Healthcare Improvement Scotland

Domestic homicide and suicide review: standards

Draft scope

January 2026

NHS SCOTLAND

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Contents

1. Introduction

Healthcare Improvement Scotland is the national health and social care improvement organisation for Scotland and is part of NHS Scotland. It provides the expertise and resources to co-produce standards which are developed, informed and shaped by people who commission, deliver and use health and/or social care services. It uses well established and robust methodology to underpin standards development. (ref to ISQUA). Our approach to developing standards is outlined in Appendix 1.

Standards are informed by:

- people with lived and living experience and their representatives/care partners
- formally collected person-reported outcomes
- current national policy and legislation
- evidence relating to effective clinical practice, feasibility and service provision.

Healthcare Improvement Scotland have been commissioned by the Scottish Government to develop standards for domestic homicide and suicide reviews. This work is funded by the Scottish Government (via the Violence Against Women and Girls Justice Unit).

2. How to feedback on the scope

The scope document outlines the key areas to be covered in the Domestic Homicide and Suicide Review standards. We are looking for feedback on the seven domains listed below in section xxx. We are keen to understand if there are any gaps of areas that we might have missed. Please submit your comments by **Monday 9 February 2026** and feedback using the online survey.

Please note, comments will not be accepted after the closing date, or in an alternative format, unless previously agreed with the project team. Please contact the project team on his.standardsandindicators@nhs.scot.

Feedback on the draft scope will be reviewed and themed by the project team and used to further develop the scope of the standards. The development group will formally agree the scope at the first meeting. A summary of the responses to scope engagement will be made available on request from the project team.

3. Background to the standards

Domestic homicide and suicide reviews aim to learn lessons following a death where abuse is known or suspected, and to help prevent future domestic abuse related deaths and suicides.[1]

[1] Testing Scotland's proposed domestic homicide and suicide review model: Phase 1 report and Scottish Government's response.

Domestic abuse is a well-recognised public health issue that spans all aspects of health.[2,3] Domestic abuse is a complex issue rooted in gender inequality, affecting both adults and children, with significant health implications for victims both physically and psychologically. Mental health issues are frequently identified for victims who often experience a range of physical and mental health problems due to the abuse they have endured. The health system plays a crucial role in identifying and supporting victim.

A number of countries have established a model to review domestic abuse related deaths. While the types of relationships and events vary across different model, they all include in the scope those killed by a partner or ex-partner. These multiagency reviews include a number of organisations, health being one where there is often a footprint in terms of interaction with the victim. This is also true for perpetrators. An analysis of domestic homicide reviews by the Home Office identified health as the agency with the greatest frequency of contact with victims.[4] Effective intervention requires collaboration between health services, police, social work, and other agencies, many of which are based in the third sector.

3.1 Policy context

The Scottish Government has undertaken work to develop and implement a national multi-agency domestic homicide and suicide review model for Scotland. This commitment has been set out in the Equally Safe Delivery Plan and further strengthened in the Scottish Government's 2023-24, 2024-25 and 2025-26 Programme for Government. The legislation, Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews (Scotland) Act 2025, to underpin domestic homicide and suicide reviews in Scotland was introduced to Parliament in 2024, which passed unanimously in 2025. The Scottish Government is currently consulting on its draft statutory guidance to support the undertaking of reviews. The consultation is open until 11 February 2026 and can be accessed here.

The development of the Healthcare Improvement standards was commissioned by the Cabinet Secretary for Justice and Home Affairs in October 2025.

3.2 Principles for developing standards

All Healthcare Improvement Scotland standards are mapped to key national legislation, policy and standards. They support the implementation of person-centred and trauma informed principles, and human rights and equality legislation. The standards will also incorporate the core principles of the Scottish domestic homicide and suicide reviews model. These are:

- person-centred
- trauma-informed

[2] Scottish Government: Equally Safe.
[3] Scottish Government: Women's health plan.
[4] Home Office. 2023. Qualitative analysis of domestic homicide reviews: October 2022 to September 2023.

- transparent
- inclusive
- domestic abuse competent.

4. Scope of the domestic homicide and suicide review standards

4.1 Title

Standards for domestic homicide and suicide reviews in Scotland.

4.2 The purpose of the standards

The standards will support the Review Oversight Committee, Case Review Panels and agencies in the undertaking of, and participation in, domestic homicide and suicide reviews in Scotland. The sectors and agencies involved in individual reviews may include healthcare (including primary care), social care, justice (Police Scotland and Crown Office), education including higher education and the third sector.

The standards should be considered best practice for any sector involved in domestic homicide and suicide reviews. The standards are to apply to the domestic homicide and suicide review model as well as to support agencies and organisations when engaging with and participating within domestic homicide and suicide reviews.

To note, the legislation and statutory guidance is expected to come into effect on 1 April 2026. It is anticipated that the standards will be finalised for publication in Spring 2027. This will allow any learning from early reviews to be considered as part of the standards development process.

4.3 Legal framework underpinning the standards

The scope of the domestic homicide and suicide reviews are clearly set out in the Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews (Scotland) Act 2025 and related statutory guidance (expected in Spring 2026) and described fully below.

The standards will apply when a review of a death has been agreed by the Review Oversight Committee. Reviews will be undertaken in accordance with the Act, where:

- there was, or appears to have been, abusive behaviour within a relationship (e.g. abuse of a partner or ex-partner)
- that behaviour has, or may have, resulted in the death of the abused person or contributed to their suicide.

The person who experiences the abusive behaviour needs to be at the time of the behaviour, one of the following:

- the partner or ex-partner of “the perpetrator”
- the child of the perpetrator
- the child of the partner or ex-partner of the perpetrator
- a young person living in the same household as the perpetrator or in the same household as the perpetrator’s partner or ex-partner.

The type of deaths covered are:

- those killed by a partner or ex-partner
- someone killing their children or the children (of any age) of their partner or ex-partner
- violent resistance where a victim of domestic abuse kills their abusive partner/ex-partner
- domestic abuse related suicide
- connected deaths of children and young people.

The type of deaths not covered are:

- death of perpetrator of domestic abuse by suicide
- death of other family relationship between abuser and victim (e.g. child – parent)
- honour related killings
- neglect or sudden deaths.

The legislation uses the term ‘connection’ to Scotland. Therefore, if the person ordinarily resided in Scotland but was killed or died by suicide outwith Scotland then the death could be a reviewable death. Equally a person who ordinarily resided in England but worked, socialised and had a relationship with someone in Scotland may meet the reviewable death criteria as they had a connection to Scotland and may have been known to services in Scotland.

4.4 The scope of the standards

The scope of the standards has been informed by a review of the evidence and stakeholder workshops held in November 2025. There were seven domains recommended for inclusion in the standards:

Leadership and governance

- shared culture of openness and transparency
- principles of working across agencies and organisations
- roles and responsibilities
- systems and processes required to support the governance structures
- timeframes for reviews
- understanding impacts of inequalities and intersectionality on individuals and cases.

Consideration of other reviews

- recognition of the role of, and interface with other review processes ongoing alongside the DHSR
- principles for working collaboratively across review processes in relation to effective communication and information sharing.

Data collection and information sharing

- legal, appropriate and safe sharing, collection and storage of information relating to reviews
- cross agency information sharing, openness and timeliness of information sharing

Working with bereaved families, children and young people

- core principles for engagement and support aligned to the Bereavement Chater for Children and Adults in Scotland
- communication with and support for bereaved families before, during and after review. For example, single point of contact, regular check-in for families not wishing to be involved
- confidentiality protections
- principles for working with children and young people where appropriate. Alignment with for example, Bairns' Hoose, Scottish Child Interview Model.

Staff training, education, support and wellbeing

- working in partnership with services to develop a culture of reflection and learning arising from DHSR
- the capacity of individuals and services to engage meaningfully with the review process
- wellbeing support for staff
- how learning is shared with staff including local and national learning.

Learning and implementation of learning:

- roles, responsibilities and oversight
- recommendations monitoring and oversight
- regular evaluation of the DHSR process.

4.4 Areas out of scope of the standards

The following areas will not be included in the standards:

- resourcing of domestic homicide and suicide reviews – this may include but not limited to includes staff time, review panel size and skill mix
- development of quality indicators or key performance indicators
- implementation of the standards.

4.5 Consideration of wider context

As part of the standards development process, the standards will take into account and consider information from other reviews, including child death reviews, child or adult protection reviews.

The standards will use terminology aligned with the relevant legislation and Healthcare Improvement Scotland standards.

5. How to take part in developing these standards

We are also seeking to recruit people to our **standards development group**. The standards development group will be co-chaired by Professor John Devaney (Dean and Head of the School of Social and Political Science, University of Edinburgh) and Dr Edward Doyle (Deputy Medical Director, NHS Lothian). The group will convene in Spring 2026 and will meet approximately four times over a 12 month period.

We are seeking nominations for development group members with strategic and operational backgrounds including representations from across sectors, organisations and networks, including:

- Care Inspectorate
- Community Justice Scotland
- Crown Office and Procurator Fiscal Service
- National and local child / adult protection committee representatives
- Other review experts and representatives including suicide reviews, serious adverse event reviews, child protection and learning reviews, child death reviews
- Police Scotland
- Policy representation with respect to domestic abuse related suicide
- Royal College and professional bodies
- Scottish Executive Nurse Directors (SEND) and nursing leads
- Social Work Scotland
- Specialist advocacy support
- Specialist support including paediatrics
- Third sector agencies and groups that provide support to people of all genders with living experience.

If you would like to nominate yourself, or a colleague, please complete the relevant section on the survey.

There will be a number of opportunities for wider stakeholders, services and networks to feedback on the standards development. This includes taking part in the 12 week consultation on the draft standards which is planned for summer 2026.

6 Further information

If you would like to find out more about the Domestic Homicide and Suicide Review standards project or be added to our distribution list for any of our consultation activities, please contact:

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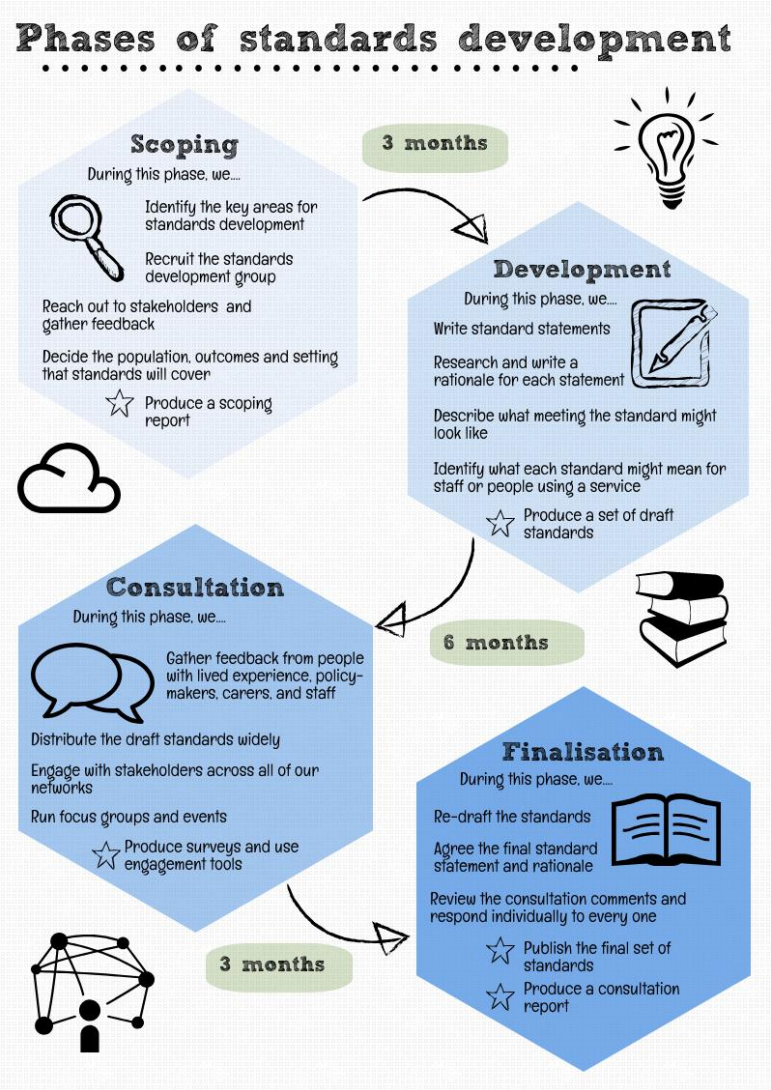
Appendix 1: Standards development methodology

Healthcare Improvement Scotland has established a robust process for developing standards, which is informed by international standards development methodology. This ensures the standards:

- are fit for purpose and informed by current evidence and practice
- set out clearly what people who use services can expect to experience
- are an effective quality assurance tool.

The phasing of all Healthcare Improvement Scotland standards development is illustrated in the figure below. For further information, please visit our website or contact the standards team at his.standardsandindicators@nhs.scot.



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