Healthcare Improvement Scotland

Domestic homicide and domestic abuse related suicide reviews

Draft standards

August 2026

NHS SCOTLAND

We are committed to advancing equality, promoting diversity and championing human rights. These standards are intended to enhance improvements in health and social care for everyone, regardless of their age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, socioeconomic status or any other status. Suggested aspects to consider and recommended practice throughout these standards should be interpreted as being inclusive of everyone living in Scotland.

We carried out an equality impact assessment (EQIA) to help us consider if everyone accessing health and social care services will experience the intended benefits of these standards in a fair and equitable way. A copy of the EQIA is available on request.

Healthcare Improvement Scotland is committed to ensuring that our standards are up-to-date, fit for purpose and informed by high-quality evidence and best practice. We consistently assess the validity of our standards, working with partners across health and social care, the third sector and those with lived and living experience. We encourage you to contact the standards and indicators team at his.standardsandindicators@nhs.scot.

Published August 2026

www.healthcareimprovementscotland.scot

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Introduction

Domestic homicide and domestic abuse related suicide review model in Scotland

Domestic abuse represents a significant public health and societal challenge in Scotland, contributing to substantial harm across a person's life course and, in its most serious forms, resulting in domestic homicide and domestic abuse related suicide. The domestic homicide and suicide review model in Scotland aims to identify learning, improvement and prevention of future domestic abuse and domestic abuse related deaths. The aim is to use reviews to "illuminate the past to make the future safer".[1]

The development of the national domestic homicide and suicide review model in Scotland has been led by a multiagency taskforce.[2] The model is underpinned by the Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews (Scotland) Act 2025 (referred to the 2025 Act throughout this document), which commenced on 1 April 2026, and related statutory guidance.

In Scotland, there are on average eight domestic homicides a year where a victim has been killed by a partner or former partner.[3] Data about domestic abuse related suicides in Scotland is less well known and not routinely collected. However, research estimates that around one quarter to one third of female suicides may be linked to domestic abuse.[4] Recent reports have identified an increase in domestic abuse related suicides between 2020-2025, which may in part be a result of increased awareness and identification of these cases.[5]

All domestic homicide and domestic abuse related suicide reviews in Scotland should be person-centred, trauma-informed, transparent, inclusive and take a domestic abuse lens. Central to the review process is an understanding of the impact of domestic abuse on a victim's experiences including their mental health, their sense of safety and perceived understanding of their options for support. The effects of coercive control, fear, isolation, harassment, physical, sexual and financial abuse and cumulative trauma may contribute to suicidal distress and behaviour.[4] Evidence has identified common patterns in victims' experiences and a range of additional vulnerabilities that may shape risk, help-seeking behaviour and outcomes.[6]

Domestic abuse occurs across all genders, sexual orientations, family structures and communities. However, across both domestic homicide and suicide cases, the majority of victims are female and the majority of perpetrators are male. However, reviews should always be alert to the experiences of victims in same-sex and LGBTQ+ relationships, whose experiences may be shaped by additional barriers to disclosure, help-seeking and recognition of abuse, including fears of being "outed," stigma and a lack of appropriately tailored services [7-9]

Children and young people are also frequently affected, both directly and indirectly, through experiencing domestic abuse within the family, witnessing abusive behaviour, living with coercive control, bereavement, and the long-term effects of trauma.[10, 11] Reviews should recognise the impact of domestic abuse, homicide and suicide on children and consider their experiences where relevant and appropriate.[12, 13]

Wider social determinants can compound vulnerability and influence access to safety and support, including poverty, housing insecurity, rurality, disability, ethnicity, culture, language, immigration status and social isolation. Women with disabilities, migrant women and other marginalised groups may face increased risks of abuse and additional barriers to accessing support and protection.[11, 14]

Understanding how these intersecting factors shape a victim's experiences, risks, coping strategies and engagement with services is essential to ensuring that reviews identify meaningful learning and opportunities for prevention.

Scope of the standards

Healthcare Improvement Scotland was commissioned by Scottish Government in October 2025 to develop standards for domestic homicide and suicide reviews in Scotland. The standards are aligned to the 2025 Act and related statutory guidance.

These standards apply to deaths currently with scope of the domestic homicide and suicide review model, which includes where:

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

The following matters are not addressed in these standards, as they are provided for in the 2025 Act and statutory guidance:

- notification or referral of a death
- circumstances where a review is not undertaken or there is reconsideration of a review
- funding arrangements for reviews
- recruitment and appointments to the review oversight committee requiring approval by Scottish Ministers.

Who the standards are for

The standards apply to all individuals, organisations and networks involved in domestic homicide and domestic abuse related suicide reviews. Specifically, the standards will support the review oversight committee (ROC), case review panels (CRP) and participating agencies in the undertaking of, and participation in, domestic homicide and domestic abuse related suicide reviews in Scotland. The 2025 Act identifies organisations required to cooperate with the review process under section 25, which includes NHS boards, local authorities, social care and Social Work Improvement Scotland.[15] However, any organisation or individual can be required to provide information for the purpose of a review, for example, a General Practice.

The standards should be applied according to the context for each service provider. For example, voluntary organisations or independent contractors will vary in organisational size and internal governance structures. Where a principle or criterion applies to a specific setting, this has been highlighted throughout the document.

Children and young people

The 2025 Act adopts a broad definition of a child that is not limited by age, reflecting the enduring nature of parent-child relationships and the wider impact of domestic abuse across families.

For the purposes of Standards 3 and 7, children and young people refers specifically to those aged under 18 years, or up to 26 years for individuals with care experienced and who were previously looked after by a local authority. This is in recognition of the:

- additional support that bereaved children and young people may require for their safety, wellbeing and future recovery (Standard 3)
- additional responsibilities and requirements that apply where a review involves the death of a child or young person (Standard 7).

All children and young people in Scotland who have been victims or witnesses of abuse or violence should have access to trauma-informed recovery, support and justice. This is underpinned by the UNCRC (Incorporation) (Scotland) Act 2024 and aligns with the key policy programmes of Bairns' Hoose, Keeping the Promise, Getting it right for every child and the National guidance for child protection in Scotland.

Terminology

We have used trauma sensitive language throughout the standards and have aligned with legislation, statutory guidance and other resources. All terminology is included in the glossary.

How to participate in the consultation process

We welcome feedback on the draft standards and will review every comment received. We are using a range of methods for consultation, including:

- targeted engagement sessions with bereaved people, staff and service providers
- circulation of the draft standards to relevant stakeholders
- an online survey open to all interested.

Submitting your comments

Responses to the draft standards should be submitted using our online survey here.

The consultation closes on **Thursday 5 November 2026**. If you would like to submit your comments using a different format, please contact the project team on his.standardsandindicators@nhs.scot.

Please note, consultation comments will not be accepted after the closing date, or in an alternative format, unless previously agreed with the project team.

Consultation feedback

Feedback on the draft standards will be reviewed and themed by the project team. The development group will reconvene following consultation to review feedback on the draft standards and agree on amendments to the standards.

A summary of the responses to the consultation will be made available on request from the project team at his.standardsandindicators@nhs.scot.

The final standards will be published in Spring 2027.

Standards summary

Standard 1: Leadership and governance of the review process

Domestic homicide and domestic abuse related suicide reviews have effective leadership, robust governance and a culture of openness and learning.

Standard 2: Supporting bereaved people

Bereaved people experience compassionate, trauma-informed, sensitive and respectful involvement and support throughout the review process.

Standard 3: Supporting bereaved children and young people

Children or young people participating in experience receive person-centred and trauma-informed care and support which ensures their safety, wellbeing and best interests.

Standard 4: Domestic homicide and suicide review process

Domestic homicide and domestic abuse related suicide reviews are high quality and timely.

Standard 5: Domestic abuse related suicide reviews

Domestic abuse related suicide reviews are supported by relevant specialist expertise in domestic abuse and mental health.

Standard 6: Combined deaths reviews and joint reviews

Where a combined deaths review or a joint review is required, participating agencies collaborate to ensure a coordinated, proportionate and effective review process.

For the purposes of the standards, this will be referred to a single review.

Standard 7: Reviews of the death of a child or young person

Reviews involving the death of a child or young person are timely, coordinated and child-centred.

Standard 8: Training and support for review members

Review panel chairs and panel members receive high-quality, role-appropriate training, supervision and support.

Standard 9: Training and support for practitioners from participating agencies

Practitioners contributing to reviews are trained and supported in line with their roles and responsibilities.

Standard 10: Sharing knowledge and learning from reviews

Robust system-wide approaches are in place to ensure learning from reviews is identified, shared and implemented.

Standard 11: Information governance

Personal data and information required for reviews is processed and shared in line with relevant legislation and guidance.

Standard 1: Leadership and governance of the review process

Standard statement

Domestic homicide and domestic abuse related suicide reviews have effective leadership, robust governance and a culture of openness and learning.

Rationale

The domestic homicide and suicide review model in Scotland has been developed to identify meaningful learning and ensure improvements that prevent further harms and deaths.[2] Reviews should be victim-centred, trauma-informed, transparent and inclusive. They should give voice to victims and recognise the gendered nature and impacts of domestic abuse. Reviews should also provide opportunities for bereaved relatives and those affected by the death to contribute their experiences and perspectives. In doing so, ROC and CRP chairs and members should recognise the complexity of family structures and relationships, including the experiences of children, young people and adult children, acknowledging that needs, vulnerabilities and the impact of loss may vary across the life course (see Standard 2). Reviews should support meaningful learning, prevention and system improvement.[16-18] Statutory duties and relevant governance frameworks relating to reviews are defined in the 2025 Act and statutory guidance.

Strong leadership and a culture of accountability are essential to an effective review process. The ROC, CRPs and participating agencies each have a role to support leadership and governance in review processes.[19] A clear strategic vision, shared across participating agencies, promotes openness, trust, collaboration and ownership. Fostering learning rather than blame and enabling meaningful reflection supports improvement and the prevention of future harm.[20]

There should be a commitment to embedding the oversight and delivery of reviews into existing governance and accountability structures including national and local public protection committees. It is important that there is a shared understanding of roles and responsibilities in relation to these reviews and relationships with other non-statutory learning reviews (see Standard 4).[21, 22]

Reviews should be delivered to a high standard within agreed timescales, with progress actively monitored and any delays communicated openly to relevant stakeholders, including bereaved people. The ROC and CRP should ensure that risk assessments in relation to safety and wellbeing of review participants are undertaken and regularly reviewed.

Quality assurance is an important aspect of the review process and roles and responsibilities should be clearly defined. The ROC, CRP chairs and participating agencies support and actively participate in all relevant quality assurance activities. Quality assurance processes should cover the accuracy, completeness and quality of information provided. The ROC provides independent scrutiny, approval and oversight of learning, recommendations and implementation.

Review governance structures should ensure that there are clearly defined policies, protocols and supporting documentation, including report templates, which are regularly monitored and reviewed to ensure reviews are delivered consistently, independently and transparently across Scotland. This should include, but not be limited to, collaborative working arrangements, role descriptions, panel member selection processes, and mechanisms for receiving, responding to and learning from feedback and complaints.

Criteria

1.1 Domestic homicide and domestic abuse related suicide reviews embed a culture of openness, transparency and learning that is:

- constructive, compassionate and blame-free
- accountable and transparent in decision-making
- committed to learning and continuous improvement
- is proactive in identifying and responding to identified risks and opportunities for prevention
- supportive of reflective practice and shared learning across systems
- focused on reducing harm and improving outcomes for individuals and bereaved people
- supported by national and local leadership.

1.2 The ROC demonstrates effective governance and oversight of reviews in line with the 2025 Act and statutory guidance, which is responsible for:

- establishing clear roles and responsibilities to ensuring independence, transparency and accountability
- establishing and progressing reviews in a timely manner
- ensuring review recommendations support learning and system improvements
- quality assurance of individual reviews and review processes
- regular reporting to Scottish Ministers.

1.3 There are effective cooperation and collaborative working arrangements between the ROC, CRPs and participating agencies, which cover:

- statutory roles and responsibilities
- alignment with other learning review processes, where relevant
- a shared commitment to review principles and learning culture
- mechanisms to support reporting into and engagement with local and national governance structures.

1.4 There is a documented process for review risk assessments, which covers:

- clear accountability and responsibility for identification and escalation of risks
- a standardised and consistent approach to risk assessment
- ongoing monitoring and regular review of identified risks
- implementation and oversight of action plans
- the identification, monitoring and tracking of emerging systemic risks across cases
- transparent recording, communication and reporting of risks.

1.5 Effective quality assurance arrangements are in place to oversee reviews, which ensures:

- they are conducted independently, consistently and to a high standard
- clear accountability for the identification, implementation and monitoring of learning, recommendations and actions.

1.6 Processes are in place to ensure that anonymity and confidentiality are maintained throughout the review process.

Where anonymity or confidentiality is breached, clear procedures are followed to assess risk, mitigate any potential harm, notify relevant parties where appropriate, and ensure lessons are identified and acted upon.

1.7 Robust systems and processes are in place to ensure the ROC effectively considers and determines whether a death will be reviewed, which include:

- comprehensive records of decisions and their rationale, including decisions not to progress a review, agreed timescales for scoping
- clear communication and documented reasons for any delays, for example, where further information is required.

1.8 Where reviews include combined deaths, joint reviews or are expanded beyond the point of death, the ROC ensures:

- early and appropriate engagement with relevant single points of contact
- robust processes are in place to ensure timely and accurate recording of reasons, recommendation and consents
- a clear review remit is developed with participating agencies which covers timelines, roles and responsibilities and reporting arrangements.

Further criteria on combined deaths are in Standard 6.

1.9 There are robust and clearly defined processes for selecting the CRP chair, which include:

- the role of the ROC chair in the selection process
- the required expertise of the CRP chair
- expected capacity and commitment
- identification and management of conflicts of interest.

1.10 Each participating agency has processes in place to:

- nominate a relevant individual as an organisational single point of contact with appropriate authority and capacity
- provide timely, accurate information for the review
- maintain effective communication with the ROC and CRP.

1.11 The organisations contributing to the review process demonstrate a commitment to learning and improvement by valuing and acting on feedback, concerns and complaints. This includes processes which:

- are easy to access, understand and complete
- are accessible in a range of different formats and languages or can be accessed through online translation services
- provide information on further support, guidance and advocacy where appropriate
- provide timely and appropriate feedback to those who raise concerns or complaints about how their contribution has informed learning, improvement or decision-making.

1.12 Information resources about domestic homicide and suicide reviews should be developed in partnership with bereaved people.

What does the standard mean for bereaved people?

- The review will be carried out to a high standard, with checks in place to ensure quality and consistency.
- You can have confidence that the learning from reviews is used to help prevent future harm and improve support for others.
- You can expect those involved in reviews to work together in a coordinated and accountable way.
- If you have concerns about any aspect of the process or have a complaint, you can be confident these will be handled fairly, openly and transparently.
- You will be supported to understand how your views and what you have shared has contributed to learning and improving services.

What does the standard mean for review staff and practitioners?

Review staff and practitioners, in line with their roles, responsibilities and workplace setting:

- are supported by effective leadership and governance structures
- are supported to contribute openly and constructively in reviews, within a culture that promotes learning, improvement and accountability
- have access to the relevant guidance to understand their roles and responsibilities in the review governance structures
- understand the national and local context relating to the review process including reporting into local governance structures or groups.

What does the standard mean for the review governance structures and participating agencies?

Review governance structures and participating agencies, in line with their respective governance and delivery arrangements:

- ensure a culture of openness, transparency and accountability that enables multiagency collaboration, communication and coordination of reviews
- undertake multiagency planning to embed reviews into existing governance infrastructures
- provide oversight and assurance of the review process in line with the 2025 Act and statutory guidance with robust systems for risk and information sharing
- ensure review staff and practitioners are supported in their roles.

Benchmarking and measuring performance: Examples of what meeting this standard might look like
• Documentation such as memoranda of understanding, describing collaborative working relationships. • Quality assurance checklists for review reports. • Risk assessment demonstrating potential safety and wellbeing concerns for participation. • Evidence of a record with all notifications, referrals, decisions and outcomes including timelines.

Standard 2: Supporting bereaved people

Standard statement

Bereaved people experience compassionate, trauma-informed, sensitive and respectful involvement and support throughout the review process.

Rationale

The term 'bereaved people' is used within these standards to include the victim's families, friends, colleagues and other community members. Compassionate engagement, advocacy and communication with bereaved people is central to the review process.[23] All contact with bereaved people throughout the review should be trauma-informed, sensitive and respectful, with clear recognition of the profound impact of their loss.

Support should be consistent and needs-led across all stages, from the immediate aftermath of the death, through to ongoing advocacy during review processes and beyond. There is no requirement for bereaved people to take part in the review process. However, they should be provided with opportunities to contribute their perspectives and experiences if they wish to do so, and supported to make informed choices about their involvement. Further requirements relating to the support and involvement of bereaved children and young people are set out in Standard 3.

The review process itself can place a significant emotional, psychological and practical burden on bereaved people during an already overwhelming period.[23] Staff and practitioners involved in reviews should be trained to recognise and minimise the risk of re-traumatisation and ensure that engagement is paced according to individual need, capacity and choice.[24]

Bereaved people who choose to participate in a review should be provided with clear information about the support available to them, who provides that support, and how agencies are working together to support them throughout the review process. Bereaved people should be offered the ability to have a named contact throughout the review process. They should have the option to choose an advocate or other trusted person, or the named contact could be the CRP chair. The purpose of a named contact is to provide continuity, minimise duplication and ensure bereaved people understand what is happening, when it is happening and why. Where other agencies are involved, for example, police family liaison, there should be agreed understanding of roles and responsibilities for communication and strategies to support bereaved people where a police investigation ends.

Communication with bereaved people should be compassionate, person-centred and trauma-informed. This includes respecting individual preferences and experiences, for example by using the terminology and language chosen by bereaved people to describe the death.[14] It is important to acknowledge that some may not accept, or may not yet be able to accept, that a suicide has occurred. The nature and significance of each person's relationship to the deceased should be recognised and respected, acknowledging that those affected may include children, young people, adult children, family members, friends and others with meaningful connections to the person who has died.

Language and accessibility are important aspects of a trauma-informed review process. Bereaved people may have different communication needs, levels of understanding, literacy, language preferences and experiences of engaging with services. Information should therefore be provided in a way that is clear, accessible and responsive to individual needs, enabling people to understand the review process, make informed choices about their involvement and participate as fully as they wish. Where interpretation or translation is required, independent and appropriately qualified services should be offered to support accurate communication, confidentiality and informed participation. Legal or procedural terminology should be used only where necessary, and should be explained in clear, accessible language.

Bereaved people should be regarded as experts in the life and experiences of the deceased and treated as equal contributors alongside professionals and agencies.[23, 25] They should be empowered to contribute to review processes if and when they wish, with a clear understanding that participation is optional. The views, questions and concerns raised by bereaved people should be taken seriously and actively considered, with findings and learning shared with those involved wherever appropriate.

Recognising the complexity of bereavement following violent or traumatic death, bereaved people should be offered tailored bereavement support, practical advocacy and clear signposting to relevant services. This includes support in dealing with the long-term impacts, suicide-specific bereavement support, specific support for children in education, workplace or occupational health for work colleagues.

In circumstances where both the victim's family and the perpetrator's family live within the same community, sensitivity is required to ensure that support services can work safely and effectively with all parties. Bereaved people should be offered choice and reassurance regarding confidentiality and, where necessary, alternative support options.

Criteria

2.1 All reviews will ensure the victim and the bereaved:

- are treated with sensitivity, compassion, dignity and respect at all times
- have their personal, spiritual, faith and cultural values, beliefs and wishes recognised and respected.

2.2 Review processes are integrated and designed around the needs of bereaved people, which ensures:

- they feel safe, supported and engaged in the process where they choose to do so
- the impact of a review on their personal life, work or education is minimised as much as possible
- information requests for reviews, including interviews, are progressed at a pace that is appropriate to their needs.

2.3 Engagement and communication with bereaved people is coordinated, person-centred and trauma-informed. Bereaved people will:

- be supported and enabled to raise any concerns
- be able to access relevant information as it becomes available
- have their communication preferences identified, documented and regularly reviewed
- receive information in formats and languages appropriate for their needs including stage of emotional development, chronological age
- have access to independent translation, interpretation and communication support, where required.

2.4 Bereaved people will be supported to make informed decisions about their involvement in the review. This includes:

- access to information resources outlining the review purpose, scope and process including the voluntary nature of their involvement
- receiving information on confidentiality, privacy and how information will be used, shared and protected
- understanding and provision of consent, where required
- having the opportunity to discuss the review process and raise any questions or concerns with appropriate staff.

2.5 Where bereaved people do not wish to engage with the review or change their mind at any point during the review, they are:

- supported and respected in their decisions
- provided with information on how to re-engage in the review, should they wish to do so
- advised that they will be contacted at the draft report stage with an offer to discuss the contents, learning, recommendations and actions, where appropriate.

2.6 Bereaved people are supported by informed and compassionate review staff and practitioners to understand the purpose and process of the review. This includes:

- what is in and out of the scope of the review
- how they can be involved in the review
- the differences between domestic homicide reviews, domestic abuse related suicide reviews and criminal proceedings or other investigations
- how they can respond to the findings and recommendations of the review
- how the review will consider and balance different testimonies, contributions and perspectives in a fair and impartial way
- how the review will identify learning and make recommendations to improve service responses.

2.7 Bereaved people will have access to a named contact to support the coordination of communication and information throughout the review process. Where bereaved people wish to choose their own advocate or trusted person to undertake this role, their choice is respected, appropriately recorded and communicated to relevant parties.

2.8 Bereaved people are supported to access specialist support throughout the review process. This includes referral or signposting to:

- independent advocacy services
- specialist bereavement support
- other relevant support services, including domestic abuse, mental health, trauma, child and family support services, where appropriate.

2.9 Engagement with the bereaved at the draft report stage should:

- be planned and responsive to agreed communication preferences
- provide sufficient time and space to reflect and provide feedback on the report findings
- include opportunities for discussions with the CRP chair and the named contact or advocate, where appropriate.

2.10 Adults who were children at the time of a domestic homicide or suicide review and did not participate or had limited engagement or recall are supported, in a trauma-informed and person-centred way, to access, understand and reflect on the findings of the review. This includes:

- ensuring clear processes are in place to enable access to relevant review information when the individual is ready
- presenting information in a way that is understandable, sensitive and appropriate to their needs
- providing opportunities to discuss any reports, ask questions and seek clarification
- offering appropriate emotional, psychological support and advocacy where appropriate
- respecting the individual's choice, pace and readiness to engage with the information
- coordinating engagement to ensure continuity, avoiding unnecessary repetition or distress.

2.11 Where the review relates to one or more parents or parental figures, including the victim and/or the person who caused harm, children are supported to understand and engage with this information in a sensitive, trauma-informed and age-appropriate way.

What does the standard mean for bereaved people?

- If you have lost a loved one to domestic homicide or domestic abuse related suicide and a review will take place, you may be asked to contribute to the review. You do not have to take part if you do not want to, and your decision will be respected.
- You can change your mind about taking part in the review at any time, including choosing to become involved at a later stage of the review process.
- You will receive clear, timely and understandable information about what is happening , who is involved, what to expect and how long the review may take.
- You will be asked how you would like to be involved in the review, how often and your preferred method of communication.
- You will not be asked to share your experience repeatedly with different agencies, to help reduce unnecessary distress.
- Your emotional and psychological safety and wellbeing is central to the review process.
- You will be treated with kindness, compassion, dignity and respect throughout the review process.
- You will be supported to share your views, experiences and concerns in a way that feels right for you.
- You will have access to support and guidance through a named contact and, where appropriate, independent and specialist advocacy service.
- You can access information about the review when you feel ready, including later in adulthood. You can ask questions, explore what the findings mean for you, and receive support that reflects what matters most to you.

What does the standard mean for review staff and practitioners?

Review staff and practitioners, in line with their roles, responsibilities and workplace setting:

- take a compassionate, respectful and trauma-informed approach to interactions and communications with bereaved people
- understand their role in communication with or providing support to bereaved people participating in reviews
- can access the relevant training or advice to support bereaved people participating in the review process
- have information to share with bereaved people about the review process, for advocacy or support services.

What does the standard mean for the review governance structures and participating agencies?
Review governance structures and participating agencies, in line with their respective governance and delivery arrangements: • ensure processes support voluntary and meaningful participation within the review process with appropriate measures for maintenance of privacy and confidentiality • support organisational named contacts or advocates to have sufficient time, support and resources to participate meaningfully and effectively in the review process • have systems and processes in place to provide timely and specialist advocacy, bereavement and other relevant support services • provide opportunities for bereaved people to provide feedback on the review process and have processes in place to respond to this feedback • ensure staff and practitioners working with bereaved people have the knowledge, skills and resources to provide support and facilitate review participation.
Benchmarking and measuring performance: Examples of what meeting this standard might look like.
• Referral pathways to specialist advocacy or bereavement support. • Provision of national leaflets in a range of languages and formats, including leaflets and videos. • Evidence of tailored support. • Capacity and resource planning to provide specialist advocacy or bereavement support. • Feedback from bereaved people on their experiences of the review process. • Best practice guidance for undertaking interviews with bereaved people.

Standard 3: Supporting bereaved children and young people

Standard statement

Children or young people participating in reviews experience person-centred and trauma-informed care and support which ensures their safety, wellbeing and best interests.

Rationale

Children and young people participating in reviews will have additional care and support needs. This standard sets out the additional requirements and considerations that the review process should provide. In this standard, children and young people refers to people aged under 18 years, or up to 26 years for individuals with care experience, including those who were previously looked after by a local authority.

Children and young people who have experienced the death of a parent or parental figure by domestic homicide or domestic abuse related suicide are at increased risk of trauma and mental health impacts.[11, 13] Children and young people may have also experienced loss of a sibling. They may also experience the death of a sibling, separation from family members, changes in caregiving arrangements, and other significant disruptions to their relationships, stability and sense of safety.

For children and young people to meaningfully participate in reviews, they should be recognised as victims in their own right. Support and engagement in reviews should be personalised, child-centred, domestic abuse informed and trauma-informed, recognising and upholding children's rights to care, protection, education and recovery.[11, 26-28]

The ROC and CRP chair should carefully consider how children and young people are involved in the review process, taking account of their rights, welfare and best interests. Particular consideration may be required in cases where criminal proceedings are ongoing or where a child may also be a witness. Consent for participation should also be carefully considered, particularly in cases where the perpetrator is involved in the child's life.[29]

The purpose of the review process is not to undertake child protection investigations or provide bereavement support directly. However, following a domestic homicide or domestic abuse related suicide, the relevant agencies have a shared responsibility to ensure the safety, wellbeing and support of bereaved children and young people.[13] Consideration should be given to family dynamics, living arrangements and caregiving circumstances, as these may significantly influence a child's experience of trauma and recovery.[11] This includes recognising circumstances where a surviving parent or caregiver may seek to limit a child's involvement or participation.

A child bereaved by a domestic homicide or domestic abuse related suicide is very likely to meet the threshold for being at risk of significant harm. Where there are concerns about a child's safety or wellbeing, local child protection procedures and national guidance should be followed, including discussions with lead professionals and an Inter-agency Referral Discussion (IRD) where appropriate.[22] A Getting it right for every child (GIRFEC) wellbeing assessment may support practitioners to identify and respond to individual needs.

Dedicated advocacy and support should be offered to children and young people (and their caregiver where appropriate) to help them understand and engage with the review process. This may include access to a Bairns' Hoose or other specialist bereavement pathways. (ref) Participation arrangements should be reviewed throughout the review and should be rights-based, age-appropriate, trauma-informed and responsive to changing needs and circumstances.

Children and young people's experiences of domestic abuse, bereavement and recovery are not uniform. They may have witnessed domestic abuse, experienced direct harm or been subjected to coercive and controlling behaviours. Where there are multiple children within a family, each child may have different experiences, needs and responses.

Children and young people have the right to express their views on matters affecting them, in accordance with Article 12 of the UN Convention on the Rights of the Child. They should be supported to participate in the review process where they wish to do so and where participation is assessed as being in their best interests.[30]

Where children and young people are within the educational system, staff should engage with educational settings to support bereaved children and their peers. A consistent and coordinated approach to support reduces uncertainty, trauma and undue delay.[27]

Additional safeguards are required in respect to requesting personal data or information relating to children.[3, 31] The ROC and CRP will ensure that any requests are necessary, proportionate and in the best interests of the children. Any communications about information sharing and right to privacy should be age-appropriate and accessible.

Reviews which involve the death of a child or young person are covered in Standard 7.

Criteria

3.1 Where a child or young person has been bereaved by domestic homicide or domestic abuse related suicide, their views and experiences are central to the review. This includes:

- ensuring their experiences are integrated into the review timeline and chronology
- understanding how the child or young person experienced domestic abuse and its impact on them
- considering relevant intersectional factors (such as, care experience, immigration status) and how these influence risk and access to support
- reviewing communication and collaborative working between adult and child services and wider public protection structures
- identifying any gaps in responses or missed opportunities to intervene or provide support.

3.2 The review process takes a multiagency approach to prioritise safety, recovery and participation, which includes:

- an assessment of wellbeing, safety planning and ongoing coordinated support
- discussion with lead professionals or referral for an IRD
- referral into therapeutic recovery services, for example, a Bairns' Hoose or local service
- alignment with local and national processes and guidance including child protection measures.

3.3 Children and young people are supported by the CRP and relevant practitioners and agencies, to ensure:

- they are listened to and their views are taken seriously
- a whole-child, rights-based and holistic approach is taken
- decisions are in their best interests and take account of their views
- opportunities for participation and engagement are tailored to meet individual needs
- they have a clear understanding of what to expect throughout the review process.

3.4 Review staff and practitioners working with children and young people have the relevant knowledge, skills and competencies. This includes but is not limited to:

- understanding the impact of domestic abuse
- methods for supporting meaningful and appropriate participation including interview techniques
- children's rights and how to uphold them.

3.5 A dedicated domestic homicide and domestic abuse related suicide advocate is offered to children, young people and their families.

3.6 Where direct participation in the review is not appropriate, the views and experiences of children and young people are represented through appropriate means. This includes:

- use of advocacy to represent the views and interests of the child or young person
- consideration of relevant records and documented experiences
- professional insight to ensure the child or young person's perspective is understood and reflected.

Decisions about representation and involvement are recorded, with reasons documented and shared appropriately.

3.7 Children and young people are supported, in a trauma-informed and person-centred way, to access, understand and reflect on the findings of the review. This includes:

- ensuring clear processes are in place to enable access to relevant review information
- presenting information in a way that is understandable, sensitive and appropriate to their needs
- providing opportunities to discuss any reports, ask questions and seek clarification
- offering appropriate emotional, psychological support and advocacy where appropriate
- respecting the child or young person's choice, pace and readiness to engage with the information
- coordinating engagement to ensure continuity, avoiding unnecessary repetition or distress.

3.8 The review considers how children and young people are actively and meaningfully involved in decisions arising from the death that affect their care, wellbeing and future arrangements. This includes:

- where and who they live with
- maintaining important family and personal relationships
- maintaining education and social activities
- accessing support and services to meet their needs.

Involvement should always be age and stage appropriate, trauma informed and person centred, with discussions recorded and shared appropriately.

What does the standard mean for bereaved children and young people?

- You will be given information about the review to help you understand what is happening and what to expect, in a way that makes sense to you.
- You will be able to choose how and when you take part, and you will not be pressured to be involved in ways that do not feel right for you.
- You will be listened to and taken seriously, and your views will be respected.
- You will be supported to help you feel safe and when you are involved in the review process.
- You will know that what has happened to you is important and will be taken into account in the review.
- You will see that the review is about learning and improving support for others.
- You will have support to help you understand difficult information, now or in the future.
- You will see that the adults and services involved are working together to support you.

What does the standard mean for review staff and practitioners?

Review staff and practitioners, in line with their roles, responsibilities and workplace setting:

- put the best interests of children and young people at the centre of their work, including taking a rights-based and holistic approach is
- support children and young people in deciding whether to participate in the review
- respect the decision of children and young people who do not wish to take part
- are knowledgeable and trained in the relevant legislation, policies and procedures
- understand how to recognise safeguarding concerns in relation to review participation and be able to access immediate advice, when required
- can refer to a relevant professional or service to provide immediate advice and subsequent assessment.

What does the standard mean for the review governance structures and participating agencies?

Review governance structures and participating agencies, in line with their respective governance and delivery arrangements:

- ensure processes are in place for children and young people's participation that have been co-designed and uphold their rights
- ensure staff and practitioners have access to practitioners skilled in working with bereaved children and young people
- ensure effective communication and appropriate information sharing between the review panel and services including child protection, health, education and social work
- consider risks or safeguarding concerns associated with participation including where the child may be a witness or the perpetrator remains involved in the child's life
- monitor the needs and participation of children and young people throughout the review process
- work in partnership with agencies to ensure that all bereaved children have pathways to therapeutic support and recovery, including Bairns' Hoose
- ensure that child protection measures, wherever possible, support the involvement of the child or young person in the review process in a way that suits them.

Benchmarking and measuring performance: Examples of what meeting this standard might look like
• Review of local and national governance processes and guidance to support review participation. • Feedback from practitioners and participating agencies to develop national guidance or processes for participation of bereaved children and young people. • Signposting to national resources and referral pathways for supporting bereaved children and young people. • Evidence of working with bereaved children and young people to inform service design. For example, development of online material or videos about review participation. • Use of Children's Rights and Wellbeing Assessment and other impact assessments to inform service design and delivery for bereaved children and young people. • Demonstrate that children's rights under UNCRC are actively implemented and reflected in report analysis and recommendations.

Standard 4: Domestic homicide and suicide review process

Standard statement

Domestic homicide and domestic abuse related suicide reviews are high quality and timely.

Rationale

The domestic homicide and suicide review model in Scotland aims to identify learning, improvement and prevention of future domestic homicides and domestic abuse related suicides. The ROC will determine whether a notified or referred death should be reviewed in line with the 2025 Act and statutory guidance. The ROC will consider factors including, relationships, the connection between abusive behaviour and the death and the likelihood for identifying lessons. The ROC should ensure timely consideration of referrals and makes prompt, transparent decisions about whether a review should proceed.[3]

All reviews should be conducted through the lens of the victim to understand their experiences. The review should also take into account interactions with services prior to their death. In all cases, the history and experience of domestic abuse is considered along with significant relationships. An intersectional and equality focused approach should be embedded in reviews. Evidence has highlighted factors that influence both increased risk of domestic abuse and barriers to accessing support. This includes but is not limited to ethnicity, disability and socio-economic circumstances including housing status and pregnancy or maternity status.[5, 14, 32]

The safety and wellbeing of bereaved people, review staff and practitioners involved in reviews is paramount. Where there is a public protection risk, the review process should be clear on roles and responsibilities and processes for information sharing across the relevant agencies. Where a review involves a child or adult at risk, the review report must also be submitted to the Care Inspectorate.[3] The ROC should ensure consider other safety and wellbeing risks, for example, the impact of the report's publication on bereaved people.

Where a review is required, a CRP chair and membership will be selected in line with agreed roles and responsibilities. The CRP will undertake the review, examining the timeline and circumstances surrounding the death to identify lessons for prevention and make recommendations for organisational and system-wide change. Terms of reference will be established for the review, which include the review scope, agencies involved and key lines of inquiry. This will be developed in consultation with participating agencies and their appointed single point of contact for the review.

Information to support the review will be gathered from multiple sources including, individual management review reports, interviews with bereaved people, and relevant case notes. There should be a consistent and structured approach to information gathering, analysis and quality assurance. Any delays will be monitored by the CRP chair and secretariat to ensure this is communicated and escalated appropriately.

Where a perpetrator may be considered as a source of information as part of the review process, this should be managed in line with statutory guidance and informed by discussions with the COPFS and other relevant agencies. Any engagement with a perpetrator's family members or friends, should be undertaken sensitively and in line with guidance on involvement.

A structured analytical framework will be used by the CRP to undertake analysis and identify the learning. The analysis should be victim centred and the approach will combine a socio-ecological analysis, contribution analysis and appreciative enquiry.[3]

Criteria

4.1 The ROC ensures the timely establishment of the CRP including chair. The CRP membership will be informed by the specific circumstances of the case to ensure inclusion of:

- relevant agencies involved with the victim, perpetrator/person who caused harm, and any children or young people affected
- relevant professional and specialist expertise
- input from victim support organisations, where appropriate.

4.2 The CRP has clear terms of reference which are regularly reviewed, which cover:

- the person(s) subject to review
- the scope including whether a review will be a single or multiple review (see Standard 6)
- establishment of agreed ways of working between agencies
- identification of relevant participants
- identification of key lines of inquiry
- the indicative timelines for each aspect of the review including report publication.

4.3 Each review can demonstrate the consideration of equality and intersectional factors throughout the process and analysis. This includes:

- identifying, taking on board and recording any relevant protected characteristics and vulnerabilities
- exploring if these factors have an impact on the victim's experiences in relation to risk identification, safety planning and support provision
- identifying any equality-related learning and recommendations.

4.4 The secretariat liaises with relevant single point of contact and agencies to ensure a planned and trauma-informed approach to engagement with bereaved people, which covers:

- key aspects of the review
- family or relationship dynamics and where there may be differences of opinion
- any safety and wellbeing concerns including child or adult protection
- timelines for contacting bereaved people.

4.5 All decisions and actions relating to contact with a bereaved person are clearly recorded and shared appropriately, including the reason(s) where contact has not been possible.

4.6 There are robust processes in place to provide oversight and assurance of the individual reviews. This includes:

- defined governance structures to oversee the progress and quality of reviews
- regular review and monitoring of progress against agreed timelines
- clear escalation routes for risks, issues or delays
- opportunities for feedback from bereaved people, practitioners and participating agencies
- mechanisms to ensure learning is identified, actioned and monitored
- ensuring conflicting views or information were appropriately managed.

4.7 There are processes to demonstrate the effective management of differing and conflicting views or perspectives from bereaved people, staff and partner agencies, which ensures:

- perspectives are actively sought, respectfully considered and addressed in a transparent manner
- opportunities are provided to discuss and reconcile differing perspectives, with resolution sought wherever possible
- clear documentation of assessment, consideration and discussion within the review.

4.8 Processes are in place to ensure that information collated:

- is comprehensive, factual and relevant
- is reviewed for accuracy, consistency and completeness, with any gaps identified early
- is reviewed to identify and mitigate any potential bias, assumptions or preconceptions
- aligns with the terms of reference and key lines of inquiry.

4.9 The ROC and CRP ensure the appropriate mechanisms are in place where the input of perpetrators is sought, which cover:

- consideration of any potential impact or distress that may be caused to bereaved people and any actions taken to mitigate the risks
- whether the information will contribute to overall learning
- discussion with the COPFS and other relevant agencies.

What does the standard mean for bereaved people?

- You can be confident that the right people, services and expertise are involved in the review.
- The review will be organised and carried out in a structured and timely way.
- There is a clear plan for how the review will be undertaken, including what it will consider and how it will be carried out.
- Your needs and circumstances will be taken into account when planning how and when you are contacted.
- Communication will be coordinated and handled sensitively, with consideration given to family dynamics and any safety concerns.
- Decisions about whether and how you are contacted are carefully considered, recorded and explained where appropriate.
- You can be confident that the review will fully consider the context of what happened, including patterns of abuse, life events and the role of services.

What does the standard mean for review staff and practitioners?

Review staff and practitioners, in line with their roles, responsibilities and workplace setting:

- are trained in review processes and individual management review reports including compiling chronologies
- identify equality and intersectional factors and potential impacts on experiences and engagement with or access to services
- identify potential conflicts of interest in relation to a particular review
- have skills to compile and quality assure reports and chronologies

What does the standard mean for the review governance structures and participating agencies?

Review governance structures and participating agencies, in line with their respective governance and delivery arrangements:

- ensure the implementation of coordinated processes to support the review governance
- ensure review participation is supported by trained staff with relevant knowledge and skills.

Benchmarking and measuring performance: Examples of what meeting this standard might look like Examples may vary according to the size and scale of the service, NHS board, organisation.
• Documented quality assurance process for chronologies and individual management reports. • Impact assessments demonstrating the consideration of equality issues and victim vulnerabilities. • Demonstration of use of national terms of reference. • Evidence of allocation of staffing to support a review.

Standard 5: Domestic abuse related suicide reviews

Standard statement

Domestic abuse related suicide reviews are supported by relevant specialist expertise in domestic abuse and mental health.

Rationale

Domestic abuse related suicide reviews require particular expertise and specific considerations to reflect the complex and multifactorial nature of the deaths under review. The requirements set out in this standard should be considered in addition to those outlined in Standards 4 and 6.

The circumstances surrounding a domestic abuse related suicide are often complex with multiple interacting factors that should be taken into account as part of the review process.[14] It is important to recognise that bereaved people may not accept, or may not yet be able to accept, that a suicide has occurred. Review processes should always take a sensitive, person-centred and trauma-informed approach to communication, engagement and support (see Standard 2).

A direct causal relationship between abuse and suicide is not necessary for a review to be undertaken.[3] The ROC should consider whether domestic abuse was, or may have been, a contributing factor to the death and avoid simplistic explanations of cause. A causal link between domestic abuse and suicide does not need to be established as part of the review.

As part of the review process, there should be discussion with the relevant NHS board(s) in relation to whether a significant adverse event review will be undertaken locally.[33] If so, then where possible, there should be agreement to undertake a single review process.

Specialist knowledge and skills are recommended to understand where domestic abuse may have been a contributing factor to a suicide, and to identify learning. The CRP should include mental health specialist expertise. There are recognised barriers to disclosure of domestic abuse and engaging with services, with recent research identifying additional vulnerabilities and needs of those individuals.

A comprehensive review can provide important learning about how agencies recognised and responded to domestic abuse, mental health needs, suicide risk and intersecting vulnerabilities. Reviews should place the victim's experiences at the centre and seek to understand the circumstances surrounding the death through the contributions of family members, friends, communities and practitioners. Significant life events may have affected the victim's safety, wellbeing or suicide risk such as the release of an abusive former partner from prison.

Learning from these domestic abuse related suicide reviews can inform improvements in policy, practice, service delivery and multiagency working, helping to prevent future deaths. Regular data collection and analysis from domestic abuse related suicides will contribute to future understanding and service response.

Information sharing in cases of domestic abuse related suicide can be complex due to the importance of confidentiality related to an individual's mental health. Information sought must be justified, reasonable and proportionate. Mental health and GP records may contain key insights into risk that were not shared across agencies. Domestic abuse related suicide reviews should acknowledge practical barriers to accessing such records and clarify the lawful basis for proportionate information requests.

The CRP may also consider as part of the review whether the former partner of the deceased presented with behaviours including suicidal ideation that intersected with coercive control or escalating risk.[3] This should be undertaken in line with guidance to protect the victim and others (see Standard 4).

Criteria

5.1 Where there is consideration of a domestic abuse related suicide, the ROC undertakes a structured discussion that:

- considers the timing and impact of domestic abuse
- examines the connection between domestic abuse and the circumstances of the suicide
- identifies relevant learning to inform prevention and improvements.

5.2 A single review process should be undertaken where there has been a domestic abuse related suicide. Where multiple reviews take place, the rationale for this is clearly documented.

5.3 For domestic abuse related suicide reviews, the CRP will consider:

- the cumulative impact of trauma, coercive control and patterns of abuse on the victim prior to death
- the impact of significant events or changes in circumstances of the victim and/or perpetrator (for example, prison release)
- intersectional factors or vulnerabilities which may have impacted access or interactions with services.

5.4 A detailed chronology should include:

- any known mental health crisis presentations
- disclosures of domestic abuse to professionals or agencies
- whether agencies and practitioners recognised domestic abuse as a risk factor for suicide
- agency responses and interactions, including opportunities for intervention
- relevant insights from general practitioners and specialist staff such as mental health practitioners.

5.5 Processes are in place to support a consistent and multiagency approach to domestic abuse suicide reviews, which cover:

- examination of relevant records such as maternity, emergency care, mental health or GP
- consideration of language and consideration of language, culture, faith and other factors that may influence a person's experiences, help-seeking and engagement with services
- involvement of specialists as part of CRP
- identifying trends and potential data points to contribute to future learning.

5.6 Review staff and practitioners recognise that bereaved people may not accept, or may not yet be ready to accept, that a suicide has occurred, and respond with sensitive, respectful and trauma-informed communication and support.

What does the standard mean for bereaved people?
• The review will look at whether domestic abuse may have affected your loved one's life and circumstances before they died. • The review will consider their experiences, relationships and contact with services. • Information about your loved one will only be requested and shared where it is relevant, necessary and lawful, and will be handled with care and sensitivity. • The review is about understanding what happened and identifying learning, not assigning blame. • Learning from the review will be used to improve support and help prevent future deaths.

What does the standard mean for review staff and practitioners?

Review staff and practitioners, in line with their roles, responsibilities and workplace setting:

- consider whether domestic abuse may have contributed to the death, without needing to establish causation
- ensure the victim's experiences and lived reality are at the centre of the review
- consider the impact of coercive control, trauma and significant life events
- identify barriers to disclosure, help-seeking and access to support
- support lawful, proportionate and effective information sharing
- work collaboratively with partner agencies to support a coordinated review process
- focus on learning, improvement and opportunities to prevent future deaths
- are compassionate and respectful when engaging with bereaved people, recognising that individuals may differ in their understanding or acceptance that a suicide has occurred.

What does the standard mean for the review governance structures and participating agencies?

Review governance structures and participating agencies, in line with their respective governance and delivery arrangements:

- ensure decision-making considers whether domestic abuse may have been a contributing factor to the death
- support access to required specialist expertise, including domestic abuse and mental health expertise
- promote a coordinated multi-agency approach and avoid duplication of review processes where possible
- ensure lawful, proportionate and timely information sharing between agencies
- support comprehensive chronologies and the inclusion of relevant information from all agencies
- consider learning related to the person’s experience of domestic abuse, mental health, suicide risk and intersecting vulnerabilities
- ensure reviews identify clear learning, recommendations and opportunities for prevention
- contribute to the identification of themes, trends and data to improve future policy, practice and service delivery.

Benchmarking and measuring performance: Examples of what meeting this standard might look like
• Engagement with local public protection committees or chief officers group to establish joint review process. • Documented ROC decision-making and rationale. • Evidence of specialist expertise informing reviews. • Review reports demonstrating consideration of domestic abuse, trauma and suicide risk. • Chronologies including relevant multi-agency information. • Evidence of consideration of vulnerabilities and barriers to support. • Documented information sharing processes and decisions. • Evidence of opportunities for bereaved people to contribute. • Review reports identifying learning and recommendations. • Action plans demonstrating implementation of recommendations. • Thematic reports identifying trends and recurring learning. • Evidence of service improvements arising from review findings.

Standard 6: Combined deaths reviews and joint reviews

Standard statement

Where a combined deaths review or a joint review is required, participating agencies collaborate to ensure a coordinated, proportionate and effective review process.

For the purposes of the standards, this will be referred to as a single review.

Rationale

The 2025 Act make provision for reviews to combined deaths reviews or joint reviews. The 2025 Act and statutory guidance allows for a single review to be taken in these circumstances. The decision to undertake a combined deaths reviews or joint reviews will be considered at the initial review stage by the ROC.[3]

The ROC, CRP and participating agencies should work collaboratively to support a single review, where possible. Undertaking a single review instead of multiple reviews should reduce the emotional burden on bereaved people and staff participating, as well as reducing potential duplication or conflicting recommendations.

Where a single review is agreed, early engagement and liaison with the relevant single points of contact will ensure that all statutory and organisational requirements and outputs are identified. This will include the terms of reference (see Standard 4).

When the circumstances trigger the requirements for more than one review process, there should always be a presumption that a joint review will take place. More than one review should only occur when this is unavoidable. Where a single review is not possible, the reasons and decision-making process should be clearly documented. Liaison staff and named contacts should work together to minimise multiple communication and ensure that information and advice from multiple reviews is consistent.

Criteria

6.1 The ROC and relevant agencies work collaboratively and in line with their statutory duties to ensure a single review process is undertaken unless there are extenuating circumstances.

Where multiple reviews are required, the reasons for this decision are clearly documented and communicated to participating agencies.

6.2 When a single review process is initiated, there is timely engagement and coordination between participating agencies. This includes the development of a shared and agreed set of terms of reference which outline:

- clear roles and responsibilities for all participating agencies
- communication and information sharing
- commitment to developing a single, coordinated set of recommendations
- agreed timelines.

6.3 There is an agreed approach during single review processes to engage with bereaved families to minimise the number of contacts and reduce potential distress.

6.4 Where multiple reviews are undertaken, there are clear processes in place to coordinate findings, recommendations and actions. This includes:

- early agreement between review leads on roles, scope and approach
- ongoing communication and information sharing between review processes
- mechanisms to identify, explore and reconcile any differences in findings or conclusions
- coordination of recommendations and actions to ensure consistency and avoid duplication or contradiction
- identification of agency ownership for specific recommendations and overseeing its implementation
- clear communication to bereaved people explaining how different reviews relate to each other and how any differences are managed.

What does the standard mean for bereaved people?
• Wherever possible, agencies will work together so that only one review is needed. • The review process will be planned and delivered in a way that is sensitive to your needs and reduces unnecessary burden. • You can expect agencies to work together and share information safely and appropriately. • You will receive clear and consistent communication, with a coordinated approach to how services get in touch with you. • You will be told if more than one review is taking place, and how these reviews relate to each other. • If any differences arise between reviews, there are processes in place to resolve these and explain them clearly to you. • The people leading the reviews will work together to ensure findings, recommendations and actions are consistent and aligned.
What does the standard mean for review staff and practitioners?
Review staff and practitioners, in line with their roles, responsibilities and workplace setting: • will work collaboratively with other agencies to support a coordinated review process • will share information appropriately • have access to the review terms of reference • receive clear communication and named contacts for key roles within a review, for example, individual with responsibility for liaising with bereaved family members.

What does the standard mean for the review governance structures and participating agencies?
Review governance structures and participating agencies, in line with their respective governance and delivery arrangements: • ensure clear terms of reference detailing timelines, communication, roles and responsibilities and outputs • enable effective collaborative multiagency working • ensure staff receive clear guidance on their roles and responsibilities within a combined or joint review • manage staff capacity and resources effectively • actively contribute to reducing duplication of work particularly in relation to multiple recommendations • agree, coordinate and regularly review communication and engagement with bereaved people to ensure it is clear, consistent and minimises unnecessary contact or distress.
Benchmarking and measuring performance: Examples of what meeting this standard might look like
• Engagement with local public protection committees or chief officers group to establish joint review process. • Example of a combined review terms of reference. • Guidance on developing and coordinating recommendations across multiple reviews. • Feedback from bereaved people and staff on the experience of combined and joint reviews.

Standard 7: Reviews of the death of a child or young person

Standard statement

Reviews involving the death of a child or young person are timely, coordinated and child-centred.

Rationale

This standard specifically relates to reviews of the death of children and young people (including those aged to their 18th birthday, this is extended to 26 years if previously looked after) and should be considered in addition to Standards 4 and 6.[34]

The death of a child or young person in the context of domestic abuse requires a robust, coordinated and proportionate response that recognises children as victims in their own right and ensures that their experiences are fully understood. Children and young people who die in the context of domestic abuse may have experienced coercive control, direct harm or exposure to ongoing abuse within their home environment. Their voices and experiences must be central to understanding risk, vulnerability and missed opportunities for intervention.

As with other reviews, there should be effective collaboration and alignment across these processes to avoid duplication, minimise delay and ensure a comprehensive understanding of the circumstances leading to the child or young person's death. A single review should be prioritised. Where multiple reviews are unavoidable, appropriate processes should be in place to manage communication and input.

Where a review involving a child also meets the requirements of the national review process for the death of a child or young person, the CRP should ensure the completion of the national hub core dataset. The CRP should reflect the services and agencies the child or young person was or should have been involved with. Local child protection committees should be involved in the development of the review terms of reference and nominate an appropriate individual to the review panel.

A child-centred, rights-based and trauma-informed approach is required, ensuring that the review honours the child's life and experience. It is also important to recognise the significant impact of the loss of a child or young person on the family including siblings and carers. Support for bereaved people, children and young people is covered in Standard 2 and 3.

Criteria

7.1 A single review process should be undertaken wherever possible following the death of a child or young person. Where multiple reviews are required, the reasons for this decision are clearly documented and communicated to bereaved people.

7.2 The deceased child or young person's experiences of domestic abuse are central to the review. The review seeks to understand their lived experience through information from relevant records, professional involvement, family members, carers and other available sources.

Where necessary, the child or young person's voice is represented through multiple sources of evidence to ensure their experiences and perspectives are reflected in the review's chronology, analysis and findings.

7.3 The review process takes full account of the child or young person's experiences and circumstances. This includes consideration of:

- how the child or young person experienced, and was affected by, domestic abuse
- intersectional factors, including care experience, disability, ethnicity, immigration status, poverty and other circumstances that may have influenced risk, resilience and access to support
- communication, information sharing and collaborative working between adult and children's services, and other public protection arrangements
- the impact of parental, caregiver or household circumstances on the child's experiences and wellbeing
- any gaps in service responses, unmet needs or missed opportunities for protection, support or intervention.

7.4 All reviews of the death of a child or young person ensure:

- effective multiagency collaboration between the ROC, CRP and relevant agencies including relevant child protection committees
- timely and effective information sharing and coordinated responses
- alignment with relevant review process, statutory guidance and legislative requirements
- active participation of relevant agencies throughout the review process
- collective responsibility for implementing, monitoring and evidencing learning and improvement actions.

7.5 The ROC and CRP ensure the review:

- meets the requirements of the 2025 Act, the national child death review and child protection learning review processes
- involves local child protection committees in the development of review terms of reference
- appoints panel members with appropriate expertise to the CRP
- includes information from all agencies involved with the child including school or higher education providers where appropriate.

7.6 The review's recommendations should:

- identify opportunities to improve the early recognition of risk to children and young people
- focus on system learning and address systemic issues across adult and children's services, and not individual practice
- strengthen communication, information sharing and accountability across adult and children's services, and support safe and effective transitions of care between providers and settings
- recognise the impact of coercive control and domestic abuse on children and young people
- support improvements in prevention, protection and early intervention.

What does the standard mean for bereaved people? ***This section should be read alongside standard 2 and 3***

- If you have lost a child or young person, you will be supported as part of the review process to understand what has happened.
- All those involved in the review process will respect your child or young person and review their experience with dignity and respect.
- The review will look at the care, experiences and circumstances leading to the loss of the child or young person. This is to learn any lessons to prevent this from happening to other children and young people.
- You will be offered information about what to expect from the review process and can access support that is right for you, should you want this.
- You can be assured that information about your child or young person will be treated sensitively and confidentially.

What does the standard mean for review staff and practitioners?
Review staff and practitioners, in line with their roles, responsibilities and workplace setting: • will use information from multiple sources to understand and represent the child or young person's lived experience within the review • are trained in review processes relating to children and young people • understand the specific national reporting requirements for deaths of children and young people • have relevant expertise in understanding the impact of domestic abuse on the experiences of children and young people ensuring a rights-based and holistic approach is taken.
What does the standard mean for the review governance structures and participating agencies?
Review governance structures and participating agencies, in line with their respective governance and delivery arrangements: • ensure effective communication and appropriate information sharing between the review panel and relevant services • work collaboratively to make a single review the default process, • ensure all national reporting requirements have been undertaken • ensure the relevant specialist staff and teams are fully involved in the review.
Benchmarking and measuring performance: Examples of what meeting this standard might look like
• Completion of the national core dataset. • Demonstrate a child-centred and rights-based approach to the review process. • Guidance aligning review processes including share outcomes and communication.

Standard 8: Training and support for review members

Standard statement

Review panel chairs and panel members receive high-quality, role-appropriate training, supervision and support.

Rationale

The statutory guidance outlines the expectations in relation to the expertise, knowledge and skills required of chairs and members appointed to the ROC and CRP. This also includes the agencies who can nominate individuals from their organisation who have the relevant seniority, expertise and organisational authority.[3]

ROC and CRP chairs, deputy chairs and panel members should have access to relevant high-quality and competency based national training, including appropriate trauma-informed practice level.[20] Training should include understanding domestic abuse and its impact on experiences and vulnerabilities, undertaking analysis to identify themes and report recommendations, and leadership within a learning culture.[20]

Proactive wellbeing support is available to all individuals involved in the review process to help prevent and mitigate the impact of vicarious trauma. This includes access to peer support, reflective practice, supervision and, where appropriate, specialist psychological or clinical support. Support should be proportionate to an individual's role, responsibilities and level of involvement in the review.

Criteria

8.1 Training and education resources for review staff are:

- underpinned by relevant local or national professional standards, frameworks and guidance
- evidence-based and informed by good practice
- quality assured and accredited, where appropriate
- informed by feedback and the lived experiences of bereaved people (including children and young people) and staff.

8.2 ROC and CRP members have access to trauma-informed wellbeing support measures including peer support, vicarious trauma services and clinical and practitioner supervision as appropriate.

8.3 ROC and CRP chairs and members undertake competency based training in line with the 2025 Act and statutory guidance, which covers:

- understanding of domestic abuse including its gendered nature, and the impact of coercive control and patterns of behaviour
- understanding suicide and associated risk factors
- recognising and responding appropriately to risk factors for domestic homicide or domestic abuse related suicide
- trauma-informed and person-centred engagement approaches to enable the meaningful engagement of bereaved people including children and young people
- cultural competence, intersectionality and equality duties
- awareness and unconscious or confirmation bias, and how to address these
- appropriate information sharing, confidentiality and data protection.

8.4 ROC and CRP chairs and members are trained to the appropriate trauma-informed practice level. This enables them to:

- understand the impact of trauma and how to minimise the risk of re-traumatisation
- communicate with sensitivity, compassion and respect
- understand and respect the individual experiences, needs and rights of bereaved people
- support bereaved people, practitioners and volunteers to feel safe and supported.

8.5 ROC and CRP chairs and members have the knowledge, skills and experience required to undertake reviews effectively. They should be enabled to:

- assess evidence and apply analytical judgement
- contribute to the development of clear evidence-informed recommendations and reports
- have professional curiosity
- understand family dynamics and their impact on the case
- consider all views equally in a balanced and impartial way.

What does the standard mean for bereaved people?

- You can be confident that people undertaking reviews are the right people to do so.
- You will be supported by trained people who take time to understand your experiences and their impact. They will support you in the best way possible.
- You will be treated with sensitivity and compassion, and supported to feel safe when sharing your experiences.

What does the standard mean for review staff?

Review staff in line with their roles, responsibilities and workplace setting:

- have the time, resources and support to participate in training, reflective practice and supervision
- are supported by a leadership culture that safely promotes openness, transparency and learning
- receive support and guidance for their own mental and emotional wellbeing
- understand their roles and responsibilities to enable them to support bereaved people and practitioners involved in reviews.

What does the standard mean for the review governance structures?

Review governance structures:

- ensure access to national high-quality training
- have the necessary expertise and skills appropriate to their roles and responsibilities to participate in reviews
- have access and time to undertake training, clinical supervision and peer support.

Benchmarking and measuring performance: Examples of what meeting this standard might look like

- Attendance at national training for reviews.
- Records demonstrating professional development against review related competencies.
- Provision and uptake of clinical or restorative supervision.
- Policies and processes to support the wellbeing of review staff including peer support.
- Evaluation of the effectiveness of wellbeing support arrangements.

Standard 9: Training and support for practitioners from participating agencies

Standard statement

Practitioners contributing to reviews are trained and supported in line with their roles and responsibilities.

Rationale

Staff and practitioners from participating agencies will be involved in aspects of the review process. Staff may be nominated by their organisation as a single point of contact or representative for communication and engagement between the CRP and the organisation. Staff and practitioners may also be asked to collate information as part of the individual management review reports for individual reviews.[3]

Domestic homicide and domestic abuse related suicide reviews are likely to expose staff to high emotional burden and vicarious trauma. This may be as a result of their professional support for a person who has died or through review of distressing information about a case. Prioritising psychological safety, compassionate and trauma-informed practice for staff training and wellbeing will ensure effective contributions to, and promote learning from, reviews. Participating agencies should ensure practitioners are supported through relevant workplace policies and procedures. This may include ensuring staff member caseload is reassigned during the review, access to counselling or peer support. Support should also be available post-review along with opportunities for debrief and discussion of review outcomes and learning.

The ROC chair and CRP play a key role in creating a learning culture and environment that enables practitioners to contribute openly, confidently and meaningfully to the review process. They provide leadership and reassurance that the review is focused on learning, improvement and prevention and take steps to support participation and minimise anxiety.[20] Where practitioners are invited to in-person discussions (such as facilitated learning events), the CRP should ensure information is provided around timings, expectations for attendance, preparations required and opportunities to ask questions prior to the session.

Criteria

9.1 Participating agencies ensure practitioners acting as single points of contact are provided with the time, resources and support to fulfil their roles and responsibilities, which include:

- facilitating communication
- coordinating information and scoping requests
- engaging with relevant colleagues or departments, as required.

9.2 All practitioners involved in reviews can access national training and support that is timely, relevant and appropriate to their role.

9.3 Practitioners from participating agencies are provided with clear information about:

- the purpose, scope and timescales for the review
- their role and responsibilities as part of a wider review team
- how they will be involved in the review process
- details of single point of contact for further questions or information.

9.4 Practitioners contributing to reviews or reports have knowledge, expertise and/or information regarding:

- the nature and extent of their agency's contact and involvement with the victim
- relevant equality, diversity and inclusion considerations
- key decisions made, actions taken and services provided
- initial reflections or lessons identified by the organisation.

9.5 Participating agencies ensure that the workloads of practitioners, volunteers and managers are reviewed to enable them to fully prepare for, and contribute to, reviews. This includes ensuring individuals:

- have allocated and protected time for preparation and report writing
- are supported to attend review meetings and facilitated learning events.

9.6 Participating agencies have workplace policies which enable staff, volunteers and students, as appropriate, to access timely wellbeing and psychological support. This includes:

- those affected by the death of a colleague through domestic homicide or domestic abuse related suicide
- those who worked with or supported the victim, bereaved people (including children and young people) or the person who caused harm
- those involved in the review process and exposed to potentially distressing or traumatic information.

What does the standard mean for bereaved people?

- You can be confident that the people involved in the review are trained, informed and supported to carry out their role effectively.
- You can expect practitioners to understand the review process and contribute in a way that supports learning and improvement.
- You can expect staff involved in the review to receive appropriate support and supervision when dealing with distressing information.
- You can expect professionals to engage with the review in a thoughtful, compassionate and informed way.

What does the standard mean for review practitioners?

Practitioners in line with their roles, responsibilities and workplace setting:

- have time and resources to develop and expand their knowledge, skills and competencies relevant to their role within the review process
- receive support and guidance for their own health and wellbeing
- are supported by compassionate managers and colleagues to safely raise any concerns
- can be confident that all professionals they work with are appropriately trained and supported.

What does the standard mean for participating agencies?

Participating agencies, in line with their respective governance and delivery arrangements:

- ensure staff are fully supported to participate in reviews through time and resources to access training
- staff are aware of how to access workplace policies and support for their own wellbeing including peer support.

Benchmarking and measuring performance: Examples of what meeting this standard might look like

- Access to national training.
- Training and development plans and audits.
- Attendance at multidisciplinary training or learning events.
- Training or shadowing opportunities with specialist trauma support organisations.
- Staff feedback on their experiences of the review process and training needs.
- Information about supervision, peer support or employee assistance programmes.

Standard 10: Sharing knowledge and learning from reviews

Standard statement

Robust system-wide approaches are in place to ensure learning from reviews is identified, shared and implemented.

Rationale

To ensure learning from reviews results in improvement and is embedded in practice, there should be a structured, independent and transparent approach with multiagency engagement.[35] There should be clear timeframes for the report to conclude and publish that are communicated to bereaved people, staff and participating agencies. The ROC and CRP have a responsibility for embedding a learning culture that is safe, open and trauma-informed (see Standard 1).[20]

Reviews should identify learning from the circumstances that led to a death, which includes patterns in agency involvement, cumulative harm, gaps in assessment or involvement and areas of good practice. Learning should explicitly consider the gendered nature of domestic abuse and structural inequalities, the influence of structural inequalities, discrimination and barriers to accessing support

Recommendations should be evidence-informed, proportionate and focused on improving policy, practice and service responses. Reviews should distinguish between learning and recommendations that can be implemented locally and those that require regional or national action. To support ownership and commitment to improvement, participating agencies should have opportunities to contribute to the development of recommendations and action plans.[36] This enables practical consideration of implementation, including potential barriers, resources and timescales. Bereaved people should also have an opportunity to review draft recommendations and provided with a right to reply to any aspect of the report (see Standard 2).[3] Anonymity, confidentiality and information governance considerations should be reviewed before publication.

Participating agencies are responsible for disseminating learning, recommendations and actions within their organisations and governance structures. In addition, the ROC multiagency members have a role in the timely dissemination of learning to their respective organisations and local or national networks. Sharing learning may include multiagency participation in national networks or events to discuss and share learning across services, to contribute to service improvement, policy development, evidence-based tools and guidance. Processes should be in place to support the structured dissemination of findings across all agencies and address any barriers to accessing or sharing learning. For example, third sector organisations and independent practitioners (such as GPs) may not have access to national or local public protection or violence against women networks.

Criteria

10.1 There is a robust process to ensure the learning identified from the review process is described in reports with clear findings, recommendations and actions. Each review report should be evidence-based and includes:

- a clear chronology and analysis of the circumstances leading to the death
- consideration of the interaction between domestic abuse and other risk factors
- identification of patterns and recurring themes from service interactions
- a focus on prevention and improved outcomes
- recognition of areas of good practice
- identification of opportunities for policy development
- recommendations for action and timelines for delivery
- implementation and review arrangements.

10.2 The CRP engages with relevant agencies and local public protection forums to ensure recommendations are feasible, proportionate and capable of implementation.

10.3 Review recommendations and action plans are developed, in line with the statutory guidance and:

- are evidence-based, proportional and measurable
- clearly identify local recommendations, including those with national applicability and national recommendations
- have detailed actions and defined timeframes to address local learning
- are assigned to a named agency and lead professional role.

10.4 Processes are in place to ensure bereaved people have the opportunity to review and provide feedback on draft reports and recommendations before finalisation.

10.5 The implementation of recommendations is regularly monitored by single points of contact and the review secretariat and includes:

- progress reporting against agreed actions and timescales
- reporting through established governance arrangements
- identification and escalation of delays in implementation
- review of impact and outcomes.

10.6 Participating agencies use existing governance structures and processes to ensure:

- learning is shared and considered with local teams, services or networks
- implementation of specific local recommendations and action plans
- consideration and application of relevant national learning from reviews
- participation in national data collection to support improvement.

10.7 There is a multiagency approach to implementing change and improving outcomes across the whole system achieved by:

- participating in local improvement work, national datasets and research
- sharing intelligence and learning
- embedding and sustaining improvements in policy, practice and service delivery.

10.8 Processes are in place to ensure that bereaved people are offered appropriate opportunities to receive updates on the implementation of recommendations, in line with their preferences. This includes:

- identifying and recording individual preferences for receiving updates
- agreeing the frequency and format of communication on a case-by-case basis
- providing clear and accessible updates where requested.

10.9 Feedback mechanisms demonstrate the impact of review learning and recommendation. This includes:

- evidencing improvements in service delivery, policy, practice and governance
- monitoring and reporting on the implementation and sustainability of actions
- providing clear information to bereaved people, staff and stakeholders about the changes made as a result of the review.

10.10 The ROC ensures that data from domestic homicide and suicide reviews, including demographic and equality-related information@

- is collected, collated and analysed to identify trends, risk factors and inequalities across different communities
- informs findings which are used to support national learning and inform service planning, improvement and prevention activity.

What does the standard mean for bereaved people?

- You can be confident that what has happened will be carefully reviewed and understood.
- Those involved will use the learning from the review to improve services and prevent similar harm in the future.
- You can be confident that actions needed to make improvements will be tracked to ensure learnings are put into practice.
- Where appropriate, you will be able to see how learning from the review has led to meaningful change.

What does the standard mean for review staff and practitioners?

Review staff and practitioners, in line with roles, responsibilities and workplace setting:

- understand how reviews can contribute to learning and prevention of domestic homicide and domestic abuse related suicides
- are enabled to support local improvement plans
- can participate in activities and professional networks that promote good practice and share learning.

What does the standard mean for review governance structures and participating agencies?

Review governance structures and participating agencies, in line with their respective governance and delivery arrangements:

- work collaboratively to develop, publish and disseminate evidence-based recommendations for implementation
- provide staff with time and resources to consider and implement learning and improvement work
- routinely monitor and evaluate recommendations and review outcomes to support improvement in local and national systems
- ensure knowledge exchange and learning from reviews is embedded into local, regional and national structures, committees and networks.

Benchmarking and measuring performance: Examples of what meeting this standard might look like
• Multiagency reflection, learning and decision-making meetings or sessions. • Identification and dissemination of good practice through national and local networks. • Use of tools supporting the dissemination of recommendations and learning, for example, 7-minute briefings. • Joint improvement work with statutory agencies, violence against women networks, voluntary organisations and independent contractors to develop local action plans, data collection and review of data. • Evidence to demonstrate the integration of recommendations into work plans of, for example, local public protection committees.

Standard 11: Information governance

Standard statement

Personal data and information required for reviews is processed and shared in line with relevant legislation and guidance.

Rationale

Data and information sharing is an essential aspect of the review process from initial notification of a death through to the conclusion and publication of a review. It is important that information sharing is in line with all relevant legislation and data protection principles, including sharing only that which is necessary to complete the review.

Review members, practitioners and participating agencies should be clear about their collective and individual roles and responsibilities for information governance and data protection, in line with the relevant legislation, policies and guidance.[37-39] Processes should be in place to ensure confidentiality and protection of anonymity. This includes mitigations to prevent inadvertent disclosure and review of requirements at key stages in the process.

Where information or data refers to children, processes will be followed to ensure the information request is necessary and in the best interest of the child.[3, 40, 41]

As part of the review process, information may be sought from a range of agencies, including the voluntary sector. Participating agencies should ensure they are responding to information requests within agreed timescales.[3]

Robust information governance mechanisms informed by the 2025 Act, statutory guidance and other relevant legislation, policies and guidance should be adhered to by all agencies throughout the review process. Source information relating to individual reviews will be retained for 21 years before records deletion.[3]

Staff should follow the relevant organisational policies to ensure the safety, efficacy and ethical use of new technologies.[42]

Criteria

11.1 The collection and sharing of personal data and information as part of a review is undertaken in line with the 2025 Act, statutory guidance and other relevant legislation. Documented processes should cover:

- joint and individual responsibilities for the use and sharing of data between the ROC, CRP and participating agencies
- clear timescales for information sharing
- escalation processes where there are delays or inappropriate information sharing
- completion of data protection impact assessments, privacy notices and data sharing agreements, as required.

11.2 Processes are in place to protect anonymity and privacy, and to minimise the risk of identification for the victim, bereaved people and practitioners. This includes:

- a review of anonymisation and confidentiality at key stages of the review (for example, at Terms of Reference and draft report stages)
- clear documentation of information-sharing arrangements and any agreed confidentiality requirements
- use of safeguards to prevent inadvertent disclosure, such as the production of anonymised or summary reports.

11.3 Data sharing and data protection relating to children and young people's personal data are managed in accordance with the enhanced protections set out in UK GDPR and relevant legislation.

11.4 Review staff involved in the governance and secretariat of reviews undertake role-appropriate training. This includes**:**

- how and when to share data and information appropriately
- maintaining confidentiality and anonymity
- understanding and application of the relevant legislation and guidance.

11.5 Access to, retention of and disposal of information relating to individual reviews is managed in line with national protocols and relevant legislation.

11.6 Processes are in place to provide assurance on the security, efficacy and ethical use of new and emerging technology, including Artificial Intelligence, in any aspect relating to the collation or analysis of information for reports.

What does the standard mean for bereaved people?
• You can be confident that information will only be shared when necessary, and this will be proportionate and in line with the relevant legislation and guidance. • You can be confident that your personal information and that of your loved one are handled safely and securely. • Your privacy and anonymity, and that of your loved one will be protected throughout the review process. • There are clear rules in place to prevent inappropriate access to or disclosure of sensitive information. • Staff involved in the review are trained to handle information respectfully and confidentially. • You can trust that information will be used responsibly to understand what happened and improve services, without compromising your privacy.
What does the standard mean for review staff and practitioners?
Review staff and practitioners, in line with their roles, responsibilities and workplace setting: • understand what appropriate sharing of information means in the review context • understand their role in keeping records and information systems safe from unauthorised access • ensure confidentiality and anonymity • are trained in information governance, including who to escalate to when there are concerns or breaches • have clear guidance on information sharing relating to reviews.

What does the standard mean for the review governance structures and participating agencies?
Review governance structures and participating agencies, in line with their respective governance and delivery arrangements: • demonstrate compliance with national guidelines and legislation related to records management, data and digital systems including retention and disposal • implement information management and information governance training related to the review process • ensure information requests are proportionate and relevant to the review • take appropriate and responsive measures to mitigate information risks, for example, prevention of jigsaw identification • ensure all required documentation is in place • work in partnership to ethically develop and test new digital tools to support the review process.
Benchmarking and measuring performance: Examples of what meeting this standard might look like
• Standardised terms of reference detailing information sharing roles and responsibilities. • Documentation detailing multiagency discussion and actions to protect anonymity and confidentiality. • Data protection impact assessment for each review. • Documented processes for information requests relating to children and young people. • Records of completed information governance training. • Audit of systems and processes to monitor information retention and disposal.

Appendix 1: Development of the standards

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.

Evidence base

A review of the literature was carried out using an explicit search strategy developed by Healthcare Improvement Scotland's Research and Information Service. Additional searching was done through citation chaining and identified websites, grey literature and stakeholder knowledge. Searches included Scottish Government, Public Health Scotland, NICE, SIGN, NHS Evidence and Department of Health and Social Care websites. This evidence also informed an equalities impact assessment. Standards are mapped to a number of information sources to support statements and criteria. This includes, but is not limited to:

- government policy
- approaches to healthcare delivery and design, such as person-centred care
- clinical guidelines, protocols or standards
- professional or regulatory guidance, best practice or position statements
- evidence from improvement.

Standards development

The standards have been informed by current evidence, best practice recommendations, national policy and are developed by expert group consensus. The standards have been co-created with key stakeholders from across a range of organisations. See Appendix 2 for the standards development group membership, contributors and project team.

The standards development process included:

- scope engagement period during January and February 2026
- three development group meetings held between April and June 2026
- an editorial review panel meeting held in August 2026.

Format of the standards

All Healthcare Improvement Scotland standards follow the same format. Each standard includes:

- an overarching standard statement
- a rationale explaining why the standard is important
- a list of criteria describing what is needed to meet the standard
- what the standard means for bereaved people including children and young people
- what the standard means for review staff and practitioners
- what the standard means for review governance structures and participating agencies
- examples of what meeting the standard might look like in practice.

The examples provided are intended to support review governance structures and participating agencies in assessing, benchmarking and evidencing their performance against the criteria. These examples are illustrative only and should not be regarded as an exhaustive or prescriptive list of all possible forms of evidence. Given the variation in scale, service configuration, population needs and delivery models across partner agencies, the specific examples relevant to each service or organisation may differ. The same piece of evidence can be used to demonstrate that review governance structures are meeting multiple criteria within these standards.

Quality assurance

All standards development group members were responsible for advising on the professional aspects of the standards. Clinical members of the standards development group advised on clinical aspects of the work. The co-chairs had lead responsibility for formal clinical assurance and sign off on the technical and professional validity and acceptability of any reports or recommendations from the group.

All standards development group members made a declaration of interest at the beginning of the project. They also reviewed and agreed to the standards development group's terms of reference. More details are available on request from standards team.

As part of the standards development process, an editorial panel was convened to undertake internal quality assurance and approval prior to publication of the draft standards (see Appendix 3 for membership).

The standards were developed within the Operating Framework for Healthcare Improvement Scotland and the Scottish Government (2022), which highlights the principles of independence, openness, transparency and accountability.

For more information about Healthcare Improvement Scotland's role, direction and priorities, please visit: Healthcare Improvement Scotland.

Appendix 2: Membership of the standards development group

Name	Position	Organisation
John Devaney (Co-chair)	Dean and Head of the School of Social and Political Science	University of Edinburgh
Eddie Doyle (Co-chair)	Deputy Medical Director	NHS Lothian
Louise Adams	National Manager – Support for Families Bereaved by Crime Service	Victim Support Scotland
Andrea Beavon	Co-chair	National Violence Against Women's Network and VAW Coordinator
Adam Brown	Detective Chief Inspector	Police Scotland
Janice Brown	Strategic Inspector	Care Inspectorate
Kevin Campbell	Health Improvement Manager	Public Health Scotland
Vicky Carmichael	Violence Against Women and Girls Justice Unit	Scottish Government
Rory Christie	Reviewer	Healthcare Improvement Scotland
Euan Currie	Protecting Children Consultant, CELCIS	University of Strathclyde
Jessica Denniff	Head of Safelives - Scotland Team	Safelives
Carol-Anne Fordyce	Head of Services	Abused Men in Scotland
Neil Gibson	Adult Social Work Policy and Practice Lead	Social Work Scotland
Grace Gilling	Nurse Director	NHS Tayside

Name	Position	Organisation
Stephanie Govenden	Consultant Community Paediatrician, Clinical Lead – Child Death Review	NHS Highland
Kim Irving	Nurse Consultant Public Protection and Gender Based Violence Lead	NHS Dumfries and Galloway
Alisdair Macleod	Principal Procurator Fiscal	Crown Office and Procurator Fiscal Service
Gill McKinna	Head of Caledonian System – National Team,	Community Justice Scotland
Jodie McVicar	National Training Manager	Scottish Women's Aid
Patricia Moultrie (from May 2026)	Retired GP	
Lynne O'Brien	Chief Officer	Aberlour
Leanne Patrick	Gender Based Violence Nurse Coordinator	NHS Fife
Gary Sergeant	Detective Chief Inspector, Domestic Abuse Coordination Unit	Police Scotland
Haylis Smith	National Delivery Lead, Suicide Prevention	COSLA
Robby Steel (from May 2026)	Principal Medical Officer for Mental Health / Consultant Psychiatrist	Scottish Government
Emma Stirling	Director of Care Quality and Professional Development	Scottish Ambulance Service
Brenda Walker (from May 2026)	National Adult Support and Protection Coordinator	Institute for Research and Innovation in Social Services (IRISS)

Contributors:

The standards development group and project team would like to thank the following people for their contributions to the drafting of the standards:

- Albert Aspinall, Healthcare Improvement Scotland
- Stuart Doig, NHS State Hospital
- Jen Douglas, Safelives
- Claire Houghton, Edinburgh University
- Erin McDwyer, Scottish Women's Aid
- Belinda McEwen, Care Inspectorate
- Sinead Power, Scottish Government
- Hamish Wyllie, Abused Men in Scotland

The standards development group, review and editorial panels were supported by the following members of Healthcare Improvement Scotland's standards and indicators team:

- Stephanie Kennedy - Administrative Officer
- Jen Layden - Programme Manager
- Carolyn Roper - Project Officer
- Fiona Wardell - Team Lead.

Appendix 3: Membership of the editorial panel

Draft standards: editorial panel membership

Name	Position, Organisation
Laura Boyce	Chief Inspector of Regulation, Healthcare Improvement Scotland
John Devaney (Co-chair)	Dean and Head of the School of Social and Political Science, University of Edinburgh
Eddie Docherty	Director of Quality Assurance and Regulation, Healthcare Improvement Scotland
Eddie Doyle (Co-chair)	Deputy Medical Director, NHS Lothian
Jen Layden	Programme Manager, Healthcare Improvement Scotland
Safia Qureshi	Director of Evidence and Digital, Healthcare Improvement Scotland
Fiona Wardell	Team Lead, Healthcare Improvement Scotland

Appendix 4: Information and resources for bereaved people

There is a range of resources available to support bereaved families, friends and communities. To note, this is not an exhaustive list of resources available.

- Abused men in Scotland
- Advocacy after fatal domestic homicide
- National bereavement care pathways
- Scottish Domestic Abuse and Forced Marriage helpline
- Scottish Women's Aid
- Supporting parents, families and carers in Scotland with the child death review process

Glossary

Term	Definition
Abusive behaviour	behaviour that a reasonable person would consider likely to cause physical or psychological harm (including fear, alarm, or distress) to the recipient. It covers all forms of behaviour, including words, actions, or failures to act, and can be directed at a person, property or through a third party. The behaviour may involve a single incident or a pattern of conduct.
Bereaved person	refers to family members, friends and colleagues who have been bereaved from a domestic homicide or domestic abuse related suicide.
Case review panel	a group tasked with conducting domestic homicide or suicide reviews, led by a chair and including members with relevant insights or expertise. Tasked with investigating and reporting on key events, missed opportunities and making recommendations.
Child	within the context of domestic homicide and suicide reviews, child refers to the parent-child relationship with no limit placed on the age of a child. This includes children and young people of the victim and /or perpetrator, or who are witnesses but not related to the victim or perpetrator, or young people living in the household.
Child and young person	in Standards 3 and 7, reference is made specifically to children and young people aged under 18 years, or up to 26 years for individuals with care experience, including those who were previously looked after by a local authority.
Combined deaths reviews	a review of multiple deaths, either due to common perpetrators or shared circumstances, which assesses each case in tandem.
Former partner	is interpreted accordingly with no requirement that the parties are living together to be partners (see definition below).
Individual management review report	a form completed by relevant agencies when they have been contacted to provide information on the persons that are subject to review.

Term	Definition
Joint review	a review that consists of a domestic homicide or suicide review and a minimum of one other review, which takes place when there is a crossover in remit between different types of review (for example a child protection learning review). When this happens, the reviews come together as a single domestic homicide or suicide review.
Looked after child	a child who has been placed under the care of local authorities, either through foster care or other child protection arrangements.
Notification	is a formal written communication to the review oversight committee about a death that may require review. It must include relevant information and be copied to the Scottish Ministers.
Participating agencies	refers to organisations including from the statutory, voluntary, third sector and private sector, who will have involvement in the review process. This may include membership of the ROC or a CRPs, acting as an organisational single point of contact, or contributing professional expertise to individual reviews.
Partner	refers to someone who is married, or in a civil partnership or in an intimate relationship with another person.
Perpetrator	is the person who exhibits abusive behaviour towards another individual in a domestic relationship.
Protocol	A formal agreement outlining processes and arrangements between key parties (Review Oversight Committee Chair, Chief Constable of Police Scotland, Lord Advocate, PIRC, Scottish Ministers) to ensure review proceedings do not prejudice criminal investigations, proceedings or inquiries.
Report	is the document produced at the conclusion of a review by the case review panel, including timelines of events, missed opportunities, conclusions and recommendations.

Term	Definition
Review governance structure	refers to the governance structures that are part of the review process and includes the review oversight committee (ROC), case review panels (CRP) and review secretariat.
Review oversight committee (ROC)	is the group established to oversee and ensure the conduct of domestic homicide or suicide reviews and responsible for appointing case review panels. It includes a chair, deputy chair and members who are either nominated and approved by Ministers or appointed directly by Ministers.
Review staff and practitioners	refers to ROC and CRP chairs and members, the Secretariat, single points of contact from participating agencies, practitioners may include volunteers or staff directly involved with the victim or perpetrator.
Reviewable death	is a death which is eligible for review and will be reviewed if it is considered by the ROC to meet the criteria.
Single point of contact	refers to a designated individual within an organisation who is the central liaison between the review secretariat and their organisation. The single point of contact facilitates communication, coordinates and quality assures information requests and responses, ensures consistency of submissions, and support the organisations involvement throughout the review process.
Trauma-informed	refers to a way of working and delivering services that recognises a person may have experienced trauma and understands the effects that trauma may have on them. In healthcare, this involves adapting processes and practices based on that understanding and aiming to avoid, or minimise the risk of, re-exposure to past trauma or the experience of further trauma. A trauma-informed service demonstrates how it is shaped by anonymous feedback from people with living and lived experience of trauma. A trauma-informed system also supports workforce resilience and is underpinned by trauma-informed leadership and organisational systems. Refer to National Trauma Transformation Programme.

Term	Definition
Victim centred	is an approach that prioritises the needs, rights and experiences of victims at every stage of a process. It involves treating individuals with dignity and respect, recognising the impact of trauma, listening to and valuing their perspectives, and ensuring they are supported, informed and involved in decisions that affect them. The aim is to minimise further harm and ensure responses have considered each person's unique circumstances and needs.
Vicarious trauma	refers to the emotional, psychological and physical distress that occurs when an individual is indirectly exposed to the traumatic experiences of others.
Violent-resistance killings	are homicides committed by victims of domestic abuse against their abuser. These cases usually occur in the context of long-term abuse, coercive control, fear, and attempts to protect themselves or their children.
Vulnerabilities	refers to people who experience specific elements that have impacted someone's access to or affected the help they received from services. Vulnerabilities include but are not limited to: • gender • sexual orientation • ethnicity and cultural factors • disability • age • complex social needs around housing, poverty and alcohol or substance use. Refer to Vulnerabilities: applying All Our Health - GOV.UK.
Young person	an individual under 18 years old, or under 26 if they were in care (a "looked after" child).

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Published August 2026

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