

Domestic Homicide and Domestic Abuse Related Suicide Review (DHSR) Standards Consultation

Social Work Scotland response

Oct 2026

Introduction

Social Work Scotland is the professional body for social work leaders and managers, working closely with our partners to shape policy and practice, and improve the quality and experience of social services. We welcome the opportunity to provide a response to the Domestic Homicide and Domestic Abuse Related Suicide Review (DHSR) Standards Consultation.

General Position

Social Work Scotland welcomes the development of standards to support Domestic Homicide and Domestic Abuse Related Suicide Reviews and agrees with the overarching aims of promoting learning, system improvement, accountability and prevention of future deaths. Members recognised that the standards aim to be comprehensive and reflect important principles including trauma-informed practice, victim and bereaved-centred approaches, children's rights, multi-agency collaboration and continuous improvement.

However, members consistently expressed concerns that the standards are overly detailed and, at times, move beyond the function of standards into operational guidance. There was a strong view that the relationship between the standards and the existing guidance is unclear, resulting in duplication, ambiguity and confusion regarding responsibilities, governance arrangements and operational processes.

Several members highlighted that the standards appear to have been developed through a strongly health-focused lens, which may not always align with the realities of multi-agency public protection practice.

Questions

Standard 1: Leadership and Governance of Review Process

Do you agree with the wording?

Generally, yes. The intent is clear and the focus on accountability, quality assurance and governance is supported.

Are there any gaps?

There are significant gaps around governance arrangements and accountability.

In particular:

- The standards do not clearly identify who holds overall responsibility for governance and oversight of reviews.
- There is limited recognition of existing local governance structures, including Chief Officer Groups (COGs), Adult Protection Committees, Child Protection Committees and other public protection governance arrangements.
- Expectations regarding risk assessment, decision-making and monitoring of recommendations are not sufficiently defined.
- There is a lack of clarity regarding communication between national review structures and local partnerships.
- Members highlighted uncertainty regarding what local agencies should expect once a notification has been made and a review is being considered.

Evidence/references

Links should be made to existing public protection governance arrangements and established review processes across adult protection, child protection and significant case review activity.

Standard 2: Supporting Bereaved People

Do you agree with the wording?

Broadly yes. Members welcomed the emphasis on trauma-informed and bereavement-centred practice.

Are there any gaps?

The standards should provide greater clarity regarding:

- When and how bereaved families are approached.
- Who has responsibility for family engagement where multiple review processes may be underway.

- How duplication of contact with families will be avoided.
- The interaction with justice processes, including Police Scotland and COPFS investigations.

Participants were concerned that unclear review pathways may result in families being approached repeatedly by different review processes, creating further trauma.

Standard 3: Supporting Bereaved Children and Young People

Do you agree with the wording?

Yes. The emphasis on children's participation, rights and wellbeing is welcomed.

Are there any gaps?

Greater clarity is required regarding:

- How participation will be adapted according to age, maturity and circumstances.
- Avoiding repeated engagement with children across multiple review processes.
- Coordination between DHSRs, Child Death Reviews and Learning Reviews.

There is also a need for clearer guidance regarding support arrangements for children affected by reviews over extended timescales.

Standard 4: Domestic Homicide Review Process

Do you agree with the wording?

The standard broadly captures the intended approach.

Are there any gaps?

Yes.

Key concerns include:

- Lack of clarity regarding interaction with criminal investigations and court proceedings.
- Limited guidance on primacy when multiple reviews are being considered.
- Lack of alignment with existing review timescales.
- Uncertainty regarding panel composition and responsibilities.
- Lack of clarity regarding decision-making processes following notification.

Participants repeatedly identified uncertainty regarding how reviews are initiated, governed and progressed in practice.

Standard 5: Domestic Abuse Related Suicide Reviews

Do you agree with the wording?

Broadly yes.

Are there any gaps?

Members supported the focus on recognising domestic abuse as a contributing factor without requiring proof of causation.

However:

- Greater clarity is needed regarding thresholds and criteria.
- The interaction between suicide reviews, child protection reviews, learning reviews and significant adverse event reviews should be clarified.
- Additional guidance should explain how historical experiences of domestic abuse are considered and what factors trigger a review.

Members discussed scenarios where a history of domestic abuse may exist many years before a death and questioned how consistently the criteria could be applied.

Standard 6: Combined Death Reviews and Joint Reviews

Do you agree with the wording?

The principle of reducing duplication is strongly supported.

Are there any gaps?

This was one of the areas generating the greatest concern.

The standards should provide:

- Clearer guidance on when reviews should be combined.
- Clarification of primacy between review types.
- Defined communication pathways between local and national review processes.
- Clear decision-making arrangements where several review frameworks apply.
- Defined timescales.

Members were concerned that the standards seek to promote single-review approaches while simultaneously acknowledging that multiple reviews may occur without explaining how these competing demands should be managed.

There is also a need to avoid situations where families and practitioners are required to participate in multiple overlapping review processes.

Standard 7: Reviews Involving the Death of a Child or Young Person

Do you agree with the wording?

Broadly yes.

Are there any gaps?

The standards require greater clarity regarding:

- The relationship with Child Death Reviews.
- Circumstances where multiple review processes remain necessary.
- Coordination between local and national review arrangements.
- Managing cases involving care-experienced children or children placed out with their local authority area.

Members discussed examples where uncertainty over review pathways had caused delays and additional stress for families and practitioners.

Standard 8: Training and Support for Review Members

Do you agree with the wording?

Generally, yes.

Are there any gaps?

The standards should:

- Specify minimum expectations for review member training.
- Clarify responsibilities for providing training.
- Better define what psychological support and wellbeing support should look like in practice.

Members also questioned whether the standards are overly prescriptive regarding matters that should remain the responsibility of employing organisations.

Standard 9: Training and Support for Practitioners from Participating Agencies

Do you agree with the wording?

Yes.

Are there any gaps?

A stronger emphasis is required on:

- Supporting practitioners involved in reviews.
- Trauma-informed support for staff.
- Workforce wellbeing.
- Time and resource implications for local authorities and partner agencies.

Participants highlighted concerns regarding the emotional impact of reviews on practitioners, particularly those closely involved in cases.

There should also be recognition of existing workforce pressures and staff retention challenges.

Standard 10: Sharing Knowledge and Learning from Reviews

Do you agree with the wording?

Yes. A learning-focused approach is strongly supported.

Are there any gaps?

There needs to be greater clarity regarding:

- How learning is disseminated.
- Ownership of recommendations.
- Who monitors implementation.
- The relationship with existing learning review and public protection structures.
- Publication processes and decision-making.

Members raised concerns that recommendations should be developed in partnership with local governance arrangements and not imposed without consideration of local context, feasibility and resources.

There were also concerns regarding anonymity in small and remote communities where publication may inadvertently identify individuals.

Standard 11: Information Governance

Do you agree with the wording?

The intent is supported.

Are there any gaps?

Yes.

Members highlighted:

- Significant uncertainty regarding information sharing arrangements.
- Lack of practical detail regarding handling of sensitive personal information.
- The need for clear national processes for information transfer.
- Uncertainty regarding local points of contact and responsibilities.

Given the highly sensitive nature of information involved in DHSRs, greater operational clarity is required to provide assurance to participating agencies.

Overall Feedback**Specific feedback on terminology**

- The distinction between "standards" and "guidance" is unclear throughout.
- Language is often highly detailed and prescriptive, making the standards read as operational guidance rather than outcome-focused standards.
- Terminology should align more closely with existing learning review, public protection and improvement frameworks to create consistency across review methodologies.
- Terms such as "joint review", "combined review" and "single review" require clearer definitions.

Additional feedback

Social Work Scotland's overarching concern is not with the intention of the standards but with their practical implementation.

Members repeatedly highlighted:

- Lack of clarity regarding governance and accountability.
- Unclear relationships between DHSRs and existing review processes.
- Absence of clearly defined timescales.
- Uncertainty regarding responsibility for coordinating reviews.

- Potential for increased trauma to families through multiple review processes.
- Insufficient attention to practitioner wellbeing and support.
- Lack of clarity regarding resources required to deliver the standards.
- The need for stronger links to existing local governance arrangements, particularly Chief Officer Groups and public protection partnerships.
- Concerns that the standards have been developed before sufficient operational learning has emerged from implementation of the review framework.

Social Work Scotland would therefore encourage Health Improvement Scotland and Scottish Government to simplify the standards, clarify their relationship with the guidance, strengthen alignment with existing review processes, and provide greater clarity regarding governance, communication, coordination and implementation arrangements. This would make the standards more accessible, more practical and more likely to achieve their intended aim of supporting learning, prevention and system improvement.

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