HOUSE OF LORDS

Domestic Abuse Act 2021 Committee

Uncorrected oral evidence: Domestic Abuse Act post-legislative scrutiny

Thursday 16 April 2026

10.40 am

Watch the meeting

Members present: Baroness Kennedy of The Shaws (The Chair); Baroness Barran; Baroness Gohir; Baroness Hussein-Ece; Lord Polak; Lord Ponsonby of Shulbrede; Baroness Porter of Fulwood; Baroness Rafferty; Lord Russell of Liverpool; Baroness Sugg.

Also in attendance: Shazia Choudhry and Michelle McManus.

Evidence Session No. 8 Heard in Public Questions 66 – 73

Witnesses

I: DCI Leeann Saunders, South Wales Police; Medina Johnson, CEO, IRISi; Patriche Bentick, Member, the British Association of Social Workers (BASW).

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Examination of witnesses

DCI Leeann Saunders, Medina Johnson and Patriche Bentick.

Q66 **The Chair:** Good morning and welcome to this meeting of the Domestic Abuse Act 2021 Committee. This committee is looking at a piece of legislation that was passed in 2021, very much a modernising piece of legislation in the field of domestic abuse. This is a post-legislative scrutiny committee, so we are looking at the effectiveness of the legislation. We are helped by different experts who come before us to give us their assessment of how the legislation is working out—the good and the bad, the disappointing and the surprising. So let us welcome our panel.

I start by welcoming those who are online. Leeann Saunders is a detective chief inspector in South Wales Police and she has been there for 24 years. She has been a front-line officer, she has worked with CID, and she spent three years seconded to the UK Border Agency. She has worked on economic crime, so she has also been a financial investigator. Over the past seven years, she has been working with the Safeguarding and Public Protection Command. She has held a strategic responsibility for domestic abuse and stalking, along with a whole range of experiences in that field, including female genital mutilation and forced marriage—the whole business of domestic abuse. She is currently involved in and leading safeguarding in Mid Glamorgan. It is really great to see you here, Leeann, because your expertise is so important. Your success rate in Wales gets the thumbs up not just in investigating but leads the way in actually getting cases to court, so we wanted to hear from you about why you have been so successful at that.

I then welcome Medina Johnson, who has worked in the domestic violence and abuse sector since 2004. She was part of the original IRIS research trial from 2007 to 2011, and in 2017 was part of the team that set up and established IRISi, so she will tell us all about IRIS and what is meant by that. Medina's background is in education and training. She has worked as a secondary school teacher, a regional trainer for a large national charity and has managed a project for single homeless people and a resettlement service for women in housing with mental health problems. She has a great deal of experience. Thank you, Medina, for being here.

I also welcome Patriche Bentick. She is a social worker engaged with the British Association of Social Workers. She has been working with children and families for 20 years. Before qualifying as a social worker, she gained experience at after-school clubs, summer camps abroad, and mother and baby units in hospitals. She has been an advocate of tackling substance misuse. That breadth of experience brought her into social work, and she is a co-founder of the not for profit PinPoint Inc. Patriche, along with fellow directors, focuses on developing positive change for underprivileged children and young people within inner-city communities. She is currently engaged with a particular set of problems in a local authority. Patriche, thank you for being here.

I will start off by asking you all to provide an outline of the way that your particular institution or organisation aims to support and improve the response of front-line workers to victims and survivors of domestic abuse. I will start with you, Leeann. Perhaps you will talk about the policing response and how effective it is, and why you think that you are getting the star in policing for good outcomes—give us an insight into this.

DCI Leeann Saunders: First, thank you for the invite today—I feel incredibly honoured to be invited to this—and for the lovely words about South Wales Police. We still acknowledge that we have a long way to go. It is only the beginning of the journey, and the Domestic Abuse Act helped with this. The biggest thing for us was the definition. When I started within public protection, "coercive and controlling behaviour" and "non-fatal strangulation" were terms that nobody really understood. So a lot of the work has been around understanding what this means—recognising that domestic abuse is about not just physical assaults but the psychological impacts; hence the work that has been done around this.

One of the key drivers for us here was the fact that there was a desire to change; it has been a cultural shift and that was required. A lot of it was driven by our chief constable and our senior management, but there was an input and buy-in with the support of the police and crime commissioner's team as well to bring in domestic abuse matters training, and that is really what shifted the culture. It is a cultural change programme, and it did do that for us. The domestic abuse matters training was a long, two-phase rollout, aimed to see things from a victim's perspective: to actually put officers in the victim's position—with children as well—and to understand why, when we turn up as officers, things may seem one way but to actually look at what is going on in the background. When someone says that they do not feel able to provide a statement at this time, there are reasons for this. That was a really key point for us.

In other work, we have also been involved with national projects such as the domestic abuse charging pilot. For us, the Domestic Abuse Act was just the start of this process that we have gone down, and now we have other departments working with us, such as criminal justice. We have a very close relationship with our Crown Prosecution Service team; when the Domestic Abuse Act came in, although the definition was clear in parts, the "personally connected" element caused lots of conversations. There were lots of email conversations back and forth with the Crown Prosecution Service at that time around what that meant: is it a relationship if there has just been one occasion? All those conversations really assisted me and my colleagues.

Section 63(1) of the Family Law Act in terms of "the family and the wider" caused confusion initially but obviously has widened things. I cannot say for definite that we are using it to the extent that it should be because the ones that we deal with are predominantly partnership, ex-partner, or it can be family, where there is child on adult, parent on child.

The other thing I wanted to point out that made a difference in the Act is post-separation abuse and the understanding of what that looks like. Just because we go along and arrest someone, that does not mean that someone is safe and the abuse stops. From there, we have seen the journey continue and an understanding around the family court and how that can be used coercively by perpetrators. There is just a whole host of things.

In January 2024 we introduced CARA, which is an out of court disposal; that is happening elsewhere in the country but has been particularly successful here. An out of court disposal is technically an early intervention where you have victims who do not really want the perpetrator to be prosecuted; they want to stay in the relationship but they want them to get support. Since CARA began, its use has increased and I have some figures here: we have had 125 referrals; of those, 100 have successfully completed the two-day programme. If they do not complete it, it is a breach of the conditions. CARA has been successful and when we come to talk about outcomes, that is an outcome and actually, sometimes that is the best outcome for our victims as well.

You have already been made aware that we also ran Operation Diogel in Cardiff from 2023. It does not run any more because it has evolved. Op Diogel was set up to provide additional support to victims: when officers turn up and take their action, at that point in time the victim may not feel able to provide a statement. With a further phone call from a specialist team, having that conversation and putting in that support and looking at special measures, the person felt supported and able to provide statements at that point. The success was due to the interaction coming at the right time.

We came to a point in our journey with this where we were looking to go force-wide and roll it out across south Wales, but at the same time we were also considering rapid video response. RVR uses specialist officers who provide a response via video, improving our initial call response times by answering the calls quicker. Because of resources, a decision was made at that point to go with RVR. The Diogel model is still in the background and still being looked at, but actually all the staff involved with rapid video response have received domestic abuse matters training and champions training. They have also undertaken the Professor Jane Monckton-Smith eight stages to homicide timeline—

The Chair: Leeann, I am going to stop you there because we want to know a bit more about a lot of these things in detail, particularly things such as the rapid video response and your Op Diogel project, and the panel will ask you about them. You have made the really strong point about how good training and culture shifts are hard to achieve and you really have to be relentless in the efforts to do that. Hold on to those thoughts because you obviously have lots of interesting things happening and we will come back and hear from you.

Medina, over to you: perhaps you could give us a general idea of the work that you have been involved in and whether you feel that the

legislation has been in any way useful, where you perhaps see gaps, or whatever, but the positive as well as anything that might be negative.

Medina Johnson: Thank you very much for the invite. I feel very old after that list of things that I have done—

The Chair: Well, you have done a lot of things and that is why you are here.

Medina Johnson: —for a very short period of time, but thank you anyway.

Lord Polak: You are quite young in this room.

Medina Johnson: Okay, I will take that. IRISi is a national charity, in its 10th year now. As you mentioned, we are born from research: from a randomised control trial in Bristol and London that looked at how we can bring together a partnership, a successful collaboration, between the health system—IRIS is primary care, general practice-based—and the specialist violence against women and girls sector. We recognise that clinicians want to do more and want to do better, but they do not want to ask a question and open a box without knowing how to deal with what comes out of it.

Survivors and victims were telling us, "We go to our healthcare providers feeling that we have a red light flashing on our head saying, 'Help me, ask me', and nobody recognises and nobody asks". Violence against women and girls services were saying, "Women keep telling us that they're going to healthcare providers and nothing is happening, they are not being supported". So we developed a five-step programme, which we call the five Rs. It is really straightforward: we support clinicians to better recognise patients affected by violence and abuse, how to respond and risk check, how to ask, how to refer, and how to record in the medical record in a useful way for potential future follow-up. On that specific point, the Act has been very helpful because it removed the ability of healthcare providers to charge for medical records or medical evidence around domestic abuse, which was a huge barrier for many of the women supported through violence against women and girls services—

The Chair: Is that because it was so time-intensive?

Medina Johnson: —and costly, yes. It was serendipitous as to what different practices charged, how much they charged and whether they did or not. We started the research in 2007 and our programmes over those last nearly two decades have worked to provide specialist training, advocacy and support, with a specialist domestic abuse worker based in a local specialist service wherever our programmes run, working hand in hand with a local clinician, usually a general practitioner. Our organisation trains them to then go on and train their local general practices.

The Chair: Is that including dentists?

Medina Johnson: That is a very good question. We did a very small trial with Manchester dental school and Bristol Dental School; it had less effective impact and outcomes.

The Chair: Why do you think that was?

Medina Johnson: I think there is something about the lack of understanding and recognition of the dental profession that this is something that is their business. There are some very good people in the profession, there are some really interesting researchers in the profession, but as a whole there is a bit of a disconnect: "This isn't my business, this isn't what I do". We know that for survivors and victims a dental appointment is additionally triggering because of the vulnerable position that you are in when you are in a dental chair and you have—

The Chair: So often punches and heavy-handed hits to the face can dislodge teeth and so on, and be an indicator of things that are going on, yes.

Medina Johnson: Absolutely, yes. We were involved in a research trial around dentistry. We continue to do training: we train dental trainees and maxfac trainees. Literally two weeks ago we had the good news of some funding from one of the London boroughs that wants us to work with it to develop our IRISi general practice programme in dentistry and pilot that over this financial year. So watch this space because hopefully there will be more and better happening in the dental space.

The Chair: Do you feel that this whole business of doing research with health practitioners of all kinds has been assisted by the new legislation and that it has provided some resource for that training?

Medina Johnson: It is wonderful that it is named in the Act; we now have legislation that names this as the responsibility of the health system to do something about it.

The Chair: Is it leading to—

Medina Johnson: Pockets? Yes. I do not want to pre-empt what might be asked, but one of the questions I was sent was asking about the pathfinder project.

The Chair: We want to talk about that.

Medina Johnson: In brief, the answer to your question is yes. There have been short pockets of funding, government funding for maybe two years or three years. Unfortunately, the funding has not been sustained so the programmes that were set up during that have not been sustained and the specialist services are simply on their knees and need infrastructure support.

The Chair: We will come to it later, but it would be great if it were introduced into medical training, nursing training, the training of dentists and hygienists and so on. All that would be really helpful if it were

introduced at the learning stage of the education of health professionals. But we will talk about that as we go on. I am coming over to you, Patriche, to tell us about your experience and how it is going.

Patriche Bentick: Good morning, everyone. I feel so honoured to be here, so thank you for having me. My position is a little different because I am a children's social worker. I manage a team. As you heard, I have been working with children and families for 20 years. Our position is one that relies heavily on a collaborative approach from others and definitely relying on our colleagues to be referring in, as well as us picking up. But we are in a position of exploration with families and remaining curious.

The focus on coercive control has been very beneficial. The focus on children being victims, whether hearing or witnessing abuse, but also being in coercive controlling relationships themselves has been very beneficial and it has allowed us to advocate more strongly for our children and our families. There are some gaps and areas for improvement, particularly in the court arena, but it allows us to advocate for our families—especially for our victims, mothers or fathers, and how the children are used in those relationships to get at one another, but also how the children are often forgotten in the middle of all that and what that means. Our little children will end up being adults one day, right? So as they grow older and they take those experiences on and live with unresolved trauma from what they have experienced, they too can start that cycle again themselves, becoming victims or perpetrators. It has allowed us to think strongly around how we can work better together, and how we can work better with our judges to think about the position of the parents at the moment.

One of my biggest reflections is when thinking about the Children's Act in the family court, how the Act itself is not used enough—how do we strengthen that collaboration? For example, I have a case at the moment where the mum is a victim of coercive control of a very high level. It is always very difficult to evidence, as are neglect and emotional abuse; it is much easier to evidence physical abuse and go through the victimless prosecution process if we have colleagues who are aware of that. But in terms of more hidden abuse that is not in your face in the same way, how do we focus on ensuring that that mum gets support so that she does not lose her child? For this mum in particular, this will be her fourth child; three children are out of her care already and this is a pivotal point for her. She is only 27. She is care-experienced and has made so much change but how do we support her through the process of healing? How do we show the judge that actually the dad is abusing her currently in this courtroom? She has been going through abuse the last few weeks—how do we keep her protected? I worry we are not doing enough to support our victims if we need to push for victimless prosecution. So there are areas for us to collaborate much more.

I had the privilege of managing a specialist domestic violence court for a few years; those court arenas are very experienced with victimless prosecutions and collaborative working. I do not always think that social

workers and other professionals are asked for their opinion prior to making those decisions of NFA-ing a case or going forward to the CPS with the evidence. How do we collaborate much earlier on? Another example: recently, a mother came into the office very early and had the confidence to talk with me about the abuse she had been experiencing for five years. I am very flattered, as a manager, that she decided to come to me to do that. I called the police and we did that work, but from that moment I was immediately excluded.

Not to point fingers at any organisation, because I have amazing moments with all my colleagues, but when people move on and move up, how do we train the next person coming into those positions to know, actually, the guidance says this is the best way to work—without sounding so far removed from practice in those moments, how do we come together more? My biggest reflection is about advising further collaborative working very early on and remaining curious. There are experts all around us. The power dynamics in that space: the judge may hold more power or a police officer may hold more power, but actually someone else in the room may be more experienced regardless—

The Chair: More knowledgeable about the particular—

Patriche Bentick: —more knowledgeable about that incident or domestic abuse as a whole. I am not in the position of managing the specialist domestic violence court right now, but I have that experience and actually in that moment when I am saying we need to prosecute victimless, I have evidence, someone else has evidence—how do we do that?

The Chair: For those listening, when you are talking about victimless prosecutions, we are talking about a situation where perhaps the victim of coercive control or actual violence is so fearful that they do not feel confident about actually participating in the prosecution, but where there may be enough evidence to proceed without them.

Patriche Bentick: Absolutely, and sometimes there are other factors, such as cognition and learning needs. Sometimes, although we can clearly see they are, the victim is on a journey of understanding that they are a victim and they are not in the position to be able to advocate for themselves in that way.

The Chair: Yes, and they have normalised behaviours that are not—

Patriche Bentick: Especially when the abuse is intergenerational.

The Chair: Yes, they have seen it all their lives so there is an acceptance. Baroness Rafferty.

Q67 **Baroness Rafferty:** Yes, my question is really directed to Medina. Thank you so much for outlining the role of IRISi and the content, and congratulations on running a randomised controlled trial; I am a nurse, but I am also an academic and I know how difficult and complex those trials can actually be.

One element I would like to pull out is on the pathfinder project and where it sits within the broader context of IRISi. Was IRISi a longitudinal project, or was it essentially a one-off and then you hope to have this centrifugal influence, if you like, on building capacity, training the trainers?

Medina Johnson: Where to start? I cannot take credit for running the randomised controlled trial; I was part of it, but it was run by my academic colleagues and I was in on the front-line support side, but thank you. It was a really interesting and important project.

IRIS stands for Identification and Referral to Improve Safety. When we had the results from the IRIS trial, we actually went back and double-checked them because the increases in recognition, identification and referral were way beyond what we expected. It was a comparative study, so half our practices were getting the project and half were not and we compared baseline data. We saw that in practices that had the IRIS intervention, women affected by abuse were six times more likely to be identified, and three times more likely to go on to accept a referral. We were staggered by this; this was much greater than we thought. We were getting really great qualitative evidence—case studies, women's voices, and really important feedback.

Clinicians were telling us that this was changing knowledge, attitudes, beliefs, and really importantly, their clinical practice. They were saying things such as, "When a patient comes in and I assess that she's depressed, I do this, I do this, and I prescribe this". That is very simplistic, not all practitioners work in that way. They were saying, "And now you're asking us to do something different. You're asking us to be curious; you're asking us to think more widely than we would normally and ask different questions. Well, that's going to take longer, it's going to be more complicated. Do we have to do risk assessments?"

What we did in the IRIS programme was to say, "Do a risk check. We want you to ask top-level questions such as, are you safe to go home? What has been threatened to you, to your children, to the wider family? If you are not safe to go home, this is the referral route that the clinician follows". If it is not high-risk, bring in the IRIS worker, the specialist worker, and she will contact the patient. The patient does not have to ring an anonymous helpline, all of which have their place, they are great, but clinicians were also saying to us, "We want a process similar to referrals we make into coronary, diabetes or gynae care where we get the follow up. We know our patient has been seen, what happened and what the next steps are". So that is what we built into the programme: the worker closes the loop.

We were passionate that this did not sit on a shelf somewhere, so we sought follow-up funding. Two of us were working part-time. We wrote commissioning guidance; we wrote train the trainer. Then the pathfinder project came up. I am looking at Baroness Barran because she was central to that. IRISi was one of five organisations working on the pathfinder project, which was a three-year pilot project that ran from

2017 with funding from two government departments to really try to establish a comprehensive health practice: a whole-health approach. We had great success in general practice but that is only one front door and we knew that many survivors, many victims, would not go through that front door. We wanted to look at mental health trusts, acute hospital trusts, and the wider community health system. It was a partnership project with AVA, Imkaan—a specialist by and for service—IRISi, SafeLives and Standing Together, and we worked in eight areas.

Areas had to apply to us to get the government funding that we managed, led by Standing Together. They had to demonstrate that they were already doing good work in two parts of the health system, and through the project we would then support them to plug gaps and respond to areas where they knew there was a need but did not have the resource to do that.

Our learning informed a toolkit, which remains free and accessible on the Standing Together website, and it provides resources around policy development, governance, data, and systems that can support. What it did not result in is a whole package that can be commissioned. There are elements that can be commissioned, and there are some really good peripheral frameworks that can go around it, but it very much speaks to the whole-health response.

The recommendations that came out included co-locating of violence against women and girls specialist workers from specialist organisations in the health system; local and central co-ordination because if we do not have the directive from on high that filters through the whole system, things do not happen but we also need to understand what happens locally; and, as I already described, training combined with effective referral pathways into specialist services. That needs sustainable funding and that is often where the system falls down: we have pockets of funding, such as this great piece of work for three years, and then the systems that are set up do not perpetuate, sadly. Then when we come back with something similar, clinicians are sceptical, it is not good enough for survivors, it is not good enough for people affected because they do not know whether they can now seek support somewhere or what response they will get.

It is also really important that domestic abuse policies in trusts are informed, kept up to date, and are real and live and do not just sit on a shelf or sit on a computer somewhere; they are practical, useful tools for clinicians and their patients.

The Chair: Lady Barran, you were very involved in this; is there anything that immediately springs to mind?

Baroness Barran: I am sitting in the glow of reflected glory, but I left SafeLives at the end of 2017 so Medina, predictably, is being unbelievably modest. Sorry, what was your question?

The Chair: It was a very progressive and leading project. Has it been

rolled out in a way that you would have considered—

Baroness Barran: No. Listening to your excellent description, the thing that sits with me is that point about co-location of specialists with healthcare professionals. My memory of it, which will be interesting because yours will be much more sophisticated, was that if you are a healthcare professional and you are not super confident on domestic abuse, it is just easier not to ask. Because if you ask and you get a response, you do not know what to do with it and you have no one to refer on to. I remember in Bristol, there were the two IDVAs in the Bristol Royal Infirmary: they were literally in a kind of broom cupboard but actually it meant that clinicians who asked the question, whether in A&E or in other places, knew that their colleagues were down the hall in the broom cupboard and when they got a disclosure, there was someone else who could then pick it up. Is that a fair reflection? I felt that unlocked everything, or were there other important things that were unlockers?

Medina Johnson: It is a very fair reflection, and we have since developed. My organisation is also running a programme in sexual health, so we are now working in sexual health clinics—still sitting in broom cupboards, but that co-location is vital. We also have colleagues working in maternity services and so on.

The Chair: Before we started this session, Michelle and I had a discussion about this very business of the separation of sexual offences and their investigation from domestic abuse, which often seems unhelpful.

Medina Johnson: It is difficult because sometimes the system—the commissioning and the funding—separates things out. Sometimes that is absolutely right but, as you say, we risk survivors having to tell their story over and again. We risk waiting lists and marginalisation; sexual violence is very often marginalised. I spoke this week to the chief executive of Rape Crisis for England and Wales, and we said this is a real risk; it often happens. People talk about DASV—domestic abuse and sexual violence—but it is always about the DA, and the SV is the weaker cousin. We were talking about this as we were waiting outside.

Again, it is about being curious: make sure that the training is right and we support professionals to understand how to ask questions, how to support, understand and hear what survivors tell us; be patient. That can be challenging because very often support services for survivors are funded only for a particular time or number of sessions, which is unhelpful; but also we can separate things off in an unhelpful way. Non-fatal strangulation—we will perhaps talk about this shortly—is a great part of the Act, but everything is intertwined and linked.

The Chair: We already heard evidence of how non-fatal strangulation is immediately is easier to respond to, particularly for investigators and police, because once they have been alerted to it, and that there is law that says this is a separate offence, it is much easier for them to go down that route. Much more complex are the other ways in which coercive

control can be exercised, as it is more subtle and often about not letting people have relationships with their families, or having their phone followed so they know everywhere they might be.

Q68 **Baroness Sugg:** My question is for Detective Chief Inspector Saunders. Thank you very much for your introduction and particularly setting out how the legislation impacts your work; that was really helpful. I wanted to hear a bit more about your initiatives to improve the response to the victims and survivors of domestic violence. You talked a bit about Diogel. From what I understand and have read, there are some fantastic initiatives in terms of training, prosecution plans, and plain clothes, which have helped victims, so I was a bit concerned to hear that it was not carrying on. It would be good to hear your reflections on that, your view on rapid video response, whether that will be as effective as Diogel, and the lessons learned that you are able to take forward.

DCI Leeann Saunders: For us, the biggest thing is the domestic abuse matters training. We differed from some other forces potentially in that we offered it to front-line officers; that included those on the Diogel team. We then rolled it out further and took it to our control room and investigation hubs. The way we work here, officers make an arrest, and then quite often domestic abuse cases get picked up as part of a secondary investigation. So we targeted those teams as well with this training.

I want to give some reassurances here: even though Diogel teams have gone, our investigative hubs are exceptional in what they do and are very well experienced and evidenced with domestic abuse. We have quite a few champions across the force area. To further reassure you in relation to this, we did a lot of work around evidence-led prosecution with the Crown Prosecution Service; in particular, targeting our investigative hubs. It is difficult with evidence-led prosecutions because we still have the res gestae and the hearsay to get through. It is not as easy as people think when we have the evidence, or so we think; it is about getting that evidence before the court. But we have made a lot of progress in this regard.

Recently, we created an online package for evidence-led, so that all officers and staff are aware from the initial point of contact with a victim and are constantly thinking in terms of evidence-led. We did this with the CPS. All this was in place around and after Diogel, which focused on the Cardiff area in particular because it is a busy city. It looked to pick up cases where, if somebody was in custody, and initially a victim had said they were not able to give a statement, usually it would have ended up with no further action unless there was evidence to go forward. So it looked at bringing in additional support: phoning the victims, potentially going to the house. We started to do virtual statements at that point; then we looked at wraparound, linking in with the public protection teams and the MARAC process.

Where we are now, RVR comes in quickly on the initial—

The Chair: Leeann, can I just ask you to explain what RVR is? I know it is rapid video response but explain for members of the public who might be listening what that is.

DCI Leeann Saunders: Rapid video response is not something I can take credit for; there is a national blueprint for it now. It aims to provide a virtual response because we understand that, for some victims, police turning up at the address in uniform is not always the right option. Likewise, with non-emergency calls, we cannot always guarantee to get there in the time that a victim requires; for instance, the short period of time when the perpetrator is out of the house for work. Rapid video response was already up and running. South Wales Police started to look at it in 2024; it went live last year, and now we have teams across the force area. When a call comes into the public service centre, if it concerns domestic abuse, it gets graded. If it requires an emergency response, officers are sent out no matter what. If the response is non-urgent, that does not mean that it is not important, but if the call does not require a response within 15 minutes, say, here in South Wales we class it as a G2—grade 2—call.

Historically, our responses to grade 2 calls took longer than they should for domestic abuse. So we wanted to make sure that we improved this because we understand that, for victims to pick up the phone or report online, that moment in time is when they felt able to contact us and tell us; if we turn up four hours or a day later, that moment has passed. The call goes through a triage process and then it is allocated to the team. This all happens quite quickly. The team have to check that it is a suitable option: is this what the victim wants? Do they have the required internet capability to do this?

The response is everything you would usually do if you turned up at the scene. If it is safe to do so, officers can even look around the property to check for damage. They can take screenshots of damage as well as injuries, which can be followed up at a later date. They can take statements virtually, and complete the risk assessment and get that actioned. They can also signpost. We have the Live Fear Free support service here. When officers have initial contact with a victim, they can put them in touch with a Live Fear Free advocate, who can provide them with support—this happens through Welsh Women's Aid—and advice; it can offer officers advice on refuge and bed spaces too. Virtual officers can do this as well, and the response is just the same. Once the package is ready, within an hour you could have a statement and a risk assessment, which would go out to the response officers, who then go and arrest the person. When it comes to evidence-led, all that evidence is captured quickly, and you have a record of the interaction from the start.

The Chair: Leeann, that is terrific. I will pause you there; I am sure the wealth of your experience means we could have a very long session on this. I am very keen for Baroness Hussein-Ece to able to ask her questions. I suspect they will be directed mainly at you. Can I remind everybody that we are tight for time?

Q69 **Baroness Hussein-Ece:** We have already touched on this to an extent, but my question is about the challenges you may face when responding to and supporting victims and survivors of coercive and controlling behaviour and strangulation. I think Patriche said some victims and women do not necessarily know that what they are experiencing is in fact a crime. Could you outline some of the challenges you have faced? It is a general question for everyone.

Patriche Bentick: It takes a lot of curiosity, time and patience. Fortunately, with our work, we have that because most of the time we do long assessments. For example, my team do long work through care proceedings for children or on child protection plans. From the police's perspective, for coercive control there needs to be a pattern, and we need evidence to demonstrate that there is a pattern. In terms of challenges, sometimes you need more time. If you are doing a child and family assessment that has to be completed legally within 45 working days, you may not have all the evidence in that time, so you often do not meet the threshold for the next step. If you do, and we have a collaborative approach, we can do it.

I come back to the point about collaboration that I picked up when we talked about sexual violence. Some organisations will have ISVAS instead of IDVAS; we need to make sure that it is not split. Sexual violence can be a one-off, but actually there is a lot of coercion in that. Consent is a big part of coercive control. It is about building trust; as a social worker, because the stigma is so negative, it takes time to do that. Demonstrating that there is an issue is easy, as long as there is strong collaboration with our colleagues, and even internally within the team; but if we do not have that, there is always a challenge. Coercive control is so complex; you cannot get that understanding in a one-day training. It takes a long time for people to get their head around what coercive control is.

The Chair: Would either of our other witnesses be interested in coming in on this, or do you feel that Patriche has covered it?

Baroness Hussein-Ece: There is a supplementary question—Medina went into some detail about this—about how clinicians can ask a patient or potential victim about coercive control. You touched on previously how that is such an important element of this.

Medina Johnson: When we train our clinical colleagues side by side with specialist service colleagues, we often talk about filter questions, so asking very broadly, "How are things at home? Tell me about your relationship. What does a usual day look like?"—or "You said sometimes somebody gets angry. What does that look like? What happens when somebody gets angry?" It is also about noticing levels of confidence, or lack of confidence, agency, or lack of agency. That erosion of decision-making and of confidence is all part of the dynamic of coercive control, which happens over such a long period of time.

An example is a woman I supported many years ago, who always looked amazing, but on one occasion she came in looking particularly amazing. I said, "Oh, your hair's great. Your outfit is lovely". She said, "Yes, he took me to the hairdressers and he bought me a new outfit". I asked, "Did you want to go to the hairdressers? Is this the outfit that you want to wear?" It is about being comfortable to unpick things and having the time.

The recognition of both coercive control and non-fatal strangulation in the Act has been very helpful. There are still things that need to be improved. A colleague from the Institute for Addressing Strangulation knew that I was coming today and recognised that the absence of a statutory definition of non-fatal strangulation can be problematic, and it would be helpful if there were a definition. A real positive is that the offence has increased awareness and helped shift understanding from it being assault to a high-risk indicator. As we know from risk assessments, if somebody says, "He's tried to strangle me"—

The Chair: I see Leeann nodding. That would be the case with the police as well. Would that be right, Leeann?

DCI Leeann Saunders: Yes. The difficulty for us comes with the evidence that goes with non-fatal strangulation. We have heard of cases where people had to pay for scans because of internal damage, so that presents an issue. Our new risk assessment, DARA, helps in indicating this. Quite often we see victims that come through first with a physical assault, and when you engage with them, the sexual assaults come out afterwards. We have extended training to our rape investigation teams around honour-based abuse because we know that there are all these potential touchpoints where other offences can be disclosed.

Q70 **Lord Russell of Liverpool:** Moving on neatly from what you just said, Leeann, minoritised victims and survivors often have particular issues, as you will be aware, sometimes to do with their immigration status, sometimes to do with honour-based abuse. It so happens that, as we sit here, the top story that just came up on BBC News is migrants making false domestic abuse claims to stay in the UK. Have any of you ever come across or witnessed that? What challenges are you trying to overcome when interacting with minoritised victims? What can we learn from that?

DCI Leeann Saunders: I have done quite a bit of work in this area. We have good links with Bawso as well as Karma Nirvana. Last year, I held survivor engagement events with Bawso to look at the particular issues around reporting. Within South Wales Police, we have Cardiff and Swansea. They are cities; there is lots of help available. But there is a corridor in the Welsh valleys where there is not much support and very little reporting comes through, and this has been noted. We went to speak with survivors of honour-based abuse, of domestic abuse, and lots of other offences, and asked them what they thought the barriers were.

Interestingly, in terms of today's panel, going to the police would not be an option for many of them. The interactions that happened, and the way they got support through Bawso and ended up coming through to us,

were through GPs, teachers and schools and third parties they had encountered. They also had concerns around the questions that we as the police asked them, first, in terms of being believed, particularly around the immigration status, but also when we asked about ethnicity; they said they had no problems with us asking about religion, but they were suspicious as to why we would ask about ethnicity. This was something we had not considered before, but they found that a particular concern.

In terms of interactions when coming into the country, when they first arrive and do not speak English, there is an opportunity to pick up on this. A lot of information is in English, or in Wales it is in Welsh, so they do not even know to call 999 or who to contact. We got quite a lot of learning there. I have a PowerPoint in relation to this, and we are able to use this now in work with Bawso, the University of South Wales and survivors on an engagement framework. I hoped to get the update for you of where that piece of work is today, but it is being developed by this group now. I was told initially it would be ready by July, but I can certainly send you more information in relation to it, as it will help all professionals with how to engage, the types of questions to ask, and the things to look for.

The Chair: Thank you. I say to members of our panel that if there is anything you want to inform us about that can be sent in written form after this, please do because we are open to hearing your expertise on any questions where we might not have enough time.

Q71 **Lord Polak:** Some of us were involved in trying to ensure that children were mentioned on the face of the Bill. Patriche, you said it was clearly worth the fight that some of us took on to ensure that it happened. Besides cloning you and having 500 Patriches around the country to ensure that children are looked after, what else can be done—I am looking to the police and others—to improve responses to children as victims?

DCI Leeann Saunders: Historically, we would not always go and speak to the children. Now we speak to all of them. Even if they are not there, we record all their details and go down the Operation Encompass route. The particular issue in relation to children is the support that is available. We have child IDVAs around, but often they are not available. When we do a risk assessment, there is a reliance on the fact that it will go down the route of multi-agency panels. A particular issue is that the Act takes notice of domestic abuse for children aged 16 and over; we see so many coming through in relationships where there is a serial perpetrator and serial victims by the age of 16. Things happen on a case-by-case basis; it can be quite difficult to get interaction. It concerns me that these relationships and behaviours come in certainly from the age of 13 onwards, and by the time they are 16, there is potentially a missed opportunity here.

The Chair: Patriche, do you want to come in on this? I am sorry, I am going to limit your time, but if you have something you really want to say, please do.

Patriche Bentick: From my experience, there is not one crime at any given time or one type of abuse happening. There is not one perpetrator or victim; it is both. It is very complex and multi-layered, but it often is not looked at this way. In contextual safeguarding, when we think about exploitation, whether sexual or criminal, things are often combined. So it is not a girlfriend and a boyfriend, or just an intimate relationship, one on one; it works both ways. I agree with what Leeann said: it is happening at a much younger age. Again, there needs to be more of a collaborative approach early on, where police work with a teacher, or social workers with the police, to have those conversations, not interviewing children on their own. They need to lean on voluntary sector, where there are some amazing organisations. Do not focus on domestic abuse or look at it as peer-on-peer abuse, but see it is covered under another element of harm. It is never one category; it is sometimes both or all.

Again, we have to be curious, open-minded and creative. We sometimes take a piece of legislation or guidance, and we are very rigid with it. How can we open it up to exploring the benefits of trying something radical, such as going to where the child is? This is why I touched on contextual safeguarding as, again, it is about going to where the child is, where they go kickboxing or hang out at a park, and seeing what is going on for that child. It is much easier to connect with them. They just want to be met where they are, and we are not doing that enough.

The Chair: That is a really interesting point.

Lord Polak: They used to call it detached youth work, going to where they are.

Patriche Bentick: Yes, going where they are.

Q72 **Baroness Porter of Fulwood:** You gave a few examples of where you think the Act improves things. If you take a step back and look at the last five years, could you all say a little more about where you think the Act has improved things, if there are areas that we have not touched on yet? Where did you hope the Act would improve things but, if you look back over the last five years, you see it has not?

The Chair: Try to limit it to three suggestions. I am sorry to do that to you. Medina, would you like to kick off?

Medina Johnson: The Act has brought domestic abuse to the fore as a public health matter. We now talk about it widely; the system is beginning to respond better. The work of the pathfinder led to Home Office funding for Standing Together to develop the Crossing Pathways programme. Unfortunately, that was for only three years, but now we have the violence against women and girls strategy that came out in December, where the Department of Health is recognised as putting funding in, and we have new programmes coming out as a result of that. So the public health approach around domestic abuse is great. DAPOs—domestic abuse protection orders—have, certainly in terms of the health

system, reminded our clinical colleagues and health teams that perpetrators are patients too; it brings that to the fore.

Part of the DAPO process—sorry, Leeann, I am probably stepping on your bit here—is to look at drug and alcohol as well as mental health assessments. That is important, but we must be careful that we do not use those as excuses and reasons for domestic abuse. How things are managed, discussed and unpacked is really important.

I am sorry, I cannot remember who asked the question about migration. It is a central concern for structural inequalities. There needs to be a much stronger recognition of the challenges, barriers, and the need for our specialist buying and service provision to be not given the crumbs after everybody else has their bit. When we talk about partnerships with our specialist by and for services around issues of intersectionality, equity and inclusion, they need to be meaningful and true partnerships. That also speaks to the NHS 10-year plan, where health inequalities are front and centre. We could be doing more and better around that.

The Chair: Thank you very much, Medina. Leeann, can you give a quick summary in one minute, please? I am sorry.

DCI Leeann Saunders: I will try to be as quick as I can. In the Act, the big thing was the clarity that it provided, as well as the opportunities for support. This led to improved Clare's law responses, where we could give disclosures, and the work that came out of that in the understanding of post-separation abuse. On what I hoped would be covered, there are particular issues on the Welsh side of things with devolution. The Act sometimes talks about England, particularly around housing. When it came in, we were waiting for the Welsh part of this to be included as well.

Multi-agency public protection arrangements are on a statutory footing for perpetrators, but there is no statutory element around the victims and multi-agency measures potentially there. We also need support and further guidance around economic abuse, as this impacts victims lifelong; it is not easy for victims to rid themselves of this burden. If there is an opportunity to address this further within the Act, it would be beneficial because the physical scars may have gone, but if you are tied to that person financially, it can make moving on really difficult.

The Chair: Leeann, thank you very much. Patriche, is there anything you would like to add?

Patriche Bentick: The focus on children was amazing and very helpful. The post-separation abuse was very important. It definitely helps when thinking about care proceedings and how children can be used as a tool in order to continue abuse. Further, we need to recognise that 16 is not the age when domestic abuse starts for children in intimate relationships, and that abuse is complex and multi-layered. I am not sure how we can talk to that, but some creativity is required. Also, a stronger multi-agency approach is needed at the beginning. I am not sure whether we can have mandatory information-sharing prior to developing a case to go forward

to the CPS. I am not sure how we do that, but if advice was sought from organisations and local authorities after a charge or sentencing, that might help with some evidence.

The Chair: The final throw goes to Baroness Gohir.

Q73 **Baroness Gohir:** Is there anything that you would like to mention that has not been addressed so far or any recommendations that you would like to make? I am particularly interested in: does the Domestic Abuse Act work for those with learning needs, and older victims? Patriche, you touched on victims with learning needs. What patterns and trends do you observe? How can we improve their outcomes, and is there anything else you would like to say?

Patriche Bentick: I do not think the Act talks to these matters specifically. Sometimes we assume that we will think about them, so it could be an area to look at. Equally, you touched on intersectionality; anti-racism and social justice is one of my areas of passion that I talk about a lot. We are unable at the moment to look at what it is like for a person going through abuse. Learning difficulties tightly link in with multicultural and global majority families. There are other elements, including alcoholism and substance misuse, which lead to poor mental health. We know that domestic abuse leads to poor mental health; how does that impact someone's cognition at the time? There could be something that touches on that and looks at the intersectionality of a person and their ability to make decisions. Are they able to say, "I'm a victim" if their mental health and learning needs are compromised? Are they able to say, "I'm a victim of domestic abuse" if their responsibility to their family is so great because of an arranged marriage? For Black African and Black Caribbean families, the weight that a victim may hold in their family as a woman is huge. Are they able to say, "I am a victim" in that moment? Not necessarily. How does the Act support that or help organisations support families in that way?

The Chair: Patriche, thank you for introducing that holistic picture into our discussions today. I thank everyone on the panel: Leeann, Patriche, Medina, our expert Shazia, and everybody who has been involved; it has been great hearing from you. It has informed us enormously, and I want you to know how much we value the time you have given us. With that, I complete this public session of today's committee hearing.