MK TOGETHER
Safeguarding Partnership

Safer MK

Milton Keynes Community Safety Partnership

Domestic Homicide Review

Executive Summary

Angelica (January 2021)

Published November 2024

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1. THE REVIEW PROCESS

This domestic homicide review was commissioned by Milton Keynes Community Safety Partnership (known as Safer MK) following the death of Angelica, a 43-year-old British South Asian woman. Her husband was convicted of her murder and in November 2021 he was sentenced to serve a minimum of 22 years' imprisonment. The review examined the contact and involvement that agencies had with Angelica, her husband and their two children between January 2014 and the time of Angelica's murder in January 2021.

To protect the identity of the family members, the following anonymised terms and pseudonyms have been used throughout this review:

Angelica – deceased aged 43
Perpetrator – husband aged 46
Older child – aged 18
Jojo – younger child aged 5

} Age at the time of Angelica's murder

1.1. Contributors to the review

The review was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) under s.9 (3) Domestic Violence, Crime and Victims Act (2004). Individual management reviews and chronologies were requested from:

- Central and North West London NHS Foundation Trust (CNWL)
- General Practitioner
- Infant School
- Milton Keynes Children's Social Care
- Milton Keynes University Hospital Foundation Trust
- MKACT (Women's Aid)
- Secondary School
- South Central Ambulance Service
- Thames Valley Police

All the authors of the individual management reviews were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved.

1.2. Review panel

The review panel comprised:

- Independent Chair and Author
- Specialist in supporting black and minoritised victims of abuse
- Assistant Director of Nursing, Central and North West London NHS Foundation Trust (specialist in drug and alcohol misuse)

- Chief Executive MKACT (Women's Aid)
- MK City Council Domestic Abuse Co-ordinator
- Deputy Service Director Mental Health Services, Central and North West London NHS Foundation Trust
- Detective Inspector Domestic Abuse Unit, Thames Valley Police
- Adult Safeguarding Lead, Milton Keynes University Hospital Foundation Trust
- Adult Safeguarding Professional Bedford, Luton and Milton Keynes Integrated Care Board
- Head of Family Support Services, Milton Keynes Council Children & Families Service
- Service Manager for Specialist Children's Services Central and North West London NHS Foundation Trust
- Specialist Nurse, Bedford, Luton and Milton Keynes Integrated Care Board
- Manager, MK Together Partnerships & Community Safety Partnership
- Partnerships Support Officer, MK Together
- Project Officer, MK Together

The panel met five times via MS Teams and twice in person. All the members were independent of the case i.e. they were not involved in the case and had no direct line management responsibility for any of the professionals involved in the case.

1.3. Author of the overview report

The chair and author of this review has been an independent consultant for 23 years. She specialises in violence against women and girls, safeguarding children and vulnerable adults with a particular focus on domestic abuse. She has no connection with any agency in Milton Keynes although she was employed as the Business Manager for Milton Keynes Safeguarding Children Board for ten months during 2010. She has completed two previous domestic homicide reviews for Safer MK (2015 & 2017).

1.4. Terms of reference and key lines of enquiry

The individual management reviews addressed both the 'generic issues' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- What knowledge or information did your agency have that indicated Angelica was a victim of abuse, coercive control or domestic violence and how did your agency protect her? How did your agency assess the risk that the perpetrator posed? What referrals did your agency make?

- If your agency had information that indicated that Angelica might be at risk of abuse, coercive control or domestic violence was this information shared? If so, with which agencies or professionals?
- What did professionals understand about Angelica's experience as a woman from a South Asian background? Did professionals consider the additional difficulties she might face? How were these difficulties mitigated?
- Did your agency consider whether Angelica's alleged drug/alcohol use may have acted as a barrier to her disclosing that she was a victim of domestic abuse? Did your agency consider drugs/alcohol when assessing the risk that Angelica faced?
- What knowledge or information did your agency have that indicated the perpetrator might be violent, abusive or controlling and how did your agency respond to this information?
- Was there anything about Angelica's children's presentation that indicated that they were witnessing domestic abuse or living in a household with domestic abuse? If so, how did your agency support and protect Angelica and her children?
- Did Covid19 have an impact on the support that was offered or provided to Angelica? Did professionals have face-to-face contact with her? If not, how did professionals assess the risk she faced?
- How did your agency triangulate the information that was provided by the perpetrator? For example, his description of Angelica's drug use. Was the information he gave simply taken at face value? How did your agency explore this information with Angelica? How were her views sought, especially when she appeared under the influence of medication, her mobile was not working or she was not contactable?

2. SUMMARY CHRONOLOGY

Angelica and the perpetrator had been married for 25 years. Theirs was a 'love match' and Angelica therefore did not have an arranged marriage. The family moved from Bedford to Milton Keynes around 2007. They had two children.

In 2011, Angelica sustained a back injury having fallen down the stairs (she told members of her family that the perpetrator pushed her). Following this injury, Angelica was in constant pain which was treated with analgesia including morphine and she struggled with her mental health.

In 2014, she became pregnant. Throughout her pregnancy, Angelica described the perpetrator as supportive and she told professionals that he had given up his job so he could care for her.

Jojo was born in early February 2014. In June 2015, Angelica self-referred to IAPT (Improving Access to Psychological Therapies). During the initial assessment she described struggling with her back pain and with parenthood. She often felt worthless and she was not able to cope with her feelings of anxiety – she was also using alcohol.

In November 2016 IAPT (Improving Access to Psychological Therapies) raised concerns with the Health Visiting Team about Angelica's "*behaviour with her child*". Angelica said that she had periods of depression, irritability and lost her temper.

On 1 June 2018, Angelica visited her GP. She said that two weeks earlier she had fallen forwards and hit the right side of her face on the kitchen sink. Her face felt numb, there was a lump, a bruise under her right eye and her teeth were not aligning. She was seen by the Maxillofacial and Orthodontic Team. There was no structural damage to her face or cheek and she was discharged from the service.

On 30 October 2018, Angelica's sister made a third-party online report to Thames Valley Police raising her concerns that Angelica was a victim of domestic abuse. Her report ended:

"*I basically want this info recorded for future, if she does go missing commits suicide or he kills her*."

An officer visited Angelica at home. Both the perpetrator and their older child were in the house. Angelica did not disclose any offences. The DASH (domestic abuse, stalking and honour-based violence) risk assessment was graded medium and a referral was made to the MASH (multi-agency safeguarding hub). On the basis that there had been no previous concerns raised by education or health, it was decided that there would be no further action.

On 19 May 2020, Angelica had a telephone consultation with her GP. She had fainted a couple of times, once that morning whilst doing the washing.

Angelica called the MKACT (Women's Aid) helpline in October 2020, because she had decided to end her marriage. She told the call taker that the perpetrator had physically assaulted her two days earlier. She wanted help with housing and was signposted to Wycombe Women's Aid as they had a place in their refuge. On 5 November 2020, Angelica told the designated safeguarding lead at her younger child's school that she had been experiencing domestic abuse for 21 years. A multi-agency safeguarding hub (MASH) referral was made and she was advised to call the police. The case was allocated to a support worker from the Children and Families Practice. Both parents were seen in November 2020 and agreed to engage. The plan was for Angelica and the perpetrator to undertake healthy relationships work and they were provided with information about 'relationship counselling'. They agreed to engage with the Children and Families Practice to understand the impact on children of exposure to domestic abuse.

On 14 December 2020, the perpetrator called South Central Ambulance Service stating that Angelica had tried to take her own life. Thames Valley Police also attended. Angelica was seen at the Emergency Department of Milton Keynes University Hospital by the Hospital Liaison Team. Three MARFs (multi-agency referral form) were completed concerning the

children – by South Central Ambulance Service, the Emergency Department and the Mental Health Hospital Liaison Team.

On 21 December 2020, a worker from the Children and Families Practice made a telephone call to the house (as Angelica was not contactable on her mobile). She spoke to the perpetrator who confirmed that they were separating. He explained that he had "*changed and understands how to control his behaviour and will not be like that again*". On 24 December 2020, the worker spoke to Angelica on the telephone. Angelica said she wanted to "*move on*" as soon as possible. Then on 30 December 2020 she told Children's Social Care that they were going to stay together, as they had had a good Christmas. Angelica asked for the case to be closed to Children's Social Care on 13 January 2020. Children's Social Care agreed as there was "*no information to suggest domestic abuse*". Both parents were described as engaging well with safety planning. The plan was that the perpetrator would go out for a walk if he felt frustrated and Angelica would listen to music.

On a day in late January 2021, the perpetrator phoned Thames Valley Police stating that he had killed his wife. At the time of Angelica's murder, Jojo was 5 years old and lived at the family home. Their older child was 18 years old and was away at university. The perpetrator was remanded in custody until his trial in October 2021. He was convicted of murder and was sentenced in November 2021 to serve a minimum term of 22 years' imprisonment.

In July 2022, the perpetrator took his own life in prison.

3. KEY ISSUES ARISING

- Last resort and the institutional context for South Asian women

Reporting directly to the police or other agencies is the last resort for many South Asian women. This is because of the multiple institutional barriers and discrimination Black and minoritised women and their families, peer-groups and community face (both historically and currently). Therefore, in many cases South Asian women only report domestic abuse to the police when they feel their life is under threat (or their child's) and when all other avenues known and available to them have been exhausted.

The perpetrator's threat to tell Angelica's family about an alleged affair should have led professionals to consider issues around 'honour' and 'shame' and the impact this may have had on her ability to leave the relationship. Moreover, his threat may have directly led Angelica to harm herself. He may have been trying to shame her to take her own life by 'reporting' her behaviour to her sister or making things "*worse for the family*". In turn Angelica may have decided that taking her own life may help to prevent family dishonour. Such honour-based abuse is a common feature in suicide and self-harm amongst Asian women.[1]

- Failure to recognise or respond to domestic abuse

[1] Siddiqui, H. and Patel, M. (2010) *Safe and Sane: A Model of Intervention on Domestic Violence and Mental Health, Suicide and Self-harm Amongst Black and Minority Ethnic Women,* London: Southall Black Sisters Trust.

As professionals did not consider the context in which Angelica was disclosing domestic abuse i.e. it was a last resort, professionals failed to understand the risk Angelica faced. This was compounded by the fact that following her disclosure, no agency undertook a risk assessment. A DASH (domestic abuse, stalking and honour-based violence) risk assessment should have been undertaken at the earliest opportunity. Had it been, the escalating concerns around her use of medication and alcohol, her deteriorating mental health, history of pregnancy (still birth), her injuries and the concerns around 'honour' may all have been identified.

Furthermore, she may have felt she was being believed and taken seriously which could have given her the confidence to disclose exactly what was happening to her at home. Professionals would then have had a better understanding of the impact and severity of her husband's abusive behaviour on the children, a more detailed picture of the physical and emotional abuse that Angelica was suffering. She would then have been recognised as a high-risk victim of domestic abuse who should have been referred to the MARAC (multi-agency risk assessment conference)[2] and MKACT (Women's Aid).

- Believing victims

During the incident in December 2020, her husband told the South Central Ambulance Service that Angelica had been suicidal for three years and was "*hysterical with her personality changing rapidly and has a? diagnosis of split personality*". He told the police officers that Angelica had recently made new friends who had "*got her into drugs*". He told the Hospital Liaison Team that Angelica's alcohol consumption had increased and that she "*binged on cocaine*". Some of this information, although completely uncorroborated was evident in the subsequent MASH (multi-agency safeguarding hub) referrals as well as within agencies' records.

Thus, all the information that her husband provided simply discredited Angelica's account of events and led professionals to minimise the abuse she was suffering. Angelica must have concluded that professionals did not believe her, as instead her husband's account of events appeared to have been taken at face value before Angelica had the opportunity to speak for herself.

The systems in place failed to identify Angelica as a victim of on-going domestic abuse. The multi-agency referral forms (MARF) did not describe what was happening in Angelica's world because they focused on worries about the child.

- Coercive control

Because Angelica was not heard, all the other forms of abusive behaviour that Angelica and her children were being subjected to went unseen. Angelica may not have reported to the police, but she had disclosed to other professionals and her disclosures demonstrated the perpetrator's controlling behaviour. Research[3] shows that coercive control is much more

[2] A multi agency risk assessment conference (or MARAC) is a meeting that is held to discuss the most high-risk cases of domestic abuse and sexual violence, to share information and to safety plan to safeguard a victim
[3]See for example, Andy Myhill and Katrin Hohl "The Golden Thread": Coercive Control and Risk Assessment for Domestic Violence, Journal of Interpersonal Violence 34(4) November 2016 – accessed online 4 July 2022

effective than physical violence as a predictor of a domestic homicide. Indeed, Angelica's sister made an online report to Thames Valley Police which stated that Angelica had been a victim of non-fatal strangulation on several occasions. Strangulation is very commonly reported by victims/survivors of domestic abuse and is "*used to instil fear, power and control*".[4] Research shows that women who suffer non-fatal strangulation are seven times more likely to be killed at a later date.[5]

It was evident from Angelica's disclosures and from speaking with her family that the perpetrator subjected her to a range of the coercive controlling behaviour. She had been isolated from her family and they described having to meet her in secret. She was only allowed to leave the house with the perpetrator's permission. According to her family she had to be home to make his meals. He made threats to harm Angelica as well as her family. She described him as "*possessive*" and "*paranoid*" – he falsely accused her of having affairs. He was invariably present when professionals visited Angelica at home. It also appeared he regularly escorted her to appointments. All this indicated a considerable level of coercive control and thus an increasing risk of harm. Yet his controlling behaviour was not identified as a risk factor by professionals.

- Economic abuse

Another aspect of the perpetrator's abuse that was not identified or considered was economic abuse. There was no exploration of the family's financial situation – nor did it raise any surprise or questions when the couple said they were separating and the perpetrator would continue to live in the family home whilst Angelica and their child would seek council housing elsewhere. He received 'carers allowance'. This income relied on Angelica requiring continuing care from him. It was unclear how a family of four managed their car, household bills and mortgage on basic benefits.

- The danger of separation

Angelica told professionals that she wanted to separate from her husband. Separation is a particularly vulnerable time for women in abusive relationships.[6] The Femicide Census 2020 [7] showed that women are at significant risk of deadly violence when they separate from an abusive partner – "*Of the cases where women had separated, or made attempts to separate, the vast majority (338, 89%) were killed within the first year and 142 (38%) were killed within the first month of separation, or when the victim first took steps to separate*

https://www.researchgate.net/publication/309656752_The_Golden_Thread_Coercive_Control_and_Risk_Assessment_for_Domestic_Violence

[4] https://www.centreforwomensjustice.org.uk/news/2021/3/1/pr-non-fatal-strangulation-to-become-stand-alone-offence - accessed online 25 May 2023

[5] Glass et al (2008) 'Non-fatal strangulation is an important risk factor for homicide of women' https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2573025/ - accessed online 25 May 2023

[6] See for example https://www.refuge.org.uk/our-work/forms-of-violence-and-abuse/domestic-violence/barriers-to-leaving/ ; www.womensaid.org.uk/domestic-violence-articles.asp?section=00010001002200020001&itemid=1126 and www.femicidecensus.org.uk The Femicide Census; 2018 Findings – accessed online 1 July 2022

[7] Femicide Census see https://www.femicidecensus.org/

even if she had not actually left the perpetrator". Indeed, work by Jane Monckton-Smith also identifies separation as a trigger event for domestic homicide.[8]

- Failure to question, triangulate and corroborate information

Agencies had a wealth of information about Angelica and her children that could have contributed to a thorough understanding of the family's situation but this was never sought or shared. Throughout the period under review, there was very little attempt to question, triangulate or corroborate information.

- The invisible man

Even the language within agency records showed a bias towards the perpetrator. The police officers who met him in December 2020 described him as "*calm but concerned for his wife*" whereas Angelica was described as "*confrontational and non-engaging*". The social worker who telephoned the perpetrator after the incident recalled him being "*pleasant and co-operative*".

The worker from the Children and Families Practice described the perpetrator as "*calm and rational*" and "*willing*" to engage. He portrayed himself as the carer in the household which again painted him as a kind, thoughtful man, who had given up his job to care for his family. Thus, no professional made the link between disability and domestic abuse i.e. disabled women are twice as likely to experience domestic abuse and are also twice as likely to suffer assault and rape.[9]

Despite often being present when professionals visited, he still managed to remain almost hidden in the household. For example, the health visitor always focussed on Angelica, even though the perpetrator was present and was always described as the main carer for Jojo.

- Failure to recognise the impact of the perpetrator's behaviour on his children

Children never just 'witness' domestic abuse[10] and the law now recognises they can be direct victims in their own right.[11] Thus victims of domestic abuse now include children who see or hear or experience the effects of the domestic abuse. Experiencing domestic abuse is child abuse, and it can have a significant impact on a child's development, health and wellbeing. Throughout the period under review, the eldest child was under 18 years of age and was clearly also a victim.

- Referrals to specialist organisations

Angelica felt comfortable and safe enough to disclose information about her life with staff at the Infant School. What she disclosed was a long history of domestic abuse. Women are

[8] Monckton-Smith, Jane (2019) *Homicide Timeline - The 8 Stages.* http://eprints.glos.ac.uk/7797/ - accessed online 1 July 2022
[9] See for example https://safelives.org.uk/sites/default/files/resources/Disabled%20Survivors%20Too%20CORRECTED.pdf – accessed online 10 August 2022
[10] https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/domestic-abuse/ accessed online 4 July 2022
[11] See s.3 Domestic Abuse Act 2021 - https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted accessed online 4 July 2022

more likely to disclose domestic abuse in spaces that they can access safely and independently which are community-based and importantly without the perpetrator's knowledge (Angelica asked professionals not to tell the perpetrator about her disclosure). These are also important spaces for discreetly linking women into Black and minority ethnic 'violence against women and girls' specialist support. Yet as no agency recognised or responded to Angelica as a victim of domestic abuse, they failed to access the correct pathways to support her.

- Good Practice in domestic abuse and honour based abuse cases

The domestic homicide review panel asked a professional who specialises in supporting black and minoritised victims of abuse to set out their thoughts on good practice around domestic abuse and honour-based abuse cases. They made a number of recommendations including:

- Do a full risk assessment for domestic abuse and look for signs of honour-based abuse in all cases

- All honour-based abuse cases should be graded high risk and should be escalated to multi-agency risk assessment conference (MARAC) and/or multi-agency safeguarding hub (MASH - children/or adult)

- All domestic abuse and honour-based abuse cases should be reviewed by a specialist police officer

- All victims should be actively referred by the response or specialist officer, not simply signposted (although this information should be made available to a victim as a matter of routine) to an independent domestic violence advisor (IDVA) or domestic violence services, or specialist IDVA/service for Black and minoritised victims (if available).

- Parental responsibility and the Family Court

Angelica's family asked the domestic homicide review panel to clarify why the perpetrator was able to contribute to the Family Court concerning the placement of Jojo.

The perpetrator, as the child's father and holder of parental responsibility, was an automatic respondent to the local authority's application for public law orders and entitled to non-means, non-merits tested legal aid to ensure his views and position were before the Court. The only other parties were the local authority and the child (who was represented via the children's guardian). The maternal family's views were heard only in the context of the assessments they completed. The imbalance this causes is obvious. The perpetrator, who controlled Angelica and ultimately took her life from her, was able to ensure his views were heard and taken into account in decisions concerning their child, but Angelica's were not.

4. CONCLUSION

It must have taken great courage for Angelica to disclose the abuse she was suffering to agencies. She clearly articulated to the school, the emergency department, mental health professionals, Children's Social Care and paramedics that she had been a victim of domestic abuse for many years. Yet her abuse was not recognised, understood or investigated.

Had it been, it is likely that she would have been afforded a very different response from agencies. It may have led to a risk assessment and a referral to the MARAC (multi-agency risk assessment conference); she may have then felt confident to work with Children's Social Care and disclose further incidences of her husband's abusive behaviour; good multi-agency working may have led to positive action being taken by the police to help and protect her; it may have enabled the police to work with her to build a case against her the perpetrator; it may have given her the strength to seek further advice about her legal and housing options; and she may have felt confident to seek support from a specialist domestic abuse service. Had agencies worked effectively, similar to the "One Chance Rule" [12], her disclosure to professionals may have been the window of opportunity which could have led to an entirely different outcome for Angelica and her children.

5. RECOMMENDATIONS

In addition to the 34 single agency recommendations in this review, there are a number of issues that require addressing to improve practice.

1. Thames Valley Police and Children's Social Care should review how to improve communication within the MASH (multi-agency safeguarding hub) so that offences around domestic abuse are identified and investigated

2. Thames Valley Police should conduct an independent review of domestic abuse cases involving Black and minoritised women across Thames Valley.[13] The review should appraise these cases against the policies and procedures of Thames Valley Police and use the opportunity to assess whether the culture, ethnicity and beliefs of victims were taken into account – including (but not limited to) for example:

    - Were the additional barriers facing Black and minoritised women identified? How were these mitigated?

[12] All professionals working with suspected or actual victims of forced marriage and honour-based violence need to be aware of the “one chance” rule. That is, they may only have one opportunity to speak to a victim or potential victim and may possibly only have one chance to save a life. As a result, all professionals working within statutory agencies need to be aware of their responsibilities and obligations when they are faced with forced marriage cases. If the victim is allowed to leave without the appropriate support and advice being offered, that one chance might be wasted. Multi-agency practice guidelines: Handling cases of Forced Marriage, HM Government 2022

[13] The author of this review has undertaken a number of domestic homicide reviews across the Thames Valley Police area involving Black and minoritised women. It is clear from these reviews that police officers struggle to consider the additional difficulties facing victims from Black and minoritised communities

- Did the officers look for signs of honour based abuse in risk assessments and was it identified? Was the risk graded correctly? If so, was the case reviewed by a specialist officer and did this add value to the investigation/understanding of the case?

- Was the victim referred to a specialist women's domestic abuse organisation?

3. An independent domestic violence advisor (IDVA) should be appointed to work in the MASH (multi-agency safeguarding hub)

4. A review of the Healthy Relationships Project should be undertaken urgently by an independent specialist domestic abuse/VAWG[14] organisation such as SafeLives or Women's Aid. All healthy relationships work with couples should be stopped until after the review has been completed

5. The MASH (multi-agency safeguarding hub) agencies together with their broader partner agencies (such as housing, schools and MKACT) should review the design and information required in the multi-agency referral form (MARF). This should ensure that professionals in other agencies understand the level of detail required concerning the child and the wider family context i.e. issues affecting the adults in the household such as domestic abuse, stalking, alcohol, drugs and mental ill health. It should also set out the referral pathways for adults in the family

6. All key professionals in Milton Keynes working with victims of domestic abuse must be trained and be capable of completing a domestic abuse risk assessment face-to-face in a professionally curious and safe manner

7. Safer MK should review the available commissioned and non-commissioned specialist 'violence against women and girls' support pathways for Black and minoritised women and girls. This should ensure that agencies always seek expert advice, support and information[15]

8. Safer MK (Milton Keynes Community Safety Partnership) together with local agencies should consider how to provide multi-agency training using this case study to help professionals handle cases of domestic abuse.[16] A woman reporting domestic violence must always be respected, believed, understood, supported and treated with fairness and decency. Sessions should focus on demystifying intersectional stereotypes, myths and assumptions that lead to victim-blaming and bias which cause harm to women

This training should be capable of highlighting issues such as:

[14] VAWG – violence against women and girls

[15] See Violence Against Women and Girls Services, Supporting Local Commissioning, Home Office Dec 2016 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576238/VAWG_Commissioning_Toolkit.pdf - accessed online 20 September 2022

[16] See Article 15 (1&2) Council of Europe Convention on preventing and combating violence against women and domestic violence, Istanbul, 11.V.2011 - https://rm.coe.int/168008482e - accessed online 20 September 2022

- Diverse communities and unconscious bias
- Honour based abuse and violence
- The dangers of working with the victim and perpetrator together
- Domestic abuse as a pattern of behaviour
- Coercive control and economic abuse
- The danger of exiting an abusive relationship
- Managing risk when working with perpetrators.

NATIONAL RECOMMENDATIONS

8. In cases where a perpetrator murders a victim, the victim's family should be supported in the Family Court with equal access to legal aid to enable them to present the voice and wishes of the victim (deceased) to the Court

9. The Department for Education should ensure that Children's Social Care Departments do not undertake domestic abuse or healthy relationships programmes with families as an alternative to commissioning specialist independent domestic abuse services.