Undertaking Domestic Homicide and Suicide Reviews: Draft Statutory Guidance Consultation Social Work Scotland response

February 2026

Introduction

Social Work Scotland is the professional body for social work leaders, working closely with our partners to shape policy and practice, and improve the quality and experience of social services. The work of our organisation covers justice, children and families, and adult social work, with protection and learning at the core of our business. We have been involved in aspects of discussions about the Domestic Homicide and Suicide Review (DHSR) Guidance and welcome the opportunity to provide a response to this consultation.

Summary

Social Work Scotland conducted a workshop which brought together stakeholders from across Scotland to review and discuss the Domestic Homicide and Suicide Review (DHSR) Guidance which aim to identify lessons following a domestic abuse related death or a connected death of a young person, with the overarching goal of preventing future abuse and death, and to facilitate systemic learning.

Members have welcomed domestic homicide being included in the learning review process and the importance of this area but have previously expressed concern about DHSR being placed in statute due to the potential hierarchy created, and the associated complexities of one review taking precedence over others. In terms of the draft guidance, they felt that, in its current form, it requires substantial revision to

ensure the model is coherent, trauma-informed, operationally workable and aligned with Scotland's existing public protection landscape. Across all sections of the guidance, members identified a consistent set of themes relating to clarity, methodology, governance and tone.

First, members considered the overall tone of the guidance to be overly legalistic and investigatory, rather than learning-focused. Despite repeated statements that DHSRs aim to prioritise learning over blame, many sections were viewed as reflecting a more procedural, compliance-driven style that did not align with Scotland's established child and adult protection learning review models. Members stressed the need for clearer articulation of the learning methodology underpinning DHSRs, including expectations around reflective practice, practitioner engagement, triangulation and systems analysis.

Members also identified significant concerns regarding the lack of clarity, consistency and integration with existing local governance structures, including Chief Officer Groups (COGs), Adult Protection Committees (APCs), Child Protection Committees (CPCs) and Violence Against Women and Girls (VAWG) partnerships. They felt that the guidance repeatedly overlooks the statutory and strategic responsibilities of these groups and fails to define their role within the DHSR process. This omission created confusion about accountability and risked establishing an unintended hierarchy between national and local review systems.

Across the guidance, members highlighted the need for more robust and accurate information-governance provisions, describing Section 6.2 in particular as incomplete and, at points, legally incorrect. They stressed the necessity of clear, operationally sound guidance on data sharing, confidentiality, storage, retention, subject access, and anonymity, especially given the highly sensitive nature of DHSR material and existing GDPR duties. These issues linked closely to broader concerns about draft-report circulation, quality assurance and publication processes.

Members emphasised that the guidance must be strengthened to ensure a genuinely trauma-informed approach. While trauma-informed language appears intermittently, members felt it was not adequately embedded across family engagement, practitioner involvement, analysis, reporting or publication. They highlighted the need for more explicit support for bereaved families and children, clearer expectations

around safe and meaningful participation, and stronger protections to prevent re-traumatisation.

A further recurring theme was the absence of detailed guidance on practitioner involvement, which members considered a fundamental weakness. They stressed that meaningful learning depends on understanding practitioners' reasoning, experiences and challenges, none of which can be adequately captured through document-review alone. The absence of structured practitioner engagement undermines the depth, nuance and fairness of the review process.

Members also identified gaps concerning overlapping and parallel review processes. DHSR-eligible cases often trigger Child Protection Learning Reviews, Adult Support and Protection Reviews, MAPPA reviews or other scrutiny processes. The guidance does not clearly define how duplication will be avoided, how precedence will be established, or how joint or combined reviews will be coordinated. Members stressed that without clear alignment, families and practitioners may experience unnecessary burden, and learning may become fragmented.

Additionally, members noted ambiguities in roles, responsibilities and decision-making authority, particularly regarding the Review Oversight Committee (ROC) and nationally appointed Review Chairs. They felt the guidance needs clearer criteria for Chair selection, stronger recognition of local expertise, and more transparent processes for resolving disagreements or tensions between local and national bodies.

Finally, members recognised the potential value of flowcharts and national biennial thematic reporting, but felt these elements are limited by underlying weaknesses in the guidance's structure and methodology. Flowcharts cannot compensate for inconsistencies in process descriptions, and meaningful national learning depends on a strong, clear foundational methodology, which the guidance does not yet provide.

In summary, members urged substantial revision to the guidance to ensure DHSRs are grounded in Scotland's well-established learning culture, supported by clear governance, informed by robust trauma-informed practice, and capable of delivering high-quality local and national learning. As drafted, the guidance sets out an

ambitious framework but lacks the clarity, coherence and operational detail required to make DHSRs effective, compassionate and credible.

Questions and responses

The questions from the consultation are presented below, along with the responses from members of Social Work Scotland who attended the workshop.

Question 4

Is the content of ‘Section 2.2 Scope and Definitions’ clear?

Members expressed significant concern about the clarity and usability of Section 2.2. They felt that the section was confusing, overly complex and difficult to interpret, with several members describing it as hard to navigate in its current form. The repeated use of terms such as “Person A,” “Person B,” “child of,” and “young person” was considered particularly problematic, as the explanations surrounding these categories were lengthy, intricate and appeared to require readers to map out extensive family structures in order to make sense of them. Members noted that the section did not take the reader through the scope in a logical or systematic way, leaving it unclear what types of deaths were actually included.

A strong theme in members’ reflections was that this part of the guidance reads too much like legislation rather than operational guidance. The language was described as legalistic, dense and inaccessible, appearing to be a direct lift from statute rather than a translation into clear, user-friendly guidance. Members felt this approach undermined the purpose of statutory guidance, which should support comprehension and practical application by those undertaking or contributing to reviews. They emphasised the need for simpler, clearer language and a more structured explanation of what the model covers and why, before introducing detailed definitions.

Members also raised concerns about inconsistent and unclear terminology. The meaning of “ex-partner” was not defined, and distinctions between “child of,” “young person,” and “child living in the household” were not easy to interpret. Members observed that these definitions did not align neatly with existing adult protection or child protection terminology, which risks confusion for practitioners who work across

multiple review processes. This lack of alignment was viewed as unhelpful and as creating unnecessary barriers to coherent and consistent practice across public protection systems.

Overall, members felt that Section 2.2 requires substantial revision. As drafted, it does not provide a clear or accessible explanation of what falls within scope and risks being misunderstood by practitioners and families. Members suggested that visual aids, such as diagrams or relationship maps, would significantly improve comprehension given the complexity of relationships described. The overarching view was that, without simplification and re-framing, this section does not fulfil its purpose as practical statutory guidance.

Question 5

Is the content of ‘Section 3 Review Oversight Committee Chair and Case Review Panel’ clear?

Members expressed considerable concern about Section 3, noting that although some parts of the section appeared superficially clear, the overall arrangements as described in the guidance were felt to be impractical, overly centralised and insufficiently connected to existing local public protection structures. Members repeatedly noted that the proposals lack clarity, coherence, and meaningful alignment with established multi-agency review processes.

Members were particularly concerned about the centralised and nationally controlled composition of both the Review Oversight Committee and the Case Review Panels. They felt that the arrangements, as drafted, provide insufficient local representation, despite local agencies being those with the contextual knowledge, historical understanding, and operational insight required to carry out meaningful reviews. Several members stressed that the absence of clear roles for Chief Officer Groups (COGs), Adult Protection Committees (APCs), Child Protection Committees (CPCs), Violence Against Women and Girls (VAWG) partnerships, and other local systems creates a significant governance gap and risks undermining established learning cultures.

Members also highlighted that the guidance does not clearly set out how local knowledge, accountability or professional expertise will be incorporated. There was a strong view that the current emphasis on national appointments (particularly of panel chairs and ROC members) creates a model that is detached from local reality, and potentially unable to identify, interpret or contextualise practice issues effectively. Members also questioned whether an externally appointed national chair, unfamiliar with local systems, would be able to lead a meaningful learning-focused process.

Concerns were also raised about role definition and membership structure. Members described the section as inconsistent and at times contradictory. For example, references to required members of the Case Review Panel differ across subsections, and there is limited clarity on how specialist expertise is sourced and incorporated. The guidance was felt to overlook obvious partners, including social work, and to give disproportionate prominence to justice agencies, which members believed risks reinforcing an investigatory rather than learning-focused tone.

Members further noted that Section 3 does not explain how these national structures will interact with existing statutory and non-statutory review processes. This absence was described as a fundamental weakness, as the lack of integration raises the likelihood of duplication, conflicting review conclusions, and a fragmented landscape of public protection learning. Without explicit arrangements for coordination, communication and shared governance, members felt the model could generate confusion for families, practitioners and agencies.

Additionally, members raised concerns about the lack of detail on administrative support, data management, and information governance. For example, the role and identity of the Secretariat remain unclear, and members questioned where information would be stored, who would have access to it, and how issues such as data breaches, subject access requests and data retention would be managed. These omissions were viewed as significant given the highly sensitive nature of the information that will be handled.

Overall, members felt that Section 3 requires substantial revision. They emphasised the need for clearer articulation of roles, stronger links with local governance, meaningful involvement of local expertise, and a more coherent explanation of how national and local responsibilities will integrate. As drafted, the section was seen as

overly centralised, organisationally disconnected from current public protection frameworks, and unlikely to support an effective or credible learning review model.

Question 6

Is the content of ‘Section 4 Death Notifications and Referrals’ clear and do you have any comments?

Members felt that Section 4, as drafted, is too narrow, too restrictive and insufficiently reflective of how information about deaths emerges within local systems. There was a strong view that the current approach of limiting notifications to Police Scotland, the Lord Advocate, and PIRC, does not take account of the wide range of agencies, advocacy groups and community-based organisations that often hold vital contextual knowledge about domestic abuse, suicide risk, or the personal circumstances surrounding a death. Members noted that third sector organisations such as Women’s Aid, specialist domestic abuse services, and other community-based supports frequently have insight into relevant patterns of behaviour that may not be immediately visible to the notifying bodies, particularly in suicide-related cases. Restricting notifications to only three national bodies was therefore considered a significant limitation.

Members emphasised that local agencies are often the first to recognise that a death may be related to domestic abuse, even where this is not initially clear to the police or COPFS. They noted that the draft guidance does not adequately acknowledge that domestic abuse-related suicides may not be identified as such during initial investigations, and that valuable opportunities for learning could be missed unless local authorities, health boards, social work services and third sector organisations can raise concerns directly. Members felt strongly that the guidance should explicitly enable these organisations to notify the Review Oversight Committee (ROC) or Scottish Ministers where they believe a death may fall within scope.

In addition, members were concerned about the lack of clarity on how local systems will be informed when a notification or referral has been made. They highlighted that the draft guidance does not describe any mechanism for Chief Officer Groups,

APCs, CPCs or other local governance bodies to be alerted promptly when a DHSR process is triggered. Without such a process, members felt that local areas would be unable to identify duplication, avoid conflicting reviews, or coordinate with parallel processes such as Adult Protection or Child Protection Learning Reviews. This was viewed as a significant gap in governance and operational planning.

Members also commented that the guidance does not sufficiently address situations where a family or non-statutory body wishes to raise concerns about a death, nor does it explain clearly how they might access the ministerial referral route. Members felt this risks creating barriers for those who may have legitimate concerns but lack the procedural knowledge to navigate the system. Ensuring clarity, transparency and accessibility, particularly for bereaved families, was seen as essential.

There were also concerns about the lack of integration between the notification/ referral process and existing local review frameworks. Members felt the guidance missed an opportunity to set out how DHSRs will align with other statutory and non-statutory reviews, including how conflicts or overlaps will be managed when deaths meet multiple review criteria. They emphasised that the current drafting risks creating a fragmented landscape, with multiple processes activated without coordination or a clear point of accountability.

Overall, members considered Section 4 to be underdeveloped and in need of substantial revision. They advocated for a more inclusive notification model, clearer routes for families and non-statutory organisations, explicit processes for informing local governance structures, and stronger alignment with existing public protection frameworks. Without these changes, members felt the notification process would be too constrained, risk missing relevant deaths, and fail to support a coherent national approach to learning.

Question 7

Is the content of ‘Section 5 Notification of review revocation: Suspension and Discontinuation of Review Proceedings’ clear?

Members felt that Section 5 lacked clarity, practical detail, and meaningful connection to the way local public protection arrangements operate. While they recognised that revocation, suspension and discontinuation procedures must reflect the statutory framework, members considered the section to be overly legalistic and insufficiently clear about how these processes will work in practice, especially in relation to local governance and decision-making.

A key concern expressed by members was the absence of any mechanism for ensuring local visibility of revocations or decisions not to proceed with a review. As drafted, the guidance does not require that Chief Officer Groups (COGs), Adult Protection Committees (APCs), Child Protection Committees (CPCs) or wider local governance structures be notified when the Review Oversight Committee (ROC) or Scottish Ministers decide a death is not reviewable or that a review should not proceed. Members stressed that without such communication, local areas would not be able to avoid duplication, manage parallel processes, or understand how a decision had been reached, particularly where local agencies hold information not immediately available to national bodies.

Members also highlighted that the section gives no explanation of the criteria the ROC will apply when determining whether a death is reviewable or whether a review should be discontinued. They felt it was difficult to understand how such decisions will be made, what information will be considered, or how disagreements will be managed. Several members noted that earlier parts of the guidance do not introduce the concept of SIFT criteria clearly, and therefore Section 5 feels disconnected and under-explained. Greater transparency about these thresholds was considered necessary for practitioners, families and local leaders to have confidence in the decision-making process.

Additionally, members questioned the practicality of revocation processes for non-statutory bodies. The guidance does not set out how agencies such as third-sector organisations, or indeed families, would understand, challenge, or seek reconsideration of a decision not to carry out a review. Members felt that in cases of domestic abuse-related suicide, for example, local organisations may have relevant knowledge that emerges after the initial notification. Without clear pathways for raising such information, there is a risk of important learning being lost.

Members also noted that Section 5 gives limited attention to the complexities of ongoing criminal proceedings, despite recognising the Lord Advocate's role in directing suspension or discontinuation. Several members observed that in child and adult protection review processes, access to practitioners, interviews and case material is often constrained by Crown Office decisions. They felt that the guidance needed to offer a more realistic account of how these constraints will affect DHSRs, including circumstances where significant delays may arise.

Overall, members felt that Section 5 does not provide a sufficiently operationally grounded or transparent framework for revocation, suspension and discontinuation decisions. They emphasised the need for clearer articulation of decision-making criteria, defined routes for local notification, opportunities for reconsideration where new information emerges, and better explanation of how these processes align with ongoing criminal investigations. As drafted, the section was considered too detached from current practice and unlikely to support a coherent, trusted or consistent review system.

Question 8

Is the content of 'Section 6.1 Terms of Reference for a review (including timeframe for the review' clear and do you have any comments?

Members felt that Section 6.1 provides an outline of the Terms of Reference (ToR) process but lacks the clarity, structure and practical detail required to support an effective and credible review framework. They expressed concern that the drafting does not reflect established learning review methodologies used within child and adult protection, nor does it incorporate what is already known about good practice in setting ToR or managing review timeframes.

A central issue raised by members was the absence of clearly defined timeframes for completing a Domestic Homicide or Suicide Review. Members emphasised that both families and practitioners require clarity about expected timescales, not only to manage emotional and organisational impact but also to maintain the integrity and relevance of learning. Members referenced evidence from other jurisdictions

showing that protracted reviews, sometimes taking years, cause significant distress to bereaved families and impede learning, and they felt strongly that Scotland should avoid repeating this pattern. They noted that the consultation team had previously indicated that timelines were intentionally omitted to allow the system to “settle”, but members felt this was insufficient and represented a missed opportunity to provide coherence and expectations from the outset.

Members also highlighted that the section does not clearly explain who drafts the Terms of Reference. The flowchart at the end of the guidance suggests that a draft ToR is prepared before the Case Review Panel is established, whereas members felt strongly that the Panel must be central to shaping the ToR. Members noted that ToR developed without the input of the practitioners and agencies who will conduct the review risk being disconnected, unrealistic or misaligned with the actual learning needs of the case. They emphasised that in both adult and child protection reviews, the panel’s collaborative role in shaping the ToR is key to producing meaningful, proportionate and coherent learning.

Members further observed that ToR can easily become overly expansive, especially in complex cases, unless the guidance offers explicit advice on proportionality and focus. Several members reflected on past experience where ToR expanded considerably when all parties were invited to contribute without a clear framework for containment. They felt that Section 6.1 does not provide sufficient guidance on how to maintain focus, avoid duplication, and ensure that reviews remain manageable and timely.

In addition, members felt that Section 6.1 insufficiently integrates the new DHSR model with existing review processes. They reiterated that many deaths in scope for DHSR will simultaneously meet criteria for other statutory or non-statutory reviews, and so the ToR must explicitly address alignment, sequencing and scope boundaries. Members found that the guidance does not articulate how these decisions will be made, nor how conflicts or overlap with Child Protection Learning Reviews, Adult Protection Learning Reviews or other processes will be resolved.

Overall, members felt that Section 6.1 requires substantially more detail and practical guidance. They recommended the inclusion of clear expectations on timescales, better definition of roles in drafting the ToR, stronger alignment with established

public protection review methods, and clearer guidance on proportionality and inter-review coordination. As written, members felt the section is ambiguous and risks creating avoidable inconsistency, delay and confusion for families, practitioners and local governance structures.

Question 9

Is the content of ‘Section 6.2 Data Sharing and Data Protection’ clear and do you have any comments?

Members expressed strong concern that Section 6.2 is one of the weakest and least developed parts of the draft guidance. The section was described as unclear, inconsistent, and lacking the level of precision required for a process that will handle some of the most sensitive personal data held within public services. Members felt that the drafting does not reflect established legal standards, good practice in information governance, or the realities of data management within multi-agency public protection work.

A key concern raised by members was that the language used in this section is imprecise and legally incorrect in several places. Terms such as “reasonably necessary” were described as incompatible with the actual legal tests for data sharing, which require information to be necessary and proportionate under UK GDPR. Members felt that the use of non-standard terminology introduces ambiguity and could create significant risk for agencies attempting to comply with the legislation. They highlighted that practitioners require clarity and confidence about the lawful basis for information sharing, and that the current drafting fails to provide this.

Members were also concerned that the guidance appears to conflate different aspects of information governance such as necessity, proportionality, retention, and purpose limitation without clearly defining them. Several members noted that nothing in the section reflects established information-sharing protocols used in adult protection, child protection or MAPPA processes. Instead, the section was described

as bearing little resemblance to how data sharing is normally regulated, recorded and audited in national or local systems.

A prominent gap identified by members is the complete absence of any detail about data storage, retention, destruction, access controls, security standards, or subject access procedures. Members felt that this omission is critical because DHSRs will bring together extensive amounts of highly sensitive information, including police intelligence, health records, social work files, digital evidence, and in some cases CCTV footage. Without a clear national framework for information handling, members felt that agencies would be left exposed to data breaches, governance failures and significant legal risk.

Members also questioned the lack of clarity about the role, identity and responsibilities of the Secretariat. Given that the Secretariat is expected to receive, collate and distribute information, members felt that the guidance must set out where data will be held, who is responsible for its security, what technical infrastructure will be used, and who will respond to subject access requests or potential data breaches. Members stressed that, because this process is owned by Scottish Ministers, the absence of these details undermines trust in the model and does not meet the level of assurance expected for national oversight.

In addition, members raised concerns about the inclusion of certain categories of personal data (such as “sexual life/sexual orientation”) in a way that felt non-trauma-informed and potentially insensitive. Members noted that while such information may occasionally be relevant, its treatment within the draft guidance appeared disproportionate, insufficiently justified, and misaligned with trauma-informed practice. They felt that clearer safeguards, ethical considerations and rationale were required.

Overall, members felt that Section 6.2 requires extensive redrafting. They called for a clear, legally accurate and trauma-informed framework that defines lawful bases for information sharing; principles of necessity and proportionality; processes for secure storage and retention; responsibilities of the Secretariat and review bodies; safeguards for sensitive data; and clarity around how information will be handled, audited and protected. Without this, members felt that the guidance is incomplete

and does not provide the assurance required for handling the extremely sensitive information central to DHSRs.

Question 10

Is the content of ‘Section 6.3 Case Review Panel and Chair’ clear?

Members expressed significant concern about the proposals set out in Section 6.3, noting that the arrangements for appointing the Case Review Panel Chair and assembling the Panel appear overly centralised, insufficiently grounded in existing Scottish public protection practice, and disconnected from local systems. There was a strong view that the section does not provide a clear, workable or credible framework for establishing and leading a Case Review Panel.

A central theme in members’ reflections was discomfort with the nationally-appointed pool of Panel Chairs. While the existence of a pool was seen as offering some potential benefits, such as consistency and avoiding local conflicts of interest, members questioned the practicality and appropriateness of Chairs being identified and appointed exclusively at national level. Several members raised concerns that Chair appointments could be made by individuals with limited understanding of local contexts, agency structures, or Scottish multi-agency public protection arrangements. The suggestion that Chairs may not even be based in Scotland was particularly troubling to members, who felt this would undermine confidence in the process and risk producing reviews that lacked relevance or depth.

Members also found the role description for the Panel Chair to be vague and incomplete. Drawing comparisons with existing guidance, such as the detailed role specifications for Independent Reviewers in Child Protection and Adult Protection Learning Reviews, members felt Section 6.3 failed to set out the required skills, experience, knowledge or competencies expected of a DHSR Panel Chair. They highlighted an opportunity to draw directly from existing practice (for example, the Annex detailing the attributes of Child Protection reviewers) but noted that this had not been done. This omission was seen as reducing transparency, making it harder

for the sector to assess whether Chairs will be suitably skilled to lead complex, emotionally sensitive and multi-agency reviews.

There was also considerable concern about the lack of clarity regarding panel composition, with members noting inconsistencies across the guidance. Section 6.3 mentions core agencies such as COPFS and Police Scotland, yet other sections list different required members or introduce additional roles such as health board representation or third-sector involvement. Members felt these inconsistencies risk confusion about what expertise must be included and who is responsible for selecting panel members. They also criticised the lack of explicit reference to social work involvement, which they viewed as an obvious and necessary omission given the centrality of social work to public protection practice.

The disconnect from local governance structures was another recurring concern. Members emphasised that Chief Officer Groups, Adult Protection Committees, Child Protection Committees and local Violence Against Women and Girls partnerships hold essential expertise and accountability for learning and improvement. Yet Section 6.3 does not provide any meaningful role for these bodies in identifying, recommending or advising on panel membership, nor does it explain how local insight will be incorporated. Members felt this omission undermines the credibility and effectiveness of the future panels and risks producing reviews that lack vital contextual understanding.

Members also noted a lack of detail about how chairing conflicts of interest will be managed, how Chairs will be supported, and how quality and consistency will be monitored. Given the complex, emotive and often traumatic nature of domestic homicide and domestic abuse-related suicide reviews, members felt that robust guidance on independence, support, supervision and ongoing training should have been included. Its absence was viewed as a significant gap.

Overall, members felt that Section 6.3 requires substantial strengthening. They advocated for clearer role definitions, stronger links with local governance structures, transparent criteria for selecting Panel Chairs and members, and meaningful incorporation of local knowledge. As drafted, members felt the section was inconsistent, overly centralised, insufficiently detailed, and unlikely to support a credible, learning-focused or trauma-informed review model.

Question 11

Is the content of ‘Section 6.4 Assembling a Case Review Panel’ clear?

Members expressed substantial concern about the proposals in Section 6.4, describing the arrangements for assembling Case Review Panels as unclear, inconsistent and insufficiently aligned with established public protection practice in Scotland. They felt that the guidance did not provide a coherent or operationally realistic framework for identifying who should sit on a panel, how members should be selected, or how local expertise would be incorporated.

A recurring theme in members’ reflections was the lack of clarity and consistency in the guidance regarding which agencies are required to be represented. Members noted that Section 6.4 appears to introduce a different set of “core” panel members than those listed in Section 3, and that additional roles, such as health board representatives or GP involvement, are described without any rationale or clear criteria. They highlighted that such inconsistencies risk confusion in practice and make it difficult to understand what constitutes a complete or competent panel.

Members also observed a notable omission of social work, which they felt was both surprising and concerning given that social work routinely plays a central role in adult protection, child protection and wider public protection processes. Members highlighted that social work involvement would, in most cases, be essential to understanding the circumstances of the death, particularly where there are histories of domestic abuse, child protection involvement, mental health needs, or vulnerabilities. The absence of an explicit expectation of social work representation was seen as a significant gap.

In addition, members highlighted that Section 6.4 does not describe how local experience, context or relationships will inform the selection of panel members. They emphasised that the existing Scottish model for learning reviews relies heavily on local knowledge, both to select the right expertise and to ensure panels are culturally, geographically and organisationally informed. Members felt strongly that without local input, panels risk being detached from the realities of multi-agency

practice and may struggle to make sense of historical patterns or missed opportunities.

Members also raised concerns about the role of the nationally appointed Chair in selecting panel members. They felt it was unclear how the Chair, who may not be familiar with the area, will determine which agencies or individuals should participate. Members feared this could lead to panels that are either incomplete, overly narrow, or insufficiently knowledgeable about the context and systems relevant to the case. They argued that clearer guidance is needed to ensure local governance bodies such as Chief Officer Groups, APCs and CPCs are involved in advising on membership, even if the ROC retains ultimate decision-making authority.

Further, members highlighted that the section does not address conflicts of interest, despite these being a routine and important consideration in review processes. Members noted that where a death has involved multiple agencies or complex histories, conflict of interest questions are inevitable, and the guidance should set out how these will be identified and managed. Its absence was viewed as a gap that could compromise transparency and public confidence.

Members also noted that Section 6.4 provides little explanation of how flexibility will operate when selecting panel members. Although the text references the possibility of ad hoc or specialist membership, it does not specify how this will be determined, what criteria will apply, or how panels will ensure proportionality and appropriate diversity of expertise. Members felt that more detailed guidance is required to ensure panels can appropriately reflect the complexity of domestic homicide and suicide cases while avoiding unmanageable or inconsistent panel structures.

Overall, members felt that Section 6.4 requires substantial revision. They advocated for clearer expectations regarding core and optional panel membership, explicit incorporation of social work and local agency knowledge, stronger alignment with established learning review processes, and more detail on managing conflicts of interest, proportionality and local involvement. As drafted, members felt the section was incomplete, inconsistent with other parts of the guidance, and insufficiently robust to support effective, credible and contextually informed Case Review Panels.

Question 12

Is the content of ‘Section 6.5 Additional expertise’ clear?

Members welcomed the principle that Case Review Panels may require additional or specialist expertise; however, they felt that Section 6.5, as drafted, lacks clarity, coherence and practical direction. They highlighted that while the section acknowledges the potential need for specialist knowledge, it does not meaningfully explain how such expertise will be identified, selected, integrated or supported within the wider review process. As a result, members considered the section incomplete and insufficiently grounded in current Scottish review practice.

A key concern raised was the absence of a clear framework or criteria for determining when additional expertise is required. Members noted that in established learning review processes, particularly in adult protection and child protection, decisions about specialist involvement are typically informed by local knowledge, historical understanding of the case, and the perspectives of local governance bodies. In contrast, Section 6.5 assumes these decisions will be made by the Review Oversight Committee or the nationally appointed Chair, without specifying how they will access the nuanced context required to judge what specialist input is needed. Members felt that this risks panels being assembled without the right expertise or, alternatively, being overloaded with specialist roles that are not proportionate to the learning needs.

Members also questioned how a nationally appointed Chair, potentially unfamiliar with local systems, will recognise the relevance of specialist knowledge in areas such as disability, mental health, cultural competence, child development, or domestic abuse dynamics. Members feared that without clear guidance, panels may either miss crucial expertise or include specialist input in ways that feel detached, tokenistic or poorly integrated. They emphasised that additional expertise only functions well when it complements, rather than substitutes for, local contextual knowledge.

Another concern was the absence of guidance on how specialist contributors will be involved in the review process. Members noted that Section 6.5 references various

forms of engagement such as full panel membership, written reports or attendance at specific sessions, but does not explain how these roles differ, how contributors will be supported, or how their input will be weighted in the final analysis. Members stressed that specialist input must be framed within a clear methodology to ensure consistency, fairness and transparency. Without this, panels may struggle to reconcile differing professional perspectives or to integrate specialist evidence coherently.

Members also highlighted concerns about the lack of detail on conflicts of interest, noting that many specialists, particularly those in smaller sectors such as third-sector domestic abuse services or culturally specific organisations, may have existing relationships with families or agencies involved in the case. The section does not explain how such conflicts will be managed, assessed or mitigated. Members felt this omission could undermine the credibility and independence of the review.

Additionally, members observed that the guidance does not address how additional expertise will be resourced or supported. They noted that specialists are often already operating with constrained capacity, and DHSRs may impose significant administrative and emotional demands, particularly where cases involve trauma, bereavement or complex cultural dynamics. Members felt that the guidance should specify expectations regarding remuneration, support, training and supervision for specialist contributors.

Overall, members felt that Section 6.5 does not yet offer a strong or operationally useful framework for involving additional expertise. They recommended that the guidance provide clearer criteria for identifying when specialist input is needed, ensure meaningful involvement of local governance bodies in those decisions, establish clear expectations regarding roles and responsibilities, and provide safeguards around conflicts of interest, support and capacity. Without these changes, members were concerned that additional expertise may be inconsistently applied, insufficiently integrated, or ineffectively utilised within DHSRs.

Question 13

Is the content of ‘Section 6.6 Combined Deaths and Joint Reviews’ clear and do you have any comments?

Members felt that Section 6.6, which addresses combined deaths and joint reviews, was one of the least clear and least operationally realistic parts of the draft guidance. They highlighted that the section does not adequately explain how Domestic Homicide and Suicide Reviews (DHSRs) will interface with existing statutory and non-statutory review processes, nor does it address the significant governance and coordination challenges that will arise when multiple review frameworks are triggered by the same incident.

Members noted that the guidance attempts to differentiate between combined reviews (multiple deaths within one incident) and joint reviews (where DHSR criteria overlap with other learning review processes), but they felt that the explanations were ambiguous, overly simplistic, and disconnected from real-world practice. Several members observed that the section appears to “touch on” the idea of integration without providing a workable process, leaving practitioners uncertain about how such reviews would actually be managed.

A major concern expressed by members was that the draft guidance does not recognise the complexity and volume of existing public protection review types. They highlighted that deaths falling within DHSR scope will often overlap with Child Protection Learning Reviews (CPLRs), Adult Support and Protection (ASP) Learning Reviews, MAPPA Significant Case Reviews, health reviews, justice reviews and other thematic or organisational investigations. Members noted that the guidance makes no mention of several of these established processes, despite the significant risk of duplication, conflicting findings and parallel demands on families and practitioners if clear alignment is not set out.

Members also noted the absence of any role for local governance structures including Chief Officer Groups (COGs), Adult Protection Committees and Child Protection Committees, in determining whether a review should be combined or joint, or how it should be coordinated. They felt this omission showed a limited

understanding of how Scottish public protection systems work in practice. Members emphasised that local bodies hold critical knowledge of ongoing processes, existing reviews, practitioner involvement and resource capacity, all of which must inform decisions about combining or conducting joint reviews.

Several members expressed concern that Section 6.6 appears to assume that the Review Oversight Committee (ROC) will be able to direct joint review arrangements without any clear reference to how local systems' responsibilities, statutory duties or independent accountabilities will interact. Members argued that this presents serious risks, including uncertainty over which framework takes precedence, inconsistent involvement of agencies, and the potential for multiple conclusions emerging across different review types.

Members also felt that the section does not realistically address resource implications or capacity pressures. They noted that both CPCs and APCs had expressed concern about the growing number of review types and the significant workload involved. There was broad agreement that introducing a new statutory review without clear rules of hierarchy or coordination would intensify existing pressures and could undermine the ability of agencies to participate meaningfully.

Additionally, members noted that the drafting seems to imply DHSRs may take precedence over other learning review processes, given their statutory status. Members described this as an "unintended hierarchy" that risks marginalising other critical safeguarding frameworks. They felt strongly that the guidance should explicitly address how review types will be prioritised, sequenced or integrated to ensure that learning is not lost and the workload remains manageable.

Overall, members felt that Section 6.6 is underdeveloped and requires substantial revision. They recommended that the guidance include a clear decision-making framework for handling overlapping reviews; meaningful involvement of local governance structures; explicit coordination principles to avoid duplication; and recognition of the full range of existing Scottish public protection reviews. As drafted, members felt the section was ambiguous, disconnected from practice and unlikely to support coherent, efficient or trauma-informed review processes in cases involving multiple deaths or overlapping statutory duties.

Question 14

Is the content of ‘Section 6.7 Combined and Joint Review Terms of Reference’ clear and do you have any comments?

Members felt that Section 6.7 lacked clarity, operational coherence and meaningful alignment with established Scottish public protection review processes. They noted that the section attempts to outline how Terms of Reference (ToR) should be developed for combined or joint reviews, but does not provide sufficient detail to support effective coordination between different review types or to ensure that learning is captured in a coherent and efficient way.

A major concern raised by members was that the guidance does not clearly differentiate between combined and joint reviews, nor does it explain how the ToR should be adapted for each. Members noted that the descriptions appear to recycle earlier sections without offering practical instruction on how different review processes such as Child Protection Learning Reviews, Adult Support and Protection Learning Reviews, justice-led reviews or thematic investigations, will interface with a Domestic Homicide or Suicide Review (DHSR). As a result, the section feels high-level and disconnected from the realities of multi-agency public protection work.

Members were particularly concerned that Section 6.7 provides no clear governance structure for determining ToR in cases involving multiple review frameworks. They emphasised that decisions about whether a review should be joint, how far its remit should extend, and how its ToR should be framed must involve the local Chief Officer Group (COG) and relevant statutory partnerships. Members observed that these bodies understand the local context, existing review activity, agency involvement and operational pressures. Yet Section 6.7, like other parts of Section 6, does not give local governance any meaningful role. Members felt this omission risked reviews being designed without an understanding of system dynamics, resulting in duplication, conflict between reviews or gaps in learning.

Members also raised concerns that the draft guidance seems to assume that the national Review Oversight Committee (ROC) will have the authority to direct or define ToR for joint reviews, without clarifying how this would align with the statutory

responsibilities already held by local partnerships under other legislation. Members described this as creating an “unintended hierarchy” in which DHSRs (because of their statutory basis) appear to supersede other review processes, even when those other processes may be better placed to lead or contribute to the analysis. They highlighted that this risks undermining established learning frameworks and may lead to confusion for families and practitioners.

The lack of detail on content, focus and proportionality within ToR was also seen as a major gap. Members noted that combined and joint reviews will inevitably involve complex histories, multiple agencies and parallel learning needs. Without clear guidance on how to set boundaries, maintain proportionality and avoid sprawling or unmanageable ToR, reviews may become unfocused and excessively lengthy. Members referenced experience from both adult and child protection reviews, noting that ToR can expand significantly without strong early guidance, which can delay completion.

Members also emphasised that Section 6.7 does not address how ToR will incorporate the needs and perspectives of bereaved families, despite the guidance elsewhere emphasising the importance of family engagement. Members felt strongly that families must have the opportunity to contribute to the framing of ToR, particularly in cases where the circumstances of the death involve multiple victims or multiple systems. The lack of explicit reference to family involvement was viewed as inconsistent with a trauma-informed, person-centred approach.

In addition, members highlighted concerns about how learning will be synthesised when multiple frameworks are involved. They noted that different reviews use different methodologies, terminologies and thresholds, and the guidance does not explain how these will be reconciled within a shared ToR. Members felt that, without this, joint reviews may produce contested narratives, conflicting recommendations or a lack of coherent national learning.

Overall, members felt that Section 6.7 is incomplete and requires significant development. They recommended that the guidance: clearly define the differences between combined and joint reviews; establish a governance process that meaningfully involves local partnerships; specify criteria for setting ToR boundaries and proportionality; articulate how family perspectives will shape ToR; and outline

how learning will be integrated across review types. As drafted, members felt the section lacks the clarity, structure and operational depth needed to support effective, coordinated and trauma-informed multi-framework review processes.

Question 15

Is the content on the ‘Section 6.8 National Hub for Reviewing and Learning from the Deaths of Children and Young People’ clear and do you have any comments?

Members noted that Section 6.8 briefly acknowledges the role of the National Hub for Reviewing and Learning from the Deaths of Children and Young People, but they felt that the section is underdeveloped, lacks clarity about its operational implications, and does not sufficiently explain how the National Hub will interact with the Domestic Homicide and Suicide Review (DHSR) process. Members considered this a missed opportunity to set out a coherent and integrated national approach to learning across review systems.

Members emphasised that the National Hub already represents an established and evolving part of Scotland’s child death review landscape, and that many deaths falling within scope of DHSRs will involve children or young people either as primary victims, connected victims, or bereaved family members. Given this, they expected the guidance to articulate clearly how the National Hub’s processes, data systems, and oversight mechanisms will align with those of the Review Oversight Committee (ROC) and Case Review Panels. Instead, they felt the section provides only a procedural instruction to upload a Core Data Set, without any explanation of the rationale, purpose, or implications.

Members also noted that the section appears to treat the National Hub as a technical add-on, rather than recognising its role in developing national learning, identifying trends, and supporting systemic improvement. They felt this minimises the potential for meaningful integration of learning across DHSRs and child death reviews. Members said that without a clear explanation of how information will flow between systems, how duplication will be avoided, or how shared insights will be synthesised, the section reads as disconnected from the broader national learning infrastructure.

Members further expressed concern that the section gives no indication of how families will experience this interface. They highlighted that bereaved families already navigate complex systems, and that introducing an additional review mechanism without clarity or coordination risks creating confusion, duplication of contact, and emotional strain. They felt the guidance should clearly set out how family communication, expectations and consent will be managed where both a DHSR and National Hub involvement are triggered.

Members also observed that Section 6.8 does not address how the National Hub's involvement will interact with other existing learning review processes, including Child Protection Learning Reviews or Adult Support and Protection Learning Reviews. This omission was seen as particularly problematic, given that cases involving young people often span multiple systems and may already activate several layers of review. Members highlighted that without clear alignment principles, the National Hub risks becoming yet another parallel process with no defined place in the wider review landscape.

Additionally, members raised concerns about data governance and information-sharing implications. Although Section 6.8 refers to uploading a Core Data Set, members noted that other parts of the guidance, particularly those relating to data protection, are already unclear. The absence of explanation about how DHSR information will be shared with the National Hub, how duplication will be prevented, or who is responsible for managing data accuracy and integrity adds further confusion.

Overall, members felt that Section 6.8 is incomplete and requires a much fuller description of the relationship between DHSRs and the National Hub. They recommended that the guidance provide clarity on roles, data flows, governance, family experience, learning integration and the avoidance of duplication. As drafted, members felt the section does not sufficiently support cohesive national learning or a clear, trauma-informed experience for children, young people and families affected by domestic homicide and suicide.

Question 16

Is the content of ‘Section 7 Engagement with Family, Friends, Colleagues and Communities’ clear and do you have any comments?

Members felt that Section 7 does not sufficiently reflect the values, practices or learning cultures that underpin existing public protection review approaches in Scotland. While the guidance emphasises the importance of involving families, friends, colleagues and communities, members found that the tone, structure and operational details of this section fall significantly short of what is required to support meaningful, trauma-informed and rights-based engagement.

A central concern raised by members was that the section reads as largely tokenistic, appearing to emphasise communication to families rather than engagement with them. Members repeatedly highlighted that the language used in this part of the guidance reflects a “done to” model, rather than a collaborative or participatory one. They noted that this contrasts sharply with current child and adult protection learning review practice, where family engagement is recognised as a core feature of understanding lived experience, shaping the Terms of Reference, and informing the interpretation of events. Members felt that the guidance needs to make this approach explicit, rather than implying that family involvement is optional or secondary.

Members were also concerned that the guidance provides insufficient clarity about the role of families in shaping the review, including how their views, priorities and questions will influence the remit and direction of the Case Review Panel. Several members observed that, although the guidance mentions families being contacted and updated, it does not offer a clear statement that families should have agency in determining how they participate. Members emphasised that families affected by domestic homicide or domestic abuse-related suicide often have diverse, and sometimes divergent, perspectives; yet the guidance does not address how their differing views will be understood, respected or reconciled.

Additionally, members felt that Section 7 does not meaningfully address how practitioners and colleagues, who often carry the emotional impact of a death and

hold critical contextual knowledge, will be engaged. Members stressed that in existing learning review processes, practitioner participation is central to understanding the complexity of decision-making, organisational pressures, systemic factors and good practice that may not be captured in case files. Excluding or minimising practitioner voices not only undermines the quality and reliability of learning but also increases the emotional impact on staff, who may already be experiencing vicarious trauma following a death. The absence of clear mechanisms for practitioner involvement therefore represents, in members' view, a major gap.

Members also highlighted concerns about the section's treatment of bereaved children. They felt that although the guidance correctly identifies the need for rights-based and developmentally appropriate involvement, the reference to IRDs (Interagency Referral Discussions) was poorly positioned and risked confusing operational safeguarding processes with review processes. Members noted that IRDs will already have taken place long before a DHSR begins and including them within Section 7 suggests a misunderstanding of how statutory child protection processes interface with review activity. Members felt that clearer, more accurate guidance is necessary to prevent procedural confusion.

Furthermore, members felt that the guidance does not sufficiently address cultural sensitivity, the role of community networks, or the diverse ways in which families and communities understand and experience domestic abuse, homicide and suicide. They noted that while the guidance references the importance of cultural awareness, it does not provide practical expectations for how the Case Review Panel Chair, Review Oversight Committee or support agencies will ensure culturally competent engagement.

Members also raised concerns about how the emotional burden on families will be managed, particularly where multiple systems such as criminal investigations, Fatal Accident Inquiries, other review processes or media interest, are happening concurrently. They felt that Section 7 does not provide enough guidance on coordinating contact, preventing duplication, or ensuring that families are not repeatedly approached by different agencies or representatives.

Finally, members felt that Section 7 lacks clarity on how feedback from families and participants will be used to improve future reviews. While the guidance mentions that

feedback may be sought, members felt this should be a standard and expected part of the process, rather than optional. They argued that learning from family experience is fundamental to a compassionate, credible and trustworthy review model.

Overall, members felt that Section 7 requires significant strengthening. They recommended that the guidance adopt a clear commitment to participatory, trauma-informed and rights-based engagement; include explicit roles for families and practitioners; provide practical mechanisms for managing competing views and minimising distress; and ensure cultural competence and consistency with established review methodologies. As drafted, members felt the section does not yet provide a robust foundation for meaningful engagement with those most affected by domestic homicide and domestic abuse-related suicide.

Question 17

Is the content of ‘Section 8 Conducting a Domestic Homicide or Suicide Review’ clear and do you have any comments?

Members felt that Section 8 is one of the most critical parts of the guidance, yet it does not provide a sufficiently clear, nuanced or operationally realistic description of how Domestic Homicide and Suicide Reviews (DHSRs) should be conducted. They expressed concern that the section reinforces a predominantly desktop, document-led approach, rather than reflecting the reflective, dialogic and participatory learning model that underpins established Scottish review practice in child and adult protection. This was seen as a significant weakness that risks undermining the quality, credibility and usefulness of DHSRs.

A consistent theme was members’ belief that the guidance fails to recognise the central importance of practitioner engagement in understanding a case. Members emphasised that meaningful learning does not arise from reviewing paperwork alone. Instead, it requires discussions with those directly involved, exploration of professional reasoning, examination of contextual factors, and consideration of the pressures and complexities present at the time decisions were made. Members

stressed that these reflective discussions are standard in Adult Support and Protection and Child Protection Learning Reviews, yet Section 8 does not reference them at all. The omission was described as “a major gap” that risks reducing the review to a file-reading exercise with limited learning value.

Members also felt that the section does not sufficiently address the value of triangulation, which requires drawing together information from chronologies, practitioner discussions, and family perspectives. Several members noted that the guidance implies that a single multi-agency chronology will simply “emerge” from agency submissions, without acknowledging the significant analytical work required to reconcile inconsistencies, verify accuracy, and interpret meaning. Members highlighted that constructing a reliable chronology is a specialist task that cannot be achieved through collation alone, and they were concerned that the guidance presents an overly simplistic and unrealistic picture of this process.

Members were similarly concerned that Section 8 does not fully recognise the important role of staff wellbeing, particularly given the emotional burden and vicarious trauma practitioners may experience following a death. They emphasised that reflective sessions are vital not only for learning but also for supporting staff. The omission of practitioner engagement risks leaving staff isolated, anxious and uncertain about the implications of the review, which members felt would be contrary to trauma-informed principles.

Members also raised concerns about the section’s handling of parallel criminal proceedings. While the guidance acknowledges that some stages may proceed alongside ongoing investigations, members felt that the description does not accurately reflect the constraints typically imposed by the Crown Office and Procurator Fiscal Service. They noted that in existing review processes, criminal proceedings can significantly limit access to practitioners, case material and sensitive information. The draft guidance’s suggestion that DHSRs can continue largely unhindered was viewed as unrealistic and likely to set false expectations for families and agencies.

Additionally, members felt that certain parts of Section 8 appeared disconnected or insufficiently justified, such as the standalone section on animals. While members recognised the importance of understanding coercive control related to harm or

threats to pets, they noted that if the guidance intends to highlight specific elements of coercive control, the focus should be broader and more consistently integrated, rather than singling out one aspect. They felt that, as written, the section felt abrupt and poorly contextualised.

Finally, members commented that Section 8 does not clearly describe how reviews should approach learning, including how themes should be identified, how analysis should be structured, or how learning across child, adult, police, health and community systems should be synthesised. They also noted the lack of links to existing Scottish review methodologies including the Child Protection Learning Review and Adult Support and Protection Learning Review frameworks, which they felt could offer a strong foundation for a consistent national approach. Instead, members found the section vague, overly procedural and insufficiently grounded in established learning principles.

Overall, members felt that Section 8 requires significant redevelopment. They recommended explicit inclusion of practitioner engagement, clear expectations around triangulation and chronology work, realistic treatment of parallel criminal processes, a coherent approach to understanding coercive control, and alignment with existing learning review methodologies. As drafted, members felt the section risks producing superficial, document-driven reviews that fall short of Scotland's ambitions for systemic, compassionate and trauma-informed learning following domestic homicide or domestic abuse-related suicide.

Question 18

Is the content of 'Section 8.2 Animals' clear and do you have any comments?

Members recognised the importance of understanding the role that harm to animals can play within coercive control and domestic abuse dynamics. However, they felt strongly that Section 8.2, as written, is poorly positioned, insufficiently contextualised, and not well integrated into the overall review framework. Members described the section as "jarring" and appearing to "come out of nowhere," noting that it was unclear why animals had been singled out for a standalone subsection

when other aspects of coercive control such as financial abuse, sexual abuse, stalking, intimidation or digital control, were not given equal consideration.

While members agreed that threats or harm to pets can be a significant component of coercive control, they felt the drafting lacked balance and proportionality. They observed that the focus on animals seemed disconnected from the broader context of coercive and controlling behaviour and would be better situated within a more comprehensive treatment of coercive control as a whole. Members emphasised that coercive control manifests in a wide range of ways, and that isolating one aspect without reference to the others risks creating an unbalanced or incomplete depiction of abusive behaviour.

Members also commented that the subsection appeared insufficiently grounded in the realities of multi-agency review practice. They felt it did not clearly explain how information about animals would be identified, assessed or integrated into the review process, nor how agencies beyond animal welfare organisations would contribute meaningfully to this aspect of the analysis. This raised concerns about whether panels would know how to apply this section consistently or proportionately.

Members also felt that the section lacked a clear explanation of the purpose of including information about animals. They suggested that the guidance should articulate whether the intention is to understand escalation, assess victim fear, explore barriers to leaving, or identify missed opportunities for intervention. Without this clarity, they felt the section does not provide meaningful direction to Review Panels.

Overall, members supported the principle of recognising harm to animals as a potential component of coercive control, but considered Section 8.2 to be insufficiently integrated, overly narrow and lacking in contextual depth. They recommended that this content be incorporated into a broader section on coercive control, situated within a more holistic analytical framework, and supported by clearer guidance on how information about animals should be gathered, interpreted and weighed within Domestic Homicide and Suicide Reviews. As drafted, members felt the section does not provide adequate clarity or balance to support consistent and meaningful application in practice.

Question 19

Is the content of ‘Section 8.3 Requesting relevant information on person A and services, including children of person A’ clear and do you have any comments?

Members felt that Section 8.3 lacks the clarity, nuance and operational grounding required to support meaningful information-gathering in Domestic Homicide and Suicide Reviews (DHSRs). While the section acknowledges the need to request information about person A and related service involvement, members felt that the guidance oversimplifies this process and underestimates the complexity and sensitivity of gathering and interpreting such information.

A principal concern raised by members was that the section appears to treat the collection of information about person A as a straightforward, procedural task, when in reality it involves navigating highly sensitive issues relating to trauma, culpability, mental health, coercive control and historic patterns of behaviour. Members felt that the guidance does not acknowledge the nuanced professional judgement required to understand which information is relevant, how it should be interpreted, and how it should be triangulated alongside family, practitioner and contextual evidence. The absence of guidance on how to handle these complexities risks inconsistent practice and weak analysis.

Members also highlighted significant concerns about the lack of alignment with children’s safeguarding processes, particularly where person A has children or regular contact with them. They noted that Section 8.3 briefly references obtaining information from services involved with children but does not set out expectations or safeguards in a way that reflects existing statutory child protection processes. Members pointed out that child-focused information cannot be requested, interpreted or shared without careful consideration of risk, consent, developmental needs and statutory duties. As drafted, the section does not acknowledge these requirements, leading members to fear that children’s information could be mishandled or insufficiently contextualised.

Additionally, members stressed that information about person A, particularly relating to mental health, substance use, offending history or historic domestic abuse, often sits across multiple agencies and may be subject to access restrictions during criminal proceedings. They expressed concern that the guidance does not acknowledge the practical limitations created by Crown Office decisions, which often restrict access to key information until criminal processes conclude. Members felt that this gap reinforces the wider issue, reflected throughout Section 8, of the guidance presenting an overly optimistic and unrealistic view of what information can be gathered during a live investigation.

Members also observed that the guidance does not describe how Review Panels should approach conflicting or incomplete information, which is common in cases involving complex trauma, coercive control and escalating risk. They emphasised that understanding person A's behaviour requires contextual and relational analysis (not simply collecting agency records) and that the guidance should explicitly recognise that files alone rarely provide a full or accurate picture. Without this, there is a risk that reviews will default to a purely documentary approach, undermining the depth and quality of learning.

Members further commented that the section does not recognise the importance of speaking with practitioners involved with person A, children or family members. Established learning review processes rely on practitioner discussions to understand why decisions were made, what pressures were present, how risk was understood, and what information was known or unknown at the time. Members noted that Section 8.3, like Section 8 more broadly, fails to mention this, reinforcing concerns that DHSRs may become overly reliant on written records rather than reflective professional engagement.

Finally, members felt that Section 8.3 should clarify the trauma-informed and ethical considerations involved in seeking information about children connected to person A. They stressed that the process must minimise the risk of re-traumatisation and ensure that children's rights and best interests remain central. Members felt that the section does not provide sufficient guidance on how to achieve this, nor does it reflect learning from other review models where child experience is treated as a core area of inquiry.

Overall, members felt that Section 8.3 requires significant expansion and clarification. They recommended that the guidance provide a more realistic account of information-gathering constraints, explicitly include practitioner engagement, align with child protection processes, describe how conflicting information should be interpreted, and embed clear trauma-informed principles. As drafted, members felt the section risks producing incomplete, decontextualised or superficial understanding of person A's behaviour and service involvement, which would undermine the purpose of the DHSR model.

Question 20

Is the content of 'Section 8.4 Involvement of family, friends and others including support services and bereaved children' clear and do you have any comments?

Members felt that Section 8.4 does not provide a sufficiently clear, trauma-informed or practically grounded framework for involving family, friends, wider support networks and bereaved children in Domestic Homicide and Suicide Reviews (DHSRs). Although the section acknowledges the value these individuals bring to understanding relationships, risks and lived experience, members found that the drafting falls significantly short of the standards expected within Scotland's established learning review culture.

Members' principal concern was that the section appears to repeat the tokenistic tone evident earlier in Section 7. They noted that the language describes a process that is procedural and extractive, seeking contributions from families and others without demonstrating how their perspectives meaningfully shape the direction, analysis or conclusions of the review. Members stressed that in both Adult Support and Protection and Child Protection Learning Reviews, lived experience is central to constructing the narrative of what happened and understanding the complexity of individual and family circumstances. By contrast, Section 8.4 reads as though involvement is an optional add-on rather than a core component.

Members were also concerned that the section does not acknowledge or offer guidance on managing the diverse and sometimes conflicting perspectives that

families, friends, and significant others may hold. In domestic abuse-related cases, particularly those involving coercive control, familial relationships may be fraught, fragmented or influenced by trauma, manipulation or fear. Members felt it was essential that the guidance reflect the need for sensitive navigation of these dynamics, yet Section 8.4 provides no direction on how Review Panels should approach situations where individuals disagree, decline to participate or request differing levels of involvement.

In relation to bereaved children specifically, members reiterated concerns already raised in relation to Section 7: that the guidance lacks the developmental, rights-based, and trauma-informed specificity necessary to ensure children are supported and not exposed to further harm. They noted that the section does not explain how children's views will be gathered safely, how advocates or specialist services (such as Bairns' Hoose or child bereavement supports) will be involved, or how to avoid re-traumatisation. Members felt this is particularly problematic given the profound impact domestic homicide and suicide can have on children's sense of safety, relationships and wellbeing.

Members also stressed that the section does not adequately reflect the critical role of support services, including domestic abuse specialists, mental health services, child support organisations and third-sector advocacy groups. These organisations often have the deepest insight into the lived experiences of victims and their families, including fears, barriers to disclosure, and patterns of help-seeking behaviour. Members felt that the guidance should explicitly recognise their role not only as information providers but as key partners in creating safe, supported pathways for family and community engagement throughout the review. Instead, the draft provides only high-level statements that lack operational depth.

Another key issue raised by members was the absence of practitioner involvement, which they felt was inseparable from effective engagement with families and communities. Practitioners are often the people who know the family best, understand relational histories and have spent time building trust. Members felt strongly that practitioner voices should be structurally embedded in this section, yet once again, the guidance omits any reference to their involvement. This omission

reinforces members' wider concern that the DHSR model, as drafted, risks becoming a largely document-led exercise.

Members also observed that the draft guidance does not address the emotional and psychological burden placed on family and community members who contribute to the review. They stressed that participation can be re-traumatising, particularly in cases involving violence, suicide or prolonged coercive control. The section does not outline safeguards, pacing considerations, or duties of care that should shape engagement, nor does it reference how support will be coordinated or funded.

Overall, members felt that Section 8.4 is underdeveloped and insufficiently trauma-informed. They recommended that the guidance provide clear expectations about how lived experience will shape the review; explicitly address how to support bereaved children; incorporate specialist advocacy and practitioner perspectives; and offer practical guidance on managing conflicting views, emotional impact and safe engagement. As drafted, members felt that the section does not yet support a compassionate, rights-based or meaningful approach to involving those most affected by domestic homicide or domestic abuse-related suicide.

Question 21

Is the content of 'Section 8.5 Establishing a timeline/ chronology' clear and do you have any comments?

Members felt that Section 8.5 significantly underestimates the complexity and specialist nature of developing a reliable and meaningful multi-agency chronology. They expressed concern that the guidance presents chronology-building as a simple collation task, rather than the detailed, iterative and analytical process that experienced reviewers recognise it to be. Members agreed that this risks creating unrealistic expectations of Review Panels and may undermine the quality and integrity of learning produced through Domestic Homicide and Suicide Reviews (DHSRs).

A core issue raised by members was the misleading suggestion that a single composite chronology will simply “emerge” from agency submissions. Members highlighted that constructing an accurate chronology requires significant work to reconcile inconsistent information, verify dates, resolve gaps, distinguish fact from interpretation, and ensure that entries reflect the correct contextual understanding. This cannot be achieved through administrative compilation alone; instead, it requires professional judgement, detailed scrutiny, and often direct clarification with practitioners. Members stressed that the guidance overlooks this entirely, giving Review Panels a false impression of how straightforward the process will be.

Members also emphasised that chronology is central to analysis, not a procedural formality. They stated that a chronology should illuminate patterns, escalation, missed opportunities, and cumulative harm, particularly in cases involving domestic abuse, coercive control, or repeated contacts with services. Yet Section 8.5 treats chronology as a technical exercise rather than a core analytical tool. Members felt this framing risks weakening the quality of learning, as an under-developed chronology will limit the Panel’s ability to understand systemic dynamics or the lived experience of those involved.

Members further noted that the section makes no reference to practitioner involvement in the development of the chronology. They stressed that direct engagement with practitioners is essential to confirm accuracy, explore nuances, and understand why certain actions were taken (or not taken) at particular points in time. Without practitioner insight, members felt that chronologies are vulnerable to error, oversimplification, or misinterpretation. They saw the omission of practitioner involvement here as consistent with wider concerns that the DHSR model risks defaulting to a document-led, rather than learning-led, process.

Additionally, members pointed out that the guidance does not acknowledge the variability and limitations of agency records, nor the challenges of integrating information from health, policing, social work, education, third-sector providers, and specialist domestic abuse services. They observed that different systems record information differently, use distinct terminology, and may hold varying degrees of detail. Without recognising these differences, Section 8.5 assumes a level of standardisation that does not exist in practice. Members felt that this oversight could

lead to frustration, inconsistency, and misaligned expectations when Panels begin chronology work.

Members also stressed that chronology work in domestic abuse-related cases must be trauma-informed and relationally informed, recognising that victims may have made disclosures at different times, in different ways, and under significant duress. A chronology that does not account for the emotional and contextual reality of victim decision-making risks reinforcing victim-blaming or obscuring coercive control. Members felt that Section 8.5 does not provide adequate guidance on this point.

Finally, members observed that the guidance does not address how chronologies should be used to support systemic learning, including how themes should be drawn from chronology analysis, how discrepancies should be handled, or how the chronology will interface with the wider analytical framework described elsewhere in Section 8. Without this direction, members felt that panels may struggle to translate the chronology into meaningful learning and actionable recommendations.

Overall, members felt that Section 8.5 requires substantial strengthening. They recommended detailed guidance on the purpose of chronologies, clearer expectations around practitioner engagement, recognition of the complexity of multi-agency timelines, and explicit links to the broader analytical process. As drafted, members felt the section does not equip Review Panels with the clarity or depth needed to undertake chronology work in a rigorous, trauma-informed and analytically robust manner.

Question 22

Is the content of ‘Section 8.6 Domestic Homicide Reviews – additional factors’ clear and do you have any comments?

Members felt that Section 8.6 recognises some important areas relevant to domestic homicide but overall, the section is underdeveloped, overly brief, and insufficiently reflective of the complexity inherent in domestic abuse-related deaths. They noted that while the section lists additional factors for consideration, it does not provide the

depth, guidance or analytical framing required to support high-quality learning in cases that are often characterised by long histories of coercive control, escalating risk, and complex multi-agency involvement.

A consistent concern raised by members was the lack of attention to coercive control. They felt that the section does not fully acknowledge how coercive control shapes the context of domestic homicide, influences victim behaviour, and distorts professional perception of risk. Members emphasised that coercive control is often cumulative and non-linear, requiring nuanced understanding that cannot be captured through case files alone. They were concerned that, in the absence of clear expectations around practitioner engagement, the guidance risks flattening the complexity of coercive control into a superficial checklist rather than supporting the deep relational and contextual analysis required.

Members also noted that the section does not provide guidance on analysing missed opportunities for intervention, particularly in situations where patterns of harm were visible but not recognised or where victims had made previous disclosures. They observed that effective domestic homicide reviews must examine the interaction between service responses, decision-making environments, and organisational cultures, yet Section 8.6 does not reflect this reality. Instead, members felt the section presents a narrow, case-focused view of additional factors, rather than situating the death within the wider systemic landscape that contributed to vulnerabilities and risks.

Members were further concerned that the section does not consider children's experiences or perspectives in domestic homicide cases, except in areas covered elsewhere in the guidance. They noted that in many domestic homicide cases, children have lived through prolonged exposure to abuse, and their experiences form an essential part of understanding the dynamics leading up to the death. Members felt that excluding this from the additional factors undermines the holistic and trauma-informed approach required for a meaningful review.

Another significant issue raised was the absence of practitioner reflection as a core component of analysing additional factors. Members stressed that understanding practitioner judgement, organisational pressures, and the information known (or not known) at the time is essential to identifying systemic learning. They were concerned

that the section, like other parts of Section 8, implicitly assumes a document-led process, which risks misinterpreting complex practice decisions or missing the wider organisational context within which practitioners operate.

Members also identified weaknesses in the treatment of intersectional factors. They felt the section does not adequately account for how gender, disability, culture, socio-economic factors, and immigration status may shape victims' experiences of risk and access to help. While some of these issues appear elsewhere in the guidance, members felt that the additional factors for domestic homicide reviews needed to explicitly incorporate these considerations to ensure that panels adopt a truly inclusive, equitable and context-driven approach.

In addition, members noted that the section does not acknowledge perpetrator-focused analysis, which is central to understanding domestic homicide. They emphasised that learning is often missed when reviews focus predominantly on the victim's actions rather than examining patterns of perpetrator behaviour, coercion, repeat victimisation, and manipulation of services. Members highlighted that Scottish practice has been shifting intentionally toward a perpetrator-patterned analysis (e.g., Safe & Together), yet Section 8.6 does not reflect this progression.

Finally, members felt that the section does not connect additional factors to the broader analytical framework required for the review, including chronology development, systems thinking, or root-cause analysis. Without this connection, members feared that panels may treat the additional factors as supplementary observations rather than essential components of a cohesive learning process.

Overall, members felt that Section 8.6 requires significant expansion and refinement. They recommended that the guidance embed a strong understanding of coercive control, include clear expectations around practitioner engagement, integrate children's experiences, address intersectionality, adopt a perpetrator-focused framework, and link additional factors to a coherent systems-based analytical model. As drafted, members felt the section does not provide the depth or clarity required to support meaningful learning from domestic homicide cases.

Question 23

Is the content of ‘Section 8.7 Domestic Abuse Related Suicide Reviews – additional factors’ clear and do you have any comments?

Members welcomed the recognition that domestic abuse-related suicides require distinct analytical considerations, but overall felt that Section 8.7 is insufficiently developed, lacks nuance, and does not reflect the complexity of practice in this area. They noted that the section outlines some high-level issues that may be relevant in domestic abuse-related suicide cases, but provides little practical guidance on how Review Panels should explore these factors or integrate them into a rigorous, trauma-informed analysis.

Members’ foremost concern was that the section does not fully acknowledge the complex interplay between coercive control, trauma, mental health, fear, isolation and cumulative harm that frequently underpins domestic abuse-related suicide. They felt that the text risks oversimplifying what are often deeply layered and multifaceted circumstances. Members emphasised that understanding suicide in the context of domestic abuse cannot be achieved through records alone; it requires careful triangulation of practitioner perspectives, family insights, chronology work and contextual analysis. However, Section 8.7 does not reference practitioner engagement at all. Members were clear that this omission would significantly undermine the quality of any suicide-related review.

Members also noted that the guidance does not address how patterns of coercive control may manifest differently when the victim dies by suicide, including the ways in which perpetrators may manipulate services, isolate victims, or distort help-seeking behaviour. They observed that the section does not encourage panels to examine whether the victim’s behaviour prior to their death may have been shaped by fear, trauma, or control, nor does it prompt a perpetrator-patterned analysis. Members highlighted that this risks inadvertently reinforcing victim-blaming narratives, unless the guidance explicitly directs panels to consider the broader structural and relational context.

Another major concern was that the section does not provide enough guidance on how Review Panels should approach mental health information, including its limits, its relationship to coercive control, or the ways in which domestic abuse may exacerbate psychological distress. Members stressed that domestic abuse-related suicide cases often involve complex mental health histories, yet mental health records cannot be interpreted in isolation. They noted that the section fails to caution against over-medicalising suicide or overlooking the central role of abuse in shaping mental health outcomes.

Members further highlighted that the section lacks discussion of service barriers and missed opportunities, such as failures to identify domestic abuse during crisis presentations, missed disclosures, gaps in inter-agency communication, or systemic blind spots regarding victims who present with distress, self-harm or depressive symptoms. Members emphasised that understanding why victims may not have accessed support, or why services did not recognise risk, is crucial to meaningful learning, yet Section 8.7 provides no direction for panels on exploring these areas.

Concerns were also raised about the absence of guidance on working with bereaved families in domestic abuse-related suicide reviews. Members noted that families are often the primary holders of contextual insight, but may also have experienced trauma, shock, or complex relational histories with person A. The section does not provide Review Panels with any framework for managing these sensitivities, nor does it reference the need for safe, paced, supported engagement, something members viewed as essential.

Members also reiterated earlier concerns about the guidance's assumption that DHSRs can continue in parallel with criminal or other investigations. In suicide cases with domestic abuse elements, members noted that access to mental health records, police information, digital evidence and practitioner testimony may be restricted, and that the guidance does not reflect these practical realities. They felt that Section 8.7 risks presenting an unrealistic picture of what information can be accessed during active proceedings.

Finally, members felt that the section lacks a coherent analytical framework. It lists factors without explaining how they relate to chronology development, systems analysis, or the broader learning methodology. Members emphasised that suicide

reviews demand particular care to avoid hindsight bias, moral judgement or simplistic causal narratives. As drafted, the section does not provide Review Panels with the analytical tools needed to handle this complexity.

Overall, members felt that Section 8.7 requires substantial strengthening. They recommended embedding a clear perpetrator-patterned and trauma-informed approach; explicitly incorporating practitioner and family engagement; addressing the relationship between domestic abuse and mental health; recognising systemic barriers and missed opportunities; and situating these additional factors within a structured analytical model. As drafted, members felt the section risks producing shallow or incomplete learning in some of the most complex and sensitive cases the DHSR model will encounter.

Question 24

Is the content of ‘Section 9 Review Analysis’ clear and do you have any comments?

Members felt that Section 9 lacks the depth, clarity and methodological grounding required to support robust and meaningful analysis in Domestic Homicide and Suicide Reviews (DHSRs). They described the section as painfully short, superficial, and inconsistent with the level of analytical rigour expected in Scotland’s established learning review practice. Members were particularly concerned that the guidance appears to reinforce a predominantly desktop exercise, rather than a systems-focused, reflective and triangulated review process.

A major issue raised by members was that the section does not provide any structured analytical framework for Review Panels to use. While the draft briefly references socio-ecological and contribution analysis, members noted that these are mentioned only in passing and without explanation, guidance or application. They felt that panels are given no direction on how to use these approaches, how to combine them, or how to adapt existing methodologies used in Child Protection Learning Reviews, Adult Support and Protection Learning Reviews, or other systems-based models. Members emphasised that without clear analytical scaffolding, DHSRs may

produce shallow findings, overly descriptive narratives, or learning that lacks coherence or relevance.

Members also highlighted that Section 9 does not address the importance of triangulation, a core feature of all credible review methodologies. They noted that effective analysis requires drawing together evidence from chronologies, practitioner discussions, Individual Management Reviews, family perspectives and agency records. Yet Section 9 makes no reference to triangulation at all, reinforcing concerns that the DHSR model, as drafted, risks becoming overly reliant on documentation rather than lived experience and professional insight. Members felt this omission would significantly compromise the depth of learning and risk misinterpreting complex decision-making contexts.

Members further observed that the section does not recognise the central role of practitioner engagement in review analysis. They emphasised that understanding why decisions were made, what information was available at the time, and what systemic factors influenced practice cannot be determined through case files alone. In their experience, the most meaningful learning emerges through reflective conversations with practitioners, supported safely and sensitively. The complete absence of practitioner involvement from Section 9 was described as a “red flag” and a significant departure from Scotland’s learning culture.

Members additionally noted that the section does not adequately address the risk of hindsight bias, which is particularly pronounced in domestic homicide and suicide reviews. They observed that reviews must make a conscious effort to understand decisions in context, rather than through the lens of a known outcome. While this is standard in other Scottish review frameworks, the draft guidance does not mention hindsight bias or offer tools to mitigate it. Members felt this omission risks unfair interpretation of practitioner decision-making and undermines the credibility of review findings.

Members were also concerned that the section does not provide guidance on how Review Panels should approach systemic analysis, including examination of organisational culture, workloads, communication pathways, referral mechanisms, thresholds, and multi-agency accountability. In complex cases, particularly those involving coercive control or cumulative harm, such systemic understanding is

essential. Members felt that by failing to outline expectations for systemic exploration, the guidance risks reducing DHSRs to incident-focused exercises rather than meaningful examinations of system functioning and opportunities for improvement.

Alongside these concerns, members noted that Section 9 fails to link analysis clearly to other parts of the review process. Chronology work, practitioner engagement, family views, and specialist insight all feed into analysis, yet the section provides no explanation of how these elements connect. Members felt the lack of integration undermines coherence and may result in fragmented or inconsistent review outcomes.

Finally, members felt that the section does not explain how disagreements within the Review Panel should be handled or documented. They emphasised that complex reviews often involve differing professional interpretations, and the guidance should make clear how these differences should be explored, reconciled or transparently recorded. Without this, members feared that important learning might be obscured or flattened out.

Overall, members considered Section 9 to be incomplete and insufficiently aligned with Scotland's established learning review principles. They recommended that the guidance include: a clear analytical methodology; explicit expectations around triangulation, practitioner engagement and systems analysis; safeguards against hindsight bias; integration with earlier stages of the review; and guidance on managing divergent interpretations. As drafted, members felt the section does not provide Review Panels with the tools required to produce high-quality, credible and actionable learning from domestic homicide or domestic abuse-related suicide.

Question 25

Is the content of 'Section 10.1 Identifying Learning, Recommendations and Actions clear and do you have any comments?

Members felt that Section 10.1 does not yet provide an adequate or coherent framework for identifying learning, formulating recommendations, or translating these into meaningful and achievable actions within Domestic Homicide and Suicide Reviews (DHSRs). They noted that while the section outlines several high-level principles, it lacks the depth, clarity and systems-oriented approach required to ensure that learning is robust, proportionate and embedded effectively across agencies. Overall, members considered the section to be incomplete and insufficiently aligned with Scotland's established methodologies for learning reviews.

A central concern was that the section appears poorly connected to the analytical shortcomings identified earlier in the guidance. Members highlighted that credible learning depends on high-quality analysis rooted in triangulation, practitioner engagement, systemic reflection and contextual understanding. Yet Section 10.1 appears to assume that strong learning will simply flow from the review process as written, despite the earlier sections failing to establish the foundations necessary for that to occur. Members stressed that without addressing these upstream gaps, the identification of learning risks becoming superficial, descriptive or overly focused on individual actions rather than systemic improvement.

Members also noted that the guidance does not define what constitutes "learning" in the context of DHSRs. They emphasised that learning should centre on understanding systemic influences such as organisational structures, cultures, policies, workloads and inter-agency communication, not simply cataloguing errors or highlighting service gaps. Members felt that the absence of an explicit systems-based definition risks reviews generating recommendations that are either too narrow, too operationally vague, or disconnected from the real-world constraints affecting practice.

Members were similarly concerned that Section 10.1 does not address the risk of hindsight bias in shaping learning and recommendations. They reiterated that without explicit safeguards, reviews may unintentionally place disproportionate focus on individual practitioner decisions instead of examining the wider structural and contextual factors at play. The lack of such guidance was viewed as a serious omission that could undermine trust and hinder meaningful system-level learning.

Members further felt that the section's expectations around formulating recommendations were too broad and lacked practical direction. They observed that the guidance refers to recommendations being specific, actionable and proportionate, yet provides no explanation of how Review Panels should ensure this. Members stressed that developing effective recommendations requires structured frameworks and multi-agency scrutiny to ensure they are realistic, evidence-based and targeted at the correct level of the system. They noted that the section does not reflect existing learning review practice, where recommendations are typically kept to a minimum, clearly linked to analysis, and focused on achievable systemic change rather than excessive or unrealistic action lists.

In addition, members highlighted that Section 10.1 does not offer direction on how recommendations should be prioritised, nor how agencies should be supported to implement them. They observed that recommendations generated without clear prioritisation or implementation planning risk overwhelming agencies already under significant pressure, reducing the likelihood of sustained change. Members noted that this issue is compounded by the broader concern that DHSRs may operate in parallel with other learning reviews, leading to competing recommendations and duplication unless clear mechanisms for coordination are established.

Members also noted the absence of guidance on involving families, practitioners and partner agencies in identifying learning and shaping recommendations. They stressed that lived experience and practitioner insight are essential to understanding the real-world feasibility and impact of any proposed changes. Without explicit expectations for this collaborative approach, members feared that recommendations could become detached from operational realities or fail to reflect the experiences of those most affected.

Finally, members felt that Section 10.1 does not explain how learning, recommendations and actions will be evaluated, monitored or fed into national thematic analysis. They emphasised that DHSRs must contribute to a coherent national learning system, yet the section provides no detail on how local findings will be synthesised, how progress will be tracked, or how recurring themes will be escalated for national attention. This gap was viewed as a significant weakness in the overall model.

Overall, members felt that Section 10.1 requires substantial development to provide a clear, structured and systems-informed approach to identifying learning and shaping recommendations. They recommended the inclusion of explicit analytical frameworks; safeguards against hindsight bias; participatory processes for developing learning; and clearer expectations for prioritisation, implementation and national synthesis. As drafted, members felt that the section risks producing fragmented, superficial or unrealistic recommendations that do not deliver meaningful, sustained improvement.

Question 26

Is the content of ‘Section 10.2 Preparing Review Reports’ clear and do you have any comments?

Members felt that Section 10.2 does not provide the clarity, depth or methodological coherence necessary to support the preparation of high-quality review reports within the Domestic Homicide and Suicide Review (DHSR) model. They described the section as overly generic and insufficiently aligned with Scotland’s established learning review practice, expressing concern that it does not reflect the complexity of synthesising evidence, analysis and lived experience into a clear, trauma-informed and meaningful report.

A key concern raised by members was the lack of guidance on how analysis should translate into the structure and narrative of the report. They emphasised that the quality of the final report depends on a clear analytical framework, yet earlier parts of the guidance do not establish such a framework, and Section 10.2 does not compensate for this absence. Members noted that the section simply lists what a report “should provide,” without explaining how panels should integrate chronologies, practitioner insight, family perspectives and systems analysis into a coherent and balanced narrative. They felt that this risks producing reports that are either descriptive rather than analytical, or fragmented and inconsistent.

Members were particularly concerned that the section does not give sufficient prominence to the voice and lived experience of families and, where relevant, children. While Section 10.2 mentions including “experiences,” members felt this was inadequate. They emphasised that in Scotland’s child and adult protection learning review models, family and practitioner voices are treated as essential sources of insight, not supplementary additions. They felt the DHSR guidance should reflect this by explicitly stating that lived experience should shape the framing, interpretation and presentation of learning within the report. The current wording was viewed as tokenistic and lacking in trauma-informed intent.

Members also observed that the section does not sufficiently address the importance of presenting learning in a way that avoids victim-blaming, particularly in cases involving coercive control or domestic abuse-related suicide. They stressed that without explicit guidance on language, framing and contextualisation, reports may inadvertently reinforce harmful narratives or fail to capture the relational and structural dynamics that shaped events. Members had already expressed wider concerns about the document’s tone and felt that Section 10.2 should provide clear expectations on how to write with compassion, accuracy and sensitivity.

Members further highlighted that the section offers no guidance on how to handle disagreements within the Review Panel, despite the likelihood that complex cases will produce differing interpretations of evidence. They felt the guidance should make clear how differing views should be recorded, and how panels should balance dissent with the need for a coherent report. Without this, members feared that reviews could either obscure important learning or produce reports lacking credibility.

In addition, members felt that Section 10.2 does not provide clarity on the role and responsibilities of the Review Chair in drafting the report. Although the final flowchart suggests that the Chair prepares the report, the section itself does not specify who drafts it, how the Panel will contribute, or how quality assurance will be managed prior to submission to the Review Oversight Committee. Members felt that this omission risks creating confusion or inconsistency in practice.

Members also noted that the section does not acknowledge the emotional impact of publishing reports, particularly for families, practitioners and communities. They felt that review reports must be written with a clear awareness of how recommendations,

narrative detail and descriptions of events may affect those who have already experienced trauma. The absence of trauma-informed writing guidance was seen as a substantive gap.

Finally, members pointed out that the section lacks a clear link to national learning, despite the DHSR model's stated ambition to contribute to wider system improvement. They felt the guidance should provide expectations on how reports will be structured to support thematic analysis, comparability and national oversight. As drafted, Section 10.2 does not explain how reports will feed into national learning mechanisms or ensure consistency across Scotland.

Overall, members felt that Section 10.2 requires significant expansion and clarification. They recommended that the guidance provide a clear analytical framework for structuring reports, embed trauma-informed and anti-victim-blaming principles, clarify roles and responsibilities in drafting, include expectations for handling differing views, and ensure reports support both local learning and national system improvement. As drafted, members felt the section does not offer a sufficiently robust foundation for preparing credible, compassionate and meaningful DHSR reports.

Question 27

Is the content of 'Section 10.5 Anonymity of persons' clear and do you have any comments?

Members acknowledged the importance of robust anonymity provisions within Domestic Homicide and Suicide Reviews (DHSRs) but felt that Section 10.5 does not provide sufficient clarity, practical guidance or nuance to support effective protection of individuals' identities. They noted that while the section establishes a general expectation that identifying details should be removed, it does not fully reflect the complexities of anonymity within small communities, multi-agency systems, or emotionally sensitive contexts such as domestic homicide and domestic abuse-related suicide.

Members were concerned that the section presents anonymity as an issue that can be resolved primarily through pseudonyms and removal of identifying information. They emphasised that in many cases, particularly in rural or island communities, where the pool of potential individuals is small, “jigsaw identification” remains a significant risk even when names and other direct identifiers are removed. Several members stressed that the guidance does not demonstrate adequate awareness of this, nor does it offer a framework for assessing or mitigating such risks. They felt the lack of recognition around local contextual factors echoed concerns raised in earlier sections about the guidance being overly centralised and insufficiently grounded in real-world practice.

Members also expressed concern that Section 10.5 does not address the tension between anonymity and accountability, particularly where significant learning involves describing organisational decisions, local service responses or multi-agency interactions. They noted that meaningful learning depends on clear, accurate description of what occurred, yet too rigid or simplistic anonymity approaches may limit the ability to articulate key findings transparently. Members felt the guidance should explicitly support panels to manage this balance rather than implying anonymity is a straightforward technical exercise.

A further issue raised by members was that the section lacks reference to engaging with families about anonymity decisions. They emphasised that bereaved families often have strong views about how much detail should be shared, what information feels sensitive or harmful, and whether they wish aspects of their loved one’s story to be anonymised or preserved. Members felt that failing to involve families meaningfully risks both re-traumatisation and a loss of trust, particularly in cases where communities may already be aware of the circumstances of the death.

Members also highlighted that Section 10.5 does not provide enough guidance on how anonymity interacts with the publication challenges raised earlier in Section 10, including how reviews should be written to minimise identifiable context without compromising the integrity of learning. They noted that meaningful anonymity requires consideration at every step of the review, not just at the final reporting stage, and felt this principle should be reflected explicitly in the guidance.

Finally, members noted that the section does not address how anonymity will be maintained during information-sharing, quality assurance, draft report circulation or discussions with other agencies. They emphasised that anonymity breaches are more likely during these earlier stages, and that supporting infrastructure such as secure storage, clear circulation processes, role-based access and data handling safeguards, must be outlined elsewhere in the guidance. Members connected this gap to broader concerns raised about Section 6.2 (Data Sharing), noting that anonymity protections cannot be meaningfully implemented without a clear operational framework for managing sensitive information.

Overall, members felt that Section 10.5 requires more detailed and contextually sensitive guidance. They recommended explicit recognition of jigsaw identification risks; involvement of families in anonymity decisions; alignment with secure data-handling processes; and clearer expectations on how to balance anonymity with transparency and systemic learning. As drafted, members felt the section does not yet provide Review Panels with the clarity needed to safeguard individuals effectively while still enabling honest, meaningful and trauma-informed reporting.

Question 28

Is the content of ‘Section 10.6 Sharing draft review reports’ clear and do you have any comments?

Members felt that Section 10.6 does not provide sufficient clarity, safeguards or practical direction on how draft Domestic Homicide and Suicide Review (DHSR) reports should be shared during the quality assurance and factual accuracy stages. They highlighted that the section appears to underestimate the sensitivity, legal complexity and risk associated with circulating draft reports, particularly in cases involving domestic abuse-related deaths, child involvement or ongoing criminal proceedings.

A core concern expressed by members was that the section lacks a clear and robust framework for controlling who sees what, when, and for what purpose. The text specifies that only the Review Oversight Committee (ROC) Chair and the Case

Review Panel Chair may share drafts, but members observed that this rule is stated without explanation of how it will be operationalised or monitored. They noted that in multi-agency reviews, ensuring tight control of sensitive information is essential, and the guidance should outline clear processes for authorisation, version control, secure transmission and audit trails. Without this, members feared there is a heightened risk of unauthorised sharing or inadvertent breaches.

Members also noted that the section does not acknowledge the substantial implications of sharing draft reports during live criminal proceedings, despite concerns raised elsewhere about Crown Office restrictions and the need to avoid prejudicing investigations. They emphasised that the guidance should explicitly address how sharing will be managed in such contexts, including whether any redactions, deferrals or legal oversight will be required. Members felt that the current wording risks giving Review Panels unrealistic expectations about the level of access and transparency possible during ongoing legal processes.

Members further highlighted that Section 10.6 fails to explain how the factual accuracy checking process will work in practice. They stressed that factual accuracy is a crucial safeguard to ensure reports are fair, balanced and credible, yet this requires careful coordination between agencies, structured mechanisms for responding to queries, and clarity about how disagreements will be managed. The lack of guidance risks confusion, inconsistency or disputes between agencies about how and when they can comment on content that concerns them directly.

Another significant concern was the absence of any reference to involving families in the draft stages of the review. Members stressed that, in child and adult protection learning reviews, families are routinely offered an opportunity to comment on the draft report to ensure that their experiences are represented accurately, respectfully and sensitively. The omission of any reference to family engagement at the draft report stage was seen as inconsistent with trauma-informed practice and with the wider aspirations of the DHSR model, which places families at the centre.

Members also felt that the section does not provide sufficient practical guidance on how to avoid jigsaw identification when draft reports are shared, particularly in small communities or cases involving intricate family structures. They reiterated concerns from Section 10.5 that anonymity is not a simple matter of pseudonyms and

redaction; rather, it requires active consideration of contextual details throughout the drafting process. Members felt that any circulation of draft reports must be accompanied by clear expectations regarding confidentiality, safe handling and the minimisation of identifying information.

Finally, members noted that Section 10.6 does not clarify how feedback will be handled, including how comments will be collated, which comments must be addressed, and what happens in cases where factual disputes or interpretive disagreements arise. Members stressed that reviews often involve differing professional perspectives, and the guidance must instruct Chairs on how to record, resolve or transparently present these differences within the final report.

Overall, members felt that Section 10.6 requires substantial expansion to provide a safe, lawful and professional framework for sharing draft review reports. They recommended clearer guidance on authorisation, confidentiality, information security, family involvement, factual accuracy processes, legal constraints, and the management of dissenting views. As drafted, members felt the section risks undermining both the integrity of the DHSR process and the confidence of practitioners, families and agencies participating in it.

Question 29

Is the content of ‘Section 10.7 Finalising draft review reports’ clear and do you have any comments?

Members felt that Section 10.7 does not provide sufficient clarity, structure or practical guidance on how draft Domestic Homicide and Suicide Review (DHSR) reports should be finalised. Although the section describes the need to incorporate comments and prepare an executive summary, members found the guidance overly simplistic and lacking in detail about the processes, safeguards and decision-making required to complete a high-quality, trauma-informed and credible report.

A key issue raised by members was the absence of clarity regarding how competing or conflicting interpretations should be managed during the finalisation stage.

Members noted that reviews of complex domestic homicide and domestic abuse-related suicide cases often involve differing professional views, contextual interpretations and agencies' perspectives. However, the guidance does not explain how such disagreements should be documented, balanced or fairly represented in the final report. Members stressed that this is a critical omission, as transparent acknowledgement of differing interpretations is essential to maintaining the integrity, credibility and fairness of the review process.

Members also observed that the section provides insufficient detail on the role of the Chair in finalising the report. While the section implies that the Chair carries responsibility for concluding the drafting process, members felt that this alone is not clear enough. They emphasised that the guidance should specify how the Chair should work with the Panel to resolve uncertainties, incorporate learning, ensure factual accuracy and avoid disproportionate influence from any single agency. Members also felt it was unclear how much autonomy the Chair has in shaping the final narrative versus how much should be agreed collectively by the Panel.

Members further highlighted that the guidance does not address how to ensure the finalised report remains trauma-informed and sensitive, particularly for families who may read or engage with its content. They emphasised that the report's tone, language and presentation must avoid victim-blaming and be sensitive to the experiences of bereaved families, children and communities. Yet Section 10.7 provides no direction on how Review Panels should ensure that revisions made at this stage uphold these principles. This omission was seen as particularly concerning in light of earlier comments about the guidance adopting an overly investigatory tone in earlier sections.

Another significant concern was the absence of guidance on how the executive summary should be prepared. Members recognised the executive summary as the version most likely to be published and widely read, particularly when full reports cannot be released. They felt the guidance should specify that the summary must reflect core learning, avoid over-simplification, uphold anonymity, remain sensitive to families and ensure that any necessary redactions do not distort learning. Members feared that, without clear expectations, executive summaries could become inconsistent, overly sanitised or risk omitting key learning.

Members also pointed out the lack of reference to how final drafts will be aligned to national learning needs. They stressed that reviews must contribute to Scotland's national learning system, and that report finalisation should explicitly consider how findings will be fed into biennial thematic reporting and wider system improvement. However, the section does not mention national learning, nor does it provide expectations on structuring conclusions in a way that facilitates consistent aggregation of themes at national level.

Finally, members reiterated concerns which were raised elsewhere in relation to Sections 10.5 and 10.6 that the guidance does not clearly address how anonymity and information-security safeguards should be maintained during the finalisation process. Members noted that this stage often involves multiple iterations of drafts and communications between agencies, increasing the risk of identifying information being inadvertently disclosed. They felt that anonymity and confidentiality safeguards should be explicitly embedded into this section.

Overall, members felt that Section 10.7 requires substantial strengthening. They recommended that the guidance include a clear process for resolving differing interpretations; explicit expectations for the role of the Chair and Panel; guidance on trauma-informed, anti-victim-blaming writing; safeguards for anonymity and data handling; and requirements to ensure executive summaries reflect national learning priorities. As drafted, members felt that the section does not provide sufficient assurance or direction to support the preparation of credible, sensitive and methodologically sound DHSR reports.

Question 30

Is the content of 'Section 10.8 Submitting report to Review Oversight Committee for Quality Assurance' clear and do you have any comments?

Members felt that Section 10.8 does not provide a sufficiently clear or workable framework for how finalised Domestic Homicide and Suicide Review (DHSR) reports will be quality-assured by the Review Oversight Committee (ROC). They noted that the section appears to assume a straightforward process of submission and review,

but fails to account for the complexities, sensitivities and system-level responsibilities involved in external scrutiny of highly confidential, trauma-laden material. Members were concerned that the guidance is overly simplistic and insufficiently grounded in the realities of multi-agency learning reviews.

A major concern related to the lack of clarity around roles, responsibilities and decision-making authority. Members noted that Section 10.8 does not outline how disagreements between the Case Review Panel and the ROC should be resolved, nor how differing interpretations of learning, evidence or recommendations will be managed. Given the complexity of domestic homicide and domestic abuse-related suicide cases, members felt it is inevitable that differing professional perspectives will arise, yet the guidance provides no mechanism for documenting, escalating or adjudicating such disagreements. Members stressed that without a transparent framework, there is a risk of decisions being made without adequate accountability or consistency.

Members also raised concerns about the absence of safeguards related to anonymity and information security at the quality-assurance stage. They noted that draft and near-final reports may include highly sensitive personal information, and yet Section 10.8 does not explain how reports should be transmitted to the ROC, who within the ROC will have access to them, or what data-handling standards apply. Members emphasised that without clear standards, particularly given earlier concerns about Section 6.2 on data protection, the risk of confidentiality breaches is significant.

Members further observed that the guidance does not clarify how the ROC will assess whether a report meets the expected methodological, analytical and trauma-informed standards. They noted that Section 10.8 references the ROC checking that reports meet statutory and Terms of Reference requirements but does not specify how the ROC will evaluate the quality of analysis, the adequacy of triangulation, the reliability of findings, or the sensitivity of language. Members argued that without clear expectations, quality assurance risks becoming inconsistent or superficial, undermining confidence in the DHSR model.

Additionally, members were concerned that the section does not address the timeliness and sequencing of ROC quality assurance. They emphasised that delays

in signing off reports, particularly when families are waiting for outcomes, can compound trauma and erode trust. Members felt the guidance should set out expected timescales, escalation pathways and mechanisms for preventing unnecessary delay. The absence of such direction was viewed as a substantive omission.

Members also noted that the guidance does not explain how ROC scrutiny will interface with local governance structures, such as Chief Officer Groups (COGs), Adult Protection Committees (APCs) and Child Protection Committees (CPCs). They stressed that local systems retain statutory responsibility for public protection and learning, yet Section 10.8 suggests that the ROC holds primary authority to approve or modify recommendations. Members felt this creates ambiguity about accountability and risks marginalising the local expertise required to ensure learning is accurate and actionable.

Finally, members highlighted that the section does not articulate how ROC quality assurance will support national learning, despite DHSRs being intended to contribute to systemic improvement across Scotland. Members felt strongly that the guidance should set out how ROC review of reports will ensure consistency, facilitate thematic analysis, and prevent duplication of learning across review types. The absence of this national learning link was seen as a missed opportunity to strengthen Scotland's wider public protection learning system.

Overall, members felt that Section 10.8 requires substantial revision. They recommended clear guidance on the scope and limits of ROC authority; consistent standards for quality assurance; robust confidentiality and information-security expectations; involvement of local governance; guidance on managing disagreements; and explicit links to national learning. As drafted, members felt the section is too superficial and risks undermining both the credibility and effectiveness of the DHSR model.

Question 31

Is the content of 'Section 11 Publication of Reports and Dissemination of Learning' clear and do you have any comments?

Members felt that Section 11 does not yet provide a clear, coherent, or operationally realistic framework for the publication of Domestic Homicide and Suicide Review (DHSR) reports and the dissemination of learning. They observed that while the section outlines broad expectations such as informing families and sharing learning, the drafting lacks the specificity, safeguards and integration with existing Scottish public protection systems required to make publication and dissemination effective, ethical and trauma-informed.

A key concern expressed by members was the lack of clarity surrounding the publication process, including who makes final publication decisions, how publication relates to ongoing criminal proceedings, and what conditions the Lord Advocate may apply when consenting to publication. Members felt that the guidance oversimplifies the complexities of publishing reports involving highly sensitive information, especially in circumstances where identifying details may be widely known within communities or where children are involved. They stressed that the guidance needs to better acknowledge the risks of jigsaw identification and the need for careful, expert-led decisions on what can safely be published.

Members also highlighted that the section does not adequately address the emotional impact on families of both publication and non-publication. Although Section 11.1 notes that families should be informed, members felt this wording is insufficiently sensitive or comprehensive. Families may experience publication as empowering and validating, or alternatively as distressing, re-traumatising or intrusive. Members stressed that families must be supported to understand what will be published, how anonymity will be preserved, and how the review may be interpreted publicly. They also noted the absence of clear guidance on how to handle situations where families disagree with publication decisions.

Members were particularly concerned about the lack of connection to local governance structures. The section does not explain how findings will be communicated to Chief Officer Groups (COGs), Adult Protection Committees (APCs), Child Protection Committees (CPCs) or Violence Against Women and Girls (VAWG) partnerships. Members noted that these bodies have statutory responsibilities for public protection learning and improvement, yet Section 11

implies that dissemination will be handled chiefly at national level. They stressed that without clear local dissemination pathways, learning may not reach those who can implement change on the ground.

Members also felt that the guidance does not set out how the ROC, Scottish Ministers, or agencies will ensure consistency and coherence in published learning. They were concerned that, without harmonised standards, published summaries could vary significantly in length, detail and tone, risking inconsistency and making it difficult to aggregate national learning across DHSRs. Members stressed that clear expectations for executive summaries (already highlighted as missing in Section 10.7) should be linked explicitly to publication requirements in Section 11.

Another major concern was that the section does not sufficiently address how learning will be disseminated in cases where reports cannot be published, such as due to legal sensitivities, risk of identification or restrictions related to children. While the section briefly mentions the possibility of alternative formats (e.g., anonymised summaries), members felt the guidance does not outline how to ensure that such alternatives still convey meaningful learning, maintain accuracy, and uphold transparency. They noted that this is a recurring challenge in learning review practice and requires detailed guidance, not a high-level statement.

Members also observed that the section does not articulate how national learning will be collated, analysed and fed back into system improvement, nor how DHSR findings will integrate with the learning emerging from other review mechanisms such as CPLRs, ASP Learning Reviews or MAPPA Significant Case Reviews. Members noted that domestic homicide and domestic abuse-related suicide often occur within multi-system contexts, and therefore the guidance must explicitly establish a joined-up learning ecosystem. As drafted, Section 11 feels siloed and disconnected from wider improvement infrastructures.

Finally, members highlighted gaps related to media interest and public visibility. The guidance does not acknowledge the challenges of media reporting around domestic homicide, coercive control or suicide, nor does it provide advice on supporting families during publication, preventing misinterpretation of learning, or ensuring sensitive public communication. Members felt that failing to address this may leave families exposed and create reputational or emotional risks for agencies.

Overall, members felt that Section 11 requires significant strengthening. They recommended that the guidance include clearer processes for publication decisions; robust family-centred support; strong protections against identification; alignment with local and national learning systems; explicit guidance for cases where reports cannot be published; and expectations for sensitive public communication. As drafted, the section does not yet provide sufficient direction to ensure learning is disseminated safely, ethically and effectively.

Question 32

Is the content of ‘Section 12 Biennial Thematic Reports’ clear and do you have any comments?

Members welcomed the intention to produce biennial thematic reports as a means of driving national learning and accountability; however, they felt that Section 12 is insufficiently detailed, disconnected from earlier parts of the guidance, and unclear about how thematic learning will be generated, analysed or used. Although the section outlines broad categories of information to be included in thematic reports, members felt it does not provide a coherent framework for how these reports will be produced or how they will contribute to system improvement across Scotland.

A primary concern raised by members was that the section appears to assume that the underlying reviews will consistently generate high-quality, triangulated, systems-informed learning. Members highlighted that earlier sections of the guidance (particularly those addressing information-gathering, analysis, practitioner involvement and family engagement) are underdeveloped. Without strengthening those areas, members felt it was unrealistic to expect that meaningful and reliable thematic learning could be extracted from individual DHSRs. They stressed that the production of thematic reports must be grounded in a clear and methodologically sound review system, which the current guidance does not yet provide.

Members also noted that Section 12 does not explain how the national learning will be synthesised, including what analytical approaches will be used to draw insights across multiple DHSRs, nor who will be responsible for this interpretive work. They

emphasised that thematic reporting requires more than simply aggregating recommendations; it demands skilled analysis capable of identifying patterns, variations, systemic constraints and cross-cutting cultural or structural issues. Members felt that the section does not recognise this complexity or the resource needed to undertake robust thematic analysis.

In addition, members felt the section does not sufficiently address how thematic learning will be connected to existing national improvement structures, such as Child Protection Committees Scotland, the Adult Support and Protection National Strategic Forum, Violence Against Women and Girls partnerships, or the National Hub for reviewing child deaths. They highlighted that domestic abuse-related deaths frequently involve cross-system issues, and therefore national learning must be shared across multiple professional networks, not contained within a DHSR-specific silo. Members felt that the absence of clear pathways for integrating DHSR learning into wider safeguarding frameworks risks fragmentation and duplication rather than meaningful system improvement.

Members were also concerned about the lack of detail regarding how learning will be fed back to local areas, including Chief Officer Groups (COGs), Adult Protection Committees (APCs), Child Protection Committees (CPCs) and relevant operational partnerships. They stressed that thematic reports will only drive change if local systems can engage with the findings, review their own processes, and implement improvements. Section 12 does not outline how this feedback loop will operate or how thematic learning will be translated into local practice.

Furthermore, members noted that the section does not articulate how thematic reports will align with the national monitoring of recommendation implementation, described earlier in the guidance. They emphasised that thematic reports must not only identify recurring themes but must also incorporate evidence of progress, barriers to implementation and system-wide gaps that persist over time. Members felt that without this, thematic reports risk becoming descriptive snapshots rather than strategic drivers of improvement.

Members also highlighted concerns about how sensitive cases will be handled within thematic reporting. They noted that patterns of domestic homicide and suicide emerging within small localities or tight-knit communities may quickly become

identifiable, even when anonymised. The section does not provide guidance on how to prevent inadvertent identification of individuals or families when aggregating learning at national level.

Finally, members felt that Section 12 does not address the resource and capacity implications of creating biennial thematic reports. They noted that the production of high-quality national reports requires skilled analytical staff, strong data architecture and close collaboration with local systems, none of which are referenced in the guidance. Members were concerned that, without appropriate resourcing, the ambition of producing meaningful thematic reports may not be realised.

Overall, members felt that Section 12 requires significant development. They recommended that the guidance set out a clear methodology for synthesising learning across reviews, establish strong links to national and local safeguarding structures, include safeguards against identification, clarify roles and responsibilities for analysis, and recognise the resource required to deliver high-quality thematic reporting. As drafted, members felt that the section provides only an outline of intent, without the practical or methodological detail required to ensure that biennial thematic reports will meaningfully strengthen Scotland's public protection system.

Question 33

Do you think 'Flowchart for each section of the whole process' is useful?

Members held mixed views on the usefulness of the flowchart but overall felt that its value is significantly limited by the weaknesses and lack of clarity in the wider guidance. While several members expressed that they are visual learners and therefore appreciate the inclusion of a flowchart, they consistently emphasised that a flowchart can only be useful if it accurately reflects a clear, coherent and well-structured process. As drafted, members felt the flowcharts fail to meet that standard.

Members noted that many parts of the guidance are unclear, contradictory, or insufficiently developed, including those relating to roles, sequencing,

decision-making, and interactions between national and local systems. They observed that the flowcharts inevitably mirror these ambiguities, resulting in diagrams that appear complex, confusing or misleading, particularly for those unfamiliar with the DHSR model. Several members stated that, although the flowcharts appear helpful at first glance, they become difficult to interpret when cross-referenced with the inconsistencies and gaps across Sections 2–12.

Some members commented that certain flowchart elements were clearer than the accompanying narrative text, which highlights the need for visual tools. However, they stressed that the diagrams must be based on a well-designed process, not used to compensate for unclear written guidance. Members felt strongly that visual clarity cannot overcome conceptual confusion, and that the flowcharts risk giving a false impression of coherence where the underlying process remains under-specified.

Members also observed that the flowcharts do not help clarify how DHSRs interface with other review processes, nor do they resolve questions about the sequencing of decision-making, information-sharing, or quality assurance stages. Several members noted that the diagrams appear overly linear, failing to capture the iterative and relational nature of learning reviews as practised within Scotland's child and adult protection systems. They expressed concern that this could mislead Review Chairs or practitioners into treating the review as a rigid procedural exercise rather than an adaptive, reflective learning process.

In addition, some members found parts of the flowchart difficult to interpret because the underlying text had not clearly defined key concepts, such as the role of local governance, the process for resolving disagreements, or the criteria for joint reviews. They felt that until these issues are addressed, the flowcharts will remain limited in usefulness and may even contribute to misunderstanding.

Overall, members felt that while the idea of including flowcharts is positive, the flowcharts as currently drafted are not fully useful because they reflect the same gaps and inconsistencies present throughout the guidance. Members recommended that the flowcharts be retained in principle but substantially revised once the guidance itself is clarified, streamlined and aligned with existing public protection review methodologies.

Question 34

Do you think there are any ways that the guidance could be improved overall?

Members felt that the draft guidance requires substantial strengthening, restructuring and clarification across multiple sections in order to function as a coherent, credible and practically usable framework for Domestic Homicide and Suicide Reviews (DHSRs). Members repeatedly expressed concerns that the guidance, while ambitious in scope, does not yet reflect the realities of Scotland's multi-agency public protection environment and is not sufficiently aligned with established learning review methodologies.

A consistent theme in members' reflections was the need for the guidance to adopt a clearer and more explicit learning-focused approach, rather than the investigatory or procedural tone that appears throughout several sections. Members noted that Scotland has intentionally moved towards strengths-based, systems-focused learning models within child protection, adult support and protection, and other review processes, yet the DHSR guidance does not adequately incorporate these principles. They felt the guidance must be rewritten to emphasise learning over blame, promote reflective practice, and encourage safe spaces for practitioner engagement.

Members also felt that the guidance requires much stronger and more consistent integration with existing local governance structures, including Chief Officer Groups (COGs), Adult Protection Committees (APCs), Child Protection Committees (CPCs), Violence Against Women and Girls (VAWG) partnerships, and other established oversight bodies. They noted that these groups currently hold statutory or strategic responsibility for safeguarding and learning, yet the guidance repeatedly omits them or assigns unclear, secondary roles. Members stressed that effective DHSRs cannot be delivered without meaningful involvement of these local systems, which hold contextual knowledge, operational understanding and responsibility for implementing change.

Members further emphasised the need for greater clarity around roles and responsibilities, noting that multiple sections lack precision about who leads, who

decides, and who contributes at each stage of the DHSR process. They highlighted that the introduction of a national Review Oversight Committee and Ministerially appointed Chairs creates a complex governance landscape that requires clear articulation of boundaries, authority and accountability. Without this, members feared duplication of effort, conflict between local and national processes, and uncertainty among agencies.

Another strong message from members was the need to improve the quality and depth of methodological guidance, particularly in Sections 8 and 9 relating to information-gathering, analysis and review conduct. Members felt that the guidance undervalues practitioner engagement, triangulation, chronology work and systems analysis, all of which are essential for meaningful learning. They emphasised that without explicit expectations for reflective discussions, contextual understanding and cross-agency insight, DHSRs risk becoming limited, document-led exercises.

Members also identified significant gaps in trauma-informed practice within the guidance. They noted that several sections, including those on family engagement, practitioner involvement, report writing and publication, lack sufficient attention to emotional impact, safety, pacing, sensitivity and the relational needs of people affected by domestic homicide or domestic abuse-related suicide. Members stressed that a trauma-informed approach must be embedded consistently throughout the guidance, not treated as an add-on.

Concerns were also raised about the lack of clarity regarding parallel and overlapping review processes. Members noted that deaths eligible for DHSRs often meet criteria for Child Protection Learning Reviews, Adult Support and Protection Learning Reviews, Significant Case Reviews, and other scrutiny mechanisms. They felt the guidance must clearly set out how processes will align, which review framework takes precedence, how duplication will be avoided, and how learning from different reviews will be coordinated. As drafted, members felt the guidance risks creating confusion, duplication and an unintended hierarchy of reviews.

Members further felt that the guidance requires significantly improved data protection, information-governance and anonymity provisions. They noted that key sections contain inaccuracies, incomplete direction or overly simplistic assumptions about confidentiality and data-sharing. Members were concerned that the guidance,

in its current form, does not adequately safeguard highly sensitive personal data, particularly in small communities or cases involving children. They stressed that robust safeguards must be embedded throughout the process, from data requests to quality assurance to publication.

Members also identified a broader need for the guidance to be substantially reorganised for clarity, reducing duplication, strengthening logical sequencing and improving accessibility. Several members described the document as difficult to navigate, overly dense in some areas and lacking operational detail in others. They expressed a preference for clearer definitions, consistent terminology, and better-structured explanations of processes such as notifications, terms of reference, practitioner involvement, analysis and reporting.

Overall, members felt that the guidance requires wide-ranging improvement to ensure it is workable, coherent and aligned with Scotland's existing learning culture. They recommended: a stronger learning-focused ethos; clearer local-national integration; more robust methodological direction; improved trauma-informed practice; strengthened data governance; clearer processes for overlapping reviews; and substantial structural refinement. As drafted, members felt the guidance sets out an ambitious vision but does not yet provide the practical, relational or systemic foundations necessary for effective Domestic Homicide and Suicide Reviews.

Question 35

Is there anything missing in the guidance that you would like to see included?

Members felt that several essential components are missing from the guidance and must be included to ensure that the Domestic Homicide and Suicide Review (DHSR) model is coherent, trauma-informed, operationally realistic and aligned with Scotland's existing public protection systems. Their views reflect a consistent message throughout the workshop: the draft guidance, while comprehensive in ambition, omits several critical elements required for effective practice.

A major omission highlighted by members was the lack of a clear, explicit learning-focused methodology. They noted that Scotland has established, evidence-based approaches to learning reviews in adult protection, child protection and other settings. Yet the DHSR guidance does not reference these models or draw on their strengths, particularly around reflective learning, systems analysis, practitioner engagement, triangulation and narrative construction. Members stressed that the guidance must explicitly include a learning methodology that sets expectations for how analysis should be conducted and how learning should be generated and interpreted.

Members also identified the absence of practitioner involvement as a major gap. They repeatedly stressed that meaningful learning cannot be generated without engaging practitioners who worked with the individuals involved. Practitioner discussions are essential for understanding the reasoning behind decisions, the pressures and constraints that shaped practice, and the wider organisational context. The omission of practitioner involvement was seen as inconsistent with every other learning review model operating in Scotland, and members called for clear guidance on how practitioners should be involved safely and meaningfully.

Another area members felt was missing was clear guidance on how DHSRs will interface with existing local review processes. They noted that cases meeting DHSR criteria will often also require Child Protection Learning Reviews, Adult Support and Protection Learning Reviews, MAPPA Significant Case Reviews or other learning processes. The guidance does not explain how these processes will be coordinated, how duplication will be avoided, or which framework takes precedence. Members stressed that the absence of this detail risks confusion, duplication, tension between local and national systems and may create an unintended hierarchy of reviews.

Members also raised the need for a comprehensive approach to trauma-informed practice, noting that while the guidance references trauma-awareness in places, it does not embed trauma-informed principles throughout. They felt the document should include explicit expectations about trauma-informed engagement with families, children, practitioners and communities; trauma-informed analysis; safeguards to prevent re-traumatisation; and support for those participating in or

affected by the review. This is particularly important given the nature of domestic homicide and domestic abuse-related suicide.

A further omission identified was the absence of detailed, accurate and practical data-protection and information-governance guidance. Members noted that Section 6.2 contained inaccuracies, jargon, and insufficient detail on data storage, retention, access controls, subject access requests and confidentiality safeguards. They stressed that the guidance must include robust, legally accurate, trauma-informed and operationally workable information-governance instructions, especially given the volume and sensitivity of data involved in DHSRs.

Members also felt that the guidance should include a clear description of the roles of local governance structures (COGs, APCs, CPCs, VAWG partnerships) throughout the DHSR process. They emphasised that these bodies are responsible for local learning and system improvement, yet the guidance does not define how they will be notified, involved or expected to act on learning. Members felt that local systems must have a clearly defined role if the DHSR process is to be effective and credible.

Members were also concerned about the lack of clear timescales for initiating and completing reviews. They stressed that timelines are essential for family expectations, staff wellbeing, organisational planning and system accountability. The absence of timescales risks prolonged reviews, uncertainty for families and delays in learning. Members called for indicative timescales, with room for flexibility where needed, based on evidence from other review models.

Another missing element identified was guidance on managing conflicting family perspectives. Members noted that families affected by domestic abuse and domestic homicide often hold differing or conflicting views due to trauma, manipulation by the perpetrator or complex relational dynamics. The guidance does not address how panels should navigate such conflicts, ensure fairness, or protect the emotional safety of all involved.

In addition, members felt that the guidance lacks clear expectations regarding national learning infrastructure, including how DHSR findings will feed into national improvement bodies, how thematic learning will be shared and how Scotland will build a cohesive national understanding of domestic homicide and suicide. They stressed that without explicit mechanisms for national learning, reviews risk

becoming isolated exercises with limited wider impact. There were suggestions that learning from other models across the UK would be welcomed.

Finally, members felt the guidance should include greater clarity around decision-making criteria, including the sift criteria, thresholds for review, criteria for combined and joint reviews, and how decisions about scope will be reached and documented. They observed that several sections assume decision-making processes that are not clearly described elsewhere in the guidance, leaving gaps and inconsistencies.

Overall, members felt that several essential components are missing and that the guidance must be strengthened substantially to provide a coherent, trauma-informed, learning-oriented, transparent and operationally practical framework. Without addressing these omissions, members felt the DHSR model may struggle to achieve its stated aims of improving practice, preventing harm and supporting meaningful learning across Scotland's public protection systems.

Conclusion

Overall, members strongly support the intention behind establishing Domestic Homicide and Suicide Reviews in Scotland, recognising the significant potential for national learning and improved responses to domestic abuse. However, they felt that the draft guidance requires extensive revision before it can operate as an effective, credible and trauma-informed framework. Across all sections, members identified issues with clarity, coherence, methodology, roles and responsibilities, data governance, and alignment with existing public protection structures. They emphasised the need for a clearer learning-focused ethos, stronger integration with local systems, and more robust guidance on practitioner and family engagement. Members believe that with substantial refinement, drawing on established Scottish learning review practice and addressing the gaps highlighted throughout this response, the DHSR model can become an important and meaningful component of Scotland's public protection landscape.

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