Criminal Justice Committee
Wednesday 5 February 2025
5th Meeting, 2025 (Session 6)

Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews (Scotland) Bill

Note by the Clerk

Introduction

1. The Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews (Scotland) Bill was introduced in September 2024.

2. Part 1 makes changes in relation to criminal cases. The Bill makes the following permanent for criminal cases:

    - using electronic signatures on court documents
    - sending court documents electronically
    - attending criminal court hearings virtually
    - increasing fixed penalty limits that may be offered by a procurator fiscal ('fiscal fines') as an alternative to prosecution through the courts
    - a national jurisdiction for first callings from custody, allowing the initial stage of some criminal cases to be taken in any sheriff court in Scotland

3. Part 1 of the Bill also makes some new changes to procedures in criminal courts. These are:

    - treating pictures of physical evidence in the same way as the original physical evidence in criminal cases
    - establishing a process for electronic copies of documents to be trusted

4. Part 2 of the Bill creates a process for reviewing deaths which relate to abusive behaviour within relationships. These reviews would look at what lessons can be learnt in relation to a death to try to stop similar things happening again. The Bill also creates an oversight committee and case review panels to undertake and manage the reviews.

Today's evidence on the Bill

5. At today's meeting, the Committee will evidence from the following witnesses.

    Panel 1

    - **Fiona Drouet,** Founder and CEO of EmilyTest
    - **Dr Marsha Scott,** Chief Executive**,** Scottish Women's Aid

Panel 2

- **Katie Brown,** Equally Safe Policy Manager, COSLA
- **Graeme Simpson,** Chief Social Work Officer for Aberdeen City and Social Work Scotland representative on the DHSR Committee
- **Dr Emma Fletche**r, Director of Public Health, NHS Tayside

6. The following submissions have been provided to the Committee, which are reproduced at the Annex—

    - Fiona Drouet, EmilyTest
    - Scottish Women's Aid
    - COSLA
    - Social Work Scotland

Previous meetings

7. At the committee meetings on 22 and 29 January, the Committee took evidence from—

    - Scottish Solicitors Bar Association
    - Law Society of Scotland
    - Edinburgh Bar Association
    - Victim Support Scotland
    - Age Scotland
    - Crown Office and Procurator Fiscal Service
    - Scottish Courts and Tribunals Service
    - Police Scotland
    - Professor John Devaney, University of Edinburgh
    - Professor Neil Websdale, Director of the Family Violence Center, Arizona State University
    - Dr Grace Boughton, Criminologist

Financial Memorandum

8. The Finance and Public Administration Committee issued a call for views on the Bill's Financial Memorandum.

9. Responses were received from the Scottish Courts and Tribunals Service, the Crown Office and Procurator Fiscal Service and Police Scotland.

10. The responses to the call for views can be found online.

Further reading

11. A SPICe briefing on the Bill can be found online.

12. The responses to the Committee's call for views on the Bill can be found online.

Clerks to the Committee
January 2025

Annex: submissions received

Fiona Drouet, EmilyTest

I want to begin by expressing my gratitude to the Criminal Justice Committee for considering this crucial issue. My submission comes from the most personal and devastating place, the loss of my wonderful, much loved and dearly missed daughter Emily; my daughter, and my best friend, whose life was stolen from us because of domestic abuse at the age of only 18 years old.

Emily was a first year law student, at the university of Aberdeen, living away from our family home in Glasgow. She was loving her life as a student, making new friends, partying, completely embracing her newfound independence.

But university wasn't all we thought it was for Emily, there was a dark side that we knew nothing of. On the 18th of March 2016, at 1:30 am, our lives changed forever, in a way that we could never have imagined possible. The police knocked on our door to deliver the worst news a parent could ever hear. Emily had been found in her student halls after taking her own life. My immediate thought was that Emily had been killed. We couldn't comprehend how this could happen to our kind, intelligent, and wonderful little girl, who we believed was flourishing at university. Emily had the world at her feet and a full beautiful life ahead of her, as a family we had a full and happy future to look forward to together.

We later discovered the unimaginable truth that during her time at university, Emily had been subjected to a sustained campaign of physical, psychological, and sexual abuse at the hands of a fellow student. Piece by piece, during the most excruciating grief imaginable, we uncovered the full extent of what she endured and how the multiple opportunities to intervene and protect her were missed.

We will always feel such gratitude to the police who delivered the news to us. Their compassion and support during the darkest moment of our lives is something for which we will forever be grateful. But after they left, we were lost. Our world had imploded, and nothing made sense. I remember calling one of Emily's friends from university. The moment I heard her voice, the screaming in the background told me this was real – this had really happened, and Emily was gone. Her friend's first words to me were, "Angus hasn't been good to Emily, Fiona."

Over the following days, weeks, and months, we learned of the horrific abuse Emily endured and how her suicide could and should have been prevented. The university failed her repeatedly - failing to recognise so many warning signs, missing opportunities to intervene, and ultimately leaving Emily feeling so hopeless and alone that she saw no other way to end her pain and fear.

As grieving parents, we were left to piece together what had gone wrong. In Scotland, there was no inquest. Unlike in England, where inquests provide a structured investigation into deaths. In Scotland, FAI's (Fatal Accident Inquiries) are discretionary and although we requested one, it was denied. The responsibility to

uncover and address so many preventable failures fell entirely on us at a time when we were at our weakest. It felt like an unbearable burden - one that no grieving family should have to bear.

I remember feeling like I had failed my children simply by living in Scotland, where no system existed to examine Emily's suicide in the context of domestic abuse. I read emails from that time, myself and my husband's desperate messages asking universities and the police to learn from the failures that led to our daughter's death, and I barely recognise myself or my husband in them. We were and are utterly broken, in agony and yet we have had to become advocates for change.

As a country, we pride ourselves on having "gold standard" domestic abuse laws; but if we are to truly claim this, we must review all deaths related to suicide and ensure that no stone is left unturned in understanding the circumstances that lead to these tragedies. This includes identifying missed opportunities, holding institutions accountable, and implementing systemic changes to better protect victims and prevent further loss of life. Without this commitment, we risk failing the very people our laws are designed to protect.

Professor Jane Monckton Smith's work highlights the stark reality that in England and Wales, two women a week are killed by a partner or ex-partner. When you include suicides connected to domestic abuse, that number is believed to be closer to ten. These are not just numbers; they are daughters, sisters, granddaughters. And yet, what happens after these lives are lost?

In Scotland, we currently have no system to review suicides linked to domestic abuse. This is a glaring omission in our efforts to prevent further needless deaths. Other countries, including England, have recognised the importance of such reviews, which provide critical insights into what went wrong and what changes are needed to protect others in the future.

It cannot be left to grieving families to uncover these failures. Each death is a tragedy, but it must also be an opportunity to learn and improve. We owe it to every victim to show that their life mattered, that their death will not be in vain, and that we will fight to prevent others from suffering the way they and their families have.

This is Emily's legacy. It is the legacy of so many victim-survivors whose lives were cut short because of domestic abuse. As a society, we must do better. We must commit to reviewing all deaths by suicide where domestic abuse is a factor. Only then can we ensure that we truly honour their memory by creating a safer, more just country. We often reflect on how our lives would be now if we hadn't had to bridge the gaps and address the inadequacies of various systems ourselves, that's something we'll sadly never know.

Thank you for considering this vital issue that could, I am in no doubt, prevent more precious lives from being lost and ensure that the people who were silenced are heard and are learned from.

Scottish Women's Aid

Scottish Women's Aid (SWA) is the lead organisation in Scotland working to end domestic abuse and plays a vital role in campaigning for effective responses to domestic abuse.

SWA is the umbrella organisation for local Women's Aid organisations across Scotland; each providing practical and emotional support to women, children and young people who experience domestic abuse. The services offered by our members include crisis intervention, advocacy, counselling, outreach, follow-on support and temporary refuge accommodation.

We also run the Scotland's Domestic Abuse and Forced Marriage Helpline taking over 1000 calls, WhatsApp messages, and texts (24h/365) every month.

Introduction

SWA welcomes this Bill and its primary focus on creating a process and regulatory regime for Domestic Abuse Homicide and Suicide Review, a mechanism that has been sorely absent in Scotland and on which SWA has lobbied and campaigned for a number of years.

PART 1 – CRIMINAL JUSTICE MODERNISATION

Section 2 - Virtual attendance at court

We note that this section modifies the 1995 Act, through a new section 303G to remove the requirement for people to physically attend court when giving evidence, and thereon permit virtual attendance at court, in certain criminal proceedings.

New section 303J in the Bill retains the Lord Justice General's power – initially created in the 2022 Act's temporary provisions – to issue determinations to change the default to virtual attendance for certain types of cases or in certain circumstance. However, the Lord Justice General cannot issue a determination that trials should be held virtually by default, this power is limited to cases where neither section 303G nor 303H applies and the court can overrule any determination.

In relation to domestic abuse complainers, we do not think that this power in the Bill goes far enough.

Despite the fact that the Bill provisions mean courts could choose to allow virtual attendance of complainers and non-public official witnesses, this would only be done on a case by case basis. This will mean there would be no consistent approach across all criminal proceedings, leading to uncertainty, concerns and upset for complainers and any individual determination by the court would be open to challenge by the defence. The result of which will be concern and increased trauma for complainers if they wish to give evidence virtually, or thought they were being allowed to do so, and this was denied.

Additionally, although section 271 of the Criminal Procedure (Scotland) Act 1995 (the 1995 Act), as amended by section 10 of the Victims and Witnesses (Scotland) Act 2014[1] (the 2014 Act), allows victims of offences, the commission of which involved domestic abuse, to be automatically regarded as vulnerable witnesses, with automatic right to have use of a screen, CCTV or supporter when giving evidence. CCTV is not always available in court. Also, this does not automatically allow other non-public official witnesses, such as family, friends, specialist support workers, to give evidence remotely.

Further change is needed and the Bill should provide that, where an offence is alleged to have been committed against the person in proceedings for an offence the commission of which involves domestic abuse, there is a presumption that attendance of complainers and non-public official witnesses, such as family, friends, specialist support workers, will be virtual and not in person. Additionally, the guidance issued by the Lord Justice General should also provide for this position.

There are sound and persuasive arguments to support this:

- It would build on the existing support for vulnerable witnesses giving evidence, as above. The harm and danger of engaging with the existing criminal court processes around domestic abuse has been repeatedly raised by SWA and extensively referred to in research around women's experiences in the criminal justice system.[2] Women cannot continue to rely on the judiciary and SCTS officials to implement improvements in practice and procedures purely on a discretionary basis.

We call on the Scottish Parliament to make a stronger statement on the need for change through an appropriate amendment to this section.

- It would not prejudice the fairness of the proceedings, or otherwise be contrary to the interests of justice. On the contrary, it is wholly in line with the Scottish Government's commitment to having victim-centred and trauma-informed justice practices supporting vulnerable witnesses to give their best evidence and participate in proceedings.[3] This aligns with the direction of travel in Part 2 of the Victims, Witnesses and Justice Reform (Scotland) Bill in introducing duties and powers to ensure the conduct of criminal proceedings in conducted in a way that accords with trauma-based practice.[4]

- It would support the work of the Summary Case Management Pilot.

- Crucially, it would implement the recommendation from the Virtual Trials National Project Board report[5] and indeed, Sheriff Principal Pyle continues to support this position. These recommendations met with the full support of the Lord Justice General and the SCTS[6] and were welcomed in the HMIPS Report on "The prosecution of domestic abuse cases at sheriff summary level".[7]

PART 2 – DOMESTIC HOMICIDE AND SUICIDE REVIEW

SWA supports the creation of a statutory model underpinning the process and regulatory regime for domestic homicide and suicide reviews, as we have lobbied for such for almost a decade.

We welcome:

- the inclusion of domestic abuse related suicide.
- domestic-abuse-related family homicide where the perpetrator kills their partner/ex-partner and associated children.
- including violent resistance homicide (where a person experiencing domestic abuse behaviours kills the perpetrator of the abuse).
- Children killed in a domestic abuse context either as direct victims or where they are killed as a means to cause additional harm and abuse to the primary victim of domestic abuse.

Our comments on the individual sections in this Part of the Bill and, where appropriate, their related Explanatory Note, are as follows.

Section 9 - Domestic homicide or suicide review

b) Section 9(1) - Definition of Domestic homicide or suicide review

"9(1) In this Part, "domestic homicide or suicide review" means a review— (a) of the circumstances in which a domestic abuse death, or a connected death of a young person, occurred,…"

We suggest amending the text to read "*domestic abuse death* ***and/or*** *a connected death…"* clarifying that these reviews can be undertaken separately or conjoined.

b) Definition of "child" and young person throughout section 9

The intent of this section is not clear and the wording confusing.

- Section 9 appears to use the terms "child" and "young person" interchangeably, with no consistency and "young person" as a shorthand for both.

- Section 9(7)(d) legally defines a young person, but not a child, and that legal definition is based on age. The only definition of a child is in the Explanatory Notes, paragraph 106, which defines a child in terms of the nature of the relationship between that person and Person A and Person B, as opposed to any legal definition relating to age.

- Given that "child" in legislation also has a legal definition relating to age, there is the potential for considerable confusion in the Explanatory Notes (see paragraphs 109, 110,) and this section, where these terms appear.

Where “child” or “young person” is stated individually, our position is that both should be used, to clarify that the deaths of children **and** young people are covered.

c) Wording in Explanatory Notes for section 9(3)

Paragraph 105 of the Explanatory Notes, states *“For the purposes of this section, person A is a person who has, or appears to have, behaved in an abusive manner towards person B. To use more everyday language, person A is therefore the “perpetrator” of the abusive behaviour (**though it is accepted that there may be some cases where abusive behaviour goes in both directions). The person who is on the receiving end of the abusive behaviour*** (our emphasis) *(i.e. person B) needs to be, at the time of the behaviour, one of the following—*

- *the partner or ex-partner of “the perpetrator”,*
- *the child of “the perpetrator”,*
- *the child of the partner or ex-partner of “the perpetrator”,*
- *a young person living in the same household as “the perpetrator”, or in the same household as “the perpetrator’s” partner or ex-partner.”*

  The wording emphasised above is not appropriate and should be deleted. The wording must be amended, to say, for example “*The person who is experiencing the abusive behaviour…”*

c) Definition of domestic abuse - section 9(7)

“9(7) - For the purposes of this section— a reference to behaviour which is abusive (however expressed) is to be construed in accordance with sections 2 and 3 of the Domestic Abuse (Protection) (Scotland) Act 2021, …

We note that to ensure all domestic abuse incidents can fall under the remit of the Review, including single incidents, the definition of behaviours in section 2 of the Domestic Abuse (Protection) (Scotland) Act 2021, which reflect the terms of the Domestic Abuse (Scotland) Act 2018, is used, as explained in paragraphs 144, 145 and 146 of the Policy Memorandum.

In relation to paragraphs 145 and 146, which discuss reporting of domestic abuse, we would point out that domestic abuse is a 24/7 phenomenon that is not well described by an incident report. Reporting to the police can be too dangerous for a variety of reasons. A lack of reporting must not be taken as an indicator that no abuse was occurring.

The descriptive text in several paragraphs of the Bill’s Explanatory Notes is not particularly appropriate and we would suggest clarification and amendments as follows:

Explanatory note

Paragraph 107

"Violent resistance" is not explained at all in the Explanatory Notes or the Policy Memorandum. This paragraph needs clarification with the addition of the descriptive text below from Michael Johnson and a link to his work in explaining the typologies: "***Violent Resistance –*** *perpetrated while resisting violence, perpetrated more by women in self-defence. Violent resistance occurs when a partner uses violence as a defence in response to abuse by a partner. It is an immediate reaction to an assault and is primarily intended to protect oneself or others from injury."*[8]

Paragraph 110

The wording of the examples set out in this paragraph is not appropriate. Referring to a scenario where a child who was on playdate at a friend's house and "*gets caught up in a domestic incident and killed"* minimises the abuse.

Paragraph 111

SWA eschew the phrase "*abusive relationship*" as relationships aren't abusive, abusers are, and to reflect that, suggest deleting the text *"For example, following an abusive relationship a man might kill his wife and then kill himself"* and substituting the following amended wording "*For instance, as part of the abusive behaviour, a man, Person A, might kill his partner during the relationship, or after it has ended, after they had separated, and then kill himself."*

Section 11 - Review oversight committee

This section refers to the appointment of the review oversight committee (the committee). This will be responsible for securing the carrying out of reviews and overseeing the review process, including the establishment of case review panels (the panel) and determining membership of those panels.

Firstly, we found the wording unclear and lacking clarity but also, in terms of ensuring domestic abuse competence in the oversight process, we have concerns around the Bill's proposals for the constitution of the committee.

Section 11(4) provides that "*In appointing members under subsection (2)(c)(ii), the Scottish Ministers must ensure that the committee includes representatives of voluntary organisations which provide services to individuals in Scotland."*

This is further defined in paragraph 118 of the Explanatory Notes which states *"For example, this might be charities which have the purpose of assisting victims of abusive behaviour,* ***or*** *(our emphasis) those which deal with matters such as substance abuse and which have experience of working with those who have suffered or been responsible for abusive behaviour in connection with that."*

Firstly, this clearly indicates that the inclusion of victim support organisations is

discretionary. There is no indication of the proportion of "voluntary organisation" members that must be from organisations supporting victims nor reference to specialist voluntary sector organisations. Therefore, the section must contain a requirement that Ministers appoint representatives from expert, specialist, voluntary sector organisations supporting as committee members.

Secondly, this section does not specify the total number of "individual" members likely to be appointed from the statutory "nominated" organisations or from voluntary organisations. This means that the majority of the individual committee members could be from statutory organisations. A balance of voluntary and statutory members must be in place to mitigate the uneven distribution of power and resources in these two sectors.

We also note that the Schedule to the Bill, at paragraph 1, specifies a list of individuals automatically disqualified from appointment as the chair or deputy chair of the committee or chair of the panel due to their holding various offices or positions with various statutory agencies. Paragraph 2 imposes a further set of restrictions on "…*members, employees or appointees of an organisation supporting of victims of crime, or an organisation involved in overseeing the provision of services to victims of abusive domestic behaviour*." It is not clear why this has been included and clarification is needed.

Section 12 - Case review panels

The panel members will not be full time and will be conducting reviews alongside other calls on their time. Explanatory Notes at paragraph 121 states "…*The intention is that this will be a role performed by people who have valuable insights to offer but who will be able to do this alongside their everyday lives and work."* There is no indication that either the panel chair or the members will be required to demonstrate any specific knowledge, competency, relevant experience or understanding around the causes, impact and dynamics of domestic abuse, the qualification being, simply that they "… *have valuable insights to offer* ...".

It is important that members demonstrate a sound understanding of the intersectional gendered dynamics of domestic abuse and experience in a related field. Therefore, a mandatory requirement for a knowledge and competency framework for both panel chairs and members must be clearly stipulated and set out within the guidance that Scottish Ministers are required to produce for the committee and panels, under section 25 of the Bill, and to which the committee and panels must have regard when exercising their functions.

Section 14 - Notification of deaths

Paragraph 162 of the Policy Memorandum states that **"…***Ministers may also receive a notification from families or an advocate on behalf of a family requesting a review. Ministers will be able to refer this into the review oversight committee for consideration."* This is an extremely important opportunity for victim's families (and supporting organisations) for them to draw Ministers' and the committee's attention to a domestic abuse homicide where a review of that homicide does not appear to be forthcoming and the families are concerned that a "*potentially reviewable death*" has occurred. This is not made clear in either the wording of the section or the relevant Explanatory Notes.

For the avoidance of doubt, it must be explicitly set out in both the section and the Explanatory Notes.

Section 16 - Determination as to whether to hold a review

The process set out in this section is not acceptable as it entirely possible for a domestic abuse homicide or suicide not to be reviewed because the committee either considers, for whatever reason, at an early and preliminary stage of the process, that there were no "lessons to be learned" or "opportunities missed, or fails to identify evidence that this was the case. We consider that it requires extensive amendment to achieve the aim of the Bill and the model.

The process is as follows:

- Under 16(1), the committee, firstly, has to satisfy itself that the death is one which is capable of falling within the review model.

- Once the committee is "*satisfied*" that the death falls withing the scope of the review model, they have to "*determine*" whether or not a domestic homicide review or suicide review should be carried out, using a "*sift*" based on two criteria/tests below, set out in 16(2). It notes that the question may be referred to Scottish Ministers if the committee is unable to reach a unanimous decision:

  - *the likelihood of the review identifying lessons to be learned from the death which would improve Scottish practice in the safeguarding of those affected by abusive domestic behaviour* ***or*** *the promotion of the wellbeing of victims of abusive domestic behaviour.*

  - *whether Scottish public authorities or voluntary organisations operating in Scotland were involved, or had the opportunity to be involved, in the circumstances leading up to the death… as the review model is about looking at "missed opportunities" by authorities or organisations in Scotland in particular cases and learning lessons from those."*

- Not only does the committee have to use these two criteria to "*determine*" whether either of the reviews should be carried out (but curiously, not whether

both should be carried out and this possibility should be considered) but 16(3) then also sets out "*factors*" to which the committee must have regard as part of the 16(2) "*tests*", noting that "*other relevant factors could be considered":*

- *the extent of the apparent connection between abusive behaviour and the death in question,*

- *the information available to the committee or a case review panel, or likely to be obtainable by either of them, in respect of the circumstances leading up to the death,*

- *the extent of the connection which the persons mentioned in section 9(3) or (as the case may be) 9(5) have or had to Scotland.*

These requirements and tests are problematic.

It is not at all clear what information the committee will use in considering the two tests and the three obligatory factors that are part of that process. As stated above, it is therefore entirely possible for a domestic abuse homicide or suicide not to be reviewed because the committee either considers, for whatever reason, at an early and preliminary stage of the process, that there were no "lessons to be learned" or "opportunities missed, or fails to identify evidence that this was the case. For clarity, it would therefore be helpful if an example be provided in the Explanatory Notes of a case that would not be reviewed.

Section 17 - Carrying out of a review

Subsection (3*)* requires the committee to set the terms of reference for the review and allows these to be modified as the committee considers appropriate.

There must be consistency across the terms of reference for all reviews, with common themes of investigation and requirements for information set out.

Paragraph 168 of the Policy Memorandum seems to suggest that information on the perpetrator (presumably relating to his criminal history with the victim(s) and any other partners, criminal offending, behaviour, compliance with bail conditions, protective orders, etc,) will not routinely be an automatic consideration in each review. "*In order for a review to be undertaken, information on the victim(s) and the perpetrator (where being considered) needs to be shared with the review."*

It is vital that the criminal history of the abuser that relates in any way to the perpetration of domestic abuse against the current victim and former partners is made available to, and ingathered by, any domestic abuse homicide or suicide review. This is important information and any review must have full details, and as complete a picture as possible, of the engagement or otherwise, of the civil and criminal justice system with the perpetrator and his behaviour toward the victim(s).

The guidance prepared by Scottish Ministers under section 25 must address this matter and make it explicitly clear that information sought by a committee and panel for reviews will include any criminal history of the perpetrator involving domestic abuse perpetration, either with this victim or others.

Section 18 - Lord Advocate's power to order suspension or discontinuation of review proceedings

While a review can take place during an investigation or criminal proceedings, section 18(1) empowers the Lord Advocate to order to prevent any prejudice to criminal proceedings by, where necessary, ensuring that the review is temporarily paused until any investigation, criminal proceedings or fatal accident inquiry are complete. Subsection (2) empowers the Lord Advocate to order the permanent discontinuation of proceedings where it appears to the Lord Advocate to be appropriate to do so, in light of any investigation relating to the death, or any criminal proceedings or inquiry under the 2016 Act.

While these powers are necessary and appropriate, it is not clear on what basis the Lord Advocate will make these decisions. Therefore, for transparency and accountability, the section should contain, firstly, a duty on the Lord Advocate to produce and publish guidance on the and secondly, provide that updates from the Lord Advocate to Scottish Ministers as to when the review can take place are required on a quarterly or six-monthly basis.

Section 19 - Protocol in relation to interaction with criminal investigations etc.

This section requires the chair of the committee, the Chief Constable of Police Scotland, the Lord Advocate, and Scottish Ministers to "*agree and maintain a protocol"* in relation to the sift process and the carrying out of reviews which must "*describe the general processes and arrangements which the parties intend to follow in order to prevent (so far as within their power to do so) review proceedings causing prejudice to any criminal investigation or any other investigation, any criminal proceedings, and inquiry under the 2016 Act*."

The Explanatory Notes at paragraph 15 explain what the protocol must cover. However, there is no requirement that this protocol be publicly published so the section must provide that this will happen. This is particularly important since it seems to allow the review oversight committee or a case review panel to provide information obtained in connection with the review proceedings to the Chief Constable of Police Scotland. Presumably this is information around possible criminal activity or offences that was not already in the hands of the police; therefore, any parties providing information to the committee or panel as part of the review process must be informed that this could be passed onto the police and the circumstances in which this could happen.

Section 20 - Duty on public authorities to co-operate

This section obliges the listed "*public authorities*" to "*co-operate with the committee, a panel and also with each other*". This includes "*participating (if asked to do so) in a*

review, providing such information or assistance as the review oversight committee or the relevant case review panel reasonably considers necessary to allow them to fulfil their functions… as soon as reasonably practicable following a request."

The Parole Board for Scotland and the Risk Management Authority should be added the list of public authorities who can be required to cooperate.

Section 22 - Reports on case reviews

This section makes provision about the report which must be prepared by a case review panel at the conclusion of its review.

Paragraph 170 of the Explanatory Notes sets out "… *certain things which must, under subsection (2), be included in a report…"* and specifically, section 22(2) provides that a report must include "… *information about any occasions when, in the panel's opinion, an opportunity was missed to— **safeguard those affected by abusive domestic behaviour, or promote the wellbeing of victims of abusive domestic behaviour…"*** (our emphasis).

The Explanatory Notes at paragraph 171 expand on this, as follows: "*What the panel considers to be key events will vary from case to case but these do not have to be something momentous. For example, this could include events which might seem relatively innocuous in themselves but in the context of other evidence take on a greater weight **(for example, the first of a series of missed appointments with healthcare or social services after a pattern of regular attendance**). **The dates of these events will be important in the context of the review because of their role in establishing things such as whether a victim had already been identified as a potential victim of abusive behaviour by the time of a particular incident**, **or whether there had been a series of events over an extended period which should have been a warning of possible difficulties***." (our emphasis).

This is missing the obvious point that it is important the review consider not only information about the victim, but also that on the known, and by default, the unknown, behaviour of the perpetrator. Information on all aspects of a perpetrator behaviour and engagement with the criminal justice system and organisations such as social work and third sector bodies, for not only the current victim but previous partners must be gathered, scrutinised, considered and included in this report. Without this, it will not be possible to identify incidents, events, patterns indicating where "*opportunities were missed*" and therefore, "*lessons*" that could be learned as a result.

For instance, referring to the example in the Explanatory Notes above, this could include:

- a series of missed appointments with criminal justice social work or third sector organisations working on bail supervision/community payback orders;
- failure to comply with bail conditions and/or terms of civil and/or criminal protective orders:
- post-separation stalking and harassment;

- police engagement where no further steps were taken; and
- "*events which might have seemed innocuous"* to those without an understanding of the dynamics of domestic abuse.

Once a report is prepared, the chair of the panel has to submit it to the committee for approval under subsection (4) and subsection (5) allows the committee to modify the report or direct the panel chair to do so and resubmit the report. The circumstances of any such modification and the limits to it must also be clarified and be explicitly stated in the guidance that Ministers must produce under section 25.

Subsection (8) provides that the committee can also choose to publish a report (or part of it), subject the Lord Advocate's consent but that they must, in every case, publish (either in the report itself or elsewhere) "*such information as it considers appropriate about the recommendations made in the report*." The section is silent on what informs the committee's discretion: around choosing whether or not to consider publishing a report and when this would not be appropriate; the information it must publish and where. Section 25 must be explicit on clarifying these points.

While we acknowledge that including too much detail may limit the flexibility of the process, it would be sensible for the Bill, or even just the Explanatory Notes, to contain text explaining what information should be considered and that this should also be detailed in the guidance that Ministers must produce under section 25.

Section 24 - Periodic reports

We support the time period in this section, which requires Scottish Ministers to prepare and publish a report on domestic abuse related death reviews every two years, beginning with the end of two years after model coming into force. The statistical information required by section 24(b), must include data on gender, age, ethnicity, disability of adult and child victims and perpetrators.

Schedule

As stated in our comments on section 11, we also note that in the Schedule paragraphs 1 and 3 specify a list of individuals automatically disqualified from appointment as the chair or deputy chair of the committee or chair of the panel due to their holding various offices or positions with various statutory agencies and that paragraph 3(2) imposes a further set of restrictions on "…*members, employees or appointees of an organisation supporting of victims of crime, or an organisation involved in overseeing the provision of services to victims of abusive domestic behaviour*."

We are unclear as to why this restriction is required as it appears to be a blanket ban and runs the risk of disqualifications being inconsistently applied. Further clarification is needed on why it has been included in the Bill and the intention, for instance whether it is intended to cover individuals from statutory or third sector organisations who have been directly supporting the victim(s) involved and if this is the case, the wording should explicitly state this.

We would also comment that in relation to the exclusion under paragraph 3(2) of those supporting, or providing services to, victims of crime, there is no corresponding exclusion for persons in any type of organisation working with, or providing services to offenders, particularly perpetrators of domestic abuse. Either both those supporting offenders and those supporting victims are restricted or both are equally eligible.

Finally, Paragraph 118 of the Explanatory Notes states *"Where the Scottish Ministers are appointing people of their own accord, they are required under subsection (4) to do this in a way which ensures that the committee includes representatives of voluntary organisations which provide services to individuals in Scotland. For example, this might be charities which have the purpose of assisting victims of abusive behaviour,* ***or those which deal with matters such as substance abuse and which have experience of working with those who have suffered or been responsible for abusive behaviour in connection with that****."* (our emphasis) This addition indicates a misunderstanding of the role that substance abuse plays in the perpetration of domestic abuse and should be deleted.

The SPA, the Scottish Ministers in the exercise of their functions under the Prisons (Scotland) Act 1989, Community Justice Scotland, Social Care and Social Work Improvement Scotland and the Scottish Social Services Council are not included and an explanation as to why this is so would be helpful.

[1] Victims and Witnesses (Scotland) Act 2014
https://www.legislation.gov.uk/asp/2014/1/section/10
[2] Women's Lived Experiences of Coercive Control, Stalking and Related Crimes, as they progress through the Criminal Justice System
https://www.sccjr.ac.uk/publication/lived-experiences-of-victims-survivors-of-coercive-control-stalking/
Domestic Abuse (Scotland) Act 2018 and the Criminal Justice System: Women's Experiences
https://www.sccjr.ac.uk/publication/domestic-abuse-scotland-act-womens-experiences/
Exploring views on sentencing for domestic abuse in Scotland
https://www.scottishsentencingcouncil.org.uk/media/ysffguhw/20240812-views-on-sentencing-domestic-abuse.pdf
[3] Domestic abuse- and trauma-informed practice: companion document
https://education.gov.scot/media/kwilejb4/da-trauma-companion-pack.pdf
A Roadmap for Creating Trauma-Informed and Responsive Change
https://www.traumatransformation.scot
Trauma Informed Justice Framework
https://www.traumatransformation.scot/app/uploads/2023/09/trauma-informed-justice-knowledge-and-skills-framework.pdf
[4] https://www.parliament.scot/-/media/files/legislation/bills/s6-bills/victims-witnesses-and-justice-reform-scotland-bill/introduced/bill-as-introduced.pdf

[5] https://www.scotcourts.gov.uk/media/31ohvzus/report-to-the-lord-justice-general-virtual-summary-trials-jan-2022.pdf
[6] https://www.lawscot.org.uk/news-and-events/legal-news/report-calls-for-virtual-summary-domestic-abuse-courts/
[7] https://www.prosecutioninspectorate.scot/media/h30hqpbr/the-prosecution-of-domestic-abuse-cases-at-sheriff-summary-level.pdf
https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2023/11/vision-justice-scotland-three-year-delivery-plan/documents/vision-justice-scotland-three-year-delivery-plan-2023-24-2025-26/vision-justice-scotland-three-year-delivery-plan-2023-24-2025-26/govscot%3Adocument/vision-justice-scotland-three-year-delivery-plan-2023-24-2025-26.pdf
[8] https://www.bethepeace.ca/articles-1/michael-johnsons-typology-of-domestic-violence
https://www.ojp.gov/ncjrs/virtual-library/abstracts/typology-domestic-violence-intimate-terrorism-violent-resistance

COSLA

COSLA is the voice of Local Government in Scotland.

We are a councillor-led, cross-party organisation who champions the vital work of Scotland's Councils and its 1226 elected councillors in order to secure the resources and powers they need.

We work on councils' behalf to focus on the challenges and opportunities they face, and to engage positively with governments and others on policy, funding and legislation.

As co-owners of the Equally Safe Strategy, COSLA is committed to preventing and eradicating all forms of Violence Against Women and Girls (VAWG). Learning lessons and applying continuous improvement in VAWG prevention is critical to the implementation of Equally Safe. This must be supported by well-funded, trauma-informed, and VAWG-competent support services for victim-survivors, robust systems to hold perpetrators accountable, and support for positive change in attitudes and behaviours.

While COSLA welcomes the principles and aims of the DH&S Review, several concerns require consideration:

• Chronic lack of capacity in and underfunding of VAWG services and systems, including lack of adequate investment in primary and tertiary preventative measures, as evidenced by the Independent Review of Funding and Commissioning of VAWG Services.
• The addition of the DH&S Review to an already complex review landscape in Scotland.
• Potential additional burdens on local authorities, which may require additional resources.
• Potential legal vulnerabilities arising from the learning review process.
• Effects on local staff morale and wellbeing, particularly in services already burdened by the rising prevalence and complexity of domestic abuse.
• The need for additional resources to implement improvements based on DH&S Review findings and recommendations.

Importance of Local Representation:

COSLA highlights the importance of including local Public Protection strategic leadership in the Review Oversight Committee. Understanding local systems, their complexities, strengths, and challenges is vital for meaningful learning and implementing positive changes. Local strategic planning leadership for VAWG and Suicide Prevention must be involved in oversight of activity towards local implementation of improvement plans.

Any death resulting from domestic abuse is unacceptable. COSLA is committed to embedding a public health approach to tackling all forms of violence against women

and girls (VAWG), as outlined in the Equally Safe Strategy and Delivery Plan. Continuous, evidence-based improvement in local systems and services is critical.

COSLA's Members will continue to consider the ongoing development of the Domestic Homicide and Suicide Review Model but highlight that the timeframe through which this bill is being driven may limit COSLA's and local authority capacity to participate fully in the effective co-design process required to ensure the model's design can effectively deliver it's intended outcomes.

COSLA has articulated clearly and repeatedly that for the prevention of domestic abuse to be achieved and, until that is done, for the protection and recovery of victims to be robust and sustainable, the chronic underfunding and lack of sustainability of specialist VAWG services and local authority systems must be addressed. A comprehensive, coordinated approach involving multiple agencies is required to support victims, hold perpetrators accountable, and prevent future abuse.

The COSLA Landscape Report underscores the necessity of holding perpetrators accountable and advocates for a collaborative approach to addressing VAWG. The financial implications of developing and implementing the DH&S Review Model and funding the proposed Scottish Government team, given the relatively small number of deaths to be reviewed, should be weighed carefully against the investment required to effectively deliver primary and tertiary prevention of VAWG, including domestic abuse. This consideration is particularly pertinent when considered alongside the pressures that local authorities, and their commissioned specialist services are operating under, including the Scottish Government's current chronic underinvestment in local services and multi-agency systems tasked with managing and mitigating the risks of serious harms posed to women and children by perpetrators of domestic abuse and coercive control.

COSLA notes that experience at local level has been that, while there are many review processes taking place including Fatal Accident Inquiries where the result is a set of recommendations for improvement, without the requisite resources, relationships, capacity and powers in place across multiple systems and sectors to respond to these, review processes may fail to bring about the improvements required.

Reviews also require to be completed in a timely manner to bring no further distress to victims' families and to ensure that outcomes are relevant. For instance, as one example (although a different system delivered at a local level) the child death reviews have a significant backlog. The reviews aligned with this bill will be different but will rely on information from local systems which are already stretched. This highlights the complexities at play to ensure joint reviews will be undertaken where appropriate and that improvement and change can be swiftly enacted. Additional investment from the Scottish Government's available resources made in existing under-resourced systems and services and in primary and tertiary prevention may deliver better outcomes.

Domestic abuse – as outlined in the COSLA Landscape Report and the Report from the Independent Review of Funding – is a core driver of significant and often long-lasting or, at worst, fatal harm encapsulated within and across a range of, and often

multiple policy areas and victim/survivors will seek or require support from a wide range of services. Many of those impacted by domestic abuse will never seek support from specialist VAWG services. Mainstream services are likely to respond to victim/survivors' needs where public services are universal in nature, and therefore knowledge of victim/survivors' experience of abuse and the impacts of this abuse on their safety, wellbeing and health may well be seen and understood by a range of professionals from across a wide panoply of universal services located across different parts of the system. As such, if domestic abuse is flagged through another form of review where a death has occurred there must be the potential for this to be highlighted to a domestic abuse review group. Such cross-working across a local system and environment is key to ensuring that deaths of victims of domestic abuse are not missed. This will be reliant on effective communication and a multi-agency, cross-sectoral professional understanding of domestic abuse, and a review process which is likely to only occur on rare occasions in a local area.

In addition, the importance of children and young people's voices being heard and discussions with families taking place, with their views considered on an equal footing with the professionals, cannot be underestimated. This requires resourcing and expert, trauma-informed approaches to be utilised.

The financial memorandum does not reflect the costs and capacity needs of local authorities and their strategic community planning partners to properly prepare and support their workforces, nor to facilitate support for family engagement, and provide ongoing (sometimes across a lifetime) services to support them where needed once a review has been completed.

The current financial memorandum pertaining to the DH&S Review implementation should be further developed in partnership with local government finance directors, senior leaders and representatives of the Local Government family professional organisations and COSLA to reflect the true costs of engaging with the Review for local authorities along with the costs required to implement sustainable improvements and changes with strategic partners. This requires to be done in tandem with meaningful action by the Scottish Government to drive improvement across and investment in the wider system, in line with the recommendations of the Independent Review of Funding for VAWG Services.

Social Work Scotland

Social Work Scotland (SWS)[1] 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.

As an organisation and across our members we are committed to service improvement and ongoing development based on evidence and research on how we can best meet the needs of those we work with and particularly those who experience the greatest challenges and barriers to their wellbeing and lives.

The social work profession is based on the principles of human rights, reflecting the value of all individuals and upholding their rights.

SWS welcomes the focus on strengthening approaches to learning from violence against women and children and therefore welcome the opportunity to provide evidence to the Criminal Justice Committee on the Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews (Scotland) Bill Part 2, in relation to the Domestic Homicide and Suicide Review (DHSR) model.

SWS welcomes the principle of reviewing and learning from domestic homicide and suicides, bringing Scotland into line with other UK jurisdictions. We agree that this is critical to focus on learning to identify areas of change and improvement, where necessary, in these rare but traumatic circumstances, in order to prevent further tragedies and give a voice to victims.

Due to the specific criteria we believe that the number of reviews in these circumstances will be small. However given the particularly distressing nature of these events, SWS is committed to supporting the development of an approach that is sensitive, trauma informed and also able to work effectively, efficiently and collaboratively to affect any identified improvement and learning across all relevant services and agencies.

The proposal as it is currently, however, requires significant further detailed consideration within the wider context of the complex review landscape in Scotland. Layering on additional Review processes onto a cluttered and unaligned landscape adds to complexity within the system. We do not believe sufficient focus or consideration has been given to this within the current proposal and working groups.

Within current Review processes, the role of social work is critical (along with local partners). In relation to children and families these include:

- Child Protection Learning Reviews
- Reviews into the Death of a Looked after Child
- Deaths of young people in continuing care and aftercare support up to their 26th birthday
- National Hub for Reviewing and Learning from the Deaths of Children and Young People

- Suicide Reviews
- Drug related deaths

In addition, Adult and Justice Social Work have a critical role in:

- Adult Support and Protection Learning Reviews
- Multi-Agency Public Protection Arrangements (MAPPA) Initial Case Review (ICR) and Significant Case Review (SCR)

The current review landscape is complex and lacks alignment. Some are statutory processes and others sit within Scottish Government National Guidance but are embedded in practice and overseen by groups such as Child or Adult Protection Committees and local Chief Officer Groups (COGs). Decision making generally sits at local level, for example within local partnership arrangements or are statutory duties for local authorities (e.g. deaths of looked after children and young people in receipt of continuing or after care).

We believe the model as currently proposed risks, unintentionally, creating a two-tier review system i.e. a statutory and government appointed process and a locally accountable non statutory process, with particular risks in relation to situations where several review processes are relevant with duplicate criteria.

SWS has had some involvement in current discussions as the model is developed, expressing those concerns. We remain concerned that this work has been taken forward at a pace that risks proper considered alignment with existing structures and therefore it has the potential to undermine all existing embedded and largely effect Review processes.

SWS are concerned that proper cognisance has not been taken of the issues raised, while pushing through the model at pace.

There has been a lack of detail and consultation with key stakeholders as this model has been developed and assumptions made without necessary full consideration of current processes. For example, we have noted a lack of involvement of local Child Protection Committees (CPCs) in relation to connections and alignment in processes and learning. This is particularly relevant and important due to the overlapping criteria within the DHSR model and the criteria for a Learning Review conducted under the National Guidance for Child Protection Committees Undertaking Learning Reviews[2] (which includes children who have been killed by domestic homicide or who have witnessed the death of a parent who has died in such circumstances).

There is also a lack of clarity on the intersection between the proposed statutory and national led process and the review processes that are non-statutory and locally led by agencies:

- what takes precedence and how are decisions made where there is overlapping criteria?

- should a joint review process be undertaken, for example a child protection learning review and a DHSR?
- how would a joint review work in practice?
- where does accountability and responsibility sit in these circumstances?

We suggest that agreement on principles in these complex circumstances is fundamental and should be agreed with key partners as part of Guidance for the DHSR process and other required Review processes in specific cases where criteria are met. This should include:

- The role of local organisations and partnerships including Chief Officers Groups (COGs)
- Links between local and national (Ministerial) decision making
- Agreeing timelines and prioritise
- Best approach to communication and engagement with families and relevant participants
- Consideration of police and justice processes
- Publication and reports

Specifically, the current proposal allows for Ministers to instigate a DHSR (even where this is not recommended by COPFS or Police Scotland) and allows for individuals and groups to petition for a DHSR. Further specific detail is needed on these processes to ensure this does not further traumatise victims and families and raise unrealistic expectations. Additionally, this has the potential to undermining other decision-making processes and the workforce.

SWS, and other stakeholders, have offered to support the development of the model as a 'critical friend' due to our members' experience in decision making and working across Review processes, this has not been taken up or indeed further acknowledged. Stakeholders have shared concerns with us about this engagement process.

SWS is committed to supporting this process through active engagement to ensure that there is clarity across the systems for Reviews and to ensure that learning is identified as quickly as possible and implemented effectively as needed.

We do not believe the DHSR is currently well defined, the scope and definitions require to be clearer to ensure that the scope is consistent. Additionally, there is a lack of detail on an implementation framework that will be critical to the success of identifying and supporting improvement and change. Fuller consideration is needed on both the approach and resourcing for this.

Additional detail is also required in relation to the involvement of children and young people, and while this is a helpful approach, it remains unclear how this would operate where a child may also be involved in other Review processes. We should not subject victims and vulnerable children and young people to different processes, for example where they are looked after or involved in child protection processes. It should also be noted that the UNCRC (Incorporation) (Scotland) Act 2024 requires that children be

involved where matters affect them, therefore the scope of their involvement is likely to be significant.

We note in the policy memorandum that '*it was considered that while these existing review processes have strengths, they also have limitations, particularly in relation to domestic abuse.'* We acknowledge that improvement may be necessary to incorporate a robust focus on domestic abuse in existing Review processes. Further detailed scrutiny is needed about whether the solution is to create another Review process that is unaligned or linked to child protection learning reviews, rather than considering if current review processes could be amended to take account of this concern.

We believe consideration is needed about linkages and welcome the statement '*where appropriate, a joint review would be undertaken*. This *would ensure that both the domestic abuse and child protection lens can be applied and that the learning generated will have wider benefits'* however there is a lack of detail on how this would work in practice and a concern about policy fragmentation in the development of DHSR.

In summary, while welcoming the commitment to learning and improvement and the focus this legislation brings to tackling gender-based violence, SWS and our members have significant concerns about how the DHSR model will operate in practice within the existing complex Review structure in Scotland. SWS has raised these concerns consistently and we do not believe this has been fully addressed.

Any plan to implement the DHSR model must also consider the Review context within which it operates. The current approach risks introducing a two-tier model with inherent tensions over decision making, ownership and accountability, and potentially resourcing and we therefore contend that there is a need to more clearly define the model or approach that will underpin DHSRs.

This information is based on the Social Work Scotland Consultation response submitted to Scottish Government.

28/1/25

[1] https://socialworkscotland.org/
[2]https://www.celcis.org/application/files/1116/3059/2654/national-guidance-child-protection-committees-undertaking-learning-reviews.pdf