Scottish Women's Convention response to the Scottish Government's consultation on:

Scotland's Domestic Homicide and Suicide Review (DHSR) Framework

February 2026

Premise

This response is submitted by our organisation to ensure that women's experiences, safety, and rights are fully reflected in the development of Scotland's Domestic Homicide and Suicide Review (DHSR) framework.

Women continue to be disproportionately affected by domestic abuse, coercive control, and domestic homicide. Many women who are killed by a current or former partner have had limited or no contact with statutory services prior to their death, often due to fear, isolation, trauma, or previous negative experiences of seeking help. For these reasons, it is paramount that women's voices and lived experience are central to any system designed to review deaths, identify learning, and prevent future harm.

As a women's organisation, we work closely with women and families affected by domestic abuse and gender-based violence. We see first-hand how systems can fail to recognise patterns of coercive control, underestimate risk, or place unrealistic expectations on women to seek help. We also see the long-lasting impact on families and communities when deaths are not reviewed in a timely, trauma-informed, and transparent way.

We therefore welcome the introduction of the Domestic Homicide and Suicide Reviews in Scotland and support their focus on learning and prevention. Our response aims to strengthen the guidance by highlighting where clarity, accessibility, and women-centred practice are essential. In particular, we emphasise the need for clear referral routes, meaningful involvement of women's specialist expertise, independent support for families, and realistic timescales that avoid increasing harm.

Our comments are informed by our organisational experience, engagement with women and families, participation in national discussions on violence against women and girls, and relevant evidence from our conferences, outreach meetings and previous consultation responses.

The Scottish Women's Convention offers this response with the aim of ensuring that DHSRs lead to real, measurable improvements in women's safety across Scotland.

The Scottish Women's Convention (SWC)

The SWC is funded to engage with women across Scotland to ensure that their views are represented in policy and decision-making processes. The SWC uses the views of women to respond to a variety of parliamentary, governmental, and organisational consultation papers at Scottish, UK and international levels.

The SWC gathers information using different methods, including roadshows, thematic conferences, surveys, and both in-person and online roundtable events. This submission presents the views of a range of women, reflecting their opinions, ideas and lived experience. Working together with many other equalities organisations and community groups, we use our broad network to ensure that women from a range of backgrounds are heard and acknowledged. We are continually reviewing innovative ways of engaging with women and developing our trauma-informed and culturally sensitive practice to support vital contributions from as many women as possible.

Questions

1. Is the content of Section 2: Legislation clear?

Mostly yes, it's clear who the reviews are meant to cover, but it should say in simpler terms that a review may still happen where domestic abuse is only suspected and not 'proven.' Many women never report abuse due to fear, coercive control, shame, or lack of access to services and this has to be taken into consideration.

The SWC feels that guidance should also stipulate that deaths involving drugs, alcohol, or where circumstances are not explicitly obvious, could still be relevant where domestic abuse may have been a factor and should not be dismissed automatically.

2. Is the content of Section 3: Review Oversight Committee Chair and Case Review Panel clear?

Some of the information is clear but it lacks practical clarity in areas such as:

- How large the committee would be
- How specialist expertise would be considered within the committee
- How women/families are kept informed of how quickly decisions would be made giving them a better of understanding of progress and developments

The SWC believes that ignoring any of the aforementioned factors could ultimately lead to further trauma for women and families.

In addition to this, the women we spoke to indicated that they felt it was vitally important that those with a real understanding of domestic abuse, coercive control or lived experience are involved in decision making processes from the outset and that any elected committee should not be reliant on senior or ministerial appointees taking precedence over other's involvement.

3. Is the content of 'Section 4 Death Notifications and Referrals' clear and do you have any comments?

It is not fully clear. The guidance should state that anyone can refer a death, including family members and support organisations, and that a lack of police or service involvement does not automatically prevent a review. This is especially important for women who were isolated or were never in a position where they could seek the relevant help. The role of Scottish Ministers in the

process should be explained as an administrative step and not as a final judgement on whether a woman's death is deemed 'serious enough.'

4. Is the content of 'Section 5 Notification of review revocation: Suspension and Discontinuation of Review Proceedings' clear?

The process in itself is adequately described however in parts it feels confusing and could potentially cause unnecessary worry for families. It should be made clear that Scottish Ministers stepping in to direct a review would be a rarity and would only be used as a safeguarding measure. Without this clarity, families may feel decisions are political rather than independent, which could have a direct bearing on the trustworthiness of the whole process.

5. 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?

The idea around the terms of reference is clear, but there's not enough information around timescales. Families and staff need to be given a rough estimate on how soon a decision will be made on whether a review will be taking place (even if full completion times vary). Without at least an intended decision timeframe, reviews could drift and take years to be considered, causing further trauma and making any recommendations less useful due to the fact that services may already have changed by the time the report is finalised.[1]

6. Is the content of 'Section 6.2 Data Sharing and Data Protection' clear and do you have any comments?

The principles are mostly clear, but the guidance should explain more fully how information will be obtained from GPs and other health services. The women that we spoke to said that health records are often crucial in understanding patterns of domestic abuse, mental health impacts and coercive control, especially where women were prevented from seeking help.

Clear national guidance would also avoid the risk of delays or uncertainty over what information can be shared, also reducing the risk of confusion at local level.[2]

[1] Healthcare Improvement Scotland: Domestic homicide and suicide review standards – Healthcare Improvement Scotland

[2] Ibid

"The police system hasn't kept up with the technology, so your bobby on the beat doesn't know how to gather evidence … and women just get fed up thinking 'what's the point in reporting it?' as nothing ever gets done when its that kind of abuse."[3]

7. Is the content of 'Section 6.3 Case Review Panel and Chair' clear?

Mostly clear, but the guidance should be more specific and stipulate the knowledge and skills of the Chair. The women we spoke to informed us that it is essential that the Chair understands their predicament and that the committee should avoid such language that looks to minimise abuse as 'mere relationship issues.' Women's safety depends on any reviews correctly recognising continued patterns of risk and abuse.[4][5]

8. Is the content of 'Section 6.4 Assembling a Case Review Panel' clear?

It is partly clear, but more practical detail could help. For example, it should be more specific on whether panels will usually meet online, how professionals' time will be funded (such as GPs, locums etc), and how women's specialist services will be included as standard rather than their input being optional.[6]

9. Is the content of 'Section 6.5 Additional expertise' clear?

The intention is clear, but the guidance should be stronger in stating that specialist women's organisations and intersectional expertise in areas such as inequality, disability, race, culture, immigration and geographical factors must be involved, where relevant. Women's individual experiences are not the same, and any reviews must always reflect this.[7][8][9]

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[3] UK Parliament: Written evidence from the Scottish Women's Convention [EOV0015] committees.parliament.uk/writtenevidence/124856/pdf/

[4] Equally Safe Supporting documents - Equally Safe 2023 - preventing and eradicating violence against women and girls: strategy - gov.scot

[5] Healthcare Improvement Scotland: Domestic homicide and suicide review standards – Healthcare Improvement Scotland

[6] UK Parliament: Written evidence from the Scottish Women's Convention [EOV0015] committees.parliament.uk/writtenevidence/124856/pdf/

[7] Scottish Women's Convention reforming-the-criminal-law-to-address-misogyny-final.pdf

[8] Scottish Women's Conventionprevention-of-domestic-abuse-scotland-bill-final.pdf

[9] Equally Safe Supporting documents - Equally Safe 2023 - preventing and eradicating violence against women and girls: strategy - gov.scot

10. Is the content of 'Section 6.6 Combined Deaths and Joint Reviews' clear and do you have any comments?

This section is not clear enough, particularly where children are involved. Child protection learning reviews work differently, and the guidance should explain clearly how decisions will be aligned so that reviews do not run in parallel or cause delays. Women and children should not be caught between different systems.[10]

11. Is the content of 'Section 6.7 Combined and Joint Review Terms of Reference' clear and do you have any comments?

Some further points of clarification are needed. It should be made clearer who leads when review processes are combined and how far back in time the review can look for information. Also, looking beyond the point of death is essential for understanding long-term coercive control and missed opportunities to protect women.[11][12]

12. 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?

The role of the National Hub is clear, but responsibility for completing data should ordinarily sit with the review Chair. Health boards should not be expected to complete this unless they have lawful access to the right information and are involved in the review. This avoids confusion, protects confidentiality, and ensures accuracy of information.[13]

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

This section needs strengthening. The women that we spoke to told us that families need clear, ongoing support and a genuinely trusted point of contact. Police family liaison officers may only be involved for a short time, and not all

[10] Healthcare Improvement Scotland: Domestic homicide and suicide review standards – Healthcare Improvement Scotland

[11] Equally Safe Supporting documents - Equally Safe 2023 - preventing and eradicating violence against women and girls: strategy - gov.scot

[12] UK Parliament: Written evidence from the Scottish Women's Convention [EOV0015] committees.parliament.uk/writtenevidence/124856/pdf/

[13] Healthcare Improvement Scotland: Domestic homicide and suicide review standards – Healthcare Improvement Scotland

deaths involve crime. Independent advocacy for families, particularly women's families, should be clearly addressed.[14]

"I felt like I was the abuser…I was already so traumatised …I was already in shock, and I was expected to go through hours' worth of interviews."[15]

14. Is the content of 'Section 8.1 Individual Management Review' clear and do you have any comments?

The requirement for IMRs is clear, but the guidance should emphasise the importance of learning from frontline practitioners' experiences, not just from written records. Understanding what it was like to work with the woman is crucial to meaningful learning.[16]

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

Useful to include, but it should be more explicit that threats to pets and animals are a known tool of coercive control and could prevent women from leaving. That in itself should be treated as a serious form of domestic abuse and not just as an aside.[17]

16. 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?

This section seems clear in principle but it should emphasise looking for patterns of behaviour and missed warning signs across services, rather than treating incidents in isolation. Women are often failed when agencies view incidents separately rather than as a continued pattern of escalating risk.[18]

17. 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?

[14] Scottish Women's Conventionprevention-of-domestic-abuse-scotland-bill-final.pdf

[15] UK Parliament: Written evidence from the Scottish Women's Convention [EOV0015] committees.parliament.uk/writtenevidence/124856/pdf/

[16] Ibid

[17] Equally Safe Supporting documents - Equally Safe 2023 - preventing and eradicating violence against women and girls: strategy - gov.scot

[18] Ibid

More clarity is needed. Families should know how they can be involved, what choices they have, and whether they can attend meetings or provide views through advocacy. Bereaved children need a specific child centred approach.[19]

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

It is clear who is responsible, but the guidance should acknowledge that gaps in records are common where women were isolated or controlled. These gaps should be treated as learning, not as failures of the review process.[2021]

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

Yes, but it should be more explicit in recognising that coercive control, separation, stalking, and escalation are central risks for women and must always be considered.

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

The section is helpful, but it should be made clearer that domestic abuse can be a factor in suicide even where mental health or substance use is also present. Women's deaths should not be dismissed as complex lifestyles.'[22]

21. Is the content of 'Section 9 Review Analysis' clear and do you have any comments?

Yes, the general approach is clear but the guidance should reassure practitioners and families that the aim is learning and prevention and not to apportion blame. Women's safety improves when the review focuses on why systems failed, not just on individual errors.[23]

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

[19] Scottish Women's Conventionprevention-of-domestic-abuse-scotland-bill-final.pdf

[20] Equally Safe Supporting documents - Equally Safe 2023 - preventing and eradicating violence against women and girls: strategy - gov.scot

[21] UK Parliament: Written evidence from the Scottish Women's Convention [EOV0015] committees.parliament.uk/writtenevidence/124856/pdf/

[22] Equally Safe Supporting documents - Equally Safe 2023 - preventing and eradicating violence against women and girls: strategy - gov.scot

[23] Ibid

Clear in structure, but it needs a stronger push for recommendations to be timely and tracked. If a review takes years, learning arrives too late to protect other women. Interim learning should be standard practice and not just in exceptional circumstances.[24]

23. Is the content of 'Section 10.2 Preparing Review Reports' clear and do you have any comments?

Yes, however reports should use language and terminology that reflects women's lived experiences and the realities of domestic abuse. Reports should also clearly identify what could have been done differently to help minimise risk.[25][26][27]

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

Somewhat clear, but it must balance privacy with meaningful learning. Over-anonymising can make reports too vague to drive change, particularly around how women sought help and where certain systems failed.

25. Is the content of 'Section 10.6 Sharing draft review reports' clear and do you have any comments?

Mostly clear, however families should clearly understand how they can comment on drafts safely and be receive assurances that their views will be taken seriously.[28]

26. Is the content of 'Section 10.7 Finalising draft review reports' clear and do you have any comments?

Yes, though it would help to explain how disagreements are resolved to maintain transparency and trust.[29]

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[24] Healthcare Improvement Scotland: Domestic homicide and suicide review standards – Healthcare Improvement Scotland

[25] Equally Safe Supporting documents - Equally Safe 2023 - preventing and eradicating violence against women and girls: strategy - gov.scot

[26] Scottish Women's Convention reforming-the-criminal-law-to-address-misogyny-final.pdf

[27] Scottish Women's Conventionprevention-of-domestic-abuse-scotland-bill-final.pdf

[28] Ibid

[29] Healthcare Improvement Scotland: Domestic homicide and suicide review standards – Healthcare Improvement Scotland

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

Yes, but it should be clear that quality assurance should explicitly include checking that women's safety and domestic abuse dynamics are properly understood.[30]

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

Yes, and the option to share interim learning is welcome. This is vitally important so that changes can be made quickly to protect other women.

29. Is the content of 'Section 12 Biennial Thematic Reports' clear and do you have any comments?

Yes, but the guidance should emphasise that themes must lead to real national action, not just on reporting.

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

The flowchart is helpful, but it is quite complex and fussy. It could better show where families and frontline practitioners fit into the process. A simpler version could perhaps be made available.

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

The guidance could be improved by clearer timescales, clearer family support arrangements, stronger emphasis on women's lived experience, and clearer links with existing child protection and learning review processes.

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

What's missing is:

- Clear independent advocacy for families,
- Clearer timescales for decisions and progress
- Clearer reassurance that women who never reported abuse are fully included
- Clearer practical guidance on joint working with existing review systems

[30] Equally Safe Supporting documents - Equally Safe 2023 - preventing and eradicating violence against women and girls: strategy - gov.scot

The SWC is grateful for the opportunity to respond to the Undertaking Domestic Homicide and Suicide Reviews consultation. As an organisation, we will continue to work with women from across Scotland to gather voices and experiences relating to this topic and its effects on women's equality.

For further information or to share your views, please contact:

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