Scottish Government
Riaghaltas na h-Alba

Domestic Homicide Reviews:
Consultation Analysis Report

December 2023

Domestic Homicide Reviews: Consultation Analysis Report

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Acknowledgements

The Scottish Government would like to extend its sincere thanks and appreciation to all the individuals who participated in the consultation. The insights, perspectives, and thoughtful responses received have been instrumental in shaping the next steps in the development of Scotland's national Domestic Homicide Review model.

We would like to thank those with lived experience of domestic abuse and those bereaved by abuse, who took part in this consultation. We recognise how difficult the subject matter is and how upsetting it can be. It was a real privilege to gain your perspectives and hear about your experiences. We would also like to express our gratitude to the professionals working in the field of domestic abuse who dedicated their time and expertise to provide detailed and constructive feedback.

We also want to thank all the organisations that facilitated engagement sessions for their support and commitment to engaging both with professionals and those with lived experience. We are also very grateful to those who provided safeguarding support to participants during and after the engagement sessions. It was a priority for us to ensure the wellbeing of all who participated, and we thank all those who made this possible.

Thank you for your contributions and commitment to this work. Your collective and active involvement has enabled us to gain a greater understanding of the key requirements of a Domestic Homicide Review model for Scotland. Your views will inform the development of the model to ensure that it is robust and fit for purpose within a Scottish context.

Domestic Homicide Review Policy Team
Scottish Government

Content Warning

Participants in the consultation shared their personal and/or professional experiences of domestic abuse and/ or bereavement due to domestic abuse. They recalled the difficulties faced navigating support services and the justice system. It is important to be aware of the potentially distressing and triggering content of this report. Services providing support are set out in Annex B.

Introduction

Domestic Homicide Reviews aim to learn lessons following a death where domestic abuse is suspected. They aim to ensure a voice is given to those who have died and help to prevent further deaths.

> "Implementing the model provides an opportunity for real change – to galvanise a wide range of organisations to engage in a guided and informed model of learning and improvement. It should be strengths-based. A key failure in the historical approach to policy around Domestic Abuse is that everyone is blamed."
>
> Professional respondent

Background

Domestic Homicide Reviews are not about finger pointing or apportioning blame. They are fundamentally about learning in order to identify areas for change and improvement to help prevent future domestic violence, deaths and homicide.

There is no universal definition for what constitutes a 'domestic homicide'. There is significant variation across different jurisdictions on what is within scope, but as a minimum, all include intimate partner homicide where there has been domestic abuse. However, the majority of jurisdictions go further and include a wider definition, such as children.

It should be highlighted that 'domestic homicide' does not necessarily mean 'domestic abuse' and, as such, there can be two different but related legal definitions. In considering what domestic homicide means in a Scottish context, it is important to be cognisant of the definition of domestic abuse which is set out within the Domestic Abuse (Scotland) Act 2018[1]. In establishing what a domestic homicide is and, in turn, a Domestic Homicide Review, it is key that the two terms are explicitly defined in order to ensure clarity for all.

The development of a Domestic Homicide Review model is a commitment within the Equally Safe Delivery Plan, co-owned by COSLA and Scottish Government. This was further strengthened in the Scottish Government's 2023-24 Programme for Government. To deliver on this commitment, a Domestic Homicide Review

[1] Section 1 of the Domestic Abuse (Scotland) Act 2018 defines the offence of abusive behaviour towards partner or ex-partner.

Taskforce was established in December 2022. The purpose of the Taskforce is to provide national leadership and drive forward change and improvement through the development and implementation of a national Domestic Homicide Review model for Scotland. This undertaking will be cognisant of existing processes and reflective of the operating context in Scotland.

In line with the scope of Domestic Homicide Review models within wider jurisdictions across the UK and internationally[2], Taskforce members **unanimously agreed that the Scottish model will include victims killed by a partner or ex-partner** (this includes adolescents in an intimate relationship). However, in order to develop an evidence-based model for Scotland, a greater understanding was required of what should be included within the scope, as well as a range of other fundamental aspects of the model.

At this stage it should be highlighted that domestic homicide is a gendered crime and the majority of domestic homicides are carried out by men against women. However, whilst acknowledging this, there are also male victims of domestic homicide. As such, the model developed in Scotland will include victims of all genders.

Purpose and Target Audience

In order to inform the development of a national Domestic Homicide Review model for Scotland, the Scottish Government launched an online consultation on **Friday, 1st of September 2023,** which closed on **Monday, 30th of October 2023**. The online consultation was complemented by a programme of virtual or in-person targeted engagement sessions as an alternative means for individuals to participate. Input was sought from targeted groups to ensure that people have the opportunity to inform, influence, and contribute to the development of the model.

The online consultation and targeted engagement sessions focused on obtaining the views of:

- people (those 18 years of age and over) who have lived experience of domestic abuse;
- people who have been bereaved due to domestic homicide/ abuse;
- people working in the field of domestic abuse, for example, the police, victim support organisations, social services, health services; and
- people with lived experience who also work in the field of domestic abuse

Overview of the Consultation

The online consultation asked questions about what the Domestic Homicide Review model should look like. Participants had the opportunity to respond to the consultation online or as a hard copy. The online consultation was set up in Qualtrics XM, an experience management platform. No identifying information was recorded for any response, making all responses completely anonymous. In the case of organisational responses, where organisations chose to be mentioned as having

[2] Of the 17 jurisdictions covered in the International Comparator Report, all include intimate partner homicide.

participated, those organisations are listed at Annex A. However, organisational responses have been analysed as a whole with no data attributable to any organisation.

The consultation comprised of six sections, with a total of 33 questions, 27 of which were relevant both to those with lived experience of domestic abuse**.** There were an additional six questions, including a specific section on 'Information Gathering and Analysis', relevant to those working in the field of domestic abuse and professionals who also have lived experience.

Participants had the option to pause, skip questions and return at a later date should they wish to do so. Participants were made aware that they could answer as many questions as they chose to. **Responses with a 13% completion rate and above were included in the analysis.** A breakdown of the consultation and targeted engagement responses is provided in Figure (1) and Figure (2).

There were a total of 235 responses, including 31 (13%) individuals with lived experience of domestic abuse or bereaved by abuse, 134 (57%) professionals working in the field of domestic abuse, and 70 (30%) professionals with lived experience working in the field of domestic abuse. Of the 235 responses, 173 (74%) participants took part in one of the 28 engagement sessions that were organised, and 62 (26%) by answering individually to the online consultation.

The sectors represented in the targeted engagement include social services, health, third sector, justice, housing, education, children's services, victim support organisations, and local authorities. There were 35 organisational responses.

Engagement Sessions

The online consultation and the engagement sessions covered the same questions, and all responses were fed into the online portal (Qualtrics XM). The final data was downloaded into SPSS (Statistical Package for the Social Sciences) for cleaning and analysis. As part of the consultation, and to enable organisations to self-facilitate engagement sessions, an engagement pack was produced by the Domestic Homicide Review Policy Team within Scottish Government. Feedback was sought from a number of victim support organisations, those with lived experience, health services and analytical colleagues. A list of organisations that facilitated engagement session can be found at Annex A.

Overall Responses

A response overview can be seen in Figure (1). It is acknowledged that the sample is not representative of all professionals in Scotland or those with lived experience of domestic abuse and/ or domestic homicide. The representation of all the sectors who responded to the consultation and the frequency of their representation can be found at Annex A.

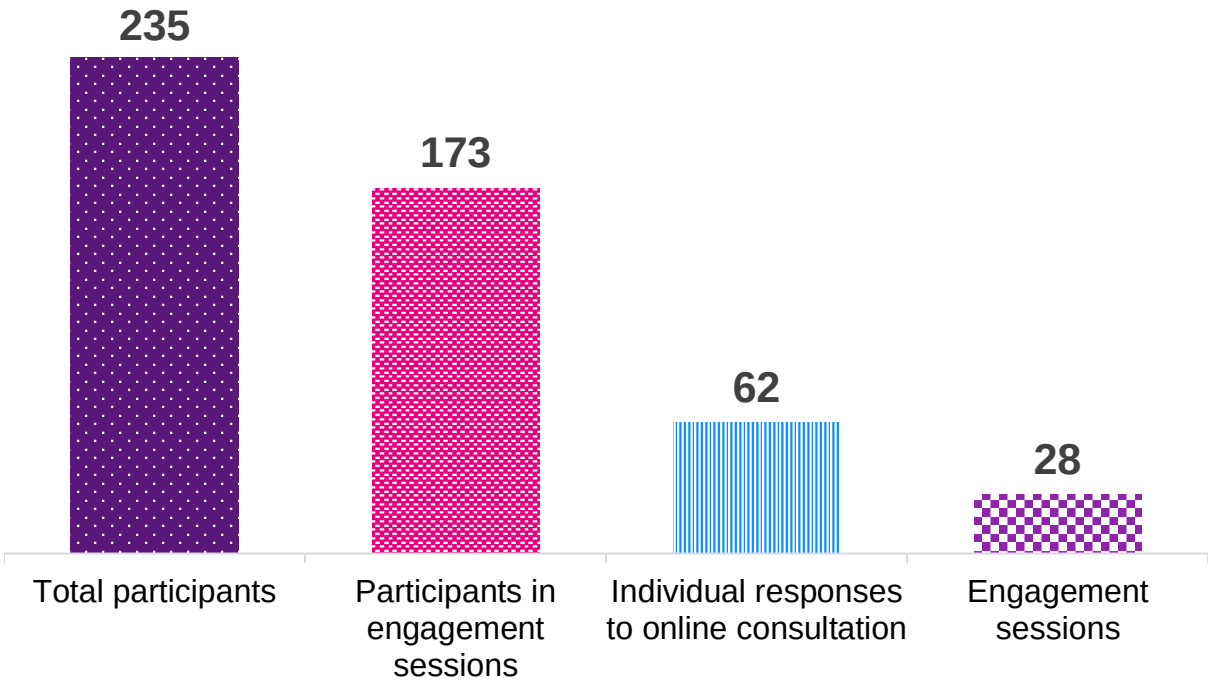

Figure (1). Consultation response overview

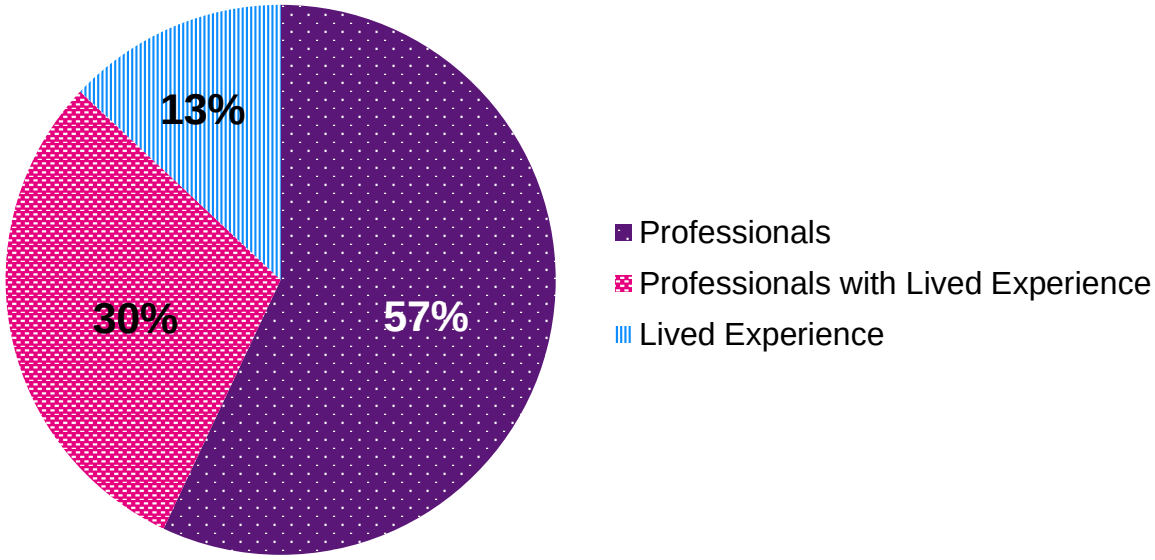

Figure (2). Responses to the consultation by respondent type (N=235 respondents)

Report Structure

The report covers six main sections as outlined below. These are all the questions that were asked during the consultation and targeted engagement:

A) Which Cases will be Reviewed (16 questions)
B) Families and Friends' Involvement (four questions)
C) Perpetrators' Involvement (four questions)
D) Information Gathering and Analysis (three questions)
E) Reporting and Learning (four questions)
F) Underpinning Scotland's Domestic Homicide Review Model (two questions)

A) Which Cases will be Reviewed

This section looked at the circumstances under which a review should be undertaken and how other relevant review processes are taken into account.

As outlined previously, Taskforce members **unanimously agreed that the Scottish model will include victims killed by a partner or ex-partner** (this includes adolescents in an intimate relationship). This is a category that is universally included within all Domestic Homicide Reviews that operate in other jurisdicitions and, as such, views were not sought on the inclusion of this category.

It is acknowledged that there is further work to be undertaken in relation to a number of the current high level descriptors used within the scope section. The descriptors used as part of the targeted engagement were intended to help provide further clarity and to support discussion with participants. Following on from the completion of the targeted engagement, work will be undertaken to update the descriptors used.

Scope

We wanted to find out what participants thought about the scope of Scotland's Domestic Homicide Review model and which cases should be included within that scope. A total of eight cases were presented to participants with the option to include the case within the scope of Scotland's Domestic Homicide Review model, exclude the case as 'out of scope' or 'don't know'. For those who thought a case should be included within the scope, we wanted to know whether participants thought the case should be included from the very beginning of the model's implementation or introduced at a later stage.

Taking into consideration those respondents who answered the questions on scope, four out of the eight proposed cases received high support (≥90%) to be included within the scope of Scotland's Domestic Homicide Review model. These included **Domestic Abuse Related Family Homicide, Violent Resistance Homicide, Domestic Abuse Related Suicide** and **Children**. Two case categories reached consensus (≥80%). These were Near Death and Associated Homicide. Finally, the last two cases that received the lowest consensus were Familial Homicide and Domestic Homicide-Suicide, with 75% and 71%, respectively. An overview of agreement rates can be seen in Figure (3).

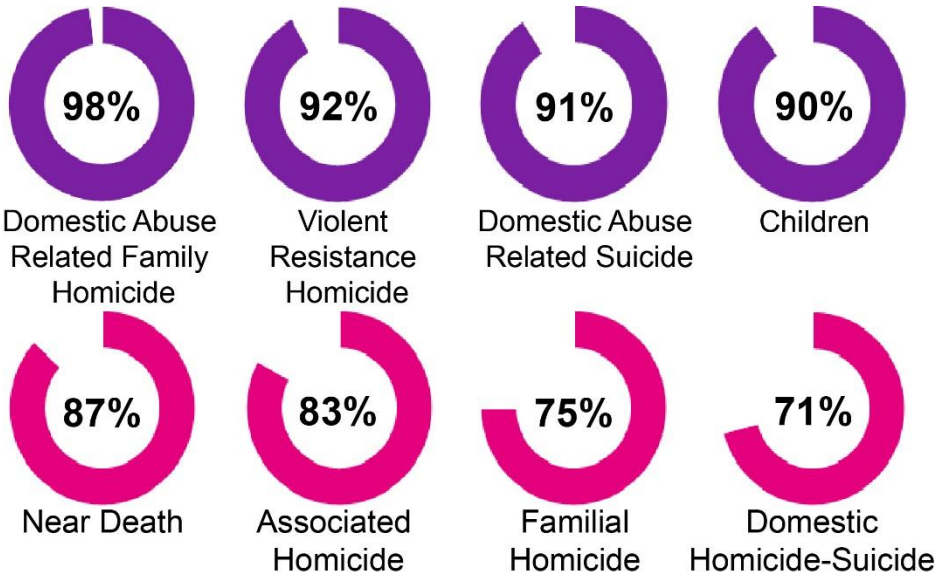

Figure (3). Percentage support to include the eight categories presented as part of the scope of a Domestic Homicide Review model for Scotland

1. Domestic Abuse Related Family Homicide: This is when someone who has perpetrated domestic abuse kills their partner or ex-partner and any related children aged under 18 years old.

Among those who answered this question, **98%** of respondents thought that 'Domestic Abuse Related Family Homicide' should be included within the review scope. Of those, **97%** said that is should be included from the beginning. This shows there is strong support for domestic abuse related family homicide to be included within the Scottish model and for it to be included from the outset.

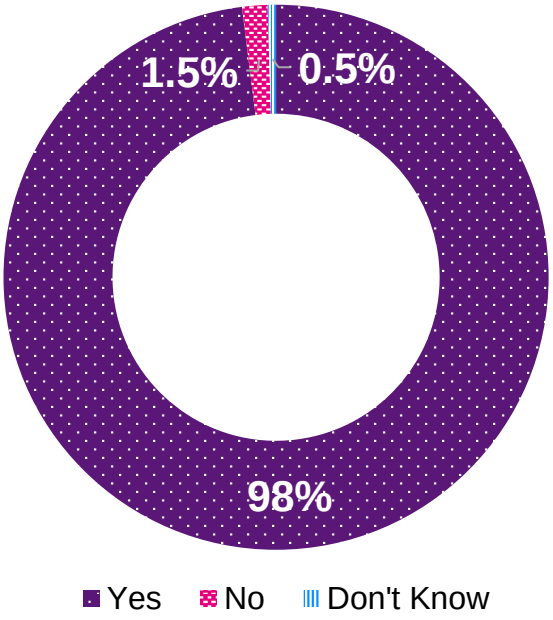

Figure (4). Percentage responses on the inclusion of **Domestic Abuse Related Family Homicide** in model scope

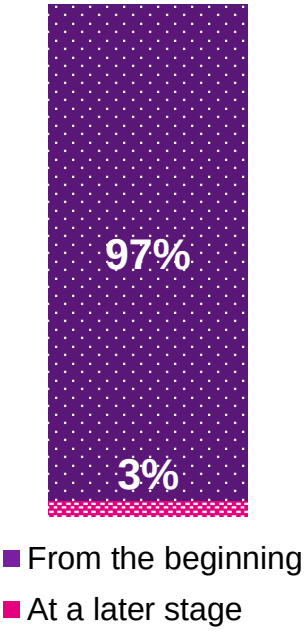

Figure (5). Timing of inclusion as answered by those who chose to include **Domestic Abuse Related Family Homicide** in model scope

"It is important that any related children who are murdered are included in the review. There is still some misunderstanding of the impact of domestic abuse on children, and how they are used to punish mothers. Including them will allow the lessons around risk to be learned by parties who perhaps are looking narrowly at the protection of the child without taking into account the impact of the abuse of the mother on the child, and the risks therein."

Professional respondent with lived experience

The majority of respondents who answered this question said that 'Domestic Abuse Related Family Homicide' should be included as a core category within the model – *"this category is part and parcel of domestic abuse".* All those responding with lived experience said that 'Domestic Abuse Related Family Homicide' is part of the wider manifestation of domestic abuse, and has not been recognised by authorities as such from their collective experience. Those with lived experience also said that time was of the essence, and the longer children and other family members are exposed to the domestic abuse, the worse the outcome will be.

Both professionals and professionals with lived experience said that these deaths cannot be treated in isolation and must be contextualised. Including them would ensure children are treated as victims in their own right.

Based on what respondents said, inclusion of this category will help ensure the interconnectedness between crimes and their relation to existing domestic abuse is captured, rather than treating them as separate cases. It was highlighted several times that this type of death is linked to the *'child aggravator'* under the Domestic Abuse (Scotland) Act 2018 Act[3], and as such, the majority of respondents thought that 'Domestic Abuse Related Family Homicide' should be included. All professionals with lived experience emphasised the importance of differentiating between child abuse and child death and the specific context surrounding both.

Caution was advised by some professionals on the importance of taking a holistic approach to these cases, by establishing joint timelines leading up to the death for both adult/s and children, and ensuring the review process would be undertaken in parallel to a Child Death Review. Resoundingly, responses across the board said that this category would ensure patterns are captured and recognised to help in future cases of domestic abuse where early intervention involving the entire family unit is prioritised.

2. Children: This is when a child (under 18 years old) dies in a domestic abuse context. This includes all children including those not related to the victim who has suffered domestic abuse e.g., if friends of the child are also killed.

[3] Please see the 'child aggravator' provisions included in the Domestic Abuse (Scotland) Act 2018

> "I felt I had to safeguard my kids from the domestic abuse by alerting social services or he would have killed them just to get at me."
>
> Respondent with lived experience

Among those who responded to this question, the 'Children' category received the fourth highest support to be included within the scope of Scotland's Domestic Homicide Review model, at **90%**. The majority of respondents who chose to include this category also chose to include it from the beginning of the model's implementation, at **97%**.

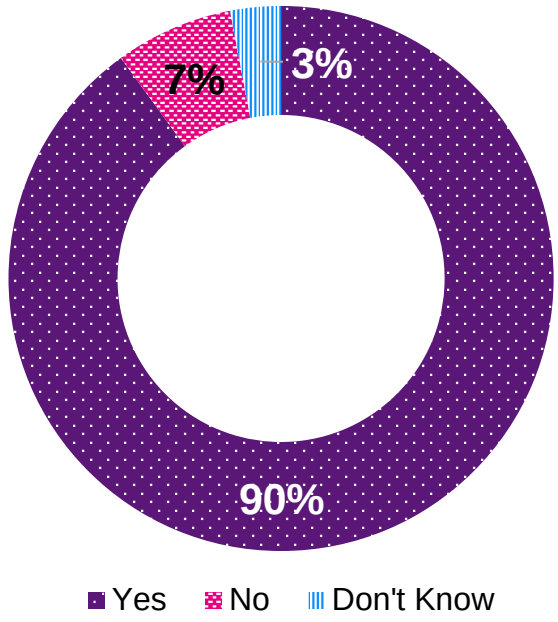

Figure (6). Percentage responses on the inclusion of **Children** in model scope

Figure (7). Timing of inclusion as answered by those who chose to include **Children**

This category again made respondents highlight the importance of treating children as victims within the context of domestic abuse. It was stated that abuse to children and other dependents related to the victim are seen as extensions of her/ him, and attacks are directed at the main victim of domestic abuse by proxy. Killing a child within the context of domestic abuse was described by those who responded as a targeted/ final act of domestic abuse. Those with lived experience unanimously agreed that 'Children' should be included as a category within the scope of the model. Some participants with lived experience discussed whether the perpetrator needs to be charged with domestic abuse for it to go through the Domestic Homicide Review process.

Two examples were also given of women who are in prison for the murder of their child despite there being *"a horrendous catalogue of domestic abuse that was just swept under the carpet"*.

Professionals and professionals with lived experience stated that a joint process with Child Death Reviews may be the way forward to ensure no gaps are left, as

domestic abuse is not the focus of Child Death Reviews. A joint review would endeavour to fill this gap by looking at the death through the lens of domestic abuse instead of a purely child protection lens. It was also mentioned that children visiting or who were around the scene of the crime should be included, if their death is a direct consequence of domestic abuse. Professionals also expressed that children should be included to provide more information surrounding the source of risks.

Including children was considered by some professionals to need a clear definition of the context and criteria for inclusion under a Domestic Homicide Review as opposed to other types of reviews. These considerations are partly:

- To streamline the review process, avoiding duplication of work and resources
- To lessen the burden a review process takes on family members involved.

3. Associated Homicide: This is when someone linked to or associated with the victim of domestic abuse is killed. For example, if someone who has perpetrated domestic abuse kills the victim's new partner or friend.

"He used to say, if I can't get you, I'll get someone close to you."

Respondent with lived experience

Among those who answered this question, the 'Associated Homicide' category received fairly high support to be included within the scope of Scotland's Domestic Homicide Review model, at **83%,** with **78%** of those choosing to include it also choosing to include it from the beginning of the model's implementation.

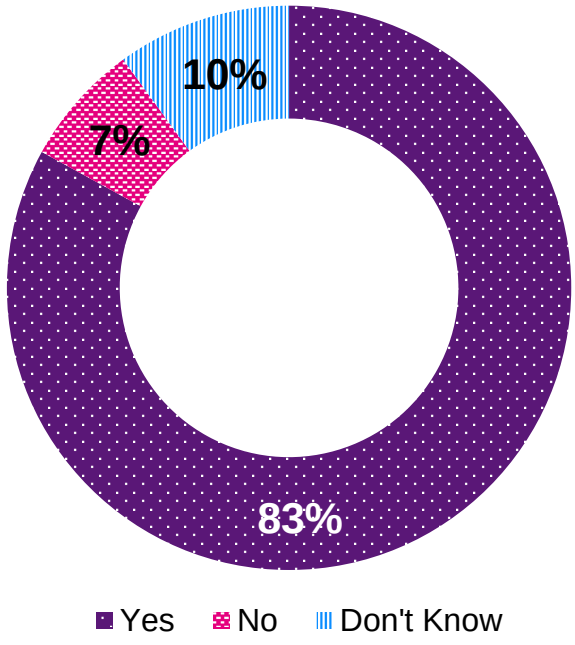

Figure (8). Percentage responses to include **Associated Homicide** in model scope

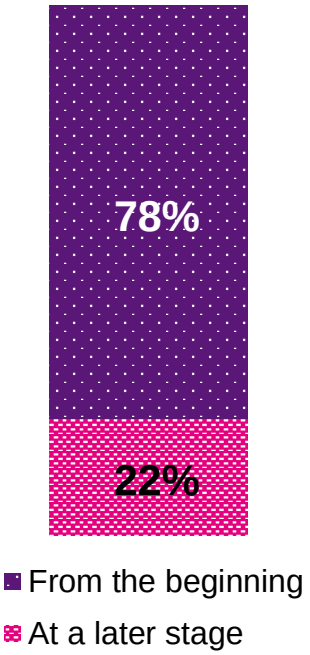

Figure (9). Timing of inclusion as answered by those who chose to include **Associated Homicide**

Despite slightly lower rates of support for inclusion within the scope of Scotland's Domestic Homicide Review model, respondents – especially those with lived experience – expressed that associated homicide is part of the wider experience of domestic abuse and the extent to which perpetrators would go to punish their victim. Some participants said that taking this perspective would alert services to the way in which perpetrators are potentially a danger to other people related to the victim in some way.

Some professionals were not sure if including 'Associated Homicide' within the scope would dilute the model, making the scope too wide. Respondents highlighted that if it was to be included, establishing that the motive behind whether the murder was indeed directly linked to domestic abuse, would be paramount.

Other professionals commented on the importance of including 'Associated Homicide' within the scope of Scotland's Domestic Homicide Review model, as separation and new partners are known risk factors for escalation, sometimes used to coerce the victim back into the relationship. Respondents said that this would allow such risks to be recognised and adopted as new best practice. Additionally, including 'Associated Homicide' within the scope was described as a way to recognise how far a perpetrator may go to coercively control and continue to perpetrate abuse, which is valuable for learning. It was stated that this is not something that currently has a risk assessment, despite it being commonly encountered by victims.

> "This is very relevant as we know that some abusers kill current partners of their ex-partners. To not include these people would prevent the scale and impact (and possible solutions) to the problem being identified."
>
> Professional respondent

Some professionals said that focusing on death/s being a direct result of the perpetration of a pattern of abuse regardless of who the victim is was extremely important. Some professionals with lived experience expressed that associated homicides should be included at a later stage, and that the model should initially focus on the victim and any children/ dependents. Others set clear criteria for including associated homicides when the victim of domestic abuse is murdered as well. For example, in instances where the victim of domestic abuse is not murdered, then an 'Associated Homicide' should not be logged.

4. Domestic Homicide-Suicide: This is when the perpetrator of the domestic abuse kills their partner/ex-partner and then dies by suicide. This may also include where the perpetrator has killed immediate and/ or extended family members then dies by suicide.

"When a domestic homicide-suicide happens, it can be a huge event. If there's no ability for a criminal trial, this should definitely warrant a review. There will be no charges brought – the review will help people move forward."

Professional respondent

The 'Domestic Homicide-Suicide' category received the lowest support to be included within the scope of Scotland's Domestic Homicide Review model at **71%**, with **88%** of those choosing to include it also choosing to include it from the beginning of the model's implementation.

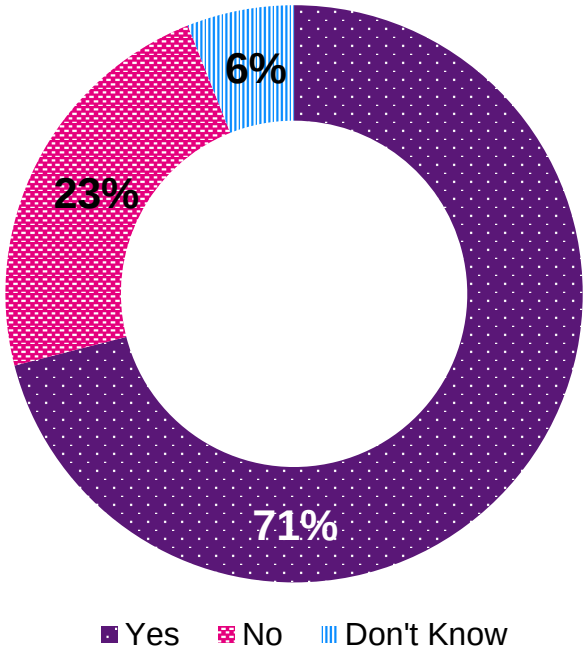

Figure (10). Percentage responses to include **Domestic Homicide-Suicide** in model scope

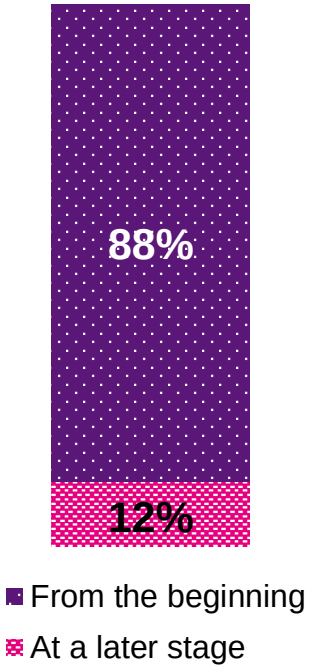

Figure (11). Timing of inclusion as answered by those who chose to include **Domestic Homicide-Suicide**

Most professionals with lived experience agreed on the importance of including 'Domestic Homicide-Suicide' for learning, and that this was the same as intimate partner homicide and part of the wider issue of perpetrating abuse. Several professionals with direct experience of such cases said that inclusion would enable the review to establish if any agency that may have had contact with the perpetrator could have shared information that may have prevented the homicide-suicide. Professionals with lived experience also highlighted that 'Domestic Homicide-Suicide' could include the *"so-called"* honour-based abuse, and strongly agreed it should be included.

There were a few polarised concerns to including domestic homicide-suicides within the scope, primarily by those with lived experience and professionals with lived experience. Concern was expressed that:

- Resources will be diverted towards the perpetrator if they complete suicide
- It could take away from 'her' voice
- A timeframe is needed between murder and suicide
- There is a risk of conflating the purpose of the review

Some of the comments suggest there may have been a misunderstanding that the review would focus on perpetrators and not the victim. Despite the concerns raised, respondents across the board generally acknowledged the importance of including 'Domestic Homicide-Suicide' within the scope, as long as it is not focused on the perpetrator as a victim.

5. Familial Homicide: This is when there was abuse or violence present within a family and a family member kills another family member or other family members (for example, parent or siblings). This may be immediate and/ or extended family.

"Really important to include. More and more instances of familial abuse and a lot of learning to be gained."

Professional respondent

Among those who answered this question, the 'Familial Homicide' category received the second lowest support to be included within the scope of Scotland's Domestic Homicide Review model, at **75%,** with **80%** of those choosing to include it also choosing to include it from the beginning of the model's implementation.

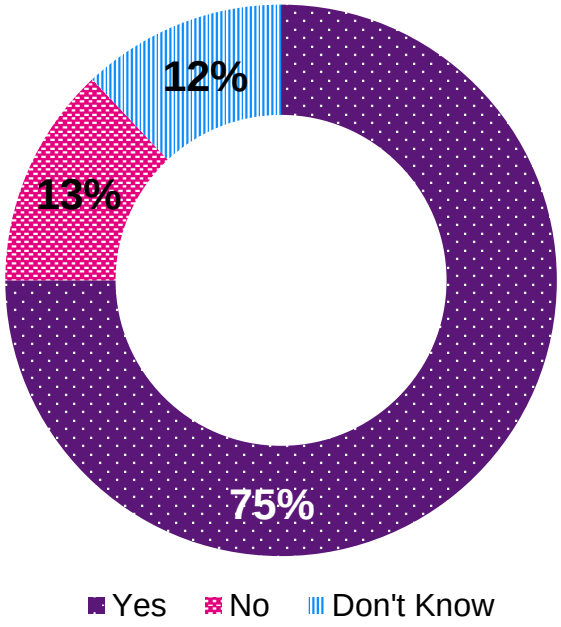

Figure (12). Percentage responses to include **Familial Homicide** in model scope

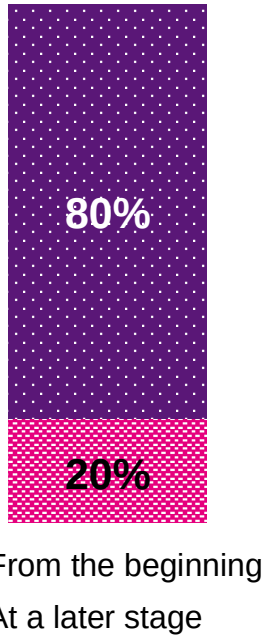

Figure (13). Timing of inclusion as answered by those who chose to include **Familial Homicide**

Unlike ‘Domestic Homicide-Suicide’, ‘Familial Homicide’ had less support from professionals, with the highest rates of ‘don’t know’ responses (**13%**), out of all eight cases presented. There appeared to be some confusion around the definition of familial homicide and what it encompassed. One of the key issues identified with including ‘Familial Homicide’ within the scope of Scotland’s Domestic Homicide Review model across all respondent categories was that it is not compatible with Scottish legislation, and specifically the Domestic Abuse (Scotland) Act 2018. However, while respondents could see potential for including these cases within the scope of Scotland’s model, as it encompasses *“so-called”* honour killings and scenarios involving forced marriages, which are not included under Domestic Abuse (Scotland) Act 2018, but are heard at Multi-Agency Risk Assessment Conferences.

Overall, those respondents in favour of including ‘Familial Homicide’ stated that it needed to have a basis of abuse related to intimate/ ex-intimate partner violence. Examples were given to include cases where perpetrators utilise children to verbally and/ or physically abuse the victim. Otherwise, familial homicides falling outside of these links would be picked up by other existing learning reviews.

6. Violent Resistance Homicide: This is when a victim of domestic abuse kills the perpetrator of their domestic abuse.

> “It may be a kill or be killed situation.”
>
> Respondent with lived experience

Among those who answered this question, the ‘Violent Resistance Homicide’ category received the second highest support to be included within the scope of Scotland’s Domestic Homicide Review model at **92%,** with **93%** of those choosing to include it also choosing to include it from the beginning of the model.

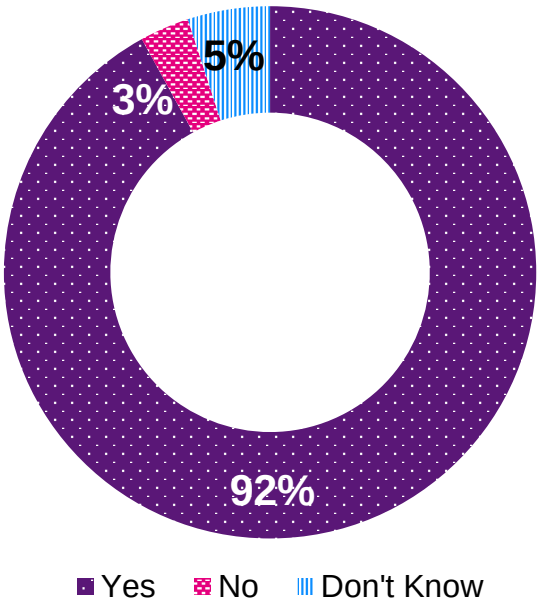

Figure (14). Percentage responses to include **Violent Resistance Homicide** in model scope

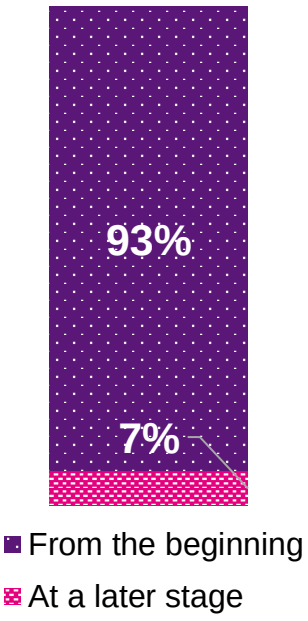

Figure (15). Timing of inclusion as answered by those who chose to include **Violent Resistance Homicide**

Overall, most respondents across all categories agreed that violent resistance homicide is an important aspect of domestic abuse. Professionals with lived experience expressed concerns about the lack of recognition of 'Violent Resistance Homicide' within the criminal justice system.

However, several points were made to ensure that the Domestic Homicide Review process is about learning and not judgement. These points included:

- Ensuring there is a link to domestic abuse
- Raising awareness among professionals and the judiciary on the drivers to violent resistance homicide
- Not to be used to paint the perpetrator as a victim, or 'victim blaming of victim'
- Focusing on missed opportunities for intervention and learning

7. Domestic Abuse Related Suicide: This is when a person has died by suicide and there was a clear link to domestic abuse prior to their death.

"I went to the police and nothing changed. I felt suicidal, I liked life, but mostly I felt out of control. I told people close to me this. I think if I had taken my life, nothing official would have said that it was because of domestic abuse that I'd taken my life."

Respondent with lived experience

Among those who answered this question, the 'Domestic Abuse Related Suicide' category received the third highest support to be included within the scope of Scotland's Domestic Homicide Review model at **91%**, with **78%** of those choosing to include it also choosing to include it from the beginning of the model.

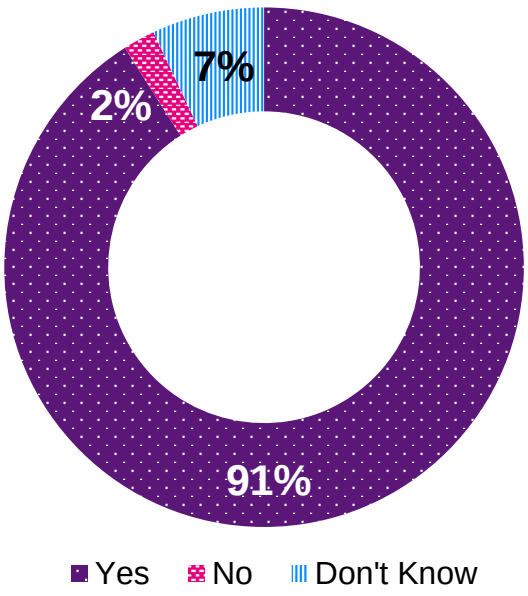

Figure (16). Percentage of responses for the inclusion of **Domestic Abuse Related Suicide** in model scope

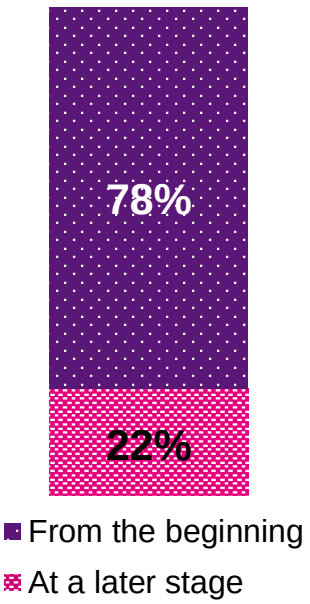

Figure (17). Timing of inclusion as answered by those who chose to include **Domestic Abuse Related Suicide**

Across all respondent types, there was overall high support to include 'Domestic Abuse Related Suicide' within the scope of the Scottish model. Respondents highlighted how 'Domestic Abuse Related Suicide' can be an extension to coercive control and the subtle ways in which it may manifest. Acknowledging this link can help raise awareness of identifying those at risk of suicide among services directly supporting victims of abuse.

Across all respondent types there was consensus that accountability for the role the perpetrator had when the victim died by suicide is vital. It was suggested that often, in such cases, there is no trial and there are no answers or closure for family members. Recognising 'Domestic Abuse Related Suicide' within the scope of the model would help answer questions and identify gaps in communication and/ or intervention.

From those professionals who answered the question, 7% responded 'don't know', as they were unclear on certain parameters of the definition of 'Domestic Abuse Related Suicide' and how it would be established, namely:

- clear link needed with guidance on how this is established
- the timing of the suicide in relation to the domestic abuse
- proving an overdose was a suicide when there is known history of domestic abuse
- the term suicide contradicts the name of the model which includes homicide
- avoid duplication with suicide review processes
- Respect to service agencies such as Scottish Women's Aid and Abused Men In Scotland, and the evidence they have from directly supporting victims

8. Near Death: This is when there has been an attempted murder where, but for medical intervention, the person would have died as a result of domestic abuse.

> "This will be the biggest learning on the impact domestic abuse has on victims."
>
> Respondent with lived experience

Among those who answered this question, the Near Death category received the fourth lowest agreement to be included within the scope of Scotland's Domestic Homicide Review model at **87%**, with **90%** of those choosing to include it also choosing to include it from the beginning of the model.

All those with lived experience agreed that 'Near Death' should be included within the scope of Scotland's Domestic Homicide Review model. Respondents with lived experience felt that this would allow the victim's voice to come forward.

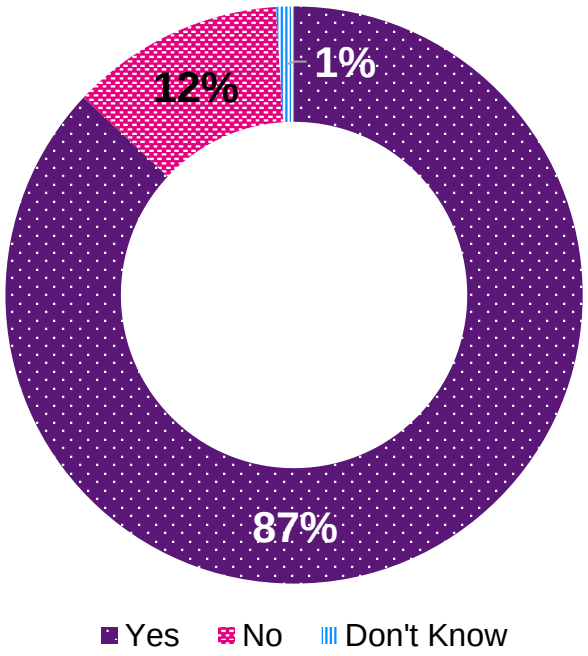

Figure (18). Percentage of responses for the inclusion of **Near Death** in model scope

Figure (19). Timing of inclusion as answered by those who chose to include **Near Death**

Although agreement levels are relatively high, professionals and professionals with lived experience cautioned on the number of cases this would potentially bring forward. Multi-Agency Risk Assessment Conferences figures were sighted as a cause of alarm, since near deaths are very common. Interventions were expanded to include escaping or surviving a murder attempt. 'Near Deaths' were seen as important to include, however, ensuring the Domestic Homicide Review model has the capacity to review the potential volume of these cases is prudent.

9. Animals: Should animals killed or injured as part of a domestic homicide be included within the review process?

"Often, cruelty to animals is a red flag/ warning sign of future harm and homicide. Valuable lessons to be learned. Killing an animal results in a level of fear – bringing death home."

Professional respondent

Over **75%** of respondents across all three respondent types agreed that animals killed or injured as part of a domestic homicide should be included within the review process. It is important to emphasise that this would not be a review for the animal in its own right, but rather the killing or harming of an animal would be considered alongside other factors and circumstances such as the killing of a partner/ ex-partner.

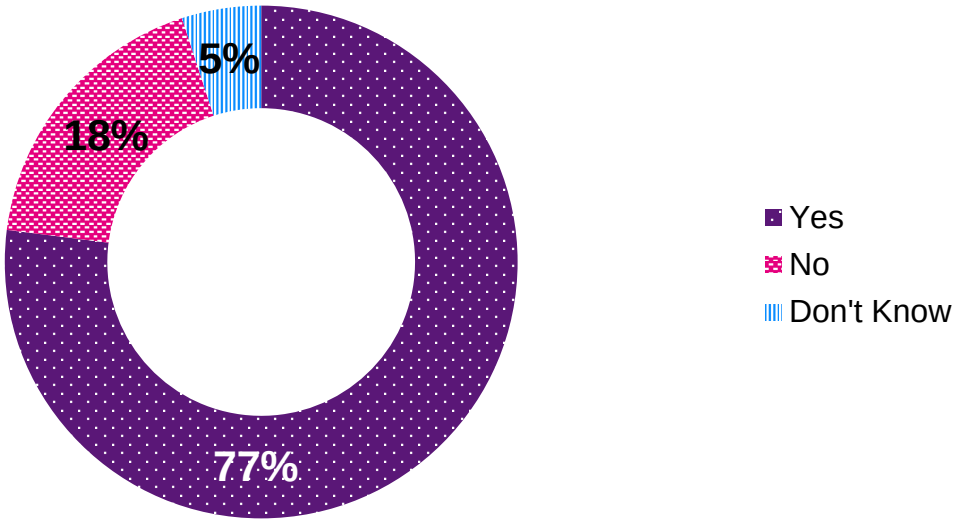

Figure (20). Percentage of responses on whether **Animals** killed or injured as part of a domestic homicide should be included in the review process

Across all respondent types, abuse of animals was acknowledged to be a risk factor[4] and its link to control can potentially highlight missed opportunities for intervention leading up to the homicide, such as during vet visits. It was also mentioned that cruelty to animals is included within Domestic Abuse (Scotland) Act 2018 and is one of the questions from the Domestic Abuse, Stalking and Honour Based Violence (DASH) and Risk Identification Checklist (RIC). Comments were made that this would correspond well by including details of animals harmed or killed as part of a domestic homicide where relevant.

Disagreement was mostly due to respondents misunderstanding that including this information would be part of a DHR and not constitute a DHR in and of itself.

10. Other types of situations not included: What other situations should be the subject of a Domestic Homicide Review process?

Figure (21). Other types of situations not covered by the scope questions, based on the frequency in which these were mentioned by respondents

[4] Mota-Rojas D, Monsalve S, Lezama-García K, Mora-Medina P, Domínguez-Oliva A, Ramírez-Necoechea R, Garcia RCM. Animal Abuse as an Indicator of Domestic Violence: One Health, One Welfare Approach. Animals (Basel). 2022 Apr 10. (Available on the National Library of Medicine website)

Flexibility and Timing

11. Flexibility: Should the system be strictly defined or include some flexibility?

> "As family members bereaved by crime, we are encountering how important flexibility in systems is, having faced barriers to finding out information…"
>
> Respondent with lived experience

From those who answered this question, almost a quarter **(27%)** selected the option whereby the review scope should be 'strictly defined', and circumstances that do not meet the criteria should never be subject to a Domestic Homicide Review. Almost three quarters **(73%)** of respondents selected the option where the system should 'include some flexibility', so that there is a process for deciding to carry out a Domestic Homicide Review in situations that do not strictly meet the criteria, but where there might be valuable lessons to be learned.

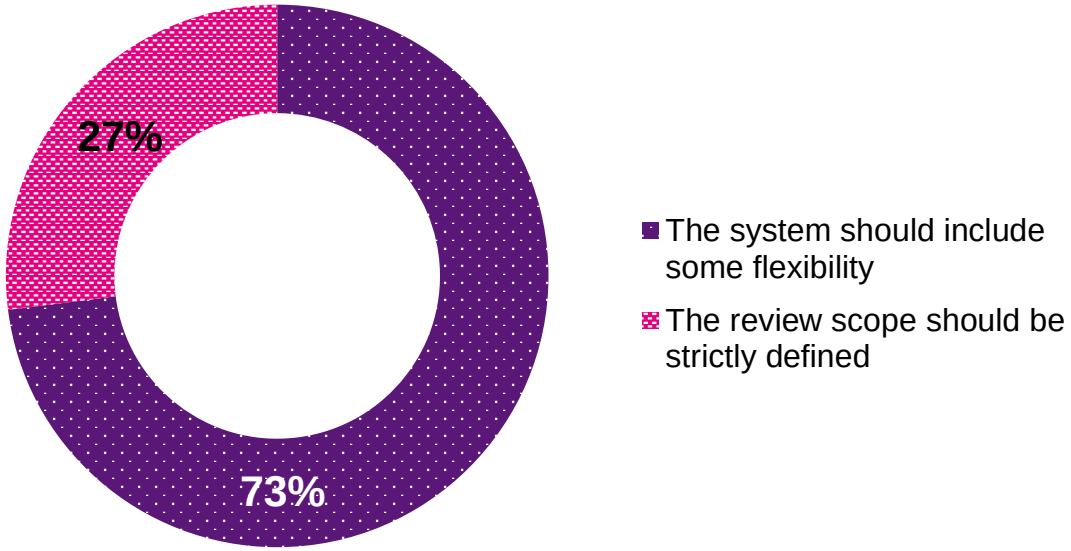

Figure (22). Percentage of responses on how flexible the system should be

All respondents with lived experience except one and the majority of professionals selected the option that Scotland's Domestic Homicide Review model should include some flexibility. The most important aspects of having a flexible system according to respondents included:

- Ensuring learning where it may be missed, not all domestic homicides are obvious.
- Women can die as a result of prolonged physical abuse but the death may occur outside of an attack.
- A "pre-domestic homicide review" review process would allow cases to be assessed as to whether they meet the domestic homicide review definition or not, and as such flexibility should be afforded.
- Flexibility at the start until knowledge and expertise are gained.

Respondents who did not agree that the system should include some flexibility and instead should be strictly defined, cited the following reasons:

- Strict criteria necessary to ensure the aim of Domestic Homicide Reviews is achieved.
- A system with no structure loses its power, flexibility can have implications for domestic abuse, diluting circumstances and losing focus.

12. Timing: When should a Domestic Homicide Review commence?

> "Criticism has been made of schemes which start only after a criminal investigation has been completed. We should learn from deficits/criticism of such schemes."
>
> Professional respondent

A quarter **(75%)** of all respondents selected that the timing of a Domestic Homicide Review should take place as soon as possible, including in parallel to a police investigation, criminal/ civil proceedings/ Fatal Accident Inquiry. Around **16%** of respondents, mainly professionals, selected that a DHR should be undertaken following conclusion of any police investigation, criminal/ civil proceedings/ Fatal Accident Inquiry. Less than **10%** of respondents selected 'Don't know'.

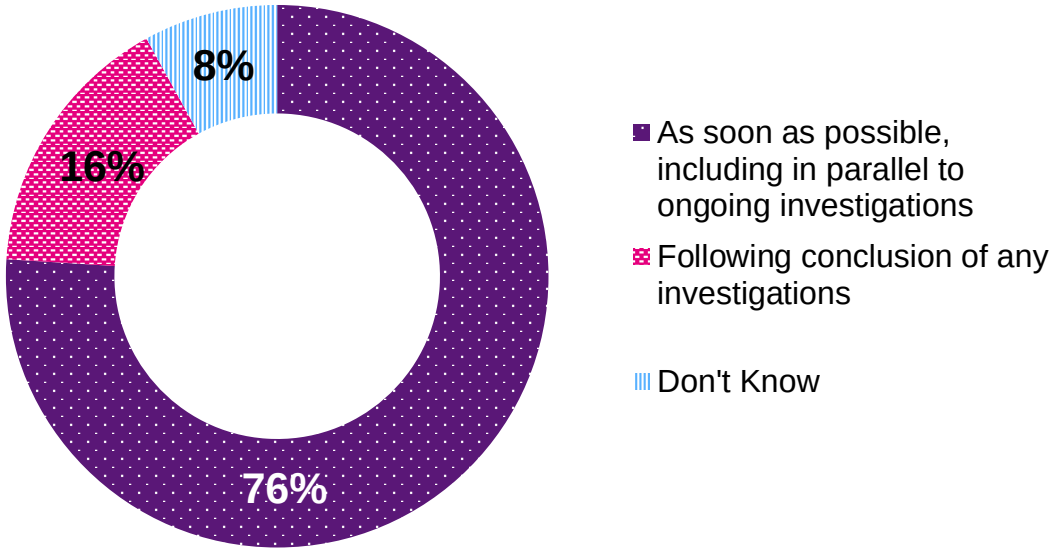

Figure (23). Percentage of responses on the timing of a Domestic Homicide Review

The majority of respondents across all respondent types selected that the timing of a Domestic Homicide Review should be as soon as possible. Reasons provided for choosing this are included in Figure (24).

Figure (24). Reasons why a Domestic Homicide Review should commence as soon as possible, based on the frequency in which these were mentioned by respondents

Professionals and professionals with lived experience shared their thoughts on the practical implications of implementing the Domestic Homicide Review as soon as possible. A summary can be seen in Figure (25) below.

Figure (25). Practical implications expressed by professionals and professionals with lived experience on implementing the Domestic Homicide Review as soon as possible, based on the frequency in which these were mentioned by respondents

Reservations around undertaking a Domestic Homicide Review as soon as possible are included in Figure (26) below.

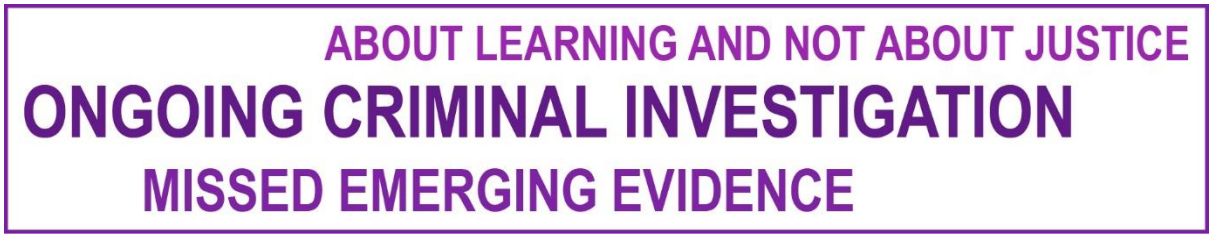

Figure (26). Reservations around undertaking a Domestic Homicide Review as soon as possible, based on the frequency in which these were mentioned by respondents

13. Decisions made by professionals: Should reviews have the option to consider the decisions made by professionals in response to the immediate needs of those directly associated with the person who has died?

> "This may help to identify what services are required in the immediate aftermath of a domestic homicide, supporting families with practical arrangements and emotional grief."
>
> Professional respondent

This question was asked to professionals and professionals with lived experience only. There was some confusion expressed by participants around the meaning of this question. This may explain the split in those who agreed that the review should have the option to consider the decisions made by professionals in response to the immediate needs of those directly associated with the person who has died.

A slight majority of respondents **(48%)** agreed that the review should have the option to consider decisions made by professionals in response to dependents, and **43%** of respondents disagreed with the review process considering these decisions. The remaining **9%** of respondents selected 'Don't Know'.

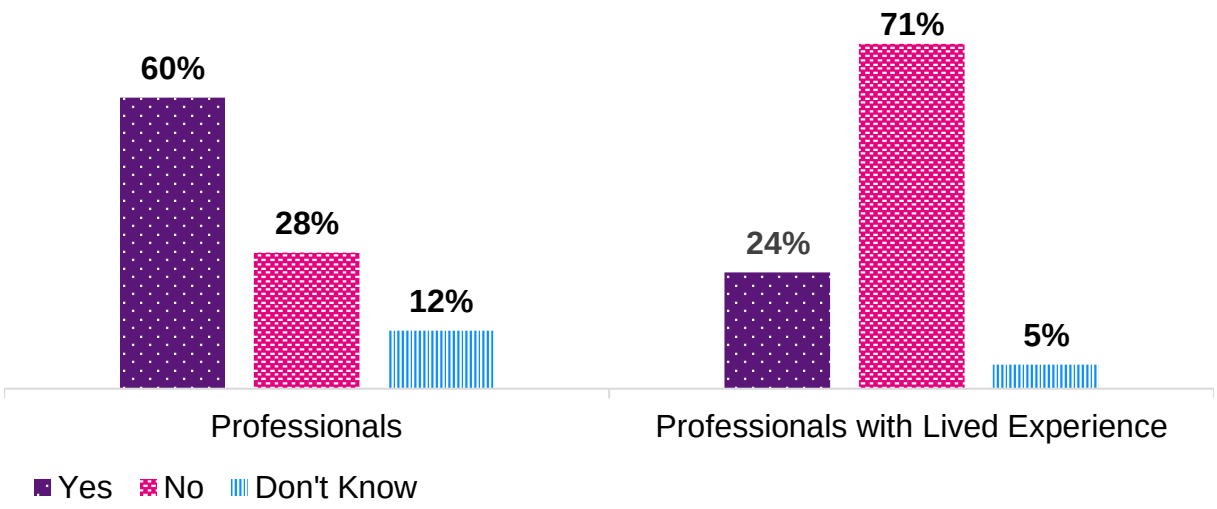

Figure (27). Percentage of responses on whether the review should consider decisions made by professionals, by respondent type

> "I think this is essential because without this view it's very hard to get a holistic view of the situation and accountability for agencies to learn and do better in the future."
>
> Professional respondent

Most professionals agreed that reviewing these decisions is really important and is essential to learning and gaining a holistic view of how the homicide has impacted children and other dependents directly associated with the victim. This learning could inform future practice and guidance. Respondents stressed that reviewing decisions

made about children and dependents ensures that the whole reach and impact of domestic abuse, which can take on many forms and be ongoing and pervasive, is responded to entirely by services.

Professionals agreed that ensuring a trauma-informed, child-centred and rights-based approach is important to mitigating the consequences of the experience on the child/ children. Key considerations here are harmonious timelines and the ability to establish consequences to decisions around placements and contact. Reference was also made to the intended amendments to the UK Government's Victims and Prisoners Bill by which parental responsibilities are to be automatically suspended following a person's conviction of murder/ voluntary manslaughter. This is also known as Jade's Law[5]. However, it is important to note that Jade's Law would only be applicable in England and Wales. The current position in Scotland remains that an application can be made to the civil courts under Section 11 of the Children (Scotland) Act 1995[6] to remove a person's parental responsibilities.

Those who disagreed, either expressed confusion about the way in which the question was worded, or mainly expressed the assumption that there must be an established mechanism that would be reviewing such decisions already.

Initial Case Review

In other jurisidictions that have a Domestic Homicide Review model, an Initial Case Review often takes place. This identifies and considers cases before the decision to proceed with a full review is made. This also happens for some existing learning reviews in Scotland.

The Domestic Homicide Review Policy Team within Scottish Government asked this question with the intent of developing a model that is open, fair, and transparent. It proposed that building in an Initial Case Review to the process would support this, as well as the inclusion of a challenge mechanism if the decision is taken not to proceed to a full review.

14. Initial Case Review: Should the process include an Initial Case Review?

Respondents were asked whether an Initial Case Review should precede a domestic homicide review. Over three quarters **(76%)** of respondents agreed that an initial case review should be undertaken.

[5] Jade's Law (October 2023):The Victims and Prisoners Bill is to be amended so parents who kill a partner or ex-partner with whom they have children will automatically have their parental responsibility suspended upon sentencing. Applicable in England and Wales.
[6] Section 11 of the Children (Scotland) Act 1995 details the court orders relating to parental responsibilities.

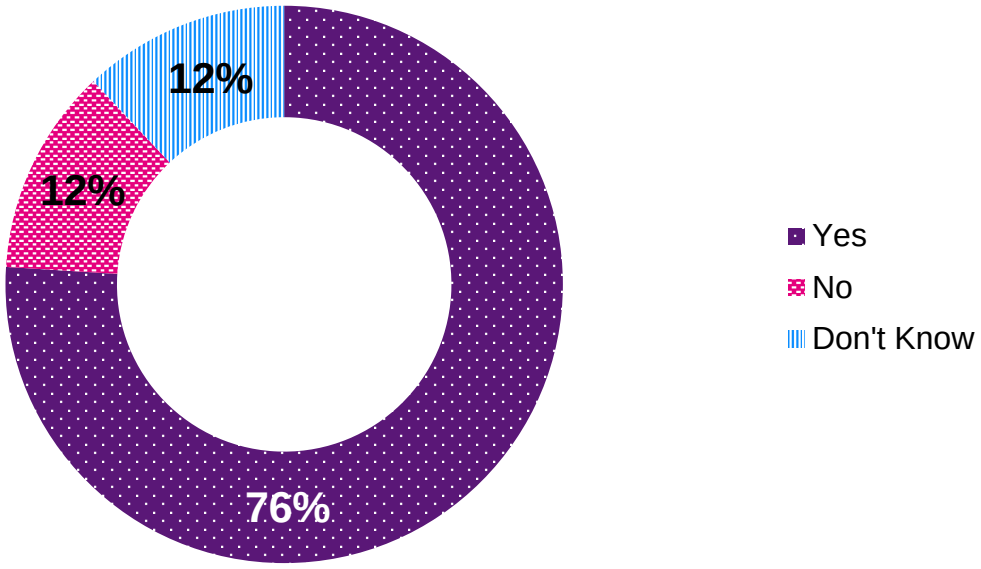

Figure (28). Percentage of responses on whether an **Initial Case Review** should precede a Domestic Homicide Review

Respondents agreed that Initial Case Reviews have the potential to filter cases as long as it is a quick process and does not prolong the commencement of a Domestic Homicide Review. It was commented that an Initial Case Review can ensure that the process is open and fair, as long as clear parameters are set in place around Domestic Homicide Reviews. It was also stated that Initial Case Reviews should not detract from a Domestic Homicide Review, and the system must be robust.

Professionals agreed that the sharing of information at the beginning was vital, however, where it is evident that a domestic homicide has occurred, there should not be a need for an Initial Case Review. Some professionals felt strongly about not having Initial Case Reviews, as they have been used in both Child and Adult Protection Learning Reviews and have since stopped. Whereas others thought Initial Case Reviews work well elsewhere and provided social work as an example. Some respondents commented that cases that meet the criteria should be reviewed regardless. Others felt that there needed to be a specialised group that undertakes Initial Case Reviews and has expert knowledge in assessing these cases.

Respondents with lived experience expressed concerns around the need to allow Domestic Homicide Reviews to take place by ensuring that an Initial Case Review is not about minimising failings by services and authorities. It was stated that Initial Case Reviews should be an exercise to include, rather than exclude.

15. Referrals by professionals: Should professionals and/or other agencies be able to refer a death where abuse is suspected, to the agency/organisation that will undertake the initial case review?

Among those who answered this question, **90%** of respondents agreed that they should be able to, with **7%** of professionals and professionals with lived experience responding ‘don’t know’, and the remaining **3%** of professional respondents disagreeing.

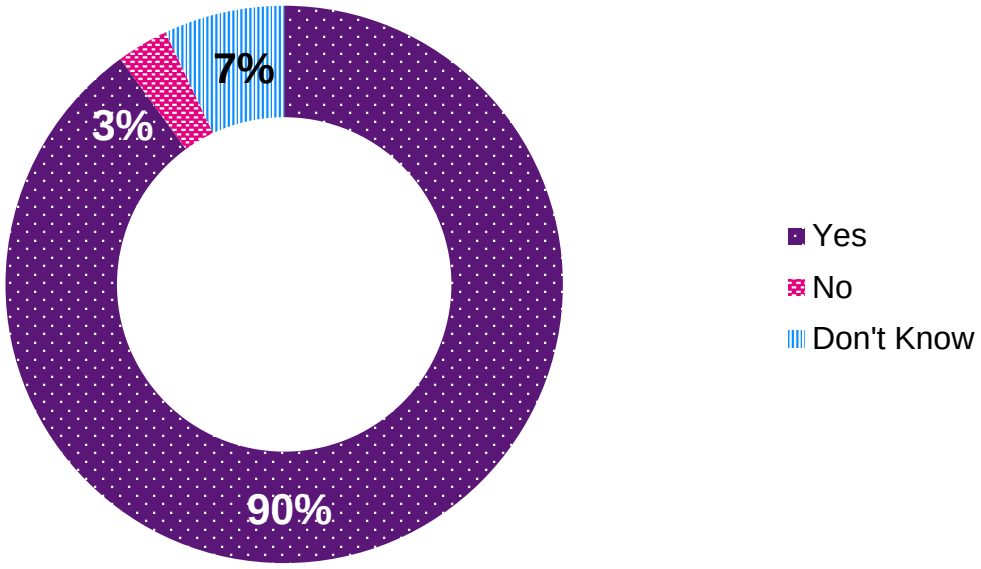

Figure (29). Percentage of responses on whether professionals and/ or other agencies should be able to refer a death where abuse is suspected

There was agreement across all respondent types that professionals and agencies can contribute towards establishing the circumstances prior to the death by knowing the victims on a personal level.

Some professionals stressed that there needs to be an onus rather than 'be able' to refer by professionals and agencies. Having this option was also seen as important to identify 'hidden victims', such as accidental deaths and suicides, as agencies often hold a wealth of information on women/ men who have been in contact with services. It was stated that professionals and agencies can be best placed to identify links to domestic abuse where no formal police report has been made. It was also noted that for male victims, domestic abuse is often a hidden issue that *"can fly under the radar"*.

Professional respondents suggest that a new framework would need to be included to support practitioners to be clear about the criteria for referral to Initial Case Reviews, given some of the types of Domestic Homicide Reviews that are being proposed.

Some professionals found the meaning of this question confusing and this was reflected in their comments.

16. Referrals by families /friends/ carers: Should families/friends/carers be able to refer a death where abuse is suspected, to the agency/organisation that will undertake the initial case review?

Respondents were asked whether families/ friends/ carers should be able to refer a death where abuse is suspected to the agency/ organisation that will undertake the Initial Case Review. Among those who answered, **74%** of respondents agreed that they should be able to, with **15%** of all respondents categories selecting 'don't know' and the remaining **11%** (professionals and professionals with lived experience) disagreeing.

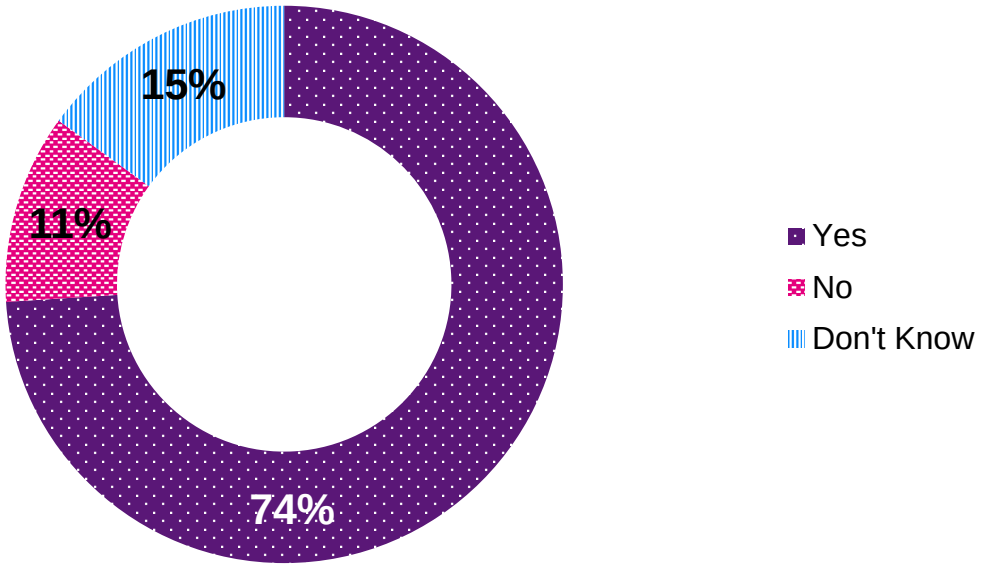

Figure (30). Percentage of responses on whether family/friends/carers should be able to refer a death where abuse is suspected

The majority of respondents agreed that families and friends should be able to refer a death as:

- It is not always professionals who note the abuse or death, and there are cases where there is no professional involvement.
- Carers should be included, particularly for disabled people who are extra vulnerable. Most of the information they hold won't be recorded as part of a criminal justice process, but they'll have a lot to contribute.
- Different route for when services are missing key elements of domestic abuse. Some respondents with lived experience, shared that the police had downplayed a lot of the experiences that fall within domestic abuse.
- Ability to pass on non-corroborated information that the police won't have been able to use – information that friends and family know, that is pertinent but doesn’t or wouldn't come out during a police investigation / criminal justice process - but is majorly important in terms of predicting domestic abuse death.
- Domestic abuse is hidden (particularly in some cultures or within some demographics such as older people). If services are not involved and/ or aware of domestic abuse, families could provide valuable information.
- Families and friends are able to tell the review panel things that they won't tell other people and describe changes of behaviour – some of which are big indicators.
- Some professionals and professionals with lived experience expressed that referrals by families and friends should be done through a support agency or advocacy service, especially in cases where the death was a suicide and there was also domestic abuse present.

There was some confusion as to whether families and friends should be able to refer a death where abuse is suspected by professionals and professionals with lived experience. Whereas others felt that this was vague and wide ranging where no confirmed criminality or concern was yet established. Other concerns raised by those

with lived experience was that there could be a danger of friends/ family members expecting to find answers from the domestic homicide review process even if it does not fit the criteria.

B) Families and Friends' Involvement

This section is about how family and friends can be included within the review process. It also asked respondents what support could look like to help family and friends to take part.

The involvement of families and friends can help to ensure the victim's voice is heard. However, not all families or friends may wish to take part in the process. Some may be concerned about potential re-traumatisation or discovering information they were unaware of.

Any involvement would be a choice for families and friends. How and when people are involved should be sensitively managed with appropriate support available during and following the outcome of the process. An important consideration is whether children and young people (aged under 18) should be involved.

17. Involvement: Which of the following should be given the opportunity to be involved in the Domestic Homicide Review process?

Participants were asked to select who from a list of eight options who should be given the opportunity to be involved in the Domestic Homicide Review process, responders could select one or more options. The results can be seen in Figure (31) below. All categories involving family and friends of the victim achieved a consensus of **90%** or above. On the other hand, three of the four categories involving family and friends of the perpetrator achieved consensus levels below **50%**, and only involving children of the perpetrator achieved **62%** consensus across all respondent types.

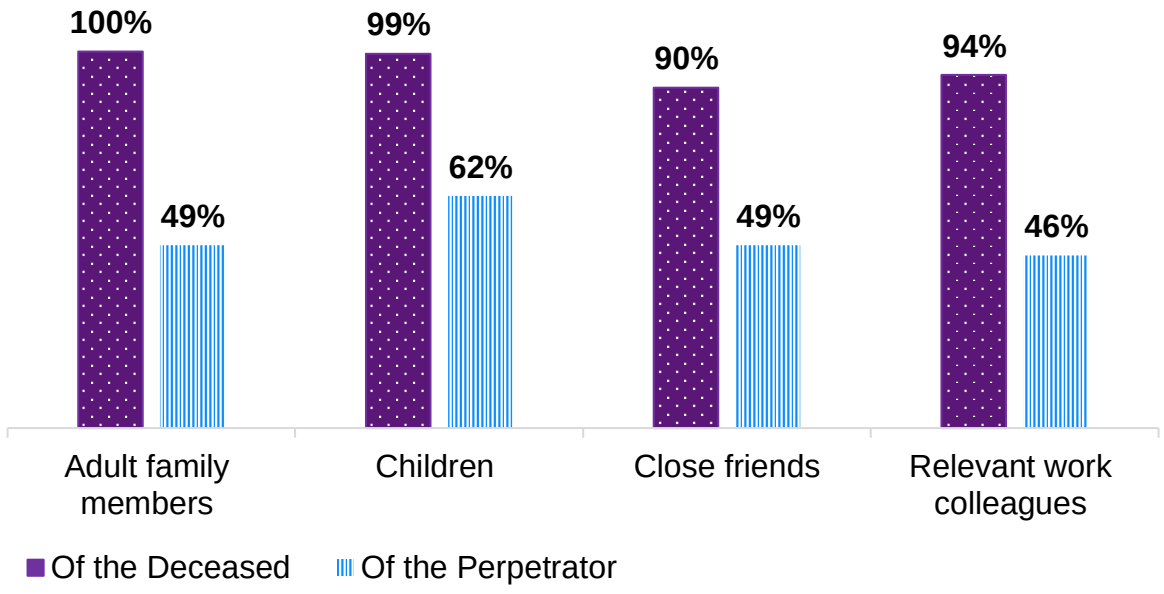

Figure (31). Percentage of respondents selecting who should be given the opportunity to be involved in the Domestic Homicide Review process

It is recognised that contributing to a review may be difficult, stressful, or upsetting for family members and friends. We wanted to understand the potential barriers and make sure that people get the support they need throughout the process.

18. Barriers: Which of the following are considered to be potential barriers to family and friends contributing to the Domestic Homicide Review process? Are there any other barriers which are not listed already?

Participants were asked to consider the potential barriers to family and friends contributing to the Domestic Homicide Review process and their responses can be seen in Figure (32). The barrier that received the highest consensus was being 'fearful of the perpetrator', which was unanimously selected as a barrier by all respondents. 'Still grieving', 'danger of re-traumatisation' and 'new caring responsibilities for children and young people' were selected as a barrier by at least **90%** of respondents.

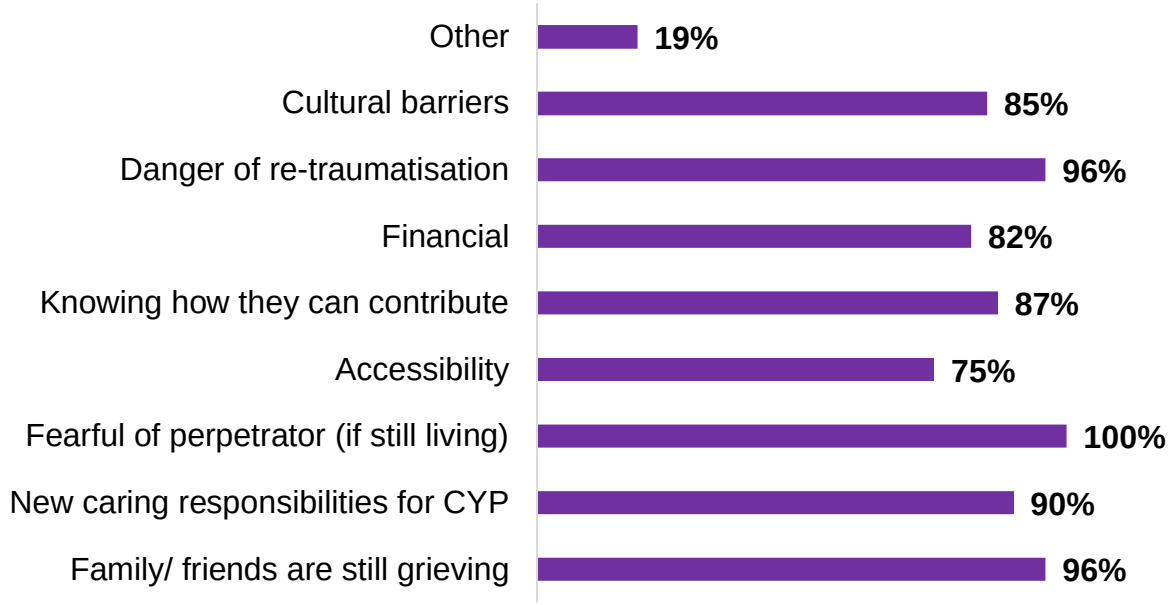

Figure (32). Percentage of respondents selecting the barriers to involvement in the Domestic Homicide Review process

Other barriers discussed by respondents stressed the risk to families and friends from the perpetrator (if still living), but also any risk or threats from the perpetrator's family. Respondents emphasised that giving careful considerations to safety is vital for known and unknown risks, specifically in cases of honour killings, suicides and associates of the perpetrator. The need for accessibility specific to rurality and for those with mental disability or hearing/ sight impairment and dementia was mentioned.

Additionally, those with lived experience expressed that many of the things that they need to do take place while there are work commitments. Having to miss work was stated as a barrier with a huge financial impact for working people. An additional barrier mentioned by respondents was not having an advocate to support and advocate on behalf of/ alongside the families, friends and carers involved.

Respondents also stressed that involving young children needs careful consideration. Some professional respondents shared that fear of the process and mistrust in the system could prevent some from participating in the review.

19. Support: What support should be in place for families and friends through the Domestic Homicide Review process?

Respondents were asked about what support should be in place for families and friends through the domestic homicide review process. Resoundingly across respondent types, two types of support were highlighted which correspond to a trauma-informed advocacy service that provides quality and safe support, and expertly facilitates the link between the formal process and the individual needs of family/ friends.

Support should include counselling services during and after the domestic homicide review takes place, to help families and friends cope and process reliving the trauma and loss. Secondly would be having a dedicated support worker/ advocator during the Domestic Homicide Review process. An effective communications plan and well trained and informed staff to be single points of contact. Safety planning should be offered and measures put in place to protect families and friends involved, especially when the perpetrator or their family/ associates are involved.

Professionals with lived experience stressed that families need to be prioritised during DHRs and courteously facilitated to attend by covering expenses, loss of income, and any other barriers that may arise. A document was shared (for use by the DHR Taskforce) on working with families in reviews from England.

20. Engagement: How should involvement and/ or engagement in the process look like for families and friends

Respondents were asked about how involvement and/or engagement in the Domestic Homicide Review process should look like for families and friends. The most frequent comments that respondents made can be seen in in Figure (33).

Figure (33). Comments on engagement with families and friends

Some professional respondents stated that families would be involved with so many services, that the domestic homicide review process may risk losing families if they are approached too early on after bereavement.

Modes of engagement included questionnaires, one-to-one interviews, and statements (both in person and in writing). The provision of safe spaces to participate in at convenient times of the day was also highlighted by professionals and those with lived experience.

C) Perpetrators' Involvement

This section is about understanding perpetrators' involvement with services prior to the death of a victim.

Similar to families and friends, the person accused or convicted of the death would have a choice as to whether they participate in the review. Any involvement or information from or about perpetrators would need to be sensitively managed to ensure the review focus remains on the victim and on learning lessons. There would also need to be a protocol in place with Police Scotland and COPFS to ensure that any engagement would not jeopardise criminal investigations or legal proceedings.

21. Risks: What are the risks of seeking input from perpetrators during the Domestic Homicide Review process? For example, traumatising for family, friends of victim and/ or perpetrator.

Respondents were asked what the risk of seeking input from perpetrators may be during the Domestic Homicide Review process. A risk that was shared among all respondents was that involvement of perpetrators could enable the perpetration of further abuse. All respondents with lived experience felt strongly about not giving a voice to perpetrators as the DHR is about a crime/murder and the focus should be on that, not gaining two sides to the story with 'he said/ she said'.

The various ways in which such harm could manifest are detailed in Figure (34).

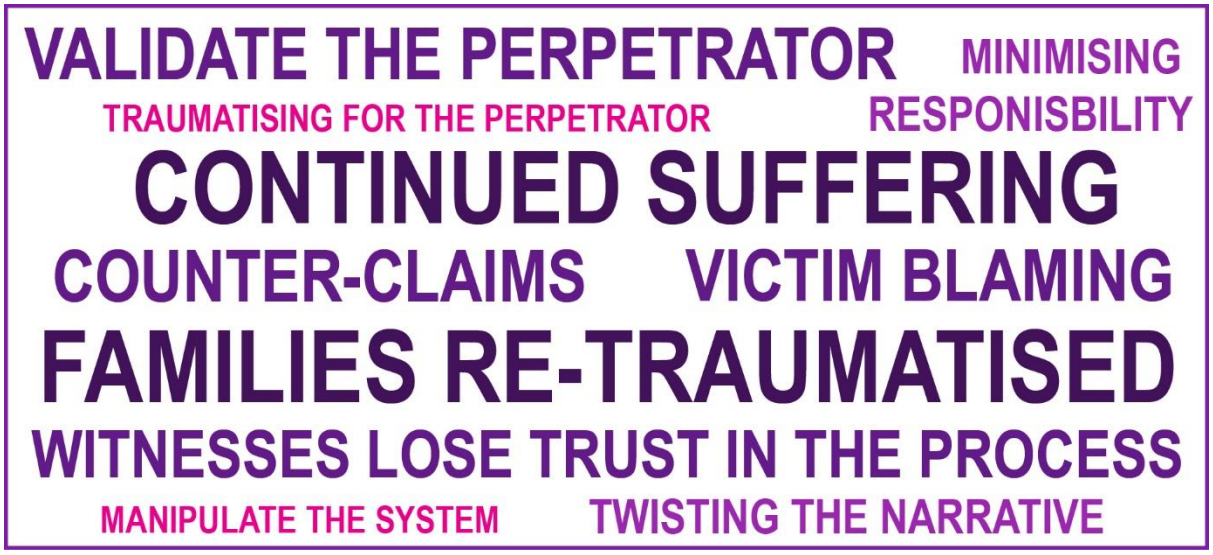

Figure (34). Harm that could be caused by perpetrator involvement

Professionals and professionals with lived experience acknowledged that seeking input from perpetrators could help in learning and is therefore crucial. It was also noted that there is value in perpetrators' involvement if the conviction is in place and accepted, as this would allow learning as to whether it may have been possible to prevent the death. This could sometimes help families and friends understand the wider circumstances of events leading up to the death. Other professionals felt the evidence from legal proceedings should be used instead to gain any information required about the perpetrator.

Clarity was highlighted as essential if input was being sought from perpetrators. Having set parameters and ensuring safeguarding mechanisms are in place regarding the information that is shared with perpetrators about others' input and the input they may provide. Respondents emphasised the need to mitigate all possible ways in which the involvement of perpetrators could facilitate further abuse and act as another platform for perpetrators to coercively control and harm surviving family members, including children, friends and carers.

22. Benefits: What are the benefits to seeking input from perpetrators during the Domestic Homicide Review process?

Less than half of responders selected any of the benefits shown in Figure (29) below. The highest selected benefit to seeking input from perpetrators by respondents **(42%)** is to 'better understand perpetrator attitudes and behaviours'. Closely behind (**41%)** was that seeking input would help 'identify potential opportunities to intervene'. The lowest potential benefit selected by respondents **(36%)** was that input could shed light on 'contact or lack of contact with services'.

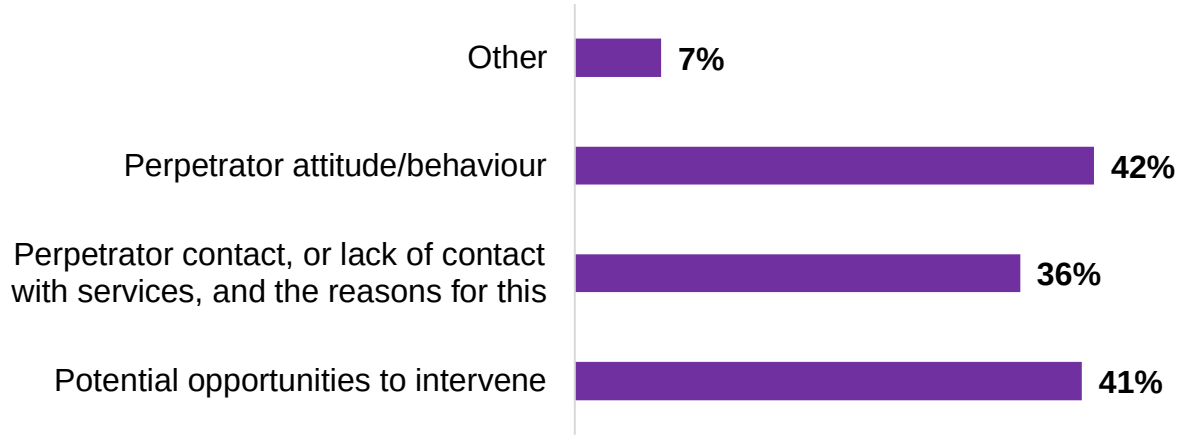

Figure (35). Percentage of respondents selecting the potential benefits to seeking input from perpetrators

There were mixed views amongst all respondents, especially those with lived experience and professionals with lived experience, about any benefits from involving perpetrators. Many of those who answered could not see a purpose to involving perpetrators, and expressed concern that involvement could serve as a new platform for perpetrators to exert control by lying and making excuses, subsequently distorting the narrative. Respondents highlighted that involvement would need to be mediated, and a system where the perpetrator is under close supervision was suggested by some.

Another benefit of involving perpetrators that was shared by respondents was the opportunity to learn lessons from perpetrator behaviour and the perceived failure of services.

A majority of professional respondents' view is that it would help in understanding and tackling the root cause of abuse and address perpetrator vulnerabilities, such as mental illness, history of abuse and drug or alcohol dependency. Ultimately, this would inform prevention guidelines, as patterns in agency or sector communication shortfalls may emerge. Building this information across multiple Domestic Homicide Reviews could facilitate early detection by identifying predictors to domestic homicide and contextualised timelines.

23. Precautions: What precautions should be put in place if the Domestic Homicide Review process seeks input from the perpetrator?

Respondents were asked about the precautions that should be in place if a Domestic Homicide Review process were to seek input from the perpetrator. A large majority of comments from those with lived experience and professionals with lived experience were against the involvement of perpetrators in any way as the best precaution. Shared comments stated that seeing the perpetrator's name in the report would be triggering to surviving family members and friends.

Professionals and some professionals with lived experience reflected on the necessary precautions to consider if involving perpetrators. These are summarised in Figure (36) below.

Figure (36). Precautions identified by respondents as necessary when considering the involvement of perpetrators in the Domestic Homicide Review

24. Engagement: How could the review panel engage with the perpetrators to learn lessons about their involvement with services prior to the death?

> "Take a bespoke approach based on comprehensive guidance and informed by professionals with the relevant experience, knowledge and skills."
>
> Professional respondent

Respondents were asked about the various ways in which the review panel could engage with perpetrators. At least one third of respondents chose a way for the review panel to engage with perpetrators. Two categories reached equal consensus of **43%**. These were 'taking account of the view of the victims' family' and 'impact on any dependents'.

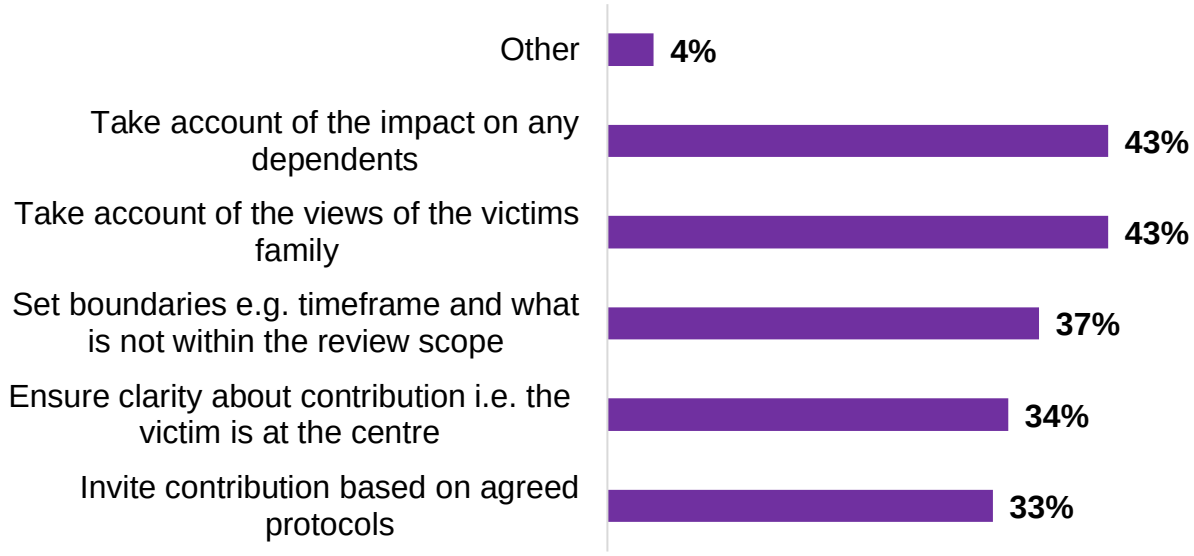

Figure (37). Percentage of respondents selecting ways in which the review panel could engage with perpetrators

Some responses reiterated that perpetrators should not be invited to engage with the Domestic Homicide Review. This is consistent with the total response rates to this question, with **43%** selecting an appropriate way to engage with perpetrators. Others stated that high level training to any staff working on Domestic Homicide Reviews was necessary, to understand the complex and intersectional nature of domestic abuse. Comments were made that only by adopting an intersectional approach, researchers, policymakers, and practitioners can gain a more comprehensive understanding of the complex and multifaceted nature of domestic homicide.

Other respondents mentioned the importance of safety for all involved and adopting a bespoke trauma-informed approach based on comprehensive guidance. Ensuring the perpetrators' vulnerabilities and additional needs are recognised.

D) Information Gathering and Analysis

This section considered how we can make sure that important information can be gathered to inform the review.

In considering how to ensure information is shared on organisations' involvement with victims and perpetrators at the time of/in the lead up to, a victim's death, it is essential that those contributing are clear about why their cooperation is essential.

25. Cooperation: What is the best way to ensure co-operation and participation of agencies in the review process?

Professional respondents and those professionals with lived experience were asked about the best way to ensure co-operation and participation of agencies in the review process. A key recommendation was the need for legislation to strengthen information sharing. Respondents also commented that statutory guidance on the aim and remit of Scotland's Domestic Homicide Review model would provide clear roles, support mechanisms, expectations and realistic outcomes. It was also noted that to support the implementation of legislation, funding would need to be committed to cover the additional workload by various agencies/ sectors.

Respondents also shared the need for flexibility in providing input and attending meetings to fit work patterns. It was also stated that agencies need to take ownership of the process and view reviews as learning opportunities, making it clear that they are not being used to criticise without offering constructive recommendations.

Some respondents cautioned that Domestic Homicide Reviews need to be integrated within existing review processes to avoid duplication and the burden or re-traumatisation of surviving family members, friends and carers. Others suggested that Scotland's Domestic Homicide Review model could use existing review models as a basis on how it operates.

26. Learning: What is the best way to ensure the Domestic Homicide Review process is about learning lessons?

Professional and professionals with lived experience were asked about the best way to ensure that the Domestic Homicide Review process is about learning lessons. Resoundingly, feedback echoed that the process needs to be supported by clear guidance and avoid blame culture. Respondents also shared that the Domestic Homicide Review needs to have a mechanism to look at this learning through a multi-agency lens to avoid any agency from acting as gatekeeper to the information.

It was also noted that the quality of the review's leadership, including the knowledge, skills and experience of lead reviewers, is absolutely critical – not just subject-specific, but a wider skill set that allows them to build findings and recommendations that support improvement. Other ways suggested by respondents included:

- Bespoke reviews tailored to the circumstances of the specific case and that are proportionate.

- A clear focus on facts and behaviour, avoiding sensationalism.
- Implement a quality assurance framework to gather feedback and monitor progress on action points.
- Acknowledge that some partners are more dominant than others or respected and valued. This is particularly important relating to the third sector - they hold significant information that's of importance.
- Role of families need to be given equal space and place in the learning process.
- Ongoing communication throughout the process. People knowing they are valued and that the work they are contributing to is valued.
- Ensure that updates are provided throughout the process.
- Support for professionals to feel comfortable sharing information, avoiding blame culture, encourage learning from the process.
- Tone of communications has to be about learning. Moving from 'significant case reviews' to 'learning reviews' in social work has helped to change the mind-set of the profession.
- Victims and families need to be clear that reviews are not investigations and not about establishing facts (this can be very challenging for them) – they will not give them all the answers they are looking for and this needs to be clear from the outset.

27. Examples of good practice: Are there any examples of good practice of review processes in and out with Scotland that operate well in relation to sharing sensitive information?

Respondents were asked whether they had any examples of good practice of review processes. Several examples were suggested and are listed below:

- Child Protection Case Conferences
- Domestic homicide review process Cumbria
- Drug Death Reviews in Tayside.
- Learning Reviews
- Multi Agency Risk Assessment Conference
- Risk Management Case Conferences

E) Reporting and Learning

This section asked about the report following a Domestic Homicide Review. Participants were asked their views on how to ensure that the learning and recommendations are meaningful and will lead to change.

Families, friends, and relevant professionals will be given the opportunity to review the report before submission to ensure that their accounts are accurately reflected.

28. Responsible organisation: To which organisations should the Domestic Homicide Review report be submitted once completed? For example, Scottish Government.

Participants were asked which organisations should the Domestic Homicide Review report be submitted to once completed. There was mixed feedback regarding the responsible organisations. The Scottish Government featured in most responses, either as the organisation in charge, or involved in other ways. Some suggestions were that the Scottish Government could act as a Chair of a Domestic Homicide Review board. Others respondents suggested that the Scottish Government could work with a commissioning body, the courts, or victim support organisations.

Some respondents considered that the Scottish Government may not have the relevant skills and experience to provide oversight of report quality, and that ownership should remain local to maximise the potential for learning.

Others suggested organisations included: Multi-Agency Public Protection Arrangements (MAPPA) Strategic Oversight Group, Social Work, Police Scotland, the Courts and Local Authorities.

29. Dissemination of learning: How should the learning from the finalised Domestic Homicide Review report be made available to those beyond the family and agencies involved?

Respondents were asked how learning from the finalised Domestic Homicide Review report should be made available beyond the family and agencies involved. There was a tie **(32%)** between respondents selecting the full anonymised report being publicly available and those who selected an anonymised executive summary is publicly available. Over a quarter of respondents **(27%)** selected that the full anonymised report should only be made available for legitimate purposes. Only **5%** of respondents selected the full report to be publicly accessible.

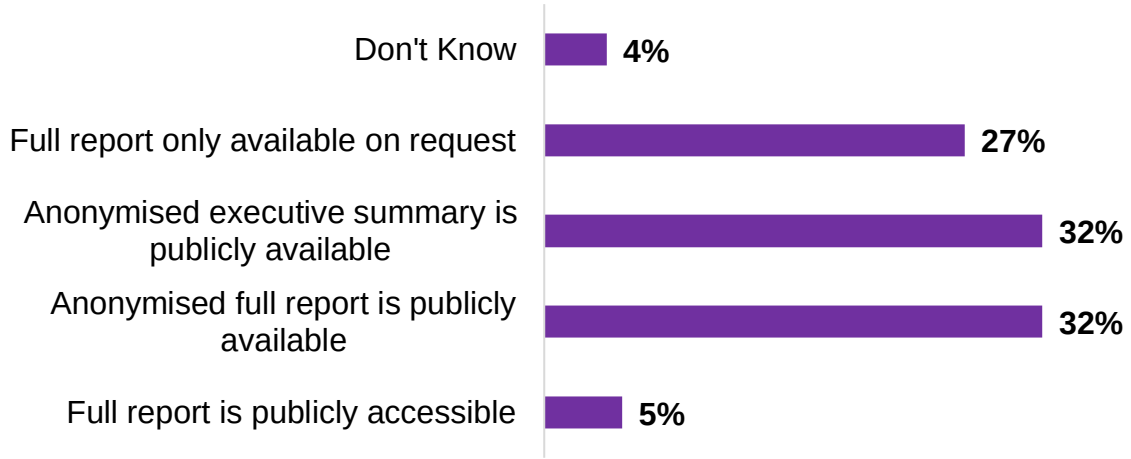

Figure (38). Percentage of respondents selecting how the learning from the finalised Domestic Homicide Review report should be made available

Respondents with lived experience felt that the perpetrator should not have access to the report, and that there was also no need for it to be published. A discussion about this led those with lived experience to question whether the dissemination of findings could be informed by the bereaved family.

Other respondents said that reports need to be publicly available and there needs to be a centralised source where they can be accessed so that different organisations

and Police forces/ stations are able to learn from them. Professional respondents believed that the report should include demographic information (such as: ethnicity, dis/ability), to explore the implications of discrimination in the victim and their family's experiences of both accessing services prior to and since the homicide.

Respondents highlighted that Domestic Homicide Reviews are about learning, transparency and sharing of lessons. People must therefore be confident enough to identify issues and failures with public shame and embarrassment. It was also stated that it is critical to protect families from the public fall out of a review. Sharing the full report was seen as unnecessary by most respondents with the need for anonymization at the very least. However, caution was advised when anonymising reports, not to de-humanise the victim/s and survivor/s.

It was also suggested that being able to access the report and the lessons through various platforms would be helpful. This access would be given upon approval to those who can contribute to learning.

30. Other ways to ensure learning: Are there other means to ensure learning in addition to a report? For example, through a learning event with the organisations that were in contact with the victim and perpetrator.

"Learning events can be excellent conduits for learning, summarised briefings, agencies meeting the bereaved families and holding events at which victims speak."

Professional respondent with lived experience

Professional respondents and professionals with lived experience were asked to share their views on other means to ensure learning in addition to a report. Many respondents agreed that local and national learning events would be incredibly useful. Learning summaries for wider dissemination was suggested and Action Learning Sessions to ensure active learning. Additionally, a clear dissemination process for each review was highlighted. Other ways that respondents identified for ensuring learning are detailed in Figure (39) below.

Figure (39). Other ways to ensure learning identified by respondents

31. Implementation of recommendations: What needs to be in place to support recommendations to be implemented successfully across organisations?

Professional respondents and professionals with lived experience were asked what needs to be in place to support recommendations to be implemented successfully across organisations. The importance of resources and funding were cited by many respondents as pivotal to ensure recommendations have an environment in which they can be implemented. Additionally, respondents think legislation and supporting guidance around the domestic homicide review process would help support the implementation of recommendations.

Ensuring strategic buy in with a strong leadership (through a governing body for instance) could provide a clear pathway of process after the conclusion of a domestic homicide review. This would help promote a continuous improvement culture. It was also noted that appropriate people at the appropriate level are involved. Other ways to support recommendations shared by respondents are:

- Debrief sessions
- Implementation plans
- Key people having accountability
- Realistic recommendations
- Sharing examples of best practice, such as best practice sheets/process sheets

It was also stated that if recommendations cross over boundaries this needs to be agreed. The wellbeing of the professionals involved was also cited as an important consideration and to ensure that the work culture is trauma informed and includes staff wellbeing.

F) Underpinning Scotland's Domestic Homicide Review Model

This section asks how the model for Scotland should be underpinned. Most Domestic Homicide Reviews across UK and internationally are reinforced by legislation. However, there are some review processes in Scotland which are not, and instead rely on guidance.

32. Legislation: Should the Domestic Homicide Review process be underpinned by legislation?

Respondents were asked whether Scotland's Domestic Homicide Review process should be underpinned by legislation. Over three quarters (**77%**) of respondents agreed that legislation should underpin Scotland's Domestic Homicide Review model with **15%** of respondents unsure and **8%** who disagreed.

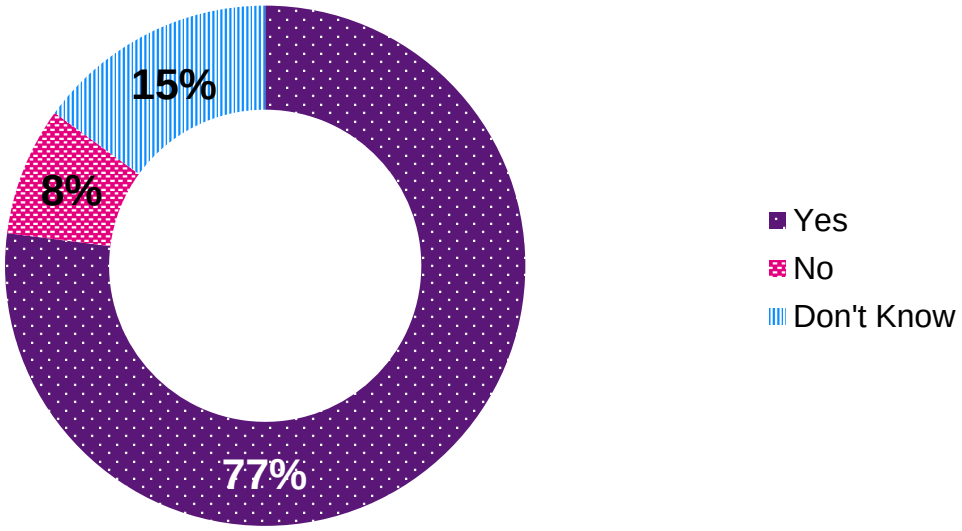

Figure (40). Percentage of responses on whether the Domestic Homicide Review model should be underpinned by legislation

Comments from respondents stated that the Domestic Homicide Review model should be embedded within legislation and undertaken within set guidelines. Ensuring accountability was mentioned, especially from agencies such as the police, or agencies supporting perpetrators.

> "Yes, if it isn't then it won't be a priority for services. By underpinning the model with legislation there could be requirements to report to parliament to ensure learning and recommendations are being implemented. It would also help with complex data sharing issues. It would also publicly show the commitment to learn lessons and that those killed were important."
>
> Professional respondent

Some of the main reasons in support of legislating Scotland's Domestic Homicide Review model are included in Figure (41) below.

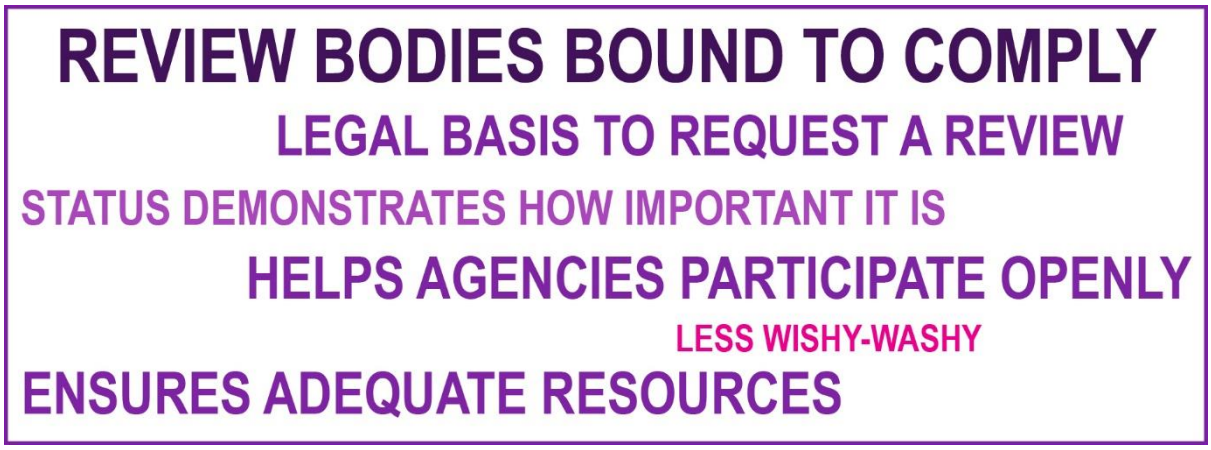

Figure (41). Reasons for underpinning Scotland's Domestic Homicide Review model by legislation

Other professionals and professionals with lived experience who disagreed with underpinning Scotland's Domestic Homicide Review model with legislation said that an issue such as domestic homicide shouldn't require legislation. Others commented that there are few domestic homicides and in their experience, all organisations are reflective and keen to learn in these circumstances.

Additionally, legislation was pointed out to be a lengthy process, resulting in delays and a lack of learning for victims and their families. Some suggestions by professional respondents was to set-up the model with all the necessary parameters, then review the need for legislation if there is insufficient buy-in from agencies.

33. Other comments: Are there any other comments about the planned Domestic Homicide Review process?

The final question asked participants if they had any other comments. It was pointed out that the work of Jane Monckton-Smith on the homicide timeline is already used in England. When looking at Domestic Homicide Reviews, Scotland would benefit from looking at such models.

Figure (42). Other comments made by respondents

Some of the professional respondents expressed that they were pleased to see that Domestic Homicide Reviews are being progressed.

> "I'm pleased that this is now happening in Scotland. It means that victims' lives are valued, which is important to not just the victim but their family. Agencies will learn valuable lessons on how to support victims and recognise the real risk they are in. More professionals and the general public will realise just how many victims of domestic abuse are killed."
>
> Professional respondent

Annex A

Sectors and Organisations

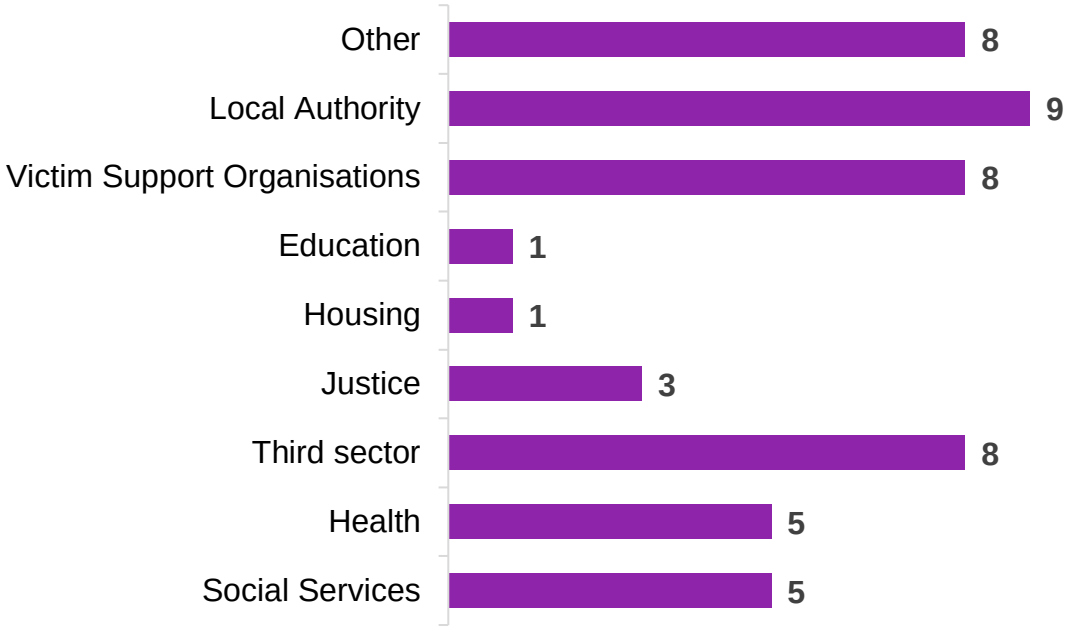

Figure (43). Frequency of representation of various sectors during engagement sessions

A list of organisations (N=31[7]) that provided a professional response is included below:

Aberlour Child Care Trust	Medics Against Violence	Scottish Borders Justice Service
Abused Men in Scotland (AMIS)	National Health Service (NHS) Scotland	Scottish Borders Women's Aid Network
Advocacy After Fatal Domestic Abuse (AAFDA)	North Ayrshire Women's Aid	Scottish Women's Aid – Survivor Reference Group
Advocacy Support Safety Information Services Together (ASSIST)	National Society for the Prevention of Cruelty to Children (NSPCC)	Shakti Women's Aid
Association of American Women of Aberdeen	Office of the Chief Social Work Advisor	The Scottish Community Safety Network
Caledonian System (Community Justice Scotland)	Perth & Kinross Council	The Willow Justice Service
Children's First	Perth & Kinross Violence Against Women Partnership	Women's Aid members – Scotland

[7] Two organisations submitted two responses to the consultation but are mentioned once in the table.

Community Safety Partnership	Police Service of Scotland	Women's Aid: North South East Multi Agency Risk Assessment Conference (MARAC)
Cruse Scotland	Public Health, NHS Ayrshire and Arran	Violence Against Women Partnership - Ayrshire
Dundee Violence against Women Partnership	Scottish Borders Violence against Women Partnership	
Edinburgh Women's Aid	Scottish Borders Domestic Abuse Advocacy Support Service	

Table (1). Organisational responses to the targeted engagement

The following organisations facilitated engagement sessions [8]:

- Aberdeenshire Council
- Scottish Borders Women's Aid
- Dundee Violence Against Women and Girls Partnership (VAWP)
- Healthcare Improvement Scotland
- National Violence Against Women (VAW) Network and Gender Based Violence (GBV) Health Network (supported by the Improvement Service and Public Health Scotland)
- National Health Service (NHS)
- North Ayrshire Women's Aid
- NRS VAW Services and Glasgow Violence Against Women Partnership
- Police Service of Scotland
- Public Health, NHS Ayrshire and Arran on behalf of a PAN Ayrshire response
- Scottish Borders Violence Against Women Partnership
- SafeLives
- Scottish Women's Aid
- Victim Support Scotland
- The University of Edinburgh
- The Scottish Government

[8] Some organisations facilitated multiple sessions but are only represented once in this list.

Annex B

Support Services

We understand that the subject matter covered within the report is sensitive and may be upsetting. If the content of the report is distressing, you may wish to speak to someone. Details of services providing support are set out below:

- Scotland's Domestic Abuse and Forced Marriage Helpline
- Victim Support Scotland
- Scottish Women's Aid
- AMIS | Abused Men In Scotland
- Samaritans
- Breathing Space

Scottish Government
Riaghaltas na h-Alba

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