

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

Social Work Scotland consultation response

10th January 2025

Introduction

Social Work Scotland (SWS) 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 a response to the consultation on the Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews (Scotland) Bill.

This response focuses only on Part 2 of the Bill, specifically in relation to the Domestic Homicide and Suicide Review (DHSR) model.

Background

The Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews (Scotland) Bill was introduced to Parliament on 24 September 2024. Following introduction, the Criminal Justice Committee has announced a call for views on the Bill which includes provisions to modernise procedures in criminal courts and to provide a legislative framework for Scotland's national multi-agency Domestic Homicide and Suicide Review (DHSR) model.

DHSR work came from a commitment in the Equally Safe Delivery Plan¹ and in response to stakeholders calling for a national review model for domestic homicide and suicide.

¹ [Equally Safe: delivery plan - gov.scot](https://www.gov.scot/publications/equally-safe-delivery-plan/pages/1-10.aspx)

The purpose of domestic homicide and suicide reviews is to identify what lessons can be learned and applied following a death where abuse is known or suspected in order to help prevent future abuse and deaths.

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

- defining and setting out the scope of domestic homicide and suicide reviews (e.g. the types of deaths and relationships included within the review scope);
- an enabling power to modify the scope and name of the review model;
- provision to establish a review oversight committee, chair, deputy chair, and case review panels and chairs;
- provisions requiring a notifying body to notify any death that meets or appears to meet the review criteria;
- provisions to ensure a review does not prejudice any other live investigation or proceedings;
- provisions to ensure co-operation, participation and recovery of information; and
- reporting requirements

Part 1 of the Bill contains other provisions seeks to make permanent some of the temporary measures that were put in place during the pandemic through greater use of digital processes and improving the resilience, effectiveness and efficiency of the criminal justice sector.

This response focuses only on the provisions in Part 2 of the Bill.

Part 2 Domestic homicide and suicide reviews

Question 7: What are your views on the proposal in the Bill to create a model for domestic homicide and suicide reviews?

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 learning.

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 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

Reviews² (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) 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.

Within a child protection context, the learning review approach that sits within Scottish Government National Guidance, emphasises a learning (and not blame) approach to Reviews, and locally CPCs have worked towards a supportive culture when undertaking local learning reviews (which involved practitioners). Learning from this improvement can offer a valuable context to take forward the DHSR model and prevent different cultures and approaches developing. We are concerned about the potential for silo working in the development of the model and for a disconnect

²<https://www.celcis.org/application/files/1116/3059/2654/national-guidance-child-protection-committees-undertaking-learning-reviews.pdf>

between a national led approach with a centralised chair and local partnership working.

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 (Incorporations) (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.

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