

Domestic homicide and suicide review: standards

Final scope

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Introduction

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

Standards are informed by:

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

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

Background to the standards

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

A number of countries have established models to review domestic abuse related deaths. While the types of relationships and events vary across different models, all models include in the scope those killed by a partner or ex-partner.

These models are multi-agency reviews involving multiple organisations including health services. Domestic abuse is a complex issue rooted in gender inequality, affecting both adults and children, with significant health implications for victims both physically and psychologically. Domestic abuse is a well-recognised public health issue that spans all aspects of health.^{2,3} Mental health issues are frequently identified for victims who often experience a range of physical and mental health problems due to the abuse they have experienced. An analysis of domestic homicide reviews by the Home Office identified health as the agency with the greatest frequency of contact with victims.⁴ This is also true for perpetrators. The health system plays a crucial role in identifying and

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

² [Scottish Government: Equally Safe.](#)

³ [Scottish Government: Women's health plan.](#)

⁴ [Home Office. 2023. Qualitative analysis of domestic homicide reviews: October 2022 to September 2023.](#)

supporting victims. Effective intervention requires collaboration between health services and all the other partner agencies including police, social work, public sector organisations and the third sector.

The Scottish Government has undertaken work to develop and implement a national multi-agency domestic homicide and suicide review model for Scotland. This commitment has been set out in the Equally Safe Delivery Plan and further strengthened in the Scottish Government's 2023-24, 2024-25 and [2025-26 Programme for Government](#). The [Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews \(Scotland\) Act 2025](#) to underpin domestic homicide and suicide reviews in Scotland was recently introduced alongside statutory guidance.

Principles for developing standards

All Healthcare Improvement Scotland standards are mapped to key national legislation, policy and standards. They support the implementation of person-centred and trauma-informed principles, and human rights and equality legislation. The standards will also incorporate the Scottish domestic homicide and suicide review model's core principles which in addition include being transparent, inclusive and domestic abuse competent.

Scope of the domestic homicide and suicide review standards

Title

Standards for domestic homicide and suicide reviews in Scotland.

The purpose of the standards

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

The standards should be considered best practice for all sectors involved in domestic homicide and suicide reviews. The standards apply to the domestic homicide and suicide review model and will support agencies and organisations engaging with, and participating in, domestic homicide and suicide reviews.

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

Legal framework underpinning the standards

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

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

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

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

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

The type of deaths covered are:

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

The type of deaths not covered are:

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

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

The scope of the standards

The scope of the standards has been informed by a review of the evidence and two stakeholder workshops held in November 2025 (a summary of the workshops is available from the Standards and Indicators project team). There were six domains for inclusion in the standards:

Leadership and governance

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

Consideration of other reviews

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

Data collection and information sharing

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

Working with bereaved families, children and young people

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

Staff training, education, support and wellbeing

- working in partnership with services to develop a culture of reflection and learning arising from domestic homicide and suicide reviews
- the capacity of individuals and services to engage meaningfully with the review process
- wellbeing support for staff

- how learning is shared with staff including local and national learning.

Learning and implementation of learning:

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

Areas out of scope of the standards

The following areas will not be included in the standards:

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

Consideration of wider context

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

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

Standards development group

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

The standards development group includes members with strategic and operational backgrounds including representations from across sectors, organisations and networks.

Further information

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

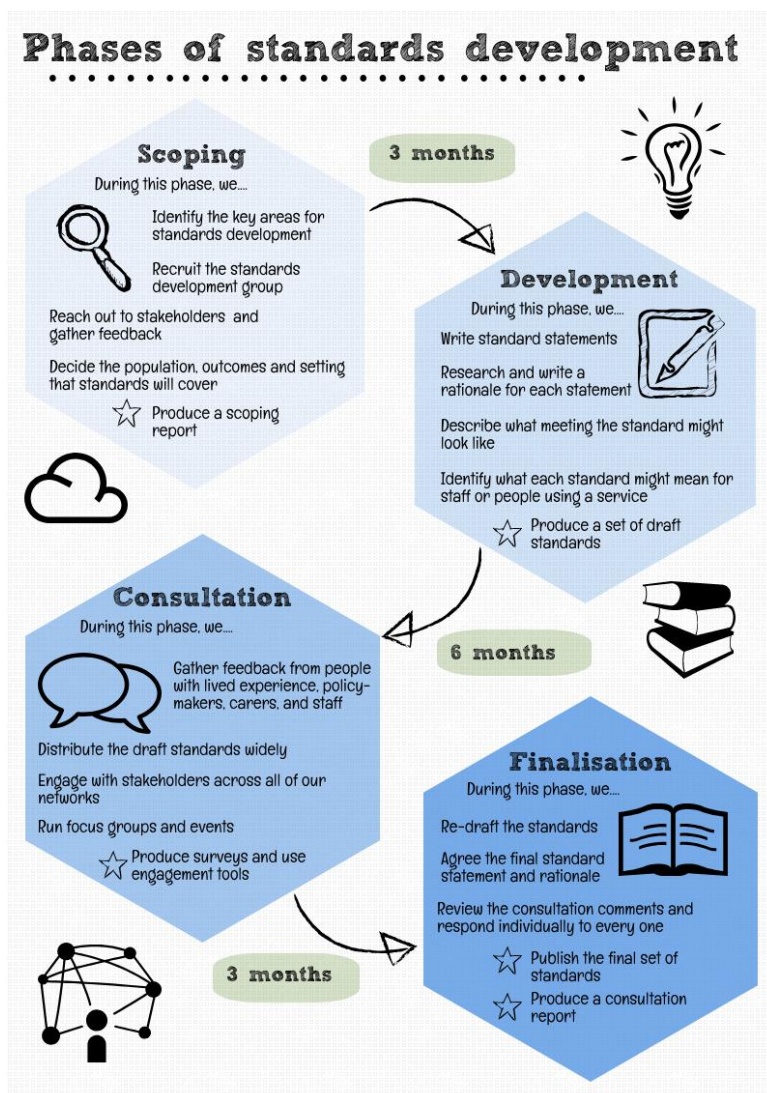
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Appendix 1: Standards development methodology

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

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

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



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