Domestic Homicide Review Taskforce Questionnaire

May 2023

Scottish Government
Riaghaltas na h-Alba

Contents

Introduction

This paper provides a summary of the results of an online questionnaire issued to the Domestic Homicide Review (DHR) Taskforce in December 2022.

The questionnaire was conducted to establish where there is common ground and differences in Taskforce members' early thinking about what a Scottish DHR process might look like. The questionnaire also aimed to identify any gaps or differences in members' understanding of key aspects of DHRs.

In total 13 Taskforce members filled in the survey (representing 45% of the 29 taskforce members).

The results were used to inform a workshop held in February 2023 that explored the purpose and scope of a Scottish DHR model in more detail.

Purpose of a DHR

The first question asked what members thought the purpose of the DHR should be. Responses can be broadly divided into six categories (number of respondents provided in brackets):

- Learning (n=10)
- Increase safety/prevent deaths (n=6)
- Understanding the details of domestic homicides (n=5)
- System improvement (n=5)
- Improved collaboration between agencies (n=2)
- Memorialise victims (n=1)

Annex 1 lists all the responses to this question.

Case Selection and Scope

Taskforce members were asked to select all the criteria that they felt should be in the scope of the DHR. Intimate partner violence (IPV) was selected by all respondents. Responses are shown in Figure 1 below.

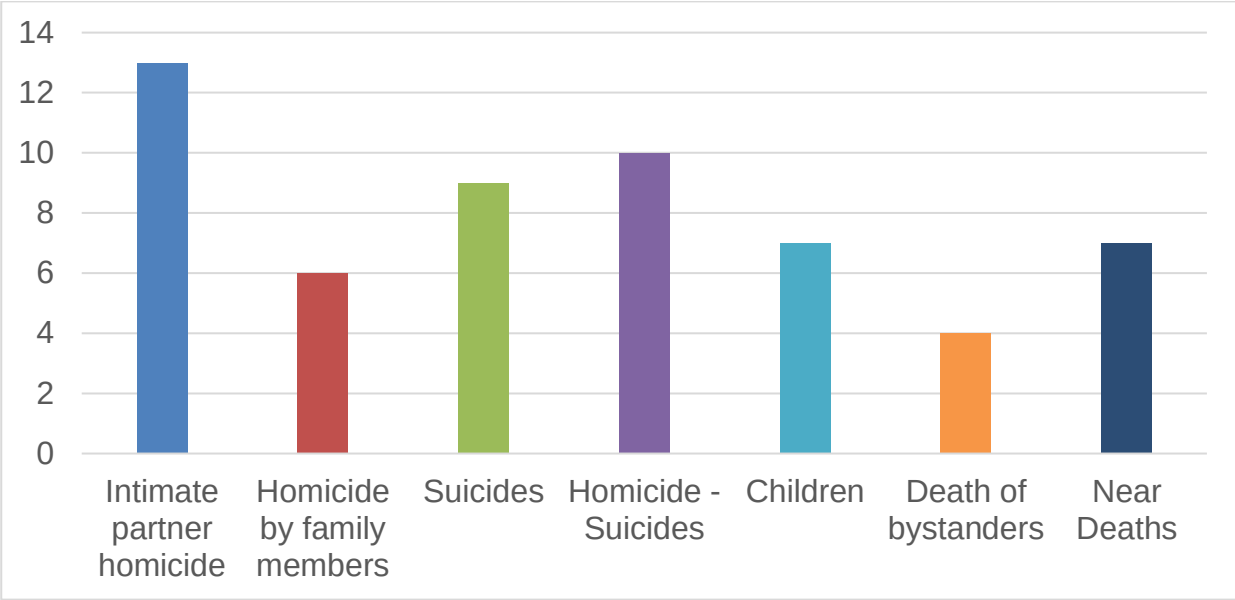

Figure 1 - Case selection criteria

There were differences in respondents' views on whether other criteria should be included in the scope of a Scottish DHR model and/or which criteria should initially be included or added at a later stage. Two respondents mentioned that when answering, the Scottish legal definition of domestic abuse should be taken into account, noting that it only included intimate partner violence.

When asked whether all cases or only a selection of cases should be reviewed, responses suggest a preference for reviewing all cases. Responses are shown in Figure 2 below.

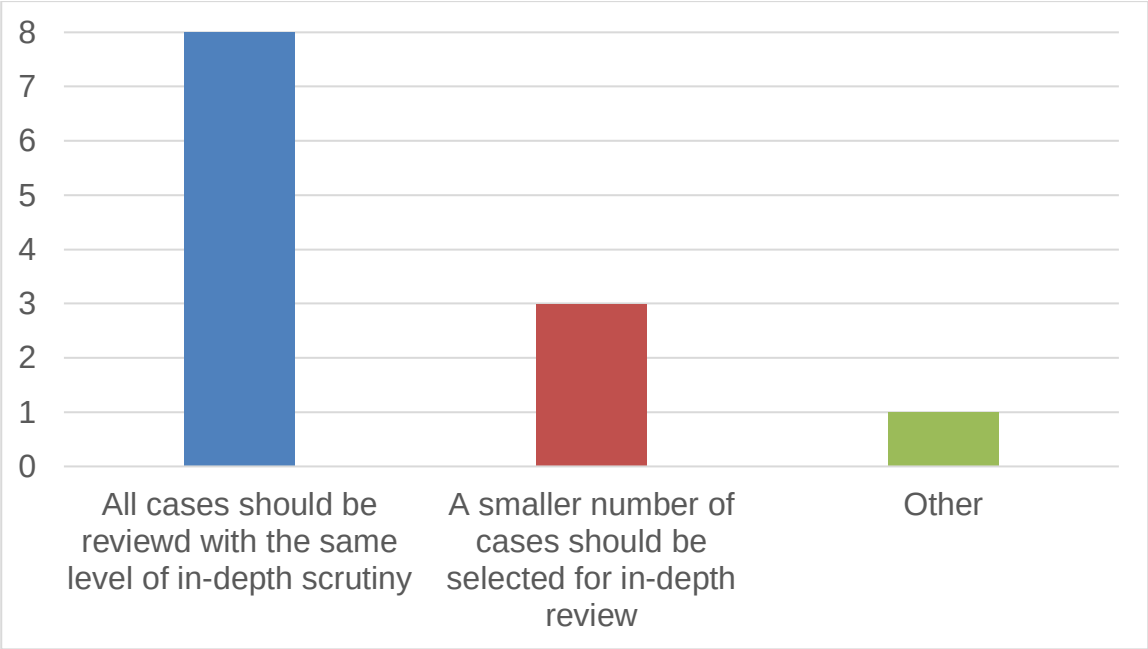

Figure 2 - Case reviews

Some comments on this question referenced concerns about resources and capacity, mentioning that ideally all cases should be reviewed, but this might not be possible and will depend on the number of cases that are within scope. For example, one respondent raised suggested a preference for a narrower scope to enable more in-depth and useful learning:

> "Too many, too shallow, under resourced DHR's would be unlikely to provide the learning outcomes that fewer in depth DHR's would give us."

Three comments referred to the relatively small number of domestic homicides in Scotland, which would allow for all cases to be reviewed. One comment referred to the merits of "having a system that reviews fewer, rather than more cases", as these cases will therefore "have a more in depth analysis, and using the learning to inform system improvements."

Additionally another respondent mentioned that each case is unique, but that some DHRs may have several agencies involved and would generate more information for review. The respondent stated that clear parameters should be set.

Other comments suggest that excluding some cases would be problematic, as it would prioritise some deaths over others through "a necessarily subjective decision". It could open "the door to screening, interpretation and discretion which reduces the integrity of the process". Although one of the respondents added that there might be a "possibility to consider some baseline level of review for all cases and then the opportunity to scale this further depending on case circumstances and other factors like family wishes".

Review Panel

A series of questions were asked about what the review panel should look like. There was strong agreement amongst respondents on the need for an independent chair (11=yes, 2='I don't know'). Most respondents did not favour having a rotating chair (7=no, 1=yes, 4=I don't know).

There was a preference for one national review panel (n=7), with only one respondent answering that a DHR should include multiple review panels (at local level). One respondent explained the preference for one national panel:

> "a single national process allows for consistency in implementation of the process itself, but also means that learning can be viewed in a broad way to inform the 'whole system' response at national level".

Two respondents suggested there might be scope for both a national panel and panels at a local level. One respondent emphasised that there should be consistency, with the right people involved and training standardised across the country. Two respondents answered "I don't know."

There was also a slight preference for a permanent review panel (n=6), although other suggestions included:

- Appointments should be time-limited
- A permanent core group of members, with ad-hoc members added depending on the particulars of the case
- A permanent panel (with fixed terms) at national level, and more ad hoc arrangements at local level
- It should be flexible and based on demand

Three respondents answered I don't know.

Other general comments on the review panel from survey respondents included:

- Need for experience (for the chair as well as the panel) in the domestic abuse field, as well as sufficient seniority
- Team of chairs (rather than a rota) might be beneficial for scrutiny
- Consistent training is needed
- Questions about the role of the panel: is it to commission and quality assure the review, or to undertake the review itself?
- Important that the DHR process "does not prejudice or put in jeopardy a prosecution or Fatal Accident Inquiry proceedings" – MOU (memorandum of understanding)/Protocol needed between the DHR panel, Crown Office and Procurator Fiscal Service and Police Scotland to establish process
- Ensure wellbeing of/trauma support for the panel
- The panel should be appointed from a pool of fully trained professionals with the required skills and knowledge
- There is a need for a robust and proactive professional secretariat.

Process of Conducting a Review

Family Involvement

The questionnaire asked respondents to provide their thoughts on how best to involve family and friends in the DHR process. Eleven people responded. There was a mix of responses on how to approach this, with common themes being the need to provide support for families, take a trauma-informed approach and provide a single point of contact/liaison officer for families. Other suggestions and comments included:

- 1 respondent suggested that the victim's family is often looking for communication, but not necessarily direct involvement

- 1 respondent pointed out the importance of including children under 18 years of age
- 1 respondent suggested that family involvement should be limited to next-of-kin only, while another respondent suggested it was important to include wider family members
- England/Wales was mentioned by 1 respondent as a good model to consider in relation to international best practice
- 1 respondent suggested that by involving family and friends this gives them the opportunity to honour the victim and tell the victim's story
- 1 respondent thought that it should be clear to friends and family what the purpose of the DHR process and their involvement is, and that there should be a consistent format for engagement
- 1 respondent mentioned that it is important to ensure engagement does not jeopardise any criminal investigation
- 1 respondent mentioned that respect and understanding should be integral to the process

Interagency Working

Ten respondents shared their thoughts on how best to ensure co-operation and participation of key agencies. The most common suggestion was the need for statutory guidance and/or legal obligations (n=6). Other suggestions included:

- 1 respondent suggested that there should be a protocol/MOU between multi-agency parties
- 1 respondent suggested to embed the learning in Equally Safe
- 1 respondent mentioned the importance of ensuring all views and contributions are respected
- 1 respondent suggested that agencies must feel safe and supported and that some awareness raising on what a DHR is might need to happen before implementation
- 1 respondent mentioned providing training
- 1 respondent highlighted the importance of demonstrating effectiveness/evidencing impact
- 1 respondent thought that it should be emphasised that the DHR is a learning process and this should be built into all of the narrative and guidance which underpins the process.

Reporting and Monitoring

Respondents were asked **how cases should be reported on**. Responses are shown in Figure 3 below.

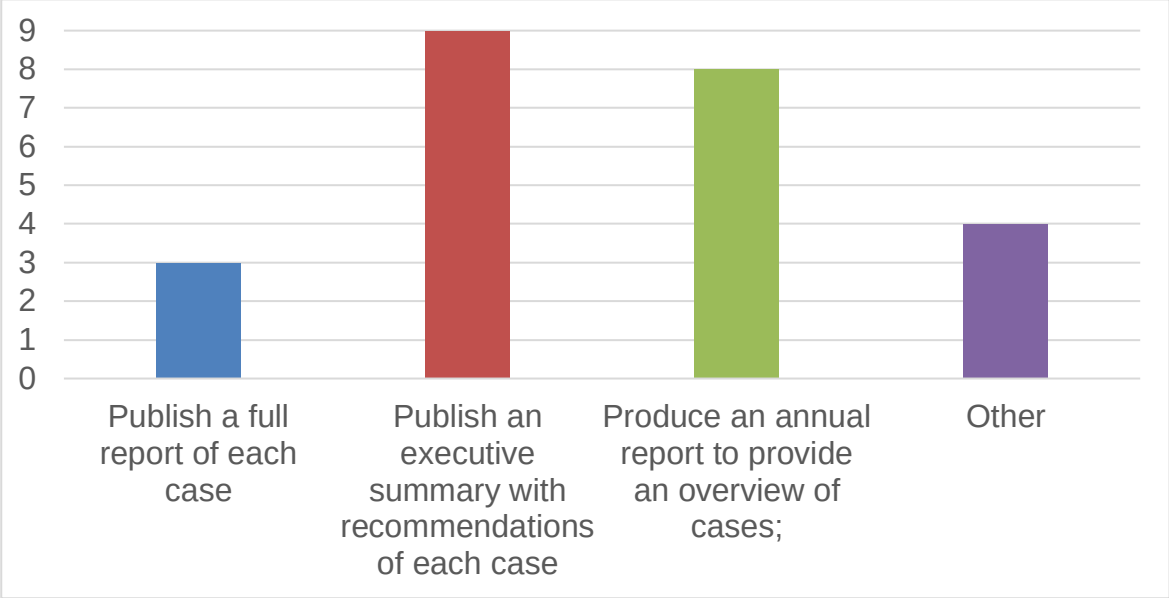

Figure 3 - How cases should be reported

Several respondents suggested a combination of the options that were given, in particular a combination of publishing an executive summary and an annual report.

Three respondents suggested that publishing a full report of each case might not be appropriate, due to the level of detail. However, one respondent suggested that in some cases it might be appropriate, for example for local agencies to have access to the full report.

One respondent suggested that it is important to publish key learning and recommendations, but that it would be essential to bring this together in a comprehensive way.

When asked to whom outcomes should be reported, a variety of suggestions were made:

- Heads of relevant agencies (n=4)
- Scottish Government/ Scottish Ministers (n=4)
- Public Protection Chief Officers Group (n=2)
- Relevant stakeholders (n=2)
- The Lord President (n=1)
- The victim's family (n=1)
- Violence Against Women and Girls Partnerships (n=1)
- Taskforce members (n=1)

- Whoever has the power to enforce recommendations (n=1)

One respondent suggested it is important that there is accountability for individual cases, at both an organisation and wider system level.

The questionnaire asked **where DHR reports should be held**. Three of the eight respondents who answered the question suggested a central/independent repository. Other responses included:

- A national DHR committee and PP COGs (Public Protection Chief Officers Group)
- Confidentially within Health and Social Care Partnerships (HSCP)
- Public Health Scotland
- Scottish Government

One respondent thought it was important for reports to be publicly accessible.

Eleven Taskforce members made suggestions on how to ensure **DHR recommendations** are followed up:

- 3 respondents said that follow-up could be ensured through a progress report, with one respondent suggesting this should be publicly available.
- 3 respondents suggested a national monitoring scheme. One respondent suggested a progress report should be part of such a scheme. One respondent referred to the existing Public Protection processes as an example of good practice.
- 2 respondents drew attention to the importance of training and development for staff.
- 3 respondents mentioned the need for a systematic approach that would produce action plans. One of the respondents added that the action plans needed to be monitored and audited.
- 1 respondent proposed that follow-up should be incorporated as part of a protocol/MOU that reflects commitments from relevant agencies.
- 1 respondent mentioned the need for preparatory funding.
- 1 respondent suggested that follow-up can be ensured through the clinical and care governance processes of a HSCP.
- 1 respondent thought that an independent domestic abuse commissioner should be established in the future, with the power to enforce recommendations.
- 1 respondent suggested that follow-up should be ensured through the efforts of the organisation or official to whom the outcomes are directed to.

Legislation

The questionnaire asked whether the DHR process should be underpinned by legislation. The majority of respondents (7 of the 12 respondents who answered this question) felt that the DHR process should be underpinned by legislation. Three respondents did not agree that legislation was required and three respondents answered “I don’t know”. Response are shown in Figure 4 below.

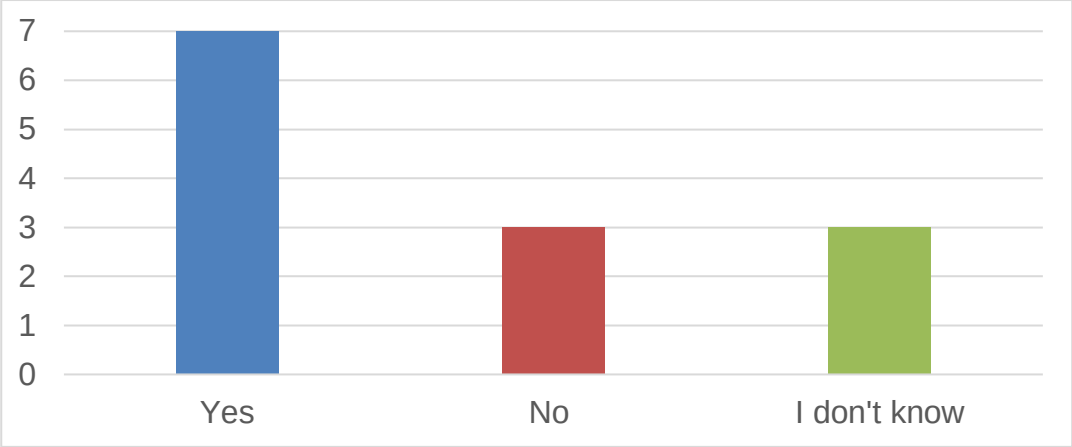

Figure 4 - Should the DHR process be underpinned by legislation?

Evidence

Taskforce members were asked to provide any additional information or evidence that they would find helpful to consider in order to develop a Scottish DHR model. Responses included:

- The role of different agencies (social work department, police, GP’s, the prison service etc.)
- The trauma impact on those involved in reviews, to ensure the process is robust and safe for all.
- MARAC data – providing insight into referring agencies, as well as the victim, person causing harm and associated children.

One respondent mentioned that what additional information is needed “may have to emerge following a journey of consideration of what is currently available”.

Several respondents also signposted to **examples of good practice/evidence** that might inform the DHR process:

- Significant Critical Incident processes
- MARAC model
- Mental Welfare Commission model for independent reviews of care and treatment prior to Mental Health Homicides: The Mental Welfare Commission

for Scotland Proposals for the Investigation of Mental Health Homicides - Final report to the Scottish Government

- National Protocol for the Police Service of Scotland, the Crown Office and Procurator Fiscal Service, and Child Protection Committees on Learning Reviews: Annex 2: National Protocol for the Police Service of Scotland, the Crown Office and Procurator Fiscal Service, and Child Protection Committees on Learning Reviews. - National guidance for child protection committees undertaking learning reviews - gov.scot (Scottish Government website)
- Child Protection Learning Reviews: All deaths of children and young people in Scotland to be reviewed to help reduce avoidable deaths. (Healthcare Improvement Scotland website)
- International DHR processes. DHRs in England, Wales and Northern Ireland. Some good examples in New Zealand, Norway, US and Canada.

Annex 1

The Questionnaire

A link to the questionnaire was sent to Taskforce members by email who completed it anonymously online.

1. Which sector do you work in?

Justice
Health
Academia
Third sector
Public Sector
Prefer not to answer
Other

Purpose of a DHR

2. What do you think the purpose of a DHR should be? Add any comment on the outcomes you expect the DHR to reach

Scope of the DHR

3. What should be captured by a DHR? Tick all that apply
Intimate partner homicide
Homicide by family members
Homicide - Suicides (where the perpetrator commits suicide after committing murder)
Suicides (as a result of domestic violence)
Deaths of bystanders (for example when a police officer or professional has intervened)
Near deaths
Children
Other

4. Of the options you selected in question 3, should all be included from the start of implementation of the DHR, or could some be added at a later stage?

Case selection

5. Considering case selection:
All cases should be reviewed with the same level of in-depth scrutiny
A smaller number of cases should be selected for in-depth review
Other

6. Add any comments you wish to make on case selection

Review Panel

7. Considering the review panel, should there be an independent chair?
Yes
No
I don't know

8. Considering the review panel, should there be a rotating chair?
Yes
No
I don't know

9. The DHR should include:
One review panel (at a national level)
Multiple review panels (at a local level)
I don't know
Other

10. The review panel should be:
Permanent
Ad hoc
I don't know
Other

11. Please provide any other thoughts you have about what's needed in relation to the review panel

Process of conducting a review

12. Please provide your thoughts on involving families and friends in the DHR process

13. Please provide your thoughts on how best to ensure the co-operation and participation of agencies in the DHR process

Reporting

14. How should cases be reported on?
Publish a full report of each case
Publish an executive summary with recommendations of each case
Produce an annual report to provide an overview of cases;
Other

15. To whom should the outcome of DHRs be reported?

16. Where should the DHR reports be held?

17. How can we ensure that recommendations are followed up and lessons are learned?

Legislation

18. Should the DHR process be underpinned by legislation?
Yes
No
I don't know

Evidence

19. What, if any, additional information or evidence would it be helpful to consider when developing the DHR model for Scotland?

20. Please signpost to examples of good practice and evidence which might inform the DHR process

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