
10 February 2026

Shared Insights

Domestic violence and safeguarding

Speakers

James Arrowsmith – Browne Jacobson (Chair)

Survivor of domestic abuse

Christopher Griffin – Domestic Abuse Related Death Review Chair, Domestic Violence/
Sexual Harm Risk Assessor



Introduction

This Shared Insights event was free to professionals working across the health and care sector.

We invite delegates to: [Donate - Support our lifesaving work - Cyfannol Women's Aid](#).

We heard the powerful story of Sarah (not her real name), a survivor of domestic abuse. Sarah bravely described her lived experience and shared her reflections on the involvement of statutory services and how this has impacted her, her children and her wider family.

We also heard from Chris Griffin, who has many years experience working with people who carry out abuse. Chris is Director of Risk for the University of Southampton and has worked in Higher Education for 6 years. Prior to this, he worked in the Criminal Justice System and Probation Service for 14 years. He Chairs Domestic Abuse Related Death Reviews (formerly known as [Domestic Homicide Reviews](#)) and is also a specialist risk assessor of domestic abuse and sexual offending.

In 2024, 108 people were killed by a partner or family member, while the number of victims of domestic abuse dying by suicide overtook domestic homicide for the second year in a row. The police receive a phone call from someone experiencing domestic abuse every 30 seconds. It is important to recognise that men experience domestic abuse. It is equally important to recognise that the statistics demonstrate that domestic homicide and domestic abuse-related suicide disproportionately impact women. In the UK, more than two women are killed by a man every week. Over 30% of women experience domestic abuse in their lifetime.

The recent "[Learning from Loss](#)" report concluded that domestic homicide remains unacceptably high, the number of deaths has remained relatively unchanged in the last 10 years and "*vital opportunities to prevent future deaths are being routinely missed across England and Wales*".

During this session our speakers shared their insights to support delegates to reflect on how professionals, organisations and systems can better support and safeguard those experiencing domestic abuse. There were practical takeaways and references to additional resources to support further reflection, detailed at the end of this note.

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A survivor's story

A survivor of domestic abuse generously agreed to speak with us in this session. To protect her identity we have called her Sarah (not her real name).

Sarah shared that she was in an abusive relationship for 12 years, which she escaped in February 2024. The relationship started with love bombing, the abuse escalating to coercive control and financial and emotional abuse. The abuse increased over the years following the birth of her children and intensified during the pandemic. Sarah recognised that friends, family and work colleagues were becoming increasingly concerned. One night, her eldest son said “*it's time to go, mum*” and she left behind her home with her children and their pets. Sarah emphasised that leaving was not the end of the journey, it just started a new chapter. She explained her experience of PTSD and anxiety. Even now, Sarah said she and her children are still suffering at the hands of her ex-partner as he has weaponised access to the children through the family courts.

After leaving the relationship, Sarah and her children were involved with a number of agencies including children's services through the Local Authority, the police, counsellors and the charity Women's Aid. The support received was a mixed bag, with some of it being excellent (Women's Aid) and some significantly lacking, particularly that provided by the Local Authority. This led to Sarah's desire to share her experiences in the hope that she can influence positive change, for all the abuse survivors who follow her.

Sarah is now re-building her life. She and her children are in their own home, she has a new job and the family have travelled and experienced things they were not allowed to do before because of the high level of control exercised by her ex-partner.

Some of the failures Sarah has observed include

Lack of consistency in social worker and thorough approach to evidence gathering

Sarah explained that she and her children have had their case handled by 14 different social workers in 2 years. This has meant that they have had to tell their story countless times.

The lack of continuity and handover of information has meant that she and her children continue to be re-traumatised by retelling and reliving the abuse.

There have been a number of poor quality investigations, with documents submitted to Court containing errors and missing vital evidence.

Reports would reference accusations raised by her ex-partner which had not been put to Sarah or her family and for which there was no supporting evidence. Additionally, accusations raised by Sarah and her children were ignored.

Lack of understanding of domestic abuse and trauma informed approach

Domestic abuse does not discriminate and it is important to challenge the stereotypes. Sarah believes that she was not perceived as a typical survivor of domestic abuse; she is from a loving family, is educated and is a senior professional. Her abuse was not primarily physical abuse, so her injuries are more difficult to see. She stressed the importance of a trauma informed approach to survivors, who are often living with trauma. This is not the approach Sarah and her family received. It is important that those professionals involved in providing support to the survivors of domestic abuse receive proper training in a trauma informed approach.

Sarah also believes that women are held to a different standard to men when it comes to relationships and parenthood and this is what she has experienced in her treatment by some of the organisations she has been involved with.

Mis-labelling of abuse as high conflict

For a long time, there was a reluctance by social workers and other professionals to recognise and name Sarah's situation as domestic abuse. Instead it was described as ‘conflict’. If we can't even name abuse when we see it, how can we deal with it? Sarah spoke out and challenged the Local Authority when she felt they were not providing the support they should, she felt she was vilified for this and seen as difficult. This mis-labelling had devastating consequences for Sarah.

It reinforced her fear that she had before she left her ex-partner that she would not be believed and it also impacted the approaches taken in her case. The language used by professionals when talking to survivors matters.

It is important for services to recognise that abusers can be very convincing and present as charming. Professionals should be alive to the fact that they are not immune to being manipulated.

To date, Sarah's ex-partner has not been held accountable for his abuse and he has not received any form of rehabilitation. More needs to be done to prevent harm and rehabilitate perpetrators of harm if the cycle of domestic abuse is to be stopped.

Lack of collaboration between organisations

Sarah detailed the lack of collaboration and information sharing she saw across organisations. There was a failure by the Local Authority to recognise their own lack of expertise in dealing with domestic abuse and to seek advice and input from other parties who had that expertise, such as the police and Women's Aid.

When expertise was offered for example by Women's Aid, it was not received by social workers as it should have been. Sarah experienced social workers actively blocking advice being provided by Women's Aid and evidence gathered by the police. It was unclear to Sarah why organisations would not want to work together to provide the best support and outcome possible for survivors.

Domestic abuse related death reviews

Christopher Griffin –
Domestic Abuse Related Death Review Chair

What is a domestic abuse related death review?

The requirement to undertake a Domestic Abuse Related Death Review (DARDR), formerly known as Domestic Homicide Reviews, is mandated in the UK under [Section 9 of the 2004 Domestic Violence, Crimes and Victims Act](#).

A DARDR is triggered when a person aged 16 or over dies because of domestic abuse by a relative, household member or someone they had an intimate relationship with.

The DARDR reviews the circumstances leading up to the death and the actions and input from agencies who were involved, to understand how and why the death occurred. The purpose is to identify any lessons learned from the death, to improve the way agencies work together, to implement local and national recommendations and to reduce the likelihood of future domestic abuse related deaths.

The review process differs from area to area depending on Local Authority practice. Generally, an independent Chair is appointed by the Local Authority Community Safety Partnerships. The Local Authority identifies the statutory and non-statutory agencies who were involved with the person prior to their death. This can include social services (children and adult), the police, NHS (including GP and hospital), Prison and Probation services, housing agencies, victim support services and charities. Families should be given the opportunity to be integral to reviews [and their involvement in the review can be supported by advocacy services](#).

The Chair has oversight of the process and draws up Terms of Reference for the review. All agencies are then invited to summarise their involvement: this input is always provided by senior independent staff who were not directly involved.

The chair will review the agency feedback and will consider which agencies' involvement requires further insight and exploration. Any agencies identified are then asked to complete an [Individual Management Review \(IMR\)](#) which requires the relevant organisation to look into the specifics of its involvement and provide a critical analysis of their service involvement, decisions, actions, potential missed opportunities and areas of good practice within the individual organisation.

All agencies are then brought back together for a meeting where the IMRs are presented and discussed, with a focus on service delivery not on individuals, to identify areas for improvement.

The Chair then writes the formal DARDR report. In doing so, the Chair will consider the agency involvement and make clear recommendations for service change to safeguard future victims of domestic abuse. The panel reconvenes for scrutiny of the draft report and to make sure the recommendations are proportionate, time limited, realistic, relevant and achievable. It is then sent to the Local Authority Community Safety Partnership and then to the Home Office for formal consideration and approval. The recommendations are robustly checked before being approved by the Home Office and there will be questions and push back if the recommendations do not feel achievable.

Where do I find DARDR reports?

To view domestic homicide review documents that are available to the public, you can [Search the Domestic Homicide Review Library](#)

What are the thematic recommendations from DARDRs?

Some recommendations from DARDRs are very service and situation specific. However, over the last 13 years since DARDRs were mandated there has been a significant repetition in the nature and theme of the recommendations.

Chris reflected that these include:

1. Understanding of trauma informed and trauma sensitive practice is not consistently embedded

This is a specific approach designed to reduce the negative impact of trauma experiences and support mental and physical health outcomes. It involves 6 key principles; safety, trustworthiness, choice, collaboration, empowerment and cultural consideration. More information can be found [here](#)

2. Governance

It has been a consistent theme of DARDRs that organisations offer limited training and inadequate policies on domestic abuse and there is a lack of consistency in the approach across organisations.

A lot of agencies have very rigid domestic abuse policies and they are not regularly reviewed. They apply a set methodology and do not encourage flexibility. For example, there might be a process for dealing with someone who does not engage, but consideration needs to be given as to why they are not engaging including any vulnerabilities that person may have. Practice will need to be flexible and case specific, tailored to the individual. Policies should be trauma informed and address how organisations support those who are labelled as "chaotic and non engaging".

3. Understanding vulnerability risk factors

This is important for those who are experiencing domestic abuse, but also in respect of those who cause the harm. The purpose of reviews is to reduce the likelihood of domestic abuse related deaths, and alongside this the approach to the people who commit abuse needs to change.

4. Rehabilitation

Whilst there is a need for punitive measures in some circumstances and some individuals need to be in prison for the safety of others, the vast majority of people who cause harm are the solution as well as the problem. Services focused on building relationships with those who cause harm and working with a strengths' based approach is the best way for those who commit abuse to gain insight and reduce the risk of them committing further harm. There are some additional resources below:

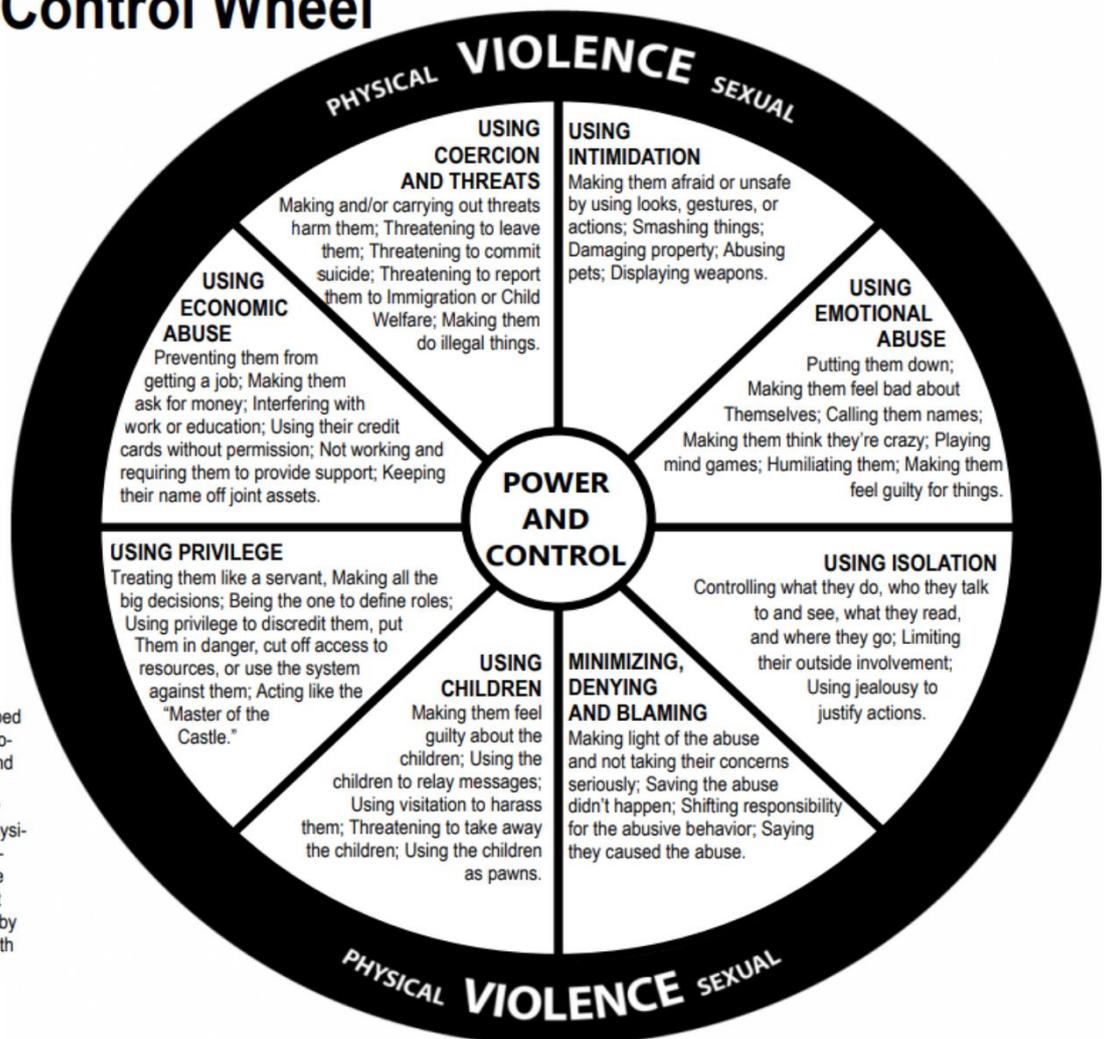
[HMPPS accredited programmes - GOV.UK](#)

[Strengths Based Ways of Working and Why it Matters for HMPPS – HMPPS Insights](#)

Understanding abuse tactics

Chris shared this Power and Control Wheel, which is a useful tool to understand the often-unseen abuse beyond violence:

Power and Control Wheel



The Power and Control Wheel Developed by the Domestic Abuse Intervention Project in Duluth, Minnesota, the Power and Control Wheel illustrates the tactics an abuser uses on their victim. Constantly surrounded by threats and/or actual physical and sexual abuse, the victim is subjected to the various tactics listed in the spokes as the abuser attempts to exert complete power and control. *adapted by Jen Snider to be gender neutral and with slight modifications not included in the original.

Key takeaways for your practice

- Challenge stereotypes. Domestic abuse does not discriminate, and victims and perpetrators do not all look or act in the same way. An example given by one delegate was [this study of healthcare professionals as domestic abuse survivors](#).
- Be careful not to mis-label abuse as conflict or something else. Language matters.
- Question everything, be alive to red flags, investigate fully, challenge accounts and follow the evidence.
- Seek out and accept advice and input from other organisations with specialism in domestic abuse and work together to achieve the best possible outcome for everyone.
- Nurture relationships with domestic abuse charities and support organisations. They offer invaluable support to your community and can help professionals too.
- Be aware that you are not immune to manipulation by someone who causes harm.
- Have a flexible approach and think about the individual involved in the case. Obstructive behaviour is not always wilful or intentional. Offer different contact options and methods.
- For mental health services, this interesting research on best practice was published recently: [Detecting and Responding Effectively to Domestic Abuse in Mental Health Settings](#)
- Embed trauma informed and trauma sensitive practice within your organisations to help understand vulnerability risk factors and the reasons why people disengage.
- Training and confidence for frontline professionals to make appropriate, trauma-informed enquiries is a really important part of detecting domestic abuse.
- Relevant risk assessment tools like the [DASH Checklist](#) can help, but the use of these tools and quality / awareness of domestic abuse policies is variable between services.
- Consider the policies and training on domestic abuse within your organisation and whether they are as robust as they need to be.
- Recognise that people may not know they are in an abusive relationship. They may not understand what "gaslighting" is and may have been groomed over months or years to believe they deserve what is happening to them. Many victims believe what is happening to them is normal. Professional Curiosity is the key - not taking every answer at face value.
- Ask the right questions of an individual you suspect is experiencing domestic abuse - are you happy? Do you feel safe? Do you have a support network around you? How is your relationship? Talk about feelings and worries, build a relationship before domestic abuse chat starts.
- Professionals also need to be aware of the appropriate next steps/options for the individual if they do make a disclosure.

How we can help

- Training for professionals dealing with domestic abuse can be provided by our speaker Chris who can be contacted on C.J.Griffin@soton.ac.uk. Further recourse can be found at [Hampton Trust, Breaking the cycle of abuse](#).
- At Browne Jacobson our team of specialist lawyers are experienced in advising health, care and other organisations on the statutory and legal obligations in connection with domestic abuse. During this session we heard that perceived legal barriers can sometimes prevent or delay effective action. We can help you tackle and overcome those barriers, understand your legal duties and provide supportive training to your teams to empower them to act effectively to safeguard those experiencing domestic abuse. We can also provide specialist legal advice and guidance on specific cases. Please do not hesitate to contact us if we can support you or your teams.
- Join us for future Shared Insights sessions. To view our programme of events click [here](#)
- You may also be interested in our Mock Inquest course. For further details click [here](#).
- You can also read our most recent Public Matters newsletter [here](#)

Resources

- [Learning from loss: ensuring the lessons from domestic homicide reviews lead to change](#)
- [IRIS programme – training, support and referral programme for GP Practices](#)
- [DASH Risk Checklist](#)
- [Detecting and Responding Effectively to Domestic Abuse in Mental Health Settings](#)
- [HMPPS accredited programmes - GOV.UK](#)
- [Strengths Based Ways of Working and Why it Matters for HMPPS – HMPPS Insights](#)
- [Domestic Abuse Commissioner](#)
- [Domestic homicide reviews: statutory guidance - GOV.UK](#)
- [Search the domestic homicide review library - GOV.UK](#)
- [Working definition of trauma-informed practice - GOV.UK](#)
- [Manchester Women's Aid Domestic Abuse health projects](#)
- [Resources - Cyfannol Women's Aid](#)

With thanks

We end with a formal note of thanks to our speakers and especially to Sarah for sharing her story with such strength and dignity. Listening to Sarah's lived experience was incredibly powerful. This session was attended by more than 260 senior leaders and professionals drawn from more than 100 health and care organisations across England and Wales. In feedback, 100% of delegates confirmed that the insights shared by Sarah and Chris will influence their future practice.

We were privileged to host this event and extremely grateful to Sarah and Chris for allowing us to do so. We invite delegates and anyone who has found this note useful to [Click here to make a donation to Cyfannol Women's Aid](#).

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