agencies was that the abuse was being described by [mother] as historic and yet it was very clear to agencies that the relationship was ongoing at least in part and was resulting in drunken arguments, alerts by neighbours and [mother's mother] resulting in police call outs. [Child] also made three disclosures of violence in the home over an 18-month period."*
>
> **– Excluded case two.**

3: One report detailed the case of a mother who murdered her two children and then committed suicide. This mother was a survivor who was experiencing domestic abuse and harassment from an ex-partner, one of the children's fathers, as well as other family members. Refuge records show that the mother had contacted a refuge but was unsuccessful for a space because another family was judged as higher priority for the vacancy at the time. The mother feared her relationship to a violent male being known might result in her children being removed from her care. This was compounded by the fact that the mother was a care leaver herself and had her own negative experience of unstable placements as a child. This case was excluded because our methodology requires cases where the killer was a perpetrator of domestic abuse.

> *"Mother's electronic diary makes it clear that she had two reasons for killing herself. The most prominent was a desire to escape from Ex-Partner, the second was a fear of her children being removed from her care, which it seems Ex-Partner was trying to exploit [...] she knew many examples of children in her network being removed due to domestic abuse."*
>
> **– Excluded case three.**

Whilst there was not a full criminal trial in either excluded case two or three, both these cases raise questions about the impact of domestic abuse on mental health. The Court of Appeal case for R v Callen[22] addressed how a lack of knowledge and evidence about coercive control at the time of the appellant's trial meant the impact of this was not considered in the original sentencing for murder. It was argued that had this evidence on coercive control been available at the time of the trial, the jury may have reached a different conclusion based on diminished responsibility. In excluded case three, the mother's concerns about having her children removed because she was subject to domestic abuse by the father must not be disregarded. In section five, we explore the importance of supporting non-abusive parents as survivors experiencing domestic abuse. Additionally, the consequences of granting residency to a parent who is a known perpetrator of domestic abuse following removal from the survivor's care has been explored in the case study of Rory.[23]

4: One case detailed a homicide committed by two teenagers who were in a relationship. Together these two young people killed one of their mothers as well as a sibling. The review explored the domestic abuse both these young people had experienced from their respective fathers, with one of the young people experiencing suicidal ideation. The report acknowledges that the mother was experiencing ongoing domestic abuse from her children's father, who was using contact arrangements and applications to family court as a form of coercive control. The report highlighted a need for a more holistic understanding of the impact of domestic abuse on families. This case was excluded because these children were neither parents nor perpetrators of domestic abuse.

Whilst excluded cases two, three, and four do not fit our search criteria, all these raise questions about the long-term impact of domestic abuse on mental health. Findings from the national Domestic Homicide Project demonstrate the strong links between experiencing domestic abuse, mental health, and victim suicide (Home Office, 2025). A recent report by the Association of Directors of Children's Services (ADCS, 2025), shows that poor mental health has surpassed domestic abuse for the first time as the common factor for children's social work assessments. Therefore, further research could be undertaken to understand how much of a role these factors play in domestic homicides involving child contact where the suspect is a victim of domestic abuse rather than a perpetrator.

22 R v Challen [2019] EWCA Crim 916.

23 Pseudonym

Key themes

1 Recognising children's experiences

> *"There is no evidence that anyone ever discussed with either parent the emotional impact on children of living with domestic abuse."*
>
> **– Case nine.**

Under the Domestic Abuse Act 2021, children who see, hear, or otherwise experience the effects of domestic abuse are now understood as victims (Domestic Abuse Act 2021, s.3). This legislation is a step forward in the right direction, acknowledging domestic abuse in families constitutes a harm to children even when they are not physically harmed by the perpetrator. Unfortunately, research demonstrates that the response to children has so far failed to meet this recognition, with only a minority of survivors who want support for their children able to access it (Domestic Abuse Commissioner, 2022). Additionally, this change in legislation falls short of fully understanding the full breadth of children's experiences when they have a parent who is abusive. Along with continuing to experience the effects of post-separation abuse, research demonstrates that children's continued involvement with an abusive father puts them as risk of physical, sexual, and/ or emotional abuse, including witnessing the abuse of their mothers (Harne, 2011; Stanley, 2011; Thiara and Gill, 2012; Morrison, 2015).

Whether or not children are direct targets of abuse, domestically abusive fathers are found to parent in ways that are authoritarian, rigid, and neglectful of children's needs (Harne, 2011; Bancroft, et al. 2012; Mackay, 2017; Humphreys et al., 2019). Research with children often reveals conflicted, mixed, and ambivalent feelings towards contact with fathers who are perpetrators of domestic abuse. These feelings range from being happy to see their fathers, and missing them when they don't, having mixed feelings, to experiencing extreme fear at the prospect (Morrison, 2009, 2016; 2020; Trinder, et al. 2013; Women's Aid and Cafcass, 2017). Children often feel both love and hate towards abusive fathers, viewing them in confused, disjointed and /or contradictory ways. The priority for nearly all children in these cases is found to be safety for themselves and the rest of their families (Radford et al., 2011; Thiara and Harrison, 2016). In other words, and as explored in further detail in section 5, children's attitudes towards contact with an abusive parent tends to mirror that of their mothers.

Children's experiences of coercive and controlling behaviour

> *"The witnessing of an alleged serious sexual assault, hearing threats of suicide and being present during an actual suicide attempt, suggested that [child's] lived experience was set in a context of uncertainty, domestic abuse, coercion and control."*
>
> **– Case eleven.**

Coercive control is as an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten the victim. This behaviour is designed to make a person dependent upon the perpetrator, by isolating them from support, exploiting them, depriving them of independence and regulating

their everyday behaviour. Common examples include isolating someone and preventing them from accessing support, repeatedly putting someone down, and making threats (Women's Aid, 2025a). Coercive and controlling behaviour is usually interwoven with periods of seemingly 'caring' and 'indulgent' behaviour as part of the overall abuse pattern (Katz, et al. 2020).

Research shows that perpetrators use the same tactics of coercive control against their children that they use against their ex-partners, and that child contact provides abusive parents with opportunities to continue their abuse of the children as well as their ex-partners (Callaghan et al., 2018; Katz, 2016; 2019; 2020; McLeod, 2018; Stark and Hester, 2019). In all the eight cases where the child who was killed was over five years old there was evidence to suggest that they were subject to coercive and controlling tactics by the perpetrator. This includes refusing access to medical treatment, not letting children speak to agencies alone, preventing the children from accessing support, isolating children from family and/ or friends, verbal and physical threats, and physical abuse of the mother in front of the child/ ren. It is also worth noting that in some of these cases the surviving siblings reported similar experiences to the reviewers.

> *"The surviving [child's siblings] said that [mother] had isolated them as children from their wider family."*
>
> **– Case six.**

In case five, the police investigation following the homicide uncovered how the father had utilised contact arrangements to exert power over the whole family, controlling their everyday lives.

> *"The police criminal investigation found that the defining feature within the family was that of father's 'horrendous' coercive controlling behaviour which dictated every aspect of the lives of the mother and their children."*
>
> **– Case five.**

In case five, two separate safeguarding referrals were made to children's social care by healthcare workers at a hospital regarding concerns about the father's behaviour. The first one occurred after the child had presented at A&E with an injury that the child explained had been caused by his father.

> *"[Child] presented by father to the Emergency Department with [details of injury]. When asked how it had happened [child's name] said 'he (father) did it.' Father gave an alternative story of it being an accident."*
>
> **– Case five.**

The father's presence during the medical examination was acknowledged to have likely compromised the procedure, which was then found to have been in line with the father's explanation. This meant the child was not given the opportunity to speak about how he explained his injury away from his father, until he was subsequently asked about it at school by the social worker in the presence of his teacher. At this point the child confirmed his father's version of events and social services closed the case. There was a pattern of safeguarding referrals being made, including during routine appointments, but opportunities to speak with the child away from the father were not explored. Tragically in this case, when the father killed the child, he tried to frame this as an accident once again. When this was discovered not to be true, the professionals involved could not believe the level of manipulation he had been able to exert over them.

> *"When the [Joint Agency Response professionals] (who were highly skilled and astute) discovered that father had been totally disingenuous in everything he had told them, they were astonished at the level of manipulation and control he was able to exert over them."*
>
> **– Case five.**

This demonstrates how abusive parents can manipulate professionals into believing false stories about children who have been abused in their care, where they are often able to create a charming public persona, impeding victims' ability to seek help and be believed (Bancroft et al., 2012; Monk, 2017). The ability of other perpetrators to present themselves to professionals in a personable manner was acknowledged in further reviews.

> *"The father always presented to the pathways worker as engaged and would speak to the pathways worker."*
>
> **– Case four.**

Covid-19

After the first national Covid-19 lockdown, the number of reported incidents of children dying or being seriously harmed after suspected abuse or neglect rose by a quarter (Department for Education, 2021). This period of restrictions presented huge operational challenges for MARAC (Multi-Agency Risk Assessment Conference) responses, with some agencies reporting a reduction in working with criminal justice agencies (Women's Aid, 2021b). For the five cases where the period of review covered the Covid-19 lockdown restrictions, it was noted that this had placed these five families in compromising situations, limiting their ability to leave their homes and reducing agency involvement. These cases evidenced perpetrators utilising restrictions and fears surrounding the Covid-19 pandemic to exercise further control over the families.

In case one, a specific Covid-19 risk plan had been undertaken, however, this failed to adequately reflect the family's need when this was not updated with relevant information. This includes an occasion where the family were visited by a Child and Adolescent Mental Health Services (CAMHS) worker and the perpetrator was described as "very hostile" and had asked the CAMHS worker to leave. On another occasion, the father emailed the child's school to explain that he would not give consent for a Covid-19 vaccination or test for his child. Although vaccine scepticism was a highly politicised issue at the time, the email written by the father conveys an alarming perception of "ownership" over his child. This language proved to be a warning sign after similar comments were made by the father during the criminal trial following the homicides.

> *"As today is the beginning of the "vaccinations" being held in school for [age-range] olds you will be having visitors to the school to administer "vaccination". Although [child] is only [total years] years of age, I am fully informing you, your future successors and your colleagues which includes all visitors, be it signed or unsigned that I [father] of sound mind, father/owner of [child], know not to give consent for any testing medically or otherwise for example swabbing for rt pcr test/lateral flow test and any administering or treatment for example nasal sprays/injections on [child]"*
>
> **– Case one [email sent by father to child's school].**

In case five there had been some concerns raised by the school who felt that "something was not quite right," including the fact that the mother appeared to be a "very private person." The mother did not interact with other parents at the school, did not allow her children to attend school trips, for their surnames to be written on books, or to have their photograph taken. There had also been some absences from school, along with frequent address changes which were not reported. None of these concerns resulted in a safeguarding referral and the school were

unaware that the child had any contact with their father, with no record of the father on their school file. When the child became electively home educated during the Covid-19 national lockdown, there was further limited opportunity to establish and assess risk. Local authorities have no formal powers or duty to monitor the provision of education at home (HM Government, 2024) and therefore some children who require the attention of safeguarding agencies may not be visible to services.

> *"The nature of the abuse of the child in this review demonstrates that parents can disguise what is happening to a child at home and demonstrates how Covid 19 and Elective Home Education could be used as a tool by parents to deliberately evade statutory agencies to keep children hidden from interested professionals and allow child abuse to continue uninterrupted."*
>
> **– Case five.**

Children's voices

> *"Officers tried to speak with [child], who was noticeably upset, his parents advised this was because he was scared of Police, although no further explanation was given or requested."*
>
> **–Case two.**

At Women's Aid, we have consistently advocated for children's safety to be at the heart of any child contact decision making in the family courts and asked for children to be granted fair opportunity to express their wishes regarding contact (Women's Aid, 2004; Women's Aid, 2016). This includes assessing children over several weeks to establish the child's perspective and whether the child is at risk, as children are unlikely to disclose abuse during a one-off interview (Women's Aid, 2004). The Harm report (Ministry of Justice, 2020) identified several barriers to children effectively being able to communicate their views in private law child arrangements proceedings. This included not enough time being spent with children to understand their perspectives about contact, along with a 'selective listening' process; whereby only children who wish to have contact are listened to, and those who do not are either not heard or pressured to change their views. In case seven, a recommendation was made to the court for a child to have contact with their father based on a one-hour assessment with a clinical psychologist instructed by the family courts. The perpetrator in this case was a known domestic abuser who had come to the attention of police. The below quote from the clinical psychologist appears to allude to the child having some mixed feelings about contact with her father, yet a proposal for contact was put forward, thus providing an example of this 'selective hearing' process.

> *"'[Child] has a need to see [their] father and [they] were able to express this need consistently and with clear understanding... albeit [they] experience ambivalence in relation to him."*
>
> **– Case seven.**

Evaluation of the Private Law Pathfinder pilots suggests that the model has brought much improvement when it comes to centring the voice of the child compared to Child Arrangement Proceedings. The Pathfinder model introduces a focus on enhancing the voice of the child by gathering the views and experiences of the child/ren from the beginning of proceedings. Along with this, children engaging directly with judges are found to be more common at pathfinder sites than under standard Child Arrangement Proceedings. Nonetheless, the evaluation highlighted that there is still more to be done to understand what the voice of the child looks like in practice and what children want from proceedings. Additionally, we are yet to hear from both adult and child survivors directly about their experiences of the Pathfinder model (Ministry of Justice, 2025).

Case Study: Mental health, suicide and the long-term impact of domestic abuse on children and young people

The death of Alex[24] by suicide is a clear example of unmet need when it comes to the long-term impact of domestic abuse on children and young people. Coercive and controlling behaviour by Alex's father, involving sporadic acts of violence, was a defining feature of Alex's home life. Alex was the subject of a child protection plan because of concerns about the damaging effects of domestic abuse on all members of the household. However, when no domestic abuse incidents were reported for a year, services stepped back from the family. Neither Alex nor their siblings were offered any services to address the trauma they had suffered as a result of living in a household where domestic abuse had been a feature of their childhoods.

A Child Protection Conference was scheduled when Alex made serious threats towards teachers and other pupils and revealed his plans to run away. Alex had an autism diagnosis, which was rarely discussed at multi-agency meetings as part of the child protection plan. Relevant NICE (National Institute for Health and Care Excellence) guidance states that where there is a diagnosis of autism, the co-existence of mental health difficulties should be considered.[25] However, Alex did not meet the threshold for CAMHS intervention and there was limited other options available in the area. Alex's parents did not promote the need for adjustments to support Alex's Autism. Alex's behaviour became increasingly concerning, and shortly before their suicide, Alex made a report to the police proposing actions that indicated a risk towards themselves.

This case highlights the long-term impact of domestic abuse on children and young people, as well as the difficulties professionals face when attempting to intervene in a family where coercive and controlling behaviour is a feature. It accentuates the need for a joined-up approach which considers the impact of power dynamics within the home, such as the Safe and Together model.[26]

24 Pseudonym

25 National Institute for Health and Care Excellence. (2017) *Autistic spectrum disorder in under 19's: recognition, referral and diagnosis*.

26 The Safe & Together tools model is designed to help child welfare professionals improve their awareness and understanding of domestic abuse, and is based on three key principles: (1) Keeping children Safe & Together with their non-abusive parent, ensuring safety, healing from trauma, stability, and nurturance; (2) Partnering with the non-abusive parent as a default position ensuring efficient, effective, and child-centred practice; and (3) Intervening with the perpetrator to reduce the risk and harm to the child through engagement, accountability, and criminal justice.

2 Professional understanding of coercive and controlling behaviour

> *"The learning from this review, however, highlights the need for a step-change in terms of how professionals, agencies, and society as a whole understand and respond to domestic abuse. There needs to be a move away from incident-based models of intervention to a deeper understanding of the ongoing nature of coercive control and its impact on women and children."*
>
> **– Case 15.**

Despite its introduction into UK legislation almost ten years ago (Section 76, Serious Crime Act 2015), controlling or coercive behaviour remains widely misunderstood by many professionals (Robinson et al, 2018; Myhill et al, 2023). Research demonstrates that many professionals struggle to recognise and effectively respond to the wide range of controlling tactics and dehumanisation that perpetrators impose on survivors (Stark, 2009; Myhill, 2015). Coercive and controlling behaviour is at the centre of domestic abuse and is therefore a significant feature of the reviews. Unfortunately, all too often in these reviews there was a focus on individual incidents, rather than recognising the pattern of behaviours that make up coercive and controlling behaviour. This echoes our findings from the *Nineteen Child Homicides* (Women's Aid, 2016), with similar tactics used by perpetrators (before and after separation). This time there appears to be more examples of these behaviours detailed in the reviews, possibly indicating some increased awareness of these behaviours by professionals.

The examples of coercive and controlling behaviour include but are not limited to:

- **Isolating them from informal support networks** i.e., confiscating the survivor's phone, monitoring their phone and emails, stopping them from seeing/ visiting family members.
- **Preventing them from accessing support** i.e., not providing agencies with mother's number, telling professionals they do not want support, disabling security protections in the house.
- **Threats to harm children and/ or mother.**
- **Threats to kill children and/ or mother.**
- **Threats to commit suicide.**
- **Stalking and harassment.**
- **Monitoring of/ obsession with the mother's private life.**
- **Manipulating professionals** i.e., not letting children or survivors speak to professionals alone, falsely raising concerns to professionals about the mother's mental health or parenting capacity, making false allegations of domestic abuse against the mother.
- **Harming pet animals.**
- **Threatening and frequent communication after separation** i.e., "abusive texts."
- **Monitoring and controlling what the survivor eats** i.e., Using medical test strips intended for diabetics to indicate what she had eaten.
- **Repeatedly putting the mother down** i.e., telling the mother she is a useless parent.
- **Controlling where they can go** i.e., confiscating the mother's keys to her home, not allowing her to go out, not allowing mother to apply for child's passport to visit mother's country of origin.

Nonetheless, there were instances where professionals did not appear to recognise the behaviour of the perpetrator as being part of a wider pattern of coercive control. In the three cases where the mother was also killed at the time of the child homicides, the DASH risk assessment had been scored as medium risk. Similarly, a study of Domestic Homicide Reviews (DHRs) published between 2017-2019, found that 66% of victims/survivors were not assessed as at high risk (Chantler et al, 2023). These findings further highlight the need for risk assessment tools that account for coercive and controlling behaviours, such as the Domestic Abuse Risk Assessment (DARA) (College of Policing, 2022).

In cases three and 12, the lack of discussion around domestic abuse was identified as a specific learning point in the reviews. In case three, the health visitors failed to complete the routine domestic abuse questionnaire, and made no attempts to investigate the father's history or parenting capacity despite knowing he did not have contact with previous children.

> *"It is notable that Health Visiting knew very little about [father]. They knew he had [another child] with whom he had no contact but did not know why this was and had not asked anything about [father's] history or made any attempt to assess his parenting capacity. The domestic abuse routine enquiry questionnaire had not been completed despite the number of visits to [mother]."*
>
> **– Case three.**

In case 12, the lack of discussion around types of domestic abuse, such as financial or economic, was identified as something that needed to be covered in training for agencies.

> *"[The mother] said, that in hindsight she recognised that [father] had some financial control over her [...] as this information was not known at the time of writing the report consideration of financial abuse was not an area explored in depth although the lack of discussion in relation to domestic abuse was identified as an area of learning. The Board will therefore need to assure itself that the domestic abuse training and the questioning of women regarding them experiencing any domestic abuse covers all aspects of abuse and does not concentrate solely on physical abuse."*
>
> **– Case 12.**

In some cases, professionals did appear to recognise controlling behaviour by the perpetrator but failed to follow up concerns or put safety measures in place proportionate to the nature of the abuse. For example, in case 11, after an incident involving the police, a multi-agency safeguarding hub referral was made. The social worker contacted the mother to discuss this and was surprised when the father answered the phone.

> *"The social worker was somewhat surprised that the telephone was answered by [father], [...]. Having enquired why he was in possession of his partner's telephone; an explanation was given that his own mobile device had been confiscated by the police."*
>
> **– Case 11.**

The social worker then contacted the police to ask why the father's phone had been confiscated after this incident and to check if this was the case. The police officer on duty was noted to also be "puzzled" by this, however, they did not actively follow this up to see if it was true. This father had already come to the attention of police for several domestic and sexual violence offences against the mother. Following this, an assessment conducted by the social worker and health team during a home visit noted several concerning aspects in relation to the parental relationship. This included intense jealousy, alcohol and substance abuse, the minimisation of previous sexual violence perpetrated by the father onto the mother, and the fact that a safety measure appeared to have been dismantled by the perpetrator. The social worker concluded that further assessment was needed but requested the parents to sign a written agreement agreeing not to argue in front of the child as a holding arrangement.

> *"An alarm system present in the house, fitted at the time of the reported sexual assault was noticed to have been deliberately dismantled by [child's] father [...] Social worker had conducted an assessment and made parents sign a written agreement not to 'argue' in front of their child. In light of the history, the word 'argue' rather underestimated the nature of the relationship issues that were being described in the assessment document."*
>
> **– Case 11.**

This example demonstrates a substantial underestimation and over-optimism of risk in the home, which led to safety not being established when the opportunity arose. This exemplifies why intervention models that work well in other contexts, such as in the context of neglect, cannot be relied upon in cases of domestic abuse, such as the use of a written agreement. The use of a written agreement is inappropriate and unsafe in cases of domestic abuse, especially within a context of coercive and controlling behaviour, where the non-abusive parent is not able to act independently or with parity.

Additional barriers

Crucial to recognising and responding to coercive or controlling behaviour is understanding the way in which perpetrators will exploit a survivor's vulnerabilities to exercise further control. Although The Harm Report (Ministry of Justice, 2020) addressed some of the intersecting structural disadvantages faced by some survivors engaged in private law child proceedings, it failed to offer a fully nuanced understanding of the specific structural barriers that some survivors face when it comes to accessing the family courts (Women's Aid, 2022). In our report, *Two years too long* (Women's Aid, 2022), we spoke with specialist domestic abuse 'by and for' service providers about the impact these barriers have on some survivor's access to the family courts. Concerns raised included limited provision for interpreters; experiences of stereotyping and discrimination; and fears regarding information sharing from survivors with uncertain or insecure immigration status.[27]

Unfortunately, these issues can be identified in two out of the three cases in the report where the mothers were from a Black or minoritised background. For example, in case one, the perpetrator used the survivor's immigration status to control her by telling her he could have her deported and stop her having any contact with their child. This form of control continued after the mother was no longer dependent on the perpetrator for her immigration status. Yet, it seems that practitioners supporting this survivor did not explore how the perpetrator was using misinformation to control her. It was also noted in the review that practitioners supporting the mother did not feel able to question whether any specific cultural norms or expectations played a role in this mother's relationship. As a result, they failed to fully explore what informal support there was available to her as well as what specific information she needed to understand to empower her.

> *"Practitioners commented that they had rarely discussed [mother's] [country of origin] culture with her, beyond light conversations about food or weddings. [Country] is a hugely diverse country and attitudes to women's rights, marriage and domestic abuse vary greatly across different regions, religions, and communities. Agencies were unable to clarify what region of [country] [mother] was from, her family's primary language or religion. This was particularly important in the context of her experience of domestic abuse. It is very clear that [mother's] family were strongly of the view that the couple should separate, and they provided practical, financial and emotional support to her to leave [perpetrator]. However, practitioners were not aware of her family's position and opening up a conversation about her cultural experiences may have been an opportunity to identify that her family members could have played a key role in her safety plan. It may also have helped to explore the misinformation [perpetrator] was using to control [mother] in respect of his ability to influence Home Office decisions about her immigration status."*
>
> **– Case one.**

27 Fears that information about uncertain or insecure immigration status will be shared with the Home Office if they engage with the family courts.

This survivor would have likely benefitted from support from a specialist Black and minoritised 'by and for' domestic abuse service. Specialist 'by and for' services are run by and for the communities they serve and offer a uniquely empowering experience through a comprehensive understanding of the additional structural barriers that some survivors encounter. Specialist 'by and for' services can respectfully explore and challenge religious and cultural misconceptions, often with the additional benefit of having speakers of the same native language as survivors (Women's Aid, 2024). Although the survivor in case one had the support of an Independent Domestic Violence Advocate (IDVA), this was not one who was employed by a specialist 'by and for' domestic abuse organisation. Provision of specialist 'by and for' domestic abuse services are scarcely limited, and most are based in London (Women's Aid, 2025b). Research into 46 cases of domestic homicides and suicides of Black and minoritised women over a ten-year period found that almost all the women who were killed were not receiving support from 'by and for' services, despite the majority having disclosed abuse to agencies (Imkaan and Centre for Women's Justice, 2023). Although the review noted that since the homicides a 'specialist minority IDVA'[28] had been employed in this survivor's area, there was only one for the entire local authority, and therefore the mother may still have been unable to access this support.

It is nonetheless imperative that all practitioners receive comprehensive training to understand the diverse needs of survivors so they can advise appropriately. The *Nowhere to Turn 2025* report (Women's Aid, 2025c) identifies a worrying trend of professionals advising on and submitting immigration applications on behalf of survivors when they are not regulated to do so. This is illegal and has serious implications on survivor's immigration options. Had the survivor had access to advice from someone regulated to provide immigration advice, this could have mitigated her fears that she was dependent upon the perpetrator for her immigration status in the first instance.

In case 14, the agencies involved did not attempt to speak to the mother alone about her relationship or provide a language interpreter. This survivor was therefore not given an equal opportunity to discuss the domestic abuse she was experiencing. This enabled the father to exploit both the mother's language support needs and limited knowledge of support services. As a result, this mother was disempowered and did not understand what was happening or what services were available to herself and the children.

> *"A key dynamic in the response to [child's] mother was her limited ability in English. It is not clear what active thought was given to her need for an interpreter. [Child's] father often spoke of her poor English, and he acted as her spokesperson, yet it is not clear that he was a [native language] speaker. Several practitioners spoke to her on the phone or face to face in his presence. It is not clear that she was ever offered an interview, advice or support in her own right, or asked if she would like or was even encouraged to have an interpreter."*
>
> **– Case 14.**

The provision of an independently trained interpreter who can report from a neutral stance and bring the voice of the survivor into the assessment analysis is a simple way services to improve their assessment efficacy. Research shows that perpetrators who are more highly educated and successful and better able to communicate in English, can manipulate survivors' accounts and persuade agencies to accept their version of events (Imkaan and Centre for Women's Justice, 2023). This distorted perception can significantly impact professionals' understanding of the narrative and support a case of disguised compliance.[29]

28 The review defined such role as someone who is 'experienced in engaging with people who are BAME, LGBTQ+ or have a learning disability'.

29 Disguised compliance is a term used to describe the behaviour of parents or carers who appear to co-operate with professionals in order to allay concerns and stop professional engagement (Reder, et al. 1993). Examples of this behaviour include minimising concerns or denying there is a problem; active concealment of information; inconsistent engagement; manipulating or misleading professionals to avoid engagement or intervention; and saying the right things or doing 'just enough' to satisfy professionals (NSPCC, 2025).

Online influence

Domestic abuse is a gendered crime; it is overwhelmingly perpetrated by men onto women, who encounter higher rates of repeat victimisation, are more likely to be subjected to coercive and controlling behaviours, experience fear relating to the abuse, and be seriously harmed or killed than male victims (Hester, 2013; Myhill, 2015; 2017; Walby and Towers, 2018; ONS, 2024). This is a result of inequality between men and women in society, where misogynistic attitudes, gender stereotypes, and gendered social norms play a significant role in women's experiences of domestic abuse. These factors set the scene for male abusive partners' coercive and controlling behaviours and serve to excuse abusive behaviour by men in intimate relationships with women (Women's Aid, et al. 2021). In our *Influencers and Attitudes* report (Women's Aid, 2023), we identified a concerning correlation between children and young people's exposure to online misogynistic content and a greater tolerance of harm within intimate relationships. To mitigate this, we recommended that the Department for Education should ensure that Relationships, Sex and Health Education (RSHE) includes teaching children and young people to think critically about such content they encounter online. This way they will be more likely to recognise when something is potentially harmful and equip them with the confidence to disagree with it.

In case one, it was noted by a social worker during a home visit that the couple were living together but leading separate lives, and that the father did not go out and spent much of his time on his computer. Whilst they were not able to obtain evidence from his computer (he destroyed it after killing his ex-partner and child), it was noted in the review that comments made during his trial suggest he had become involved with toxic masculinity and conspiracy theory groups online. The father in this case exercised a range of coercive and controlling tactics over the family, including monitoring the mother's phone and emails, controlling her diet, and making threats to kill her and the child. A quote below from the judge during the trial suggests that the father believed killing his child and ex-partner was justified based on information he had read online.

> *"You have attempted to justify these murders by reference to a deeply flawed set of beliefs about the law that you appear largely to have derived from internet searches. You say that [mother's] infidelity with [mother's new partner] was a form of treason and that the punishment for treason is death. You say that killing her was therefore legal. You say that [child], being your [child], was your property, and you therefore had the right to kill [child] rather than leave [child] behind after your death to be looked after by what you consider to be a corrupt system."*
>
> **– Case one.**

We solely explored the impact of exposure to misogynistic online content on children and young people's attitudes towards domestic abuse in our *Influencer's and Attitudes* report (Women's Aid, 2023). However, the perpetrator in this case was not a child or young person, he was an adult living with a dependent child. Neither was he known as having any additional learning needs or mental health support needs. This therefore raises questions about just how potent the influence of this type of content can also be for adults, possibly indicating a need for further research in this area. From our other research we know that many domestic abuse services across England are running domestic abuse prevention or educational work without any dedicated funding (Women's Aid, 2025b). Cases such as these highlight the need for these services, especially ones that address the impact of online content.

3 Understanding child contact as a tool to manipulate professionals

> *"There is also no evidence of any discussion with Mother about managing the potential risks of separation, however mutual the decision might appear to be at that point."*
>
> **– Case nine.**

There is a considerable body of research demonstrating the way in which coercive and controlling tactics often escalate at the point of separation, and how post-separation contact can facilitate the continued abuse of women and children (Harne, 2004; 2008; 2011; Morrison, 2015; Katz, 2020). In some cases, this form of post-separation abuse can take the form of a deliberate strategy to erode the mother's confidence in her own parenting skills and influence the views of professionals involved in child contact arrangements (Thiara and Gill, 2012; Mackay, 2017; Humphreys et al, 2019; Women's Aid, 2018; Birchall and Choudhry, 2022). Along with restricting the families' access to support agencies, many perpetrators in these cases also attempted to manipulate professionals' perceptions of the mother specifically regarding issues relating to contact.

> *"[Father] controlled what she did and where she went, and she was frequently told by him that she was a useless parent and could not look after her children. She was threatened with exposure and losing her children if she spoke out about what was happening."*
>
> **– Case 15.**

In case 15, there was a non-molestation order in place to prevent the father from contacting a previous partner and the child they had together. It was detailed in the review that when the father breached this order, he told agencies that his actions were solely a result of the mother preventing him from having access to his child. He then made the same argument to the reviewers regarding his actions towards his subsequent partner and the child they had together who he had killed. Comments made by third parties in the review state that they believe the father "could easily dupe people into thinking he was OK and a good father." In this case, the police responded to numerous domestic abuse incidents and the father attempted to position the mother as mentally unwell and unable to cope as a parent.

> *"[Father] told officers that [mother] was struggling to cope with being a new mother and [...] also said that [mother] had postnatal depression but would not seek medical treatment."*
>
> **– Case 15.**

Claims by perpetrators that their abusive behaviour was a result of only wishing to see their children was common in these case reviews where the father was a known perpetrator of domestic abuse. It does not appear that this led to an increased understanding of risk for the survivor and child by professionals, indicating a minimisation of domestic abuse on behalf of professionals.

> *"The abuse intensified after the birth of their child - perpetrator made numerous references to not being allowed contact with his child as a driver of harm he may inflict."*
>
> **– Case 17.**

> *"The police attended a domestic incident at the mother's home. Mother reported that the father had tried to snatch [child], but there was no report of physical assault or injury. The father claimed that he only wished to see his daughter regularly."*
>
> **– Case seven.**

In case eight, the father sought support from a health professional regarding his mental health, including thoughts of deliberate self-harm and suicidal ideation. The GP "assessed that his relationship with [child] was a protective factor" for that father. The father in this case had made previous threats to the mother that if he killed himself, it would be her fault. He then went onto to kill his child, the two pet dogs, and himself after he had sent a message to the mother saying he would "only leave her with memories." A key recommendation made as part of this review was that children themselves should not be considered a protective factor when it comes to undertaking risk assessments with adults.

Pro-contact culture

A key issue identified in The Harm Report (Ministry of Justice, 2020) which impacts on the family court's ability to identify, assess and manage risks to children and adults was evidence of a pro-contact culture in the courts. This included the systematic minimisation or disbelief of abuse, along with the acceptance of counter-allegations without robust scrutiny. In case seven, the father had come to the attention of police on numerous occasions for physical abuse of both the mother and the children following the parent's separation. The father made an application to the family court for residency of his biological child and the mother in turn expressed that she and both her children had been subjected to domestic abuse and stalking from the father. The judge was concerned by the father's written submissions and evidence he provided to the court and granted the mother residency of both children and stated that contact with father's biological child must take place in a neutral venue.

> *"The father's submission to the court contained extremely demeaning statements about the mother. He presented himself as having offered significant assistance and encouragement to all of the family members, who had, he stated, benefited from his involvement in their lives."*
>
> **– Case seven.**

Following this the father made a series of applications for child contact to the family court over a long period. The court made orders on several occasions to arrange either supervised or indirect contact (via the exchange of letters). The court took the view that unsupervised contact should not take place until there was evidence that the father could have contact with the child without upsetting them or placing them at risk. Although this point of unsupervised contact was never reached, with instances of the child not responding well to supervised contact, on multiple occasions the court instructed the mother to behave congenially towards these arrangements.

> *"On more than one occasion the court made an order which sought to determine the details of interpersonal behaviour (for example instructing that the mother should encourage [child] to respond positively to cards and letters sent by [their] father or provide him with details of [their] preferred leisure activities)."*
>
> **– Case seven.**

The Harm Report identified the acceptance of counter-allegations without robust scrutiny, including allegations of so called 'parental alienation.' Research demonstrates gendered myths and assumptions underlying discourses of 'parental alienation' (Feresin, 2020; Meier, 2020) which undermine the prevalence, seriousness and gendered reality of domestic abuse (Nicholson-Pallett, 2024). Barnett (2020a: 10) argues that under the concept of parental alienation, 'to be a "good", non-alienating mother, women must not only permit, facilitate and encourage contact, they must be "enthusiastic" and self-denying, whatever the behaviour of the father might be'. We do not

know if the perpetrator made counter-allegations of so called 'parental alienation' in this case. Regardless, it is arguable that the court's repeated requests for the mother to be encouraging of this contact, despite their own reservations about the father's behaviour, is demonstrable of the sexist expectations placed on mothers underpinning the theory. Additionally, the mother expressed a belief to the reviewers that she would be dismissed or regarded as difficult if she expressed the true extent of her concerns regarding contact to the court.

> *"She felt that when she voiced fears about what could happen (i.e. that [child] could be abducted or she could be seriously harmed) there was a perception that she was 'crazy' [...] [Child's] mother had been very aware that she risked being viewed as 'obstructive' in the court process to a reasonable resolution if she voiced the level of concern that she had actually felt."*
>
> **- Case seven.**

One of the provisions brought about as part of the Domestic Abuse Act 2021 includes implementing a new section into the Children Act (1989), clarifying how barring orders (section 91(14) orders) should be used. This enables courts to prevent perpetrators of domestic abuse from persistently taking survivors back to court over child contact (Foster, 2021). Recent research suggests that these are being granted more frequently in cases involving domestic abuse since the Domestic Abuse Act 2021 (Barnett, 2024). Whilst in this case there was evidence of ongoing domestic abuse and stalking, it is not clear whether a consideration for an order was made. However, it seems likely from the mother's worries regarding raising concerns about the contact that this was not the case. There is evidence that the family court is an area where economic abuse can be facilitated and perpetuated (Women's Aid, 2018; Surviving Economic Abuse, 2025). In this case, the father's repeated applications to the family court impacted all the mother's decisions, as she was kept in a perpetual state of worry about whether she would be able to fund court involvement.

> *"She had been constantly in a struggle to fund involvement in the court because of the fear that legal aid would not be available. The fear of financial difficulties constrained all her other choices."*
>
> **– Case seven.**

Case Study: Sexual abuse and pro-contact culture

Charlie[30] disclosed that they had been subject to sexual abuse by their father whilst living with their mother and siblings. Charlie was having regular contact with their father who had previously spent time in prison for having sexually abused a child. Upon his release he was put on a licence stating that that he was 'high risk' and was not to have contact with anyone under 18 years old. This however did not apply to his own children, including Charlie, where the outcome of a Children's Social Care assessment established that he could have contact with them if this was supervised by another family member. The presumption here was that he did not pose a risk to his own biological children because his previous victim had been unrelated to him.

There was a review of these contact arrangements following the school enquiring about the situation after observing the father collecting Charlie and siblings from school on his own. Children's Social Care agreed the requirement for supervised contact could be 'relaxed,' following a conversation with the Police Sexual Offender Manager (SOM)[31], "who confirmed there was no requirement for him to be supervised with his own children as far as his registration was concerned." Nonetheless, the father remained on the Sexual Offenders Register and there was a conversation with the mother where she was told she needed to remain cautious and that he may remain a risk. Following the ease of these restrictions, a routine unannounced visit by the SOM discovered the father to be looking after Charlie and siblings as well as some of their friends unsupervised. As it had been made clear that he should not have unsupervised contact with other children action was taken in this instance. This however did not include a reassessment of the father's risk towards his own children, even though the father had now been identified as failing to meet the expectations of this contact on two occasions.

The mother explained to the reviewers that she had felt too afraid of the father to report the domestic abuse she was experiencing from the father. Both she and the children were afraid of him, as he would often get angry and could be controlling. Whilst the mother did not report it, there were indicators that could have been picked up on, including contacts to the police made by neighbours and this being shared with children's social care. A key area of learning identified from this review was recognising that child sexual abuse often co-exists with other risks to a child, such as domestic abuse or neglect. This case demonstrates the pervasiveness of a pro-contact culture and a need for a joined-up approach which recognises that children who need protecting includes those who experience harm in their own family as outlined in statutory guidance.[32]

30 Pseudonym

31 A Sexual Offender Manager (SOM) is a police officer responsible for managing sexual offenders in the community.

32 See: HM Government (2023) *Working Together to Safeguard Children 2023*.

4 Agency separation as a risk factor

> *"The combination of father living apart from them, with contact taking place supervised at [third party's] home, was the status quo judged to keep [child] safe."*
>
> **– Case two.**

A key issue identified in *Nineteen Child Homicides* (Women's Aid, 2016), was a common misconception amongst professionals that parental separation equated to the end of domestic abuse and a reduction in risk for the child(ren) and mother. Whilst this theme still emerged in these case reviews, there was also evidence of some improvements possibly indicating some increased awareness of this. An example of this includes case one where a DASH risk assessment was regraded from 'medium' to 'high' after professional judgement was applied to the contextual information. It highlighted the fact that the mother "was looking to leave a lengthy abusive relationship which has included rape, violence, isolation and control, this significantly impacts her risk for the future." An Independent Domestic Violence Advocate (IDVA) was then allocated, and the case was referred to the local authority's Multi-Agency Risk Assessment Conference (MARAC).

Nevertheless, some of the cases demonstrated a continued lack of understanding of the duality of risks for **both** the mother and child post separation. For instance, in case 17 the perpetrator had a criminal history of domestic abuse and had been assessed as posing a medium risk of serious harm to intimate partners, particularly if they ended the relationship. The fact that he had recently become a father through a relationship that had not long ended did not lead to an increased perception of risk amongst professionals. A related key theme which was commonly identified in these case studies was the issue of **agency separation**; whereby agencies ceasing their support of families and failing to share relevant information with one another became a risk factor. In the same way that the point of leaving the perpetrator is a crucial risk indicator, so is the point in which agencies step down and end involvement. In a few cases the issue of agency separation would appear to correspond directly with understanding parental separation as a risk.

> *"Although [survivor] told the school in [date] that she was making concrete plans to move out from the family home, the school was not aware of the [analysis in the DASH risk assessment] that this could increase the danger."*
>
> **– Case one.**

The cases in this report illustrate how lack of information sharing between agencies impacts crucial decision making when it comes to supporting families around child contact.

> *"Whilst there was reference to the three reports to the police from neighbours about verbal arguments at the family home, it also indicates that the police had not referred these incidents to DAP under the domestic violence information sharing arrangements. This appears to have influenced the decision that there was no role for CSC, despite [mother's] current pregnancy."*
>
> **– Case 15.**

> *"During the first pregnancy the midwife asked the mother if there was any domestic abuse, substance misuse or parental mental health difficulties in the parent's histories. She was assured by the mother that no such factors were present. Although the father's name was known, and the midwife made an informal telephone call to the Safeguarding Hub. She didn't make a formal contact as set out in the local procedures. The safeguarding hub had no record of the phone call. If a formal contact had been submitted to the safeguarding hub, information about the father's mental health and substance misuse issues could have been highlighted. This affected the midwife's assessment of risk and a prebirth assessment was not triggered."*
>
> **– Case four.**

> *"The mother reported to the police that her solicitor had inadvertently revealed her new address to the father in legal papers. She was concerned that he would seek to remove [child] and that previously he had stated in court that he had been stalking them. She stated that she was very worried for the safety of the children. The police recorded this information correctly in records and sought to pass it to the neighbourhood policing team for further action. It was passed in error to the wrong neighbourhood team where it was closed without further action."*
>
> **– Case seven.**

In case two, the father had spent time in prison for seriously harming one of his children and their mother. Following his release, the children were made subject to a child protection plan and care proceedings were initiated. Both parents underwent parenting assessments, and it was decided that father would not be allowed to be a primary caregiver to his children. Following this, the court implemented a Supervision Order requiring the children to live solely with their mother. As a result, the child protection plan in place ceased, and then Children's Social Care suspended their involvement with the family within days of the supervision order expiring.

> *"Children's Social Care ceased their involvement within days of the Supervision Order expiring."*
>
> **– Case two.**

Following this, the family came to the attention of agencies on multiple occasions, who once again became involved. Unfortunately, there were numerous failings by statutory agencies to discuss relevant information with each other. The father attempted on multiple occasions to terminate the involvement of agencies as part of his coercive and controlling behaviour. Finally, when none of the other five agencies involved were able to report any engagement with the parents, the survivor advised the midwife that the father had moved back into the family home because of the Covid-19 lockdown. Despite this presenting a risk, this information was not escalated either internally or externally. Not long following this, the father killed and seriously harmed his other child.

> *"Mother advised midwifery that father had moved into the home because of the Covid lockdown [...] Despite this being a known risk to [the children], this information was not escalated within Health or shared with any other agency."*
>
> **– Case two.**

This is one of the five cases where the review period covered the Covid-19 national restrictions. In all these cases, it was acknowledged that these restrictions had played a role in limiting survivors' ability to leave their homes and agencies' ability to engage with families. In our report, *The impact of the Covid-19 pandemic on children experiencing domestic abuse 2022* (Women's Aid, 2022), we explored how every statutory service, agency and system had been affected by Covid-19. This included the way things were run, processed, handled and the impact on the time that these things take. However, even in cases where the lockdown restrictions were not relevant, agency separation was still a common theme.

> *"Police took mother to hospital but did not have a direct conversation with a clinician about the reasons for her coming to hospital because of the absence of systems for speedy confidential exchange of information between Police Officers and medical staff."*
>
> **– Case six.**

> *"[Mother's] disclosure to the police of [father's] threat to kill her and her [number removed] children did not result in a thorough investigation and action to protect them; there were missed opportunities to refer the case to children's services who could have made their own risk assessment of potential harm to the children."*
>
> **– Case eight.**

Resource constraints and silo working

The Harm Report (Ministry of Justice, 2020) identified four key issues hindering the court's ability to recognise and adequately respond to domestic abuse in private family law proceedings. Two of these were resource constraints and silo working, corresponding directly with the theme of agency separation in this section. The two cases in this report where contact had been formally arranged through a Child Arrangement Order (CAO) in the family courts provide further evidence of these issues.

In case six, both the police and children's social services were delayed in providing CAFCASS with relevant information for their safeguarding checks and assessment for the family court. For children's social services, this was noted to be linked to administrative delays. When social services did provide this information to CAFCASS this was not reflective of the full history they had on record.

> *"There were a number of areas where information sharing between professionals could be improved: [including] the delay in [local authority] Police providing CAFCASS with information when they were undertaking safeguarding checks; and the third was the lack of detailed information provided by Children's Social Work Services to CAFCASS."*
>
> **– Case six.**

Case seven involved two separate local authorities, including one where the family had previously resided together, and the other where the family had fled to upon leaving the abusive father. At the time there was no procedural requirement on the professionals involved to notify the MARAC coordinator that the family had moved.[33] This led to different understandings of the risks associated with child contact between these separate local authorities.

> *"Social workers in [local authority] felt that the efforts to promote contact between [child] and [child's] father were not in [child's] interests and would continue to be fruitless. However, staff in the [other] local authority did not express this view and limited their reports largely to factual reporting on the practicalities of contact, as they had been asked to do."*
>
> **– Case seven.**

Under existing legislation, the court may ask Cafcass or the local authority to assist its decision making when considering making an order by preparing a section 7 report on the welfare of a child.[34] The national protocol to help determine which agency should take responsibility for a section 7 report states that when an agency is or has recently been involved with the family it should be allocated the case (ADCS and Cafcass, 2022a). In

33 There is now national guidance for the transfer of cases between MARACs when a victim moves between areas.

34 A section 7 report seeks out to obtain more information about a child's welfare and what action is in their best interests (Children Act 1989, s.7). The court can order a section 7 report to consider, where a child should live, who a child should spend time with, the wishes and feelings of a child, whether they have suffered or are at risk of suffering harm, etc. (ADCS and Cafcass, 2022b; Rights of Women, 2023).

case seven, this was identified as the local authority, who at the time did not have a full understanding of the domestic abuse. The review acknowledged that this case would likely have benefitted from further Cafcass involvement.

> *"[Child's] interests would have been better served if Cafcass had been more involved in this case and prepared some or all of the Section 7 reports. This is likely to have allowed better oversight of the issues of residence and contact and a better understanding of the role and powers of the courts that a specialist can bring."*
>
> **– Case seven.**

In case seven, private law proceedings in relation to residence and contact arrangements had started many years earlier and remained active at the time of the homicide. Cafcass new Domestic Abuse Practice Policy promotes greater emphasis on the role of Cafcass practitioners, especially in long running or repeat proceedings. This includes opportunities to carry out a 16 A risk assessment.[35] The Policy allows for this to be scrutinised more with a focus on gaps and themes throughout proceedings. In case seven, there were repeated attempts to arrange contact with the father, who did not respond in a proactive manner. Had the policy been in place at the time, it would have been mandatory that Cafcass continuously reflect and assess the case and make no recommendations "without clear evidence of recognition, acceptance of responsibility, action to demonstrably change their behaviour and attitudes and an assessment of reduced risk, on the abusive parent's part" (Cafcass, 2025).

> *"In this case however it is apparent that the killing of [child] is linked to the history of domestic abuse in the family and it is legitimate to ask whether, knowing that there had been a substantial history of violence in the family, professionals might have prevented the death if different steps had been taken to shield [child] from contact with [child's] father or to protect other family members."*
>
> **– Case seven.**

Additionally, there was evidence in some of the cases where contact was informally arranged that resource constraints and silo working had impacted information sharing between agencies.

> *"The GP did not flag the concerns regarding the father to the midwife, after the mother booked her first pregnancy with the GP [...] There were significant staffing issues in the surgery which meant it was short staffed. At that time midwives did not have access to GP records which is why this information wasn't detected as part of routine enquiries made by the midwife."*
>
> **– Case four.**

In case 18, the perpetrator had signed an agreement with probation that he would disclose any new relationships with the probation service. There was then a mechanism in place for the women's support worker to contact partners and make them aware of risks posed by the perpetrator because of his recent domestic abuse convictions. As requested, the perpetrator shared that he was back in contact with a previous partner to a staff member at the probation service. Whilst this information was recorded in the worker's case notes, the procedure required that the probation officer must be informed of this specific development both verbally and then followed up in writing. Due to high caseloads the probation officer was unable to read the case notes thoroughly in detail and flag this information themselves.

> *"The probation officer relies on the system working, so although in ideal circumstances, they would read the case notes and hence would have picked up the information and made the relevant referral to the [Women's Support Worker] themselves, that did not happen in this instance. The probation officer was responsible for 60 cases at the time, so was unable to prioritise reading all the case notes."*
>
> **– Case 18.**

35 Section 16A of the Children Act 1989 states that: "If [...] an officer of the Service [...] is given cause to suspect that the child concerned is at risk of harm, he must a) make a risk assessment in relation to that child and b) provide the risk assessment to the court." (Children Act 1989, S.16A).

Limited history and relevant information

Another issue was that sometimes the agency involved did not have access to a full comprehensive history of the cases allocated to them. This in turn impacted these professionals' understanding of the situation and possible risks.

> *"There is no evidence to confirm whether the midwife shared the history and concerns relating to mother mental health with the health visitor. However, it is established from the health visitors records that they do not appear to be aware of her history which would have informed their assessment of her health needs."*
>
> **– Case six.**

In case four, the lack of comprehensive chronology on the social care record impacted the understanding of the family's situation. It is an expectation that chronologies are a standard part of social work records, but this is often undermined by frequent hand off points when the family case moves teams, and the significant turnover of staff in many local authorities. We know that there can be an adversarial nature to social work, with cases being pushed through and closed quickly and social workers not being afforded the necessary time to review cases ahead of intervention. Had this information been available, this family would have met the threshold for a pre-birth assessment during the mother's pregnancy.

> *"The worker had known the mother for some years but when she was allocated to him, although there was a chronology on file, it was not a comprehensive chronology. This impacted upon the understanding of the full impact of the mother's adverse childhood experiences and the previous concern that she had been exploited by the father of [child] in [year]. […] This family was a family that would have met the threshold for a prebirth assessment if all of the available information had been pieced together."*
>
> **– Case four.**

In case 17, a key learning outlined in the review was that applications for Police National Computer (PNC) checks submitted by children's service practitioners should seek to obtain information relating to a person's offending history beyond the most recent two years.

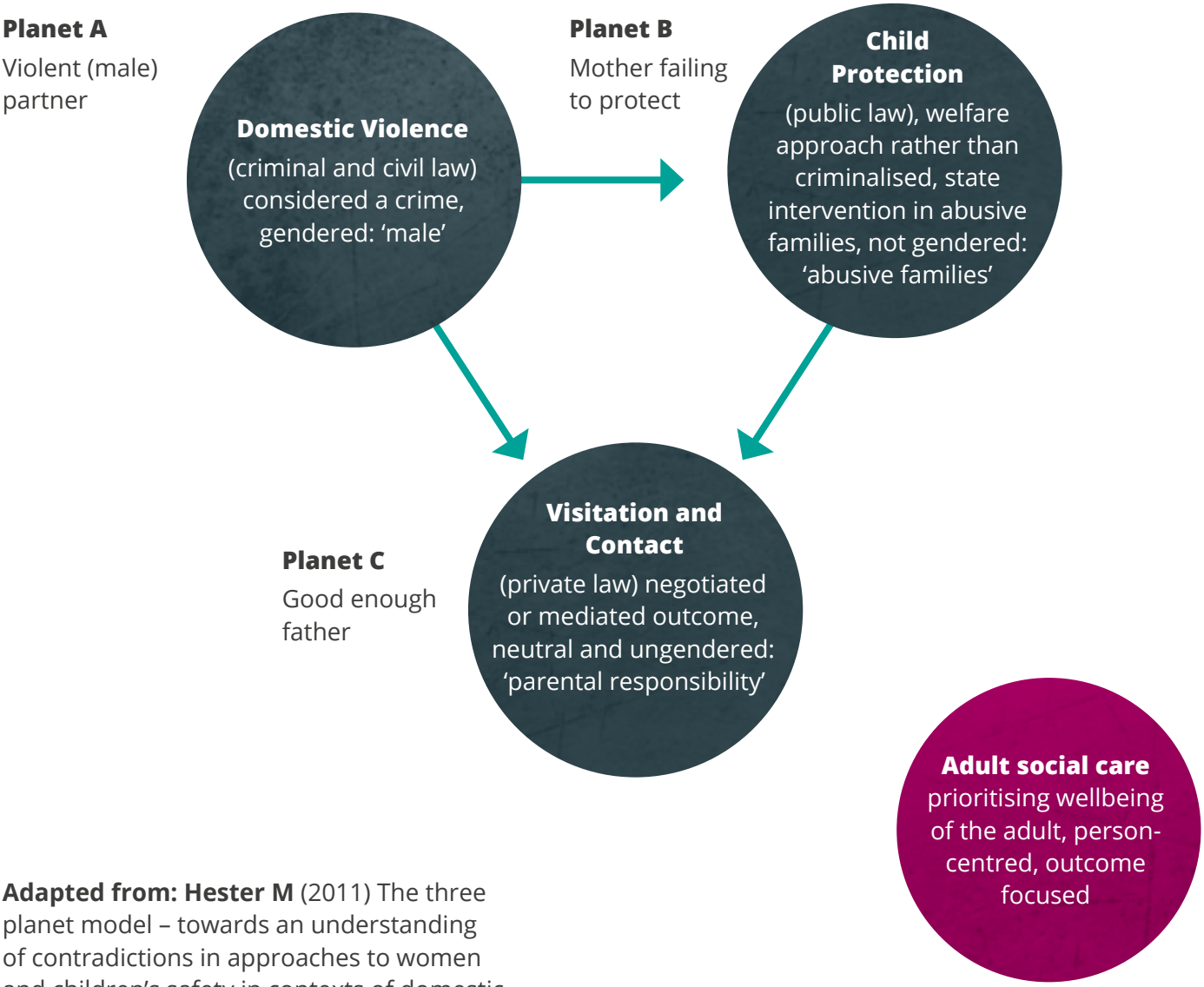
> *"PNC checks submitted by children's services practitioners will routinely seek disclosure to include all information relating to a person's offending history and make clear this is not limited to just information from the preceding two years."*
>
> **– Case 17.**

These issues highlight the need to develop a mechanism that can drive the transparency, accountability and learning needed to improve the family courts and relevant statutory agencies' response to domestic abuse. Whether or not failures to follow procedures correctly or thoroughly are linked to limited available information or resource constraints, the problem remains that survivors have limited means to challenge injustices they have experienced. This is especially the case in the family courts, where the only means of redress is to appeal a case. This is not an option for many survivors, the majority of whom have faced years of abuse and trauma, do not have access to legal representation or advice, and likely will have run out of funds by the time the appeal stage comes.

5 Supporting non-abusive parents as survivors

> *"[Third party] expressed his anger that social workers did not do more to help [mother] because they 'knew what he was like.' "*
>
> **– Case 15.**

Research reveals that survivors receive conflicting expectations from the family courts compared to other agencies, where they are encouraged by the courts to put experiences of abuse behind them and focus on their children having contact with both parents (Coy et al, 2012; Women's Aid, 2018; MOJ, 2020; Birchall and Choudhry, 2021). These contradictory messages have been theorised in Hester's 'three planets' model, where perpetrators being seen as violent criminals in the criminal courts, invisible in child protection proceedings, and 'good enough fathers' in family court proceedings (Hester, 2011).



Adapted from: Hester M (2011) The three planet model – towards an understanding of contradictions in approaches to women and children's safety in contexts of domestic violence. *British Journal of Social Work.* 41, 837-853.

A key theme identified from the reviews in this report is the need for professionals to recognise and respond to non-abusive parents as survivors experiencing domestic abuse themselves. As discussed in section one, children are often subjected to the same coercive and controlling tactics that perpetrators use against their partners. In turn, and as demonstrated in the case study of Charlie, abuse of children can be an indicator that there is also domestic abuse happening to a parent. Moreover, in two of the cases in this report, the perpetrators had a history of committing child sexual abuse, including child sexual exploitation. In case four, the review detailed how professionals had failed previously to understand the abusive nature of this relationship and how this resulted in them taking no further action. The father, who had abused and exploited this mother when she was a child, subsequently went on to kill one of the children in the cases in this report.

> *"There were some indicators that [the mother] was being exposed to exploitative behaviour from older males. One of those 'older males' was the father of [child]. The mother was under 16 years of age and the father was [years] older than her. The risks to the mother were not well understood in [year] and when professionals were told it was not an intimate relationship by the mother, no further action was taken, a rather naïve response."*
>
> **– Case four.**

The duality of child and parental abuse evidenced in these case studies demonstrate a need for professionals to respond in a way that recognises this reality. Unfortunately, there were cases where professionals appeared to victim-blame the non-abusive parent. For example, in case seven comments made by the family court psychologist appear to blame the mother for previously reuniting with the father, arguing that by doing so she had placed her child at risk. This is in stark contrast to that same psychologist's recommendation that the child should have contact with their father (see section three).

> *"The psychologist was also clear, on the basis of previous experience, that in order to be able to advise the court properly on the potential future risks, she needed to try to understand why the mother had previously left the father and returned to him, why she had made other decisions that had placed her child at risk and why she had now left him again."*
>
> **– Case seven.**

The mother expressed how despite the family court's knowledge of the domestic abuse the father had perpetrated against her, she felt that they had been treated as equals through the assessment process. In this case, professionals appeared reluctant to address cultural factors when the parents' sought advice from an Imam over their relationship difficulties. The Faith and VAWG Coalition (2020) affirms the importance and unique role that faith and community leaders can play in responding to domestic abuse.[36] However, this was explored as a possible avenue for the mother, who reported having been frightened by the intervention of the local authority and the police, who were both concerned about the children. She felt vulnerable and powerless and feared losing the children. There did not seem to be a level of support that matched the fear that she had of the father.

> *"The [local authority] MARAC meeting noted that 'cultural factors' added to the risk to the mother, presumably a reference to the fact that the couple's religious beliefs had influenced their decision to reconcile. However, prior to the meeting and subsequently there is no evidence of any attempt to understand what these cultural factors were and how they operated."*
>
> **– Case seven.**

36 Faith and VAWG Coalition (2020: 6) states: "faith leaders may be asked, then, to provide spiritual guidance and counselling to both the survivor and the perpetrator. To be done comprehensively and safely this requires faith leaders and community members to not only acknowledge and understand abuse but also to educate themselves and have an awareness of statutory and specialist services that survivors and perpetrators can be referred to."

Empowering survivors

One way that professionals could have better supported many of the non-abusive parents in these cases was by equipping them with sufficient information about their rights, options, and in some cases the perpetrator's history of domestic abuse. Relating to this is a need to acknowledge and explore the economic circumstances of each family against a backdrop of a cost-of-living crisis and lack of adequate housing. In five cases the parents were living together despite being separated, resulting in inevitable unsupervised child contact with the perpetrator. There were examples where it does not appear that professionals explored opportunities to assist survivors to find safe accommodation even when they expressed a desire to do so. For example, in case nine the mother had attempted to leave the perpetrator on three separate occasions but told police she could not do so because she was dependent upon the father financially.

> *"Mother does not recall any support being offered by the police, beyond being given a lift to Paternal Grandmother's house as somewhere else to stay"*
>
> **– Case nine.**

Under the Domestic Violence Disclosure Scheme (also known as Clare's Law)[37], the police can enact the 'right to know' element of the scheme to share information about a person's previous violent or abusive offending. This includes emotional abuse, controlling behaviour, or financial abuse by a person and can be used to protect a partner or ex-partner from being a victim of abuse. There were two cases in these reviews where opportunities to provide the survivor with relevant information about the perpetrator's history of abuse were not utilised. In case 17, this man had been identified as a medium risk of serious harm to known adults (intimate partners), particularly if they ended the relationship, following a previous offence.

> *"Following the first police incident, Clare's Law was not explored to its fullest extent. This created a missed opportunity. The police made reference to the prior understanding that [mother] had told them she was aware of the DVDS. The police could have enacted the 'right to know' element of the DVDS but did not. Equally, pregnancy is usually deemed a high-risk indicator and a decision to override the DASH was not made - it was known to police at the time that she was [number of weeks] pregnant."*
>
> **– Case 17.**

In case 18, the Guardian expressed how the failure of police and probation to inform her about the perpetrator's convictions (as detailed in section four) meant she was unable to act on this information before he killed the child.

> *"[Guardian] also blames the police for not informing her about her then partners convictions. In fact, Probation [...] had a duty to inform her. She said, that had she known, she would have immediately taken steps to distance herself from him."*
>
> **– Case 18.**

37 See here for further information about The Domestic Violence Disclosure Scheme.

The burden of responsibility placed on non-abusive parents

> *"The police recorded Mother's view that Father would not intentionally harm the children".*
>
> **– Case nine.**

Evidence from the case reviews suggest a burdensome level of responsibility placed on the non-abusive parent to disclose the domestic abuse and accurately report on the risks posed towards themselves and their children. In case six for example, there appeared to be an issue with information sharing with the school about the domestic abuse incidents, leaving it up to the non-abusive parent to inform the school. As a result, the school were left with a partial view of the risks posed by the perpetrator, who in this case was the mother.

> *"An issue that was discussed at the workshop was information sharing with schools regarding domestic abuse incidents. In this case, in accordance with protocols in place at the time, the Police informed health professionals and Child Social Work Services about the domestic abuse incidents, but the school only heard about them from father, meaning they had a partial view and possibly were less aware of the risks posed by mother."*
>
> **– Case six.**

As discussed in section four, issues with information sharing between agencies in case four meant a pre-birth assessment was not undertaken where it would have been applicable. The midwife instead continued to accept the mother's assurances that there was no domestic abuse without recognising the cycle of coercive and controlling behaviour she was likely trapped in. Additionally, when there was an anonymous referral made about the father this was disregarded as being malicious and therefore not shared with appropriate agencies. The allegation about the father was strongly linked to the history the GP had on record about the father.

> *"In [date removed], an anonymous referral was made about the father. It was reported that he had been using and selling heroin, was seen driving a car whilst intoxicated with a child in the car and was reported to have mental health issues. The Safeguarding Hub did contact the pathways worker whose role it was to support the mother. He shared that to his knowledge the father did not have access to a car or have a driving licence. The father's previous history, which was available to the Safeguarding Hub, was again not shared with the pathways worker. No checks were made with the GP to establish if the father had mental health issues and as a result, the referral was considered to be malicious, and no further action was taken. This meant that the information known to the GP that the father misused substances was not shared to inform the response to this referral and the GP was not made aware that such a referral had been made."*
>
> **- Case four.**

All these examples highlight the burden placed on survivors to disclose the abuse to multiple agencies who often have a duty to share this information with each other. Evaluation of the Pathfinder model (Ministry of Justice, 2025) suggests one of the key benefits to the model compared with Child Arrangement Proceedings is the reduction in re-traumatisation for both adult and child survivors of domestic abuse during proceedings. This was thought to be largely attributed to a more supportive process and a better court environment, including the direct support of domestic abuse support services and the provision of a single point of contact for families.[38] Sadly, even in some

38 Case Progression Officers are a newly appointed role under the Pathfinder model, employed as the court administrative team to focus on case coordination and provide a point of contact and support for families (Ministry of Justice, 2025).

cases where the non-abusive parent did report the abuse it was still not met with a response adequate to the level of risk posed to the either the children or themselves.

> *"[Mother's] disclosure to the police of [father's] threat to kill her and her [...] children [..] did not result in a thorough investigation and action to protect them; there were missed opportunities to refer the case to children's services who could have made their own risk assessment of potential harm to the children." – Case 10.*

Case study: Residency given to known domestic abuse perpetrator after child removed from mother's care

Rory[39] had been placed in foster care shortly after their birth, following the outcome of a pre-birth assessment where it was concluded that Rory would not be safe in the care of their mother. Rory's mother had complex support needs involving substance misuse and Rory was born with Neonatal Abstinence Syndrome (NAS), requiring a level of care much higher than that of a child with no additional health needs.

Not long after the Family Court ordered Rory to be placed with their father and father's partner. Children's Social Services expressed concerns regarding this placement. These concerns centred around the father's history of domestic abuse, a history of children being removed from his care, as well as a questionable motivation and commitment to this child (he had previously denied paternity for Rory and failed to attend contact visits). The foster carer also raised concerns regarding the complexity of Rory's need, and the competing demands of two babies (Rory's father was also caring for another child of the same age, within his existing relationship). Despite these reservations, Rory was placed with their father and father's partner as a "testing placement."

Within one month of this placement, Rory was observed to be pale and in pain with a swollen leg. A paediatric medical examination identified three different fractures found to have been caused on separate occasions. The examination concluded that these were non-accidental injuries and had happened in the previous weeks whilst placed with his father and father's partner. Both the children were removed by the police after it came to light that Rory had suffered physical harm at the hands of their father. Rory's father pleaded guilty to neglect and received a non-custodial sentence.

This case demonstrates an extremely flawed approach to safeguarding children, where Children's Social Care found themselves seesawing between concluding proceedings and allowing the family the appropriate time to test their care in a daily lived situation. The review concluded that "the couple's ability to effectively care for [child] could only have been appropriately tested by placing him with them." However, there were other factors that were minimised, such as referrals to parenting and domestic abuse programmes not being met with motivation and commitment on behalf of the father.

39 Pseudonym

Conclusion

It is essential that lessons are learnt from the deaths of these 19 children and four women. Responsibility for the deaths of the 19 children and four women identified in this report lies with the abusive parents who killed them. Nonetheless, this report documents the serious consequences of overlooking or downplaying domestic abuse and demonstrates the need for agencies to respond to families in a way that reflects where they are – trapped in a context of coercive and controlling abuse.

This report contains some examples of very young children who have been killed, highlighting the importance of identifying abuse early, including pre-birth. Current legislation falls short of understanding the full breadth of children's experiences when it comes to domestic abuse. There is substantial underestimation of risks as well as significant over optimisation that perpetrators of abuse can still be "good enough" fathers. Case seven illustrates the well-evidenced 'pro-contact' culture in the family courts – despite the judge having their own reservations about the father, they still encouraged the mother to promote contact cordially.

It appears that there have been some improvements in the response to domestic abuse since the publication of our *Nineteen Child Homicides* report. Examples include the family court's decision to order supervised and indirect contact only in case seven, along with the regarding of a DASH risk assessment from medium to high after applying professional judgement in case one. Nevertheless, not enough has changed in the overall response to domestic abuse by professionals involved in child contact. There were instances of clear failed opportunities to ask or follow up concerns regarding domestic abuse. This included not providing children with sufficient opportunity to disclose abuse or time to explore their feelings about contact with an abusive parent.

It is crucial that a whole system response is taken to protecting children and non-abusive parents from a parent who is a perpetrator of domestic abuse. As explored in the theme of agency separation, gaps in multi-agency working can be a substantial risk factor for the safety of survivors and children. There are cases in this report that specifically highlight the barriers to accessing formal contact arrangements and having the resources to separate from abusers. Whilst more of the homicides in this report occurred through informal contact arrangements than formal, many of the themes identified correspond with the Ministry of Justice's Harm Panel report findings. These themes Including the pro-contact culture and the minimisation of abuse, siloed working, and resource constraints.

This report exemplifies the need for a culture shift at all levels in the response to domestic abuse from professionals involved in child contact arrangements, whether informal and formal. Nearly a decade has passed since our *Nineteen Child Homicides* report and half a decade since the publication of the harm panel report. The urgency for a much-needed culture shift and improved consistent approach could not be more evident given the loss of a further 19 children. Unless the safety and wellbeing of children is put first, including addressing economic factors such as access to welfare and housing, contact arrangements will continue to enable circumstances that can ultimately cost the lives of the children, and sometimes their mothers' lives too.

Recommendations

Principles for Private Law Children's Proceedings

Recommendation	Type of Change	Responsible	Urgency
Through urgent legislation to be brought forwards by government, repeal the presumption of parental involvement.	Legislative	Ministry of Justice	**High**
Commit to full implementation of the Harm Panel's recommendations in the upcoming VAWG Strategy, with clear timelines, to ensure the family courts have: ▶ A culture of safety and protection from harm ▶ An approach which is investigative and problem solving ▶ Resources which are sufficient and used more productively ▶ A more coordinated approach between the different parts of the system	Legislative, Policy, Funding, Guidance, Training	Ministry of Justice, Cafcass, President of the Family Division, Family Justice Board, Local Family Justice Boards	**High**
As recommended by the National Audit Office, clear and measurable objectives for better serving children and families should be created by government to ensure they can access the support needed to make safe contact arrangements.	Policy	Ministry of Justice, Department of Education, HMCTS, Cafcass	**Medium**

Enhancing the voice of the child

Recommendation	Type of Change	Responsible	Urgency
Following the initial findings of the Pathfinder project, explore options for hearing from and providing advocacy, representation and support for children as a central consideration for social care workers, including in Child Impact Reports.	Policy	Department for Education, Children's Social Care	**Medium**
Explore options for hearing from and providing support for children by healthcare professionals, within their safeguarding duties as well as routine inquiry on domestic abuse.	Policy	Department for Health and Social Care, NHS England	**Medium**
Conduct a rapid evidence review of the experiences of children bereaved by domestic abuse, including a review of the statutory and voluntary sector provision available to them.	Policy	Home Office, Ministry of Justice	**Medium**
Amend the Children's Wellbeing and Schools Bill to create a safer and higher quality education system for every child by introducing Children Not In School registers to help ensure no child falls through the gaps when educated not in school.	Legislative	Department for Education	**High**

Communication, coordination, continuity and consistency

Recommendation	Type of Change	Responsible	Urgency
Put in place functioning mechanisms for communication, coordination, continuity and consistency at national and local levels between statutory agencies, which includes more detailed logging of both the survivors' and perpetrators' histories. Secure regular and mandatory training* to be developed in partnership with specialist domestic abuse services, including 'by and for' led services, which covers all aspects of domestic abuse, such as coercive control and economic abuse.	Policy, Funding Training, Funding	**National** – Home Office, Ministry of Justice, Ministry of Housing Communities and Local Government, Department for Work and Pensions, Department for Health and Social Care, Judiciary, Cafcass **Local** – Adult social care, Children's social care, Healthcare professionals, Police, Probation, Education professionals, Local Family Justice Boards	**High**
Ensure that social workers undertaking assessments for private law children's proceedings are not only accredited, but reviewed as part of their career progression by domestic abuse specialists to help ensure the requisite knowledge and skills are sufficiently assessed.	Policy	Ministry of Justice, Department for Education, Cafcass, Local Authority Social Workers	**Medium**
Guarantee the use of interpreters/ translators in British Sign Language (BSL) and community languages by the police and across the criminal justice system.	Policy, Funding	Cabinet Office's Disability Unit (alongside Home Office, Ministry of Justice and VAWG Advisory Board), NPCC, National Centre on VAWG	**High**

* Whilst some statutory agencies have already had to undertake domestic abuse training, the findings of this report, the continued failure to assess risk and need accurately, and other findings from Women's Aid research shows the persistent need for continuous specialist training.

Recommendation	Type of Change	Responsible	Urgency
Ensure all family justice professionals are aware of, and able to signpost to, 'by and for' services for Black and minoritised survivors, D/deaf and disabled survivors and LGBT+ survivors to ensure they have the option of specialist, tailored support.	Guidance	Ministry of Justice, Cafcass, President of the Family Division, Family Justice Board, Local Family Justice Boards	**High**
Amend the Children's Wellbeing and Schools Bill to require all educational settings to participate fully in Operation Encompass and embed these expectations in Keeping Children Safe in Education.	Legislative	Department for Education	**Medium**
Amend Children's Wellbeing and Schools Bill, the Department for Education to require all safeguarding partners to fully participate in Operation Encompass and embed these expectations in Working Together to Safeguard Children.	Legislative	Department for Education	**Medium**

Resourcing

Recommendation	Type of Change	Responsible	Urgency
Invest a minimum funding settlement of £502 million per year for specialist domestic abuse services in England, including £150 million ringfenced funding for specialist services led 'by and for' Black and minoritised women, D/deaf and disabled women and LGBT+ survivors. This should be divided into a funding settlement of £222m for refuge services and £280m for community-based support services*.	Funding	HM Treasury, Home Office, Ministry for Housing, Communities and Local Government, Ministry of Justice, Department for Education, Department for Health and Social Care	**High**
Create a ring-fenced fund of £46m to ensure that at minimum all refuges and community-based services have a dedicated children and young person's worker.	Funding	HM Treasury, Home Office	**High**
Ensure that quality assured perpetrator interventions are consistently available – addressing risks from primary prevention (like bystander responses and awareness raising communication campaigns) to behaviour change group work, to specialist responses for the most dangerous and serial perpetrators.	Funding	Home Office, Ministry of Justice	**Medium**
Tackle sexism, misogyny, racism, homophobia and transphobia and other forms of discrimination and structural inequality online and offline, including economic inequality, that enable and tolerate abuse and prevent survivors from getting help when they need it - this should be a central pillar of the upcoming VAWG Strategy. In the interim this should be addressed through the continuation of the Flexible Fund, and in the long term should be addressed through the abolition of the no recourse to public funds condition and exempting survivors from the benefit cap and the two-child tax credit limit.	Policy, Funding	Home Office, Department for Work and Pensions, Department for Business and Trade, Department for Science and Technology	**Medium**

* This will enable services to fully engage in the Pathfinder pilot and/or national rollout.

Recommendation	Type of Change	Responsible	Urgency
To ensure local and statutory services are better prepared for surges in domestic abuse, including high risk and high harm reports, explore and understand what new elements of service provision that improve accessibility are sustainable and beneficial. This should also involve assessing existing and emerging virtual provision and processes to identify what digital service support should be continued, enhanced, or removed.	Policy	Home Office, Ministry of Housing, Communities and Local Government, Ministry of Justice	**Medium**

Further research

Recommendation	Type of Change	Responsible	Urgency
Commission a specialist domestic abuse organisation to undertake specific research into children from diverse backgrounds' experiences of coercive control, both within family households and also in their own intimate relationships.	Policy	Department for Education, Ministry of Justice	**Medium**
Commission a specialist domestic abuse organisation, in partnership with academics, to develop an outcomes framework for trainee social workers on the university route to monitor attitudes and understanding, and the impact of placements and training.	Policy	Department for Education	**Medium**
Commission a specialist domestic abuse organisation to undertake specific research into the impact of online misogyny on adult men's attitudes and their behaviour as an intimate partner.	Policy	Home Office, Department for Science, Innovation and Technology	**Medium**
Commission a specialist domestic abuse organisation to undertake specific research into the resources required by the domestic abuse sector, and a 'by and for' organisation on the particular needs of 'by and for' services, to provide support for children who have experienced domestic abuse within their families, and experienced domestic abuse in their own intimate relationships.	Policy	Home Office, Department for Education, Ministry for Housing, Communities and Local Government, Ministry of Justice	**Medium**

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Women's Aid Federation of England,
PO Box 3245, Bristol, BS2 2EH

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