



OFFICIAL REPORT
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DRAFT

Criminal Justice Committee

Wednesday 5 February 2025

Session 6



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Wednesday 5 February 2025

CONTENTS

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CRIMINAL JUSTICE MODERNISATION AND ABUSIVE DOMESTIC BEHAVIOUR REVIEWS (SCOTLAND) BILL:
STAGE 1 1

CRIMINAL JUSTICE COMMITTEE

5th Meeting 2025, Session 6

CONVENER

*Audrey Nicoll (Aberdeen South and North Kincardine) (SNP)

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

*Katy Clark (West Scotland) (Lab)

*Sharon Dowey (South Scotland) (Con)

*Fulton MacGregor (Coatbridge and Chryston) (SNP)

*Rona Mackay (Strathkelvin and Bearsden) (SNP)

*Ben Macpherson (Edinburgh Northern and Leith) (SNP)

*Pauline McNeill (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Katie Brown (Convention of Scottish Local Authorities)

Fiona Drouet (EmilyTest)

Dr Emma Fletcher (NHS Tayside)

Dr Marsha Scott (Scottish Women's Aid)

Graeme Simpson (Social Work Scotland)

CLERK TO THE COMMITTEE

Stephen Imrie

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Criminal Justice Committee

Wednesday 5 February 2025

[The Convener opened the meeting at 09:31]

Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews (Scotland) Bill: Stage 1

The Convener (Audrey Nicoll): Good morning, and welcome to the fifth meeting in 2025 of the Criminal Justice Committee. We have received no apologies for the meeting. Pauline McNeill is joining us online.

Our first item of business is to continue our stage 1 scrutiny of the Criminal Justice Modernisation and Abusive Domestic Behaviour Reviews (Scotland) Bill. I am very pleased that we are joined this morning by Fiona Drouet, the founder and chief executive officer of EmilyTest, and by Marsha Scott, the chief executive of Scottish Women's Aid, who is online.

Welcome to both of you, and thank you for taking the time to attend today's meeting and for both of your submissions, which are much appreciated. I also extend our thanks to you, Fiona, for your very personal and powerful submission, which reflected your commitment to improving the system around domestic homicide reviews.

I refer members to papers 1 and 2. I intend to allow up to 75 minutes for this evidence session.

I will start by asking a general opening question, and I will come to Fiona first and then bring in Marsha. As you know, the second part of the bill sets up a system of abusive domestic behaviour reviews, and I understand that both of you are supportive of that. Could you elaborate on why that is? Could you also set out whether you have any particular changes that you want to propose to improve the bill?

Fiona Drouet (EmilyTest): As you said, I fully support the domestic abuse-related death reviews and their establishment in legislation. That is important, because we owe it to every life that is lost—to all of those tragedies—to ensure that it does not happen again and that people are not losing their lives in vain.

We need to make sure that it is not left to families to uncover the systemic failures and bring about meaningful change. For the past almost nine years, that is something that our family has faced in having to uncover the many failures in

Emily's case. It takes a huge and significant toll when you have not only lost a child to suicide but then have to familiarise yourself with laws and look at what has happened to ensure that another tragedy does not happen, so the proposals will be a very welcome change for us and many other families.

As to whether I would suggest any changes, I know that the finer detail is being worked through, and I have been pleased with the sensitivity that has been afforded to that. I echo some of the evidence on resourcing that those who have participated in other sessions have given. We need to ensure that the bill is fully and properly resourced and financed to ensure that its impact is meaningful, because any underfunding could lead to a diluted process, and that is not what victims or survivors deserve.

The issue of anonymity has been raised before. Anonymity is crucial, particularly because Scotland is such a small country. We have a limited number of cases, so we need to ensure that we do everything to ensure anonymity and avoid any unintended breaches. That is another reason why refining the process is important. It is important that we have accountability, because the worst thing to do is to put a family through that process, and then at the end of it leave them wondering what will happen afterwards. We are still seeing those failures, so I welcome the accountability that is included in the bill.

The one concern that I have is ensuring that we consider any potential unintended consequences if the reviews are published. Specifically, that would involve vulnerable individuals being exposed to suicide methods and perpetrators potentially using reports as a how-to guide. Those are my concerns. I feel confident that we are giving due consideration to them, but that we must consider all of it in depth.

The Convener: Thank you for those interesting points. As well as the review process, there is a duty of care wrapped around that process that we need to think about—you mentioned publication. One of the key objectives of the review process is learning lessons and improving practices. Before I bring in Marsha Scott, I would be interested to hear any other thoughts that you have on the output from and outcomes of the process. Is what is proposed enough or should there be more consideration of liability, which is not in the bill at the moment? Does the bill have the right balance?

Fiona Drouet: I agree with the current balance. The biannual report to ministers gives a higher degree of accountability, and that is what is lacking in the current processes. Currently, we can go through the process, learn lessons and see where the failures lie, but then what? The balance may need some more work, but it is certainly quite

promising. I do not have significant concerns about that.

The Convener: That was helpful. Marsha, my original question was about the key points that you agree with. I would also like to hear any points that you would like to make on improvements or changes that you are interested in.

Dr Marsha Scott (Scottish Women's Aid): Good morning, everybody. Setting up a review process such as this is quite a complex task. As you will know if you have read our submission, we have lots of suggestions and criticisms—that is our job. However, I say at the outset that the process until this point has demonstrated what happens when we bring expertise to bear on a wicked issue, which is what domestic abuse deaths are. I commend the work of Professor John Devaney and the working groups; we sit on all of them. That is my overarching headline.

Six years ago, we were, along with staff from the ASSIST—advocacy, support, safety, information, services together—project, instrumental in raising the lack of a reviews process as being a critical gap in Scotland's response to domestic abuse. I am sad that it has taken all this time for us to develop one, and it is still going to be years before we have changed our system in response to the issue.

One advantage of being last in the United Kingdom to do that is that you learn from what is not working well in other places. When we first started speaking out about the issue, I received private messages from people on review panels in England, who were telling me that if we were going to do it, we had better be careful about how we did it and take cognisance of what was happening down there. One woman who sat on a number of review panels said, "It's action plan after action plan after action plan, but no action."

In order for learning to occur, we have to reduce the amount of blame that is involved in the system. I totally agree with the proposed balance, but there absolutely has to be accountability for change in the system. I really welcome the reporting, because it is an integral part of how we make ourselves accountable for how the processes work.

As I said in the task force meetings, I am deeply uncomfortable about calling the reviews domestic homicide reviews. We know that the vast majority of the deaths are women and children and that they are domestic abuse deaths, so I would welcome the eradication of domestic homicide from our vocabulary.

My concern about the way that the bill is laid out is that it needs a lot of tightening. There is a lot of confusing language, which I understand comes out of trying to get something ready to test, but

some of the definitions are unclear. We have laid out in our submission some of the areas in which we think redrafting is required.

My overarching concern is that the review process comes off the back of survivors and victims organisations calling for it, yet we are really unclear whether our role in reviews is protected in the bill. We are actually barred from some of the roles that are laid out in it, and we have not had a good explanation of why a statutory organisation is more appropriate. Statutory organisations are much more likely to be held accountable for needing to change their processes than voluntary sector organisations.

I also worry—I know that one of the committee's previous witnesses commented on this—that survivors' voices are not very evident in the process. Where are survivors and surviving families? On a practical point, the groups of survivors who have called for this kind of process will not be involved in reviewing recommendations as part of what a previous witness called "listening sessions". Those could be set up in lots of different ways.

I am very concerned that we have got to this point. We have seen no improvement in the number of deaths and suicides in Scotland, and, in fact, we do not even know how many suicides are related to domestic abuse. That is because statutory bodies are well intentioned but have an awful lot of priorities that are, frankly, not about victims. I would like there to be a fairer balance of engagement and decision-making powers in the processes, because at the end of the day, we are, along with the survivors that we work with, the experts on domestic abuse. When you pull us out of the system, you pull out a big capacity for learning.

09:45

The Convener: Can—

Dr Scott: I will touch on my concerns about the definitions of domestic abuse. We completely agree with Emma Forbes that those need to match the existing legislation in the Domestic Abuse (Scotland) Act 2018.

I hear you, Audrey, so I will stop there—although, of course, I have a few more things to say.

The Convener: I never like interjecting, but you have covered very well a lot of the points that are set out in your written submission, and I know that members will probe a wee bit more on those—and on others, I am sure.

I open the discussion to members.

Liam Kerr (North East Scotland) (Con): Good morning. Dr Scott, you have just raised some concerns, but I am not sure that I heard you talk about the finances. As you will know well, the committee has been concerned about laws being brought in without sufficient backing to implement or deliver on admirable intentions. You say, rightly, that your organisations are the experts. It has been suggested that, due to a lack of funding, some organisations that are involved in preventing domestic abuse might struggle to support the reviews or to implement any recommendations that are being brought in by the bill. Do you share that concern, and do you have a view on the finances that are allocated to the bill?

Dr Scott: I certainly cannot tell you what the cost will be. However, having read the evidence of Malcolm Graham and of some of the statutory organisations that will be most affected by calls for change and for requirements to participate, I can tell you that I worry that we are not counting the cost of not acting. Scotland has failed to act on domestic abuse reviews for 20 years. The cost of that is tragedy and death. I want to remind us that that is the cost that we are trying to bring down.

I absolutely agree—and I tear my hair out—about the failure to implement the Children (Scotland) Act 2020 and the Domestic Abuse (Protection) (Scotland) Act 2021. We are told very clearly that that has been because the money was not set aside in the process of passing those acts. I therefore ask the committee to consider how it includes in the bill arrangements for guaranteeing adequate funding. When it comes to what exactly those would look like, I know that, in other jurisdictions, money is set aside as part of the legislative process. Something has to change to keep us from doing really good work in committee rooms and Parliament chambers then having absolutely nothing change on the ground for the women and children who live with domestic abuse.

Liam Kerr: I am very grateful.

Fiona Drouet, I ask you the same question about finances.

Fiona Drouet: It is a concern but, as Marsha Scott said in a really good point, we are not counting the cost of not acting. We know that each suicide costs the economy £1.6 million. When it comes to statistics on how many women take their own life on the back of domestic abuse, Professor Jane Monckton-Smith's research has said that, in England and Wales, although two women a week are killed by a partner or ex-partner, if suicides were included the figure could be at least 10. We also know that those figures are underestimated. When it comes to counting the cost to the economy, not to invest in the services and organisations for making sure that such tragedies

do not happen in the first place is a false economy.

Liam Kerr: You have both made powerful points.

Dr Scott, you said earlier that the process so far has been pretty good. However, given the concerns that both witnesses have just raised about the finances, has your organisation had an opportunity to raise directly with the Government those financial concerns, as well as any other concerns about the timescales for implementing the legislation?

Dr Scott: We always have the opportunity to do so. We sit on all those groups, so we can always say, "Uh-oh".

From the perspective of an organisation that is absolutely minuscule in comparison with the courts service, the Crown Office or Police Scotland, we are less concerned about the cost for us. We have already engaged in the process without being paid for it; that is our landscape.

The issue for us is that the people who will be critical in changing the system need to ensure that we do not come back here five years from now and say, "Well, those reviews were great, but nothing happened as a result because there was no follow-up." I guess that I am trying to say that, yes, we could feed those things in, but we are not the ones who are saying, "Oh no—this is going to cost too much" or "We don't know how much this is going to cost".

Some of the process between now and stage 2 will perhaps involve getting specific figures, but we should remember that we do not really know how many reviews will go forward, and we will not know how that approach will work until we test it. We need to be careful about asking for a degree of certainty that will just stop the process, rather than help us to test it.

I am a big improvement freak—we should test it small, start it out and have a review process. The police and everybody else will have then have a much better idea of what it is going to cost them to participate. There has to be an organic process, or it will just not work.

Liam Kerr: I put the same question to Fiona Drouet. Are you and your organisation being listened to by the Scottish Government on funding and timescales?

Fiona Drouet: Absolutely. We have not taken forward our concerns about the funding and timescales because we have focused on developing a robust process that will serve victims/survivors. As Marsha Scott said, it is for other organisations to focus on the costs and taking that to the Government, but we have been involved at every stage, and there is full

transparency throughout every opportunity that is afforded to us to contribute to the process.

Liam Kerr: I am grateful to you both.

The Convener: I call Rona Mackay, to be followed by Sharon Dowey.

Rona Mackay (Strathkelvin and Bearsden) (SNP): Good morning, Fiona, and thank you for your submission; I am pleased that you are very supportive of the bill. In your submission, you say that, in England,

“inquests provide a structured investigation into deaths.”

How would you compare what we are proposing with what they have in England?

Fiona Drouet: As I said in my submission, we, as a family, felt quite robbed that there was no statutory process after we lost Emily. We had to do all the work ourselves to uncover the failures that had occurred. That was—and, nine years on, it continues to be—exceptionally difficult for us as a family.

We are talking about two different systems, but I certainly think that what we are proposing here will uncover the failures that so many families are uncovering. There are many other failures, or weaknesses, in the system that need to be considered—for example, in the investigative processes. Last week, Emma Forbes was before the committee talking about how the decision on any fatal accident inquiry or any investigation after a sudden death falls to the Lord Advocate. We need to be realistic and honest that there are some failures in that regard. The proposed process limits the gaps that people might fall through, and I think that, through it, we will get some of the answers that are so desperately needed in order to avoid deaths in the future.

Rona Mackay: That is helpful—thank you. In your first answer to the convener, you mentioned anonymity. Will you expand on that a wee bit, including on the importance of anonymity and what you mean by it?

Fiona Drouet: If the reviews are to be published, we should remember that they will contain exceptionally intimate and private details about somebody’s life and the horrific events that they endured, as did their family, their friends and their loved ones. Giving them anonymity is really important in providing them with respect and in taking a trauma-informed approach to the families and the loved ones who are left behind. Anonymity is also important because not attaching names avoids any potential bias and allows us to learn from such events.

It will be a challenge in a small country. Will we be able to leave in enough detail so that the reviews are meaningful and helpful to any of the

organisations that want to access them? We are still working through that.

Rona Mackay: That is good—thank you. Dr Scott, I want to come to you on my question about a comparison with the English system. Do you have any comment on that?

Dr Scott: It is quite difficult to say what the English system is because the police arrangements and systems there are so different from ours. The definitions are different, too.

The big issue for us is the implementation gap. The bill still needs to be tightened up and so on, but I think that everybody has been very mindful as we have been working on it that, if it does not change the system, it will all have been a big waste of money and trauma. Our opportunity and challenge is to create a system that holds itself accountable.

From what I can gather, there is little consistency across the reviews in England. We have lots of colleagues who work down there who are involved in them. The chairing is critical. If you have a good chair, you have a good review—not necessarily good implementation, but a good review. Therefore, one of our concerns is that the competencies for those who will be involved in making decisions around the review are laid out pretty clearly in our process.

In the grand scheme of things, it comes down to the committee, the Parliament and the statutory organisations being willing to move into a space that we have not been in before, understanding that we will make mistakes, and holding ourselves accountable for making improvements. That sounds vague, but it applies across the piece. I really hope that the committee and the Parliament come back and look at the legislation as it is laid out, with a really helpful post-legislative scrutiny process that considers what we have learned so far and which questions are outstanding.

Sorry—that was a long answer, but it is a complicated comparison.

Rona Mackay: Absolutely—I get that. Earlier, you said that you agreed with Dr Emma Forbes about the definition being too wide. She said that she felt that it diluted the Domestic Abuse (Scotland) Act 2018, which is regarded as the gold standard. Is that your view, too? Will you expand on how you would like us to refine the definition?

Dr Scott: There is something that I want to lay out here. I think that the folks who want to expand the definition are well intentioned—I read Professor John Devaney’s comments about that in his testimony to the committee. We agree on and all want the same outcomes. Our difficulty is that the domestic abuse sector fought really long and hard for the Scottish Government to deliver on its

promise that it understood the dynamics and gendered underpinnings of domestic abuse. As Emma Forbes pointed out, the 2018 act allows us to provide a much more expert and specialist response to domestic abuse, which I note is not a niche problem but the biggest problem that our police and courts deal with. I understand why folks want to try to be more inclusive, so I say let us do that, but let us not do it by diluting the progress that we have made.

We have lots of conversations outwith the development of the domestic homicide review process about what we are doing about murders and abuse that are committed by family members. Professor John Devaney raised the issue of women being killed by their adult sons. Our perspective is more about what happens when abuse is perpetrated by a family member on behalf of the perpetrator, which is more common than we would like. Our systems do not respond to that or to honour-based abuse.

10:00

It should not be a binary decision between changing the definition and not changing the definition. We need to be better at implementing our responses within the definition and be willing to grasp the nettle, ask why the system is not working for honour-based abuse and other permutations of domestic abuse deaths, and design systems and provide services that do. It should not be an either/or.

Rona Mackay: I have a quick final question for Marsha Scott. Your submission says that

“the criminal history of the abuser that relates in any way to the perpetration of domestic abuse against the current victim”

should be made available to the review. Will you talk about that, please?

Dr Scott: This might be to do with needing to tighten up some of the language more than anything else, but I cannot imagine that, if you were doing a review of a domestic abuse death, you would not look at, for example, police responses to somebody who has committed multiple offences. One of your previous witnesses said that most domestic abuse offenders do not have a previous conviction, but I do not believe that that is true—well, they might not have a previous conviction, but many of them have been involved with the police. I cannot therefore imagine that we would not want that information to be part of the review, so I am confused about what the bill is trying to do on that.

There was extensive discussion in the working groups about whether perpetrators should be allowed to speak or to be witnesses in a review. We are vehemently opposed to that, partly

because we live in a culture and community that says that there is no excuse for domestic abuse and then it turns round and makes every excuse for domestic abuse—he was drinking; he was unemployed; he was stressed; it was Covid. Do not try to persuade me that the professionals who are involved in the review panels are not still holding some of those flawed assumptions.

The review needs to be about the people who have died—mostly the women and children—the families that are left grieving and the system that let them down.

Rona Mackay: Thank you—that is helpful. Fiona Drouet, do you want to come in on any of that?

Fiona Drouet: Yes. I agree that we should not be constrained by the definition. We have to think about the country that we live in and represent the whole population, and I am not sure that the 2018 act lets us do that. I do not think that honour-based killings fall under that definition, so I welcome the wider scope of the bill in that regard.

I also agree with Marsha Scott about chair competencies and bias. There is a lot of bias and victim blaming. We need to ensure that the chair can remove that bias or at least be conscious of it, and that we manage that through the process. We have discussed chair competencies at length.

We also need to get the timescales absolutely right and consider in a trauma-informed way how we will ensure that the process is meaningful and that it is no longer than it has to be. That is for the families and everyone else who is involved. Then we can come on to costs—we always focus on victim survivors first.

Rona Mackay: Thank you—that is really helpful.

The Convener: Did you want to come in, Marsha Scott?

Dr Scott: Yes. I will say one thing about the definition. On the differences between England and the system that we are trying to set up here, one of the points that has been raised by Emma Forbes is that part of the problem with the implementation down south is the sheer number of cases that are being reviewed, which is because their definition is so wide.

One of the advantages of maintaining the definition in the 2018 act—which this body supported—is that it would help us to focus on the critical cases that the system will, I hope, be designed to address. That does not mean that those other deaths are not important and should not be investigated—that cannot be what people take away from those of us who are trying to protect the existing definition.

The Convener: Thanks for providing that clarity. I will bring in Sharon Dowey, then Katy Clark.

Sharon Dowey (South Scotland) (Con): Some of the written evidence has raised concerns about adding a new system of reviews to an already complex review landscape. Do you share those concerns? If so, what could we do to alleviate potential problems?

Fiona Drouet: I share those concerns. We need to be careful that there is no duplication of processes. That is also something that has been discussed, and we want to ensure that there will be a review of which review process is most suited to each case. If another review is under way, we should ensure that they align with each other.

We have been talking about that at length, particularly in terms of suicides. Suicide reviews in Scotland have not long started; they are not being undertaken across the country as a whole, but they are being undertaken. We need to make sure that there is no duplication with regard to learning lessons and that we do not confuse the situation, nor add to the trauma of families.

In the working group, we have managed to get a good broad range of people representing all the different reviews to look at the granular detail and to ensure that there is a streamlined process that avoids any unnecessary confusion and duplication.

Sharon Dowey: Dr Scott, do you have any comments on that?

Dr Scott: That concern is always one of the arguments for not challenging the status quo. When we were first talking about the Domestic Abuse (Scotland) Bill, there were comments that we did not need another domestic abuse act, and that we just needed to be better at implementing the laws that we already had. We hear that all the time, and I roll my eyes pretty much every time that I hear it. Clearly, if those review processes were adequate, we would not need to have domestic homicide reviews.

Having said that, I agree with Fiona Drouet. I think that everybody was mindful about the bureaucracy that would be involved, and, especially when we are talking about child deaths, the potential for overlapping reviews. The commitment is to have joint reviews. Everybody in the system is aware of the importance of not, if we can help it, further retraumatising families by duplicating processes, and also of making sure that we access expertise across the piece.

Sharon Dowey: We do not want to have overlapping reviews, but do you think that there is a risk that we spend too much time doing reviews and not enough time focusing on the action points from those reviews?

Dr Scott: No, I actually do not think that. You need to have both of those things—the action points will be meaningless if they are not well informed by the review process. Again, it is about getting the professionals involved together to agree what the most sensible process is that gives you the maximum amount of learning. Then there will be actions that come out of that; it is a whole other process to make sure that there is an implementation function that can be held up to scrutiny.

Sharon Dowey: Fiona Drouet, in your submission, you mention the university

“failing to recognise so many warning signs, missing opportunities to intervene”.

Would the reviews that are currently available cover that? If not, would the reviews that are included in the bill cover that?

Fiona Drouet: I believe that they would. There were many failures at university level that led to us losing Emily. Many different departments had separate pieces of information but did not work holistically, so we as a family had to identify where there were gaps in policies, processes and procedures. If we are doing a meaningful review of any death—this is certainly the case in Emily’s situation—we should be looking at the events that led up to that death, because that is where most of our learning is. I absolutely think that the university would have stood out quite starkly if there had been a review process. I believe that it would have identified the same or similar systemic failures that we did.

Sharon Dowey: No current review process would have covered that.

Fiona Drouet: No. There is not a review process in Scotland that would have covered that, so what the bill includes would be, I believe, life changing for many people.

Katy Clark (West Scotland) (Lab): I will come to Fiona first, if that is okay, to ask about the role of families in the process, because the way that I have become involved in individual cases has almost always been through families. Those who are left behind often have a huge amount of knowledge of what has happened. How do you envisage that families would be involved in the process?

Given that the proposal is for anonymity—I understand that that is how it operates in Wales—to what extent do you think there should be full disclosure with families? Dr Scott made a point about the situation in which the perpetrator is or may be a family member, which is a slightly different situation. In a situation in which there is no suggestion that the family are in any way

involved, how do you see the role of families in the process? What would you recommend?

Fiona Drouet: I recommend that they are listened to. Families often have the answers that our justice system does not have. They have lived with that person and have seen their life up until that moment. In Emily's case, and in all other cases of families I have spoken to where this has happened, the families are the closest to the victim or survivor. They are the main voice in the situation and should always be central to any review. It was an exceptionally frustrating experience to not be heard and to be seen as almost problematic because they were going to the police with information, and I know that that feeling is shared by many families. If families were listened to, we would get justice a lot quicker. They unlock many of the answers.

I am really pleased to see in the bill that a family can come forward and voice concerns and suggest a review, because there often may not be a service footprint. No one else may know of the domestic abuse that has occurred, so we need to listen to the voices of the people who were close to the person who has lost their life.

Katy Clark: I do not know a lot of the detail of how the process operates in Wales or the role of families there. Have you been able to look at that?

Fiona Drouet: Not in as much detail as I would have hoped to.

Katy Clark: I presume that your view is that the report and other information should be shared with families and that there should be disclosure with families. Is that fair?

Fiona Drouet: Absolutely.

Katy Clark: Beyond that, you think that the process should be anonymous and that those who have access to the report should be highly restricted. Is that the conclusion that you have come to?

Fiona Drouet: Not on the report. The families should have the right to see the report. Families should, absolutely, be involved in the process from start to finish and should be kept informed along the way.

I do not know whether I have been misunderstood, but, with regard to anonymity, I meant when there is publication of a report. If it is in the public domain, we need to be careful that the information on the victim/survivor does not make them identifiable, because that can be hugely traumatic for the families.

10:15

Katy Clark: You think that the report should be redacted in some way to try to ensure that it is not

possible to ascertain who it is about. Is that a fair summary?

Fiona Drouet: Yes, that is exactly right.

Katy Clark: I ask Marsha Scott to come in on that as well.

Dr Scott: I believe that it has been proposed—I cannot remember whether this is in the bill or in some of the witness testimony that the committee has heard—that there should be a high-level report in the public domain about what the learnings are. It should not be published before it has been put through a filtering process to ensure that it does not retraumatise the family or invite the public to see details that they have no right to see.

However, it is also important to publish the findings and what commitments to improvement have been made, so that that information is in the public domain and the people who are making decisions about the findings and recommendations have access to it all. Again, there would be tiered detail and—exactly as Fiona Drouet said—the families should have access to all the detail. I can imagine that that would be traumatic in itself, and people such as Fiona can help to guide us in how to go about it in the most trauma-informed way, because there ain't no way to do this without telling people hard things. It is about finding a way to make the information available without insisting that it be considered.

Fulton MacGregor (Coatbridge and Chryston) (SNP): Good morning to both Fiona Drouet and Marsha Scott. I feel sorry for you, Fiona, as you are the only witness in the room, sitting on your own, but you are doing very well. Before I ask my question, I wonder whether you recall a film in which you participated: "Bruised" by Carla Basu. Carla is a constituent of mine, and we ran a screening of the film in the Parliament just a couple weeks ago. Rona Mackay was there, as was Audrey Nicoll, along with various other members from across the parties, including Government ministers. The event was really well attended, and I thought that your contribution to the film was extremely powerful.

Fiona Drouet: Thank you.

Fulton MacGregor: I think that everybody who was in the room for that screening very much agreed, so I wanted to put that on the record today.

I will put my question to you first, Fiona. I was originally going to go down a line of questioning similar to that of Rona Mackay and Katy Clark, but that area has very much been covered. I will ask instead about the provision in the bill that allows reviews to be carried out in parallel with other proceedings that might be going on, including criminal proceedings, with the Lord Advocate

having the power to pause or end a review to prevent any prejudice to those other proceedings. What views, if any, do you have on that?

Fiona Drouet: It is an important power for the Lord Advocate to have. Obviously those decisions would be made after consultation with, potentially, the chairs of the reviews. I do not know the finer details, but I do not see any reason to oppose that power.

What we do not want is an outcome whereby we do not have a robust process for either proceeding. We do not want one to contaminate the other; I imagine that that would be the only case in which the Lord Advocate would exercise those powers.

Fulton MacGregor: Dr Scott, do you have any views on that? Are they pretty similar?

Dr Scott: It is eminently logical that there would be a concern about crossover between criminal proceedings and the review process, and I have concerns about the Lord Advocate having such a broad power in that regard, I suppose. Scottish Women's Aid has suggested that guidelines must be laid out in the bill or in the explanatory notes that set out the circumstances under which that would happen and that the Lord Advocate would have to report to ministers regularly about reviews that have been delayed or shut down because of the criminal proceedings in a case.

In the grand scheme of things, where is the public benefit in setting the need for a conviction against learning how to prevent such deaths? God knows—and the committee knows—that I am going to support convictions for domestic abuse murders, but where is the benefit in that regard? It is unlikely that somebody who is enmeshed in the system—who works for the Crown, for example—is going to be as alive to the benefits of the learning for the system as they are to ensuring that they protect their processes. There needs to be some scrutiny there. I have every faith in the folks in the Crown Office at present, but we all know that those people will change. We need a system that keeps it right, rather than well-intentioned people.

Fulton MacGregor: Do you think that the reviews should be carried out in parallel when there is another process on-going as standard, apart from in exceptional circumstances?

Dr Scott: Yes. The exceptional circumstances should be few and far between, and the processes could be carried out in parallel. It does not seem to me that it would be rocket science to manage to keep them separate from each another. I am sure that it is more complicated than I know, because it is not my bread and butter, but the emphasis should be on the final outcome for the system.

With regard to the Lord Advocate delaying a review, it is one thing to delay it for a reasonable amount of time but, given the amount of time that it currently takes for cases to come to the High Court, I am a little concerned that we would be retraumatising a family over a long period of time. We need to be very mindful of the boundaries around that power and must invite scrutiny to the process should we find that a larger number of cases than we had expected are being delayed or shut down.

The Convener: I will pick up on a final point on part 2 of the bill, and then members will ask questions on part 1.

Marsha, you touch on part 1 in your submission, but my final question on part 2 is around training for members of the review oversight committee and/or for panel members. My thinking is that training would be appropriate for panel members in particular, but I am interested in hearing your thoughts on that proposal. I ask Fiona to answer first, and then Marsha.

Fiona Drouet: If we want to have a robust process, we must ensure that that training is comprehensive. We have not looked into the finer detail of what it will look like, but we know some of the elements that it will need to include—for example, as I mentioned earlier, removing any unconscious bias.

There is a slight concern, which was mentioned in one of the previous evidence sessions, that we could see the same faces doing these reviews, so we need to ensure that no bias creeps in there unintentionally. That would have to form some of the training. We would need to ensure that panel members have a certain skill set and a clear understanding of domestic abuse in all its forms.

It is also important that they have chairing skills, as they may have a lot of knowledge on domestic abuse but be unable to chair the process. We are looking for a comprehensive skill set. Although training has not been developed, we are looking at other jurisdictions to learn from what they are doing—what they feel is missing and what the weaknesses have been, so that we do not repeat those mistakes. I feel confident that we will develop a good process, but that is quite far off at the moment.

The Convener: Thank you for that. Marsha, do you want to come in?

Dr Scott: It is a really good question, and I have a couple of points to make. As we are an organisation that has a national training arm, I am probably cutting my own throat here, but it is important for us to understand that training is not a silver bullet. It does not necessarily eradicate people's unconscious biases or challenge their myths about domestic abuse. Where training is

important relates to people's competencies before we let them in the door. That is really important, as I have mentioned before.

However, another important point, which will be far more powerful, is that we should balance the members of the panels and the oversight committees with experts from the domestic abuse sector. To be honest, there is nothing that keeps it more real than being able to say to somebody, "Actually, no—that is not how domestic abuse works. Let me tell you why and how, and where the data and the research is, and all of that." Those things will not automatically come into the room with a panel member or the oversight committee, so I cannot emphasise enough the importance of ensuring that we balance the statutory representatives with those who are experts on domestic abuse. We also need to find ways to engage survivors—not the family; it is about hearing the voices of survivors—in reviewing the processes going forward.

In other words, given that we need to learn from and test the process through the first reviews—we will not set this up for every review—we could have the process and the recommendations suitably anonymised and reviewed by survivors in a listening session. If they are willing to participate, they could test some of the internal assumptions that are made transparent by some of the questions.

The Convener: In reference to the case review panel provisions, you point out in your submission that the explanatory notes state:

"The intention is that this"

—the panel function—

"will be a role performed by people who have valuable insights to offer but who will be able to do this alongside their everyday lives and work."

Given what we are looking at and the nature of a review, do you think that that is appropriate?

Dr Scott: To be frank, it makes no sense to me. When I speak to people down south, they say that experts from the sector are involved in the reviews. If we, in Scotland, want people to undertake the role in addition to their regular roles, are we erasing the expertise that exists here in order to make the review process robust? I am not sure why that was considered. Maybe it was so that we do not have to pay panel members—I have no idea, but it does not make much sense. If we are saying that these people should be independent, does that mean that they have to be retired professionals, for instance? It makes no sense to me.

The Convener: I put that question to Fiona Drouet.

Fiona Drouet: That has been discussed with people who are currently doing reviews, particularly in England, with regard to how challenging that could be, given the length of time for which a review can go on and the viability of someone doing that alongside their day job. Equally, we have the challenge of wanting those people to be involved because they are the experts and they have current knowledge in the field. Although it would bring challenges, I am sure that we could find solutions, but I share the concern.

The Convener: It is a tricky balance to achieve, I guess.

We will move on to part 1 of the bill in a moment. First, does anyone want to come back in?

10:30

Liam Kerr: Dr Scott, Rona Mackay asked you about the definitions in section 9. Let us assume that we do not import the definitions from the Domestic Abuse (Scotland) Act 2018. In your written submission, you expressed concern about the definitions of "child" and "young person" that are used in the bill. For the record, will you articulate your concern and what you would like the committee to do in relation to those definitions?

Dr Scott: I will be honest—I read section 9 at least three times in an attempt to figure out what the hell the difference was between a "young person" and a "child", and why it was laid out as it was. I am a relatively intelligent woman, and I could not figure it out. The drafting needs to be tightened. If a distinction was intended between "young person" and "child", that needs to be made explicit, so that we can understand what was intended. Maybe Fiona Drouet knows the answer to that. The working group on children has not been operating for very long, so it may well be that that work is in development. I am concerned about the confusing wording, not the intentions.

The Convener: I will open up discussion on part 1 of the bill. I put this question to you, Marsha, given that you included some commentary on part 1 in your submission. You commented on section 2, which deals with virtual attendance at court. Will you comment generally on the position of Scottish Women's Aid on that provision?

Dr Scott: As the committee well knows, I have spoken a number of times previously about the importance of creating alternative ways for victims to engage with the justice process, because of the libraries of evidence that show that the existing processes are a barrier to disclosure and getting help. It is very clear to everyone, including the public, and it is especially clear to victims, that the

process of being involved in a court case is traumatising. I repeat what so many survivors have said to us: the criminal trial process is as traumatising as the abuse itself.

What are we going to do about that? It is our responsibility, and it has been for 20 years, to fix that. One wonderful benefit of technology is that we can create processes that allow victims to give their best evidence. We all like and believe in the argument that there is no evidence that virtual attendance by victims means that they give worse evidence—in fact, the evidence is that virtual attendance will improve justice. In the light of that evidence, we need systems that are flexible. I support what Kate Wallace from Victim Support Scotland said: there needs to be choice for victims. Not every victim wants to give testimony remotely.

This morning, I reread some of the queries on the subject in a previous evidence session. I struggle with the idea that the status quo is safe and that we need to worry about the dangers of remote input by witnesses. If you think about what it is like to give evidence in the same room as somebody who has, in essence, terrorised you for years and who has the capacity to terrorise you when you walk out of the courtroom, you cannot imagine that that is good practice, yet that is what we have done in Scotland for years.

The status quo has put up a good fight against victims giving evidence remotely. There are vested interests in keeping the process as it happens now. During Covid, there was a great willingness on the part of the Crown Office and Procurator Fiscal Service, witnesses and victims organisations such as Victim Support Scotland and Scottish Women's Aid to find ways of making virtual attendance a reality. Despite that, only about nine cases went forward in a year and a half, because of objections to the process. Our overarching observation is that there has been more movement on virtual attendance, but it has been tiny and extremely slow. The ability to obstruct it is still present in the system.

I am sorry—I am finally getting round to my point. We would like there to be stronger language in the bill that, in essence, sets out guidelines to the effect that the choice to engage virtually should be a presumption, and that the sheriff principal involved or whoever is making the decision about whether the process should go forward should be able to ask people to demonstrate that proceeding in that way would mean that there would be poorer rather than better evidence. I am talking about defence solicitors, who, for the most part, have been very obstructive.

The Convener: Thank you, Marsha. Fiona, do you want to add to that?

Fiona Drouet: It is not my area of expertise—part 2 of the bill is—but what we experienced through the court system was exceptionally traumatising. We were not the ones who were subjected to the perpetrator's abuse, but having to be in the same space as him—on one occasion, he would have been within touching distance of myself and Emily's grandfather—was exceptionally traumatising. That is something that stays with you for a lifetime. As Marsha Scott said, our systems are not trauma informed, and they need to be reviewed. I can see why the ability to give evidence remotely would be beneficial.

Again, I am not an expert in these processes, but I have experience of the manipulation that goes on. As Marsha said, defence lawyers have a job to do, and I am sure that it is sometimes not very pleasant for them. The last time we were in court in relation to our daughter's case, an apology was made to me before I was cross-examined. That stuck with me, as the cross-examination was very unpleasant—it took me back years from a recovery point of view, if you can ever recover from such a thing.

Would I have felt safer in another space where I felt secure? Yes, absolutely. I do not know whether it does people a disservice to deny them that choice. The defence lawyers used particular tactics with the sheriff and judge that I found upsetting and confusing, but perhaps there would not be the opportunity for that in a remote hearing. I can definitely see the benefits, although I add that I am not an expert in the field.

The Convener: That was a very insightful piece of commentary, and we are grateful to you for it.

Ben Macpherson (Edinburgh Northern and Leith) (SNP): Good morning, all. Noting, and not disputing, what has just been said by our witnesses, I recall what the committee has been told in recent weeks about the practicalities of implementation. Dr Scott, I am curious to hear your position on whether, given what you propose in your written evidence, which you have elaborated on in your oral evidence this morning, additional time would be required before implementation for the courts and any other facilities to be properly and fully equipped so that virtual evidence could be taken in every appropriate case. Is that something that you would deem to be acceptable?

We have heard some interesting evidence in recent weeks to the effect that the commencement of the bill as drafted would be appropriate, but that there would be quite a time period thereafter before anything happened, despite the fact that the pilot has resulted in the provision of facilities in some places. It seems that, if more use is to be made of virtual evidence, we need to significantly add to the provision that there is just now.

Dr Scott: Again, being an improvement geek, I think that the implementation process should not be done nationally in one fell swoop, and that, given the work in Grampian that Sheriff Principal Pyle is involved in and the work in Glasgow that Sheriff Principal Anwar is involved in, an awful lot of what we are talking about is already in place, and, as Kate Wallace pointed out, we are already doing this with vulnerable witnesses.

I think that a vested interest is being served by focusing on the difficulties instead of the benefits, and by not thinking of alternative ways of rolling out the arrangements in such a way that we learn as we do that.

I would also say that, from our perspective, there are not as many of what we might call the bricks-and-mortar implications as is being suggested. I do not think that we need to have high-spec soundproofed rooms. I am grateful to Victim Support Scotland for having set up those sites, but Kate Wallace and I have often talked about the fact that it seems that we are somehow trying to make those sites more robust than the existing provision in a courtroom.

We need to think broadly about what needs to be done. I agree with the thrust of Pauline McNeill's questions in a previous session. I do not think that anybody is proposing that witnesses give evidence from the comfort of their own home, but I think that there are appropriate facilities in communities.

I am in Orkney, and I have to say that I think that there are benefits, in geographical terms, to someone being able to participate in a meeting such as this one from a setting in their own community or a nearby community—not in their home, but in a Victim Support office, a citizen's advice office, a community centre or whatever. We need to think more broadly about the community spaces that could be made safe for such a process, because that would improve the experience for victims and would allow them to give better evidence than if they were in a courtroom. We have to find a way to do that and to stop thinking that we need to build expensive sites in order to protect people from every eventuality, when we have existing very unsafe facilities that are being used every day in Scotland. Again, the issue is the cost of not acting.

On the issue of delays in implementation, I have not seen a good case laid out for any timetable. During the pandemic, the Crown Office and Procurator Fiscal Service was ready and willing to do what is proposed. Granted, there were some other circumstances there, including the fact that, at the time, procurators fiscal were not actively engaged in their usual work. However, only nine cases went forward. That was not because of the difficulty with facilities; it was because the defence

solicitors objected. That is the first barrier, and we need to get over that barrier, fix the problem and create an implementation plan that can be delivered. Again, I am not in favour of doing it on a national basis all at once; I think that we should roll it out in places where work has already been done.

I am sorry for going on at length; you can tell that I care a lot about this issue.

One of the proposals that has been on the table for years—Kate Wallace, Sandy Brindley from Rape Crisis Scotland and I sat in a room in the courts service a long time ago to talk about this—is setting up in sheriffdoms, on a trial basis, specialist domestic abuse courts that would do virtual trials. It was a brilliant plan, and it got nowhere near fruition because we had not dealt with the obstacles.

10:45

There is expertise in the system. We need to facilitate the flow of cases through the system and solve the problems around where victims would be and how we make sure that they are safe and that their evidence is protected. It is not rocket science. Some of the witnesses have made it sound as though it is rocket science, but that is because it is change.

Ben Macpherson: Thank you; that is helpful for our inquiry.

The Convener: Rona Mackay will ask the final question.

Rona Mackay: My question is for Fiona Drouet. Fulton MacGregor mentioned the film that his constituent produced and your very powerful part in it. In that film, and in your submission, you talk about how you felt let down by the university's response and how it had missed some vital signs that something had gone wrong. Is it your understanding that things have changed in the past nine years?

Fiona Drouet: It is my understanding that things have changed, although not as broadly as we would have hoped, as you can see if you look at specific institutions. In the University of Aberdeen, which Emily went to, there has been a complete transformation. However, that is a result of our work and our charity's development of a framework of minimum standards that are evidence based, and asking universities and colleges to adopt those. Those standards involve the institutions having some external scrutiny of their policies, practices and procedures in relation to all forms of gender-based violence and what they are doing with regard to prevention, intervention and support.

That approach has been adopted by many universities and colleges, but not all of them. I wonder whether, if there had been a review that resulted in that level of public accountability, we would be further forward than we are at the moment, because it was left to our family to bring that change. We are still fighting to see more consistent change, so that every student in Scotland is afforded the same level of safety, no matter which university they go to. However, that does not exist yet.

In short, I think that the reviews might have had a positive impact.

Rona Mackay: Well done for all the work that you have done. It has made a huge difference.

Fiona Drouet: Thank you.

The Convener: That brings this session to an end. Thank you very much, Marsha, as ever; and thank you, Fiona—your evidence has been invaluable to us.

10:48

Meeting suspended.

10:55

On resuming—

The Convener: We are now joined by our second panel of witnesses this morning: Katie Brown, equally safe policy manager at the Convention of Scottish Local Authorities; Graeme Simpson, chief social work officer at Aberdeen City Council, here representing Social Work Scotland; and Dr Emma Fletcher, director of public health at NHS Tayside. Welcome to you all, and thank you for your written submissions, which have been circulated in advance of today's meeting. I intend to allow about 60 minutes for this evidence session.

As with our previous panel, I will start with a general opening question. I will work from my left and then move across the panel. I will therefore start with Katie Brown, followed by Graeme Simpson and then Emma Fletcher.

Can you set out in general terms your organisation's views on part 2 of the bill and the system of abusive domestic behaviour reviews? What, if any, improvements or refinements would you like to make? In short, do you have any particular areas of concern, or are there aspects of the provisions in the bill that you particularly welcome?

Katie Brown (Convention of Scottish Local Authorities): I am here representing the Convention of Scottish Local Authorities and our members, so I am bringing you their views. In

responding to that question, I will start by identifying that there is concern about the limited time that has been invested to date. Obviously, I am talking not about the commitment or energy that has gone into things, but about the fact that there has been limited time to allow full engagement from local expertise in the development of the proposed legislation. That is the first point that I wish to make.

The second point is whether consideration of the legislation is actually needed. Might the current arrangements across the already complex review environment have been better developed to deliver the desired outcomes? That is a concern. As I have said before, there has been limited engagement with local systems, public protection bodies and chief officers. That was pointed out in a number of your submissions from bodies that felt somewhat disappointed that their expertise, knowledge and understanding had not been more centred in the context of the design or co-design process to date.

We need to ensure that there is coherence, connectivity and alignment to produce the impact that we are all committed to seeing and the outcomes that we are all committed to delivering across local systems and services. Without local expertise, we are unlikely to be able to produce that. At this point, that is a concern.

As far as my capacity has allowed, I have been involved in the work, on behalf of COSLA, across a number of the working groups, and there has been a limited response to issues that have been raised and requests for proper consideration and reflection of the current pressures on local systems and the capacities and resources of local authorities, local authority services and chief officers to prepare for, participate in, co-ordinate responses to and action the recommendations.

There is no reflection in the financial memorandum of the resourcing impacts and pressures that will bear down on local authorities or of how that may affect the quality of participation and engagement and the capacity of local authorities and their strategic partners to participate. That will affect the outcomes, so there is a concern about that.

11:00

Another area that our members are concerned about is the potential impact on an already overwhelmed and exhausted local professional workforce and the pressure of the reviews potentially traumatising and retraumatising staff members who are involved. That is not to undermine in any way the potential for the retraumatisation of families in the context of any

time delays because systems are not coherent or connected.

Finally, a clear observation from COSLA's membership is that we have, and are proud of, co-ownership of the equally safe strategy with the Scottish Government. We work collectively across the system with key stakeholders on that and we have been doing so since 2017. It is a five gold stars strategy that is acknowledged worldwide. It is also an impressive road map, and progress against its highly ambitious goal of eradicating violence against women and girls from Scotland is slowly being made.

We have recently received the report and recommendations from the independent review of funding for violence against women and girls services that was commissioned by the Scottish Government. The review, which was informed and supported by leading experts on Scotland's systems to prevent and respond to domestic abuse and other forms of violence against women and girls, found that the system is beyond depleted and we need an overhaul to ensure that it is delivering the outcomes that will ensure that we do not have these tragedies in the first place.

Our members feel that, given the timeframe in which the legislation is being developed and the lack of engagement and consideration of the existing expertise in local authorities to enable the proposal, if it is to be developed and if the resources that are to be invested in it are not invested in what is an already depleted and under-resourced system, we need to be sure that we are not creating something for which we actually have the answers before we begin.

Graeme Simpson (Social Work Scotland): Social Work Scotland welcomes the intention to develop learning from domestic homicides and suicides. We can take a lot from those.

We recognise that there is a gap in some of the policy intentions, and thinking about how we can plug that gap is important. However, we question whether the bill in its current format is the right way to achieve that.

Building on Katie Brown's points, the review landscape is already very cluttered. I will give the committee an example of what I mean. In the case of the death of a child who is already known to social work services, there might be a review through our child protection learning process. The child's death would also be reviewed through the national child death review hub. The offender might well already be subject to measures through the court system, so there could be a multi-agency public protection arrangements review or a significant learning review. The child's mother might have some vulnerabilities, so an adult support protection review would also be required.

The child might have been living in a kinship arrangement, so a statutory review would also be required to be undertaken on behalf of the Care Inspectorate. Layering another review process on top of all that would add complexity and challenge to an already challenging review landscape.

We also have to think of the context of those reviews. Some of them are laid out in statute while others are laid out in policy. Is there therefore a risk of creating a two-tier review system? Which review system would assume prominence? Assurance on that has not been fully thought through at this point in time.

We welcome the intention to hold a joint or single review, but I question how it would work in reality. How do you align the starting points so that they are all at the same point? How do you align a local system with a national system to bring coherence to the process? Thus far, the guidance does not fully address those issues to Social Work Scotland's satisfaction.

The reviews are one thing, but embedding the learning and system change following the review are probably the more significant parts of the review process. How can a workforce think about the demands that are placed on it?

I also have concerns about the impact of the multiple review system process on children and families, and on the workforce. How do they make sense of the landscape and navigate all of that?

We know that the Crown Office sometimes asks for reviews to be delayed until justice processes have been concluded, which is fine and appropriate, but does it mean that learning has not been taken promptly enough in order to think about how to respond and improve systems? We also have to recognise that the bill would allow individuals to directly petition ministers for a review. How would such a connection align with the other reviewing systems?

A lot still needs to be unpicked, and we need to give ourselves permission and time to deliver a bill that is coherent and aligned and does not overwhelm the system, which is already stretched.

Dr Emma Fletcher (NHS Tayside): Good morning. My professional public health perspective is that I fully understand the rationale for the reviews. By way of background, I have first-hand experience of chairing drug death reviews in my previous role as a consultant in public health. In my team, I currently have colleagues who are integrally involved in suicide reviews and child death reviews, which are conducted on a local basis but interface with national structures.

Many of my reflections echo those of my colleagues. We have to be mindful of the balance of resource and how we achieve that balance to

the greatest effect and impact. There is a recognition that there is a focus in other review processes, particularly drug death reviews, on the downstream impact. In addition to taking an upstream community-based preventative approach, how do we avoid losing that focus on resource allocation in any review process context?

To echo my colleagues' points, it is important to have assurance about how we adopt the learning from those reviews. As I have described, it is a complex landscape, so it would be of value to ensure that any new review process does not duplicate existing structures but works within them for maximum impact.

I have alluded to the complexities around the interface between national and local levels, and I am mindful of how national reviews would be constructed and local teams appropriately represented.

I am also thoughtful about the interplay of that process with legal proceedings that it would run alongside. I am mindful that the culture that is aspired to in the reviews is one of learning, but given the criminal justice process that is going on alongside it, what assurances or support can we give to people who are involved in the review process that it is an environment in which they can contribute fully and transparently, and be supported to do so, so that we can take forward the true aspiration of learning?

The Convener: Thank you. There was a lot in those responses, which is helpful. I open the discussion to members.

Liam Kerr: Katie Brown, you spoke in your opening remarks about funding and resources, and the helpful submission from COSLA raised that as a specific issue, saying that there is a

"Chronic lack of capacity in and underfunding of VAWG services"

by the Scottish Government and that the financial memorandum needs more work in relation to the costs to local authorities of implementing the bill.

Do you worry that the figures in the financial memorandum are insufficient to implement the bill properly and action any recommendations from reviews? What do those figures need to be?

Katie Brown: I do not know what the figures need to be, because I do not have the local expertise that is required to inform that. However, as I outlined earlier and in the submission, there will be a range of impacts in relation to local authorities working with their community planning strategic partners. There will be a range of impacts on capacity, and investment costs must be invested in that capacity. At the moment, local authorities are working in the context of a fiscal environment where there are no huge margins of

comfort. If we are doing one thing, something else is not happening—that is where we are at.

Given the way in which the reviews model is set up at the moment, local authorities will have to prepare, participate, provide information, respond, co-ordinate responses and take action on recommendations. They will require to oversee and drive all of that not in one place but in many places across the system. That has to be driven forward, monitored and evaluated, and there is no identification at the moment of a learning repository or another system whereby local authorities and their strategic partners will be able to take learnings from those reviews and apply them pre-emptively.

All of that will happen across a range of areas, which could include services and multi-agency systems that are set up, run and resourced by local authorities to plan strategically to prevent violence against women and girls, such as the violence against women and girls partnerships and the protective and risk management multi-agency partnership mechanisms. They will all have to respond, as will specific services, primarily, but not necessarily limited to, housing services, children's services, schools and so on. A range of different services is involved around the lives of people who are affected by and harmed by domestic abuse in multiple and often lifelong ways, and local authorities continue to support them.

There are also services and responses to perpetrators, and, across our current system, we are not engaging and investing in work with perpetrators in a way that is producing effective change.

All those things will be part of what a local authority and the relevant systems and services will have to deal with in relation to implementing the bill.

I did not say this at the beginning, but I want to say very clearly that COSLA's members are deeply committed to continual improvement. We are also deeply committed to improving action on domestic violence and all forms of violence against women and girls—we share the same ambitions as everyone does in relation to improving that.

Do we think that continual learning and improvement is key in this area? Of course we do. We also think that investment and pressures have to be considered more fully, particularly in relation to the systems that are already in place, using the expertise that is already there to make things right, and that we have to consider how we balance that investment against prevention and early intervention. We do not want to learn from tragedy any more. We recognise that we have to, but we

need to balance what we do to ensure that we prevent those tragedies in the first place.

11:15

Liam Kerr: I understand—thank you.

Dr Fletcher, I have a similar question. Does the financial memorandum take sufficient account of the costs to the NHS of supporting the reviews and implementing any recommendations?

Dr Fletcher: My reflections echo what has been said about financial considerations having an opportunity cost. It is about how we set up the function to be as efficient and effective as possible; that will inform the balance of financial resource direction.

We have limited resource at the moment across all public sectors, for a number of different reasons, and we have to be very mindful of how we spend that to achieve the greatest impact. The process under the bill would introduce implications for the direction of both financial and human resources, and resources would have to be directed to it from elsewhere in the system, whether that be our schools or public transport, because the resource pot is limited. We have to be certain that we are delivering maximum benefit and impact for the resource that we put in.

Liam Kerr: Thank you. Graeme Simpson, feel free to answer the finance point in your response, but I also want to ask you about the Social Work Scotland submission, which suggests that there has been a lack of “consultation with key stakeholders” in developing the model. Is a lack of consultation widespread across many key organisations? Do you have a view on what might have been different in the model had consultation taken place?

Graeme Simpson: A key organisation that has not been consulted is Child Protection Committees Scotland. The current policy sets out the responsibilities for child protection committees in relation to learning reviews for children who die or are at risk of significant harm. There is scope in the policy intention for review processes to be revised to give a much clearer steer and direction with regard to the need for the inclusion of a domestic abuse lens in circumstances in which children have been killed or experienced significant harm, but without imposing another layer on to the system. The frameworks are there, but, rather than add to them, we could amend those that are in place to take account of the need to include that lens.

Building on points that Emma Fletcher and Katie Brown have made in relation to the finance question, I note that the other bit is resources. No matter what review is being conducted, in a local

system, it is often the same people who are responsible for co-ordinating, driving and delivering reviews. For example, at local level, there are public protection teams in Police Scotland and in local government. It is also often the same people who are involved in co-ordinating, driving and undertaking the learning from those reviews and who must ensure that the system changes in the ways that are required in relation to that learning. It is a question of layering and which aspect comes first. It is about the financial cost in terms of pounds, shillings and pence, as well as the human cost to the workforce of delivering the multilayered review system that exists at present. I hope that that answers your question.

Liam Kerr: Yes. I am grateful to you all.

The Convener: Pauline McNeill, I think that you were looking to come in with a follow-up question on that.

Pauline McNeill (Glasgow) (Lab): Yes—thank you, convener. It is a question for Katie Brown. I thank you for introducing to the conversation the importance of effecting change. I just want to understand the funding for equally safe. Is there national funding for the programme? I know that it is not rolled out in every school, as we would hope.

To be clear, as you mentioned it, is the bill the right place in which to address the finances of all programmes like equally safe?

Katie Brown: With regard to the national funding for equally safe, there is £19 million that comes to violence against women and girls services, in the main, and to some cross-sectoral programmes, which reflects the commitment to multi-agency cross-sectoral working in local areas.

That £19 million is a central fund—it is competitive and a lot of energy and resource is invested in moving that forward. It is not linked in any robust manner to local needs. The engine that drives equally safe’s strategic approach in local areas, which is identified in the equally safe strategy, is the multi-agency violence against women and girls partnerships. Those partnerships are obviously not, however, in a position to drive forward funding bids to a competitive fund against their constituents.

What we know, and has been clearly evidenced, is that there is a huge weight of investment from local authorities in services dealing with the harms of domestic abuse and other forms of violence against women, as well as in universal services. We know, for instance, that, early on, women are more likely to seek support from universal services rather than from those in key roles such as violence against women and girls specialist services. Local authorities are not only investing in

the harm costs of those universal services, in terms of picking up early harm, but trying to commission against the needs of local services.

The equally safe road map is, from a Scottish Government point of view, funded through that £19 million, which is focused quite robustly—but not robustly enough, as has been evidenced—to support those specialist services and their key role.

On your point about schools, there are programmes that are being funded in the context of schools, involving work towards the prevention of domestic abuse and other forms of violence against women and girls, which are driven by expert services in collaboration with local services or other national bodies. Their development is funded, but their implementation is not, so there is a resource implementation gap between those ambitions and the implementation in the context of our schools. Schools have to make up their own minds as to whether they have the capacity to support that aspect as a central tenet of how they take things forward. We all know how important that is as part, although not the whole, of prevention.

There are gaps. There are also other sporadic pockets of funding. For instance, in the context of justice, there is funding that supports victims organisations, some of which are supporting victims. There are other pockets of funding that support work in some local authorities with perpetrators and other such things, but that funding is short term and it is not particularly robust in terms of its sustainability.

That is where we are—it is a patchwork environment.

The Convener: Perhaps if there is anything further on equally safe funding, which is an interesting point to pull into the discussion, it might be easier to bring that in by following up in correspondence to the committee. It would be helpful for us to have sight of that.

Pauline, do you want to come back in?

Pauline McNeill: No. I just raised that because Katie Brown mentioned it in her opening statement. She also mentioned the financial memorandum. My only other question is a yes or no supplementary. Does the funding have to be addressed in the financial memorandum?

Katie Brown: The impact of the costs has to be addressed, whether or not they are outlined in the financial memorandum.

Pauline McNeill: Thank you.

Rona Mackay: Good morning. So far, we have talked a lot about resources and finance, and I understand the importance of that. That said, I

would like to take issue, Katie, with what you said at the start about the equally safe fund being depleted and not serving local needs. Frankly, I just do not believe that. Some £19 million has been given out to local authorities to work on such needs and on the preventative strategies that you said were not happening. I am just going to take issue with the premise of that. We might argue about the amount of it, but I would say that that fund fits perfectly into what we are trying to do here.

So far, all that I have heard about are barriers to the bill. If we could just go back to the bill that is in front of us, I am unsure whether any of you support its introduction. If we take finances out of the picture for a moment, do you support the previous witness's view that there has been a long-standing gap in Scotland? England has a system in which families and victims are served better and that is what we are trying to do here. If you could clarify whether you support the bill, I would appreciate it.

Katie Brown: Our members absolutely and 100 per cent support the bill's intention as you outlined it. We are all committed to that. Reflecting on what my colleagues said earlier, and using Graeme Simpson's words, we question the layering of another system on top of existing ones, rather than focusing on improvements to and connectivity across those systems to make them function better. That is the part that we are—

Rona Mackay: You would be confident that, with what exists currently, the outcome that the bill proposes could be achieved. In other words, there is a gap that is not filled and you are saying that it could be filled by the existing structures. I am not hearing that, so that is what I am trying to get at. Surely, we need to implement a structure that stands alone, as they have in England.

Katie Brown: COSLA takes advice from our professional experts who work within and drive the local systems as they stand. We take seriously their advice that, at the moment, within the timescales and the context of the design to date, we have perhaps not explored the systems as deeply as we might have done. We would like them to be looked at more deeply before the model in the bill is determined to be the only one.

Graeme Simpson: To be absolutely clear, I fully support the intentions of the bill, as does Social Work Scotland. However, we question whether the proposed approach is the right one to deliver on the bill's intentions. Do we need to do more to join up public protection arrangements to ensure the learning? We would say yes, so a standstill response is not the outcome. We must think about what needs to be in place, such as additional policy guidance.

In my earlier statement, I mentioned that there is already variance across the landscape. Some review processes are legislated for, while others are not. In my opinion, the more effective ones are those that are not legislated for, because they have buy-in from the workforce and we approach and undertake those reviews with learning at heart, as well as support for improvement.

There is a question whether legislation is required or whether improvements could be achieved by amending existing policies and guidance that cover the area. We are moving at pace to deliver integrated public protection arrangements and we want to continue to drive that work forward.

11:30

Rona Mackay: Is there a danger of a patchy system and a postcode lottery if that happens, with some bodies adhering to guidance and others not doing so? Surely, the people of Scotland should have confidence that they can go to a system if they have suffered a tragic loss.

Graeme Simpson: Absolutely. I fully respect that we need the public to have confidence in whatever system is put in place. We always want to strive to achieve as consistent a process and arrangement as we possibly can. However, we need to recognise that each individual circumstance is different and our response needs to take account of the child or the adult and all those around them who are affected. Having clear guidance is really important, but whether that is done through legislation or policy amendment is the question that is still debatable.

Dr Fletcher: I support the bill. With apologies, my hesitation is that I do not have a vast experience of bill writing, so I do not know what the scope is for what could be included in the bill. I have come here to share my reflections so that you can think, "Can that be incorporated, should that be incorporated, or can that be addressed elsewhere?" That is why I am here today, and I hope that that explains my—

Rona Mackay: I totally understand. Thank you.

The Convener: A few members still want to come in and I am conscious of the time, so I ask for succinct questions and answers.

Sharon Dowe: It is good to hear that you all support the bill. I do not think that you are putting up barriers; it is perhaps the practicalities of implementing the bill that everybody is concerned about.

In your written submissions and in your opening statements today, everybody mentioned a lack of engagement. Police Scotland said in its submission last week that there was a lack of

engagement and that it wanted more communication. I think that it was Police Scotland that said that part 2 had been "tacked' onto the end" of the bill.

My quick question on engagement is this: do you have a note of how many meetings and how much correspondence you have had with the Scottish Government on part 2 of the bill? Is that information available?

Katie Brown: For COSLA, I have attended and I sit on as many of the oversight groups that have been driving the review work as possible. I have done that to my fullest extent and that has culminated in this becoming a huge percentage of my work to date. That has happened because the work has been extraordinarily intense and deep. That is in no way to undermine that or the commitment that has been driving it, but the process has been very fast paced and intensive. I have been engaged with and received the papers from all the groups. I have one other colleague who sits on one of the other groups.

Maintaining an oversight of how we have gone from important and deep discussions about the work, to the bill and understanding the time limitations of taking it forward, has created, for us, a sense of lost opportunity. I was involved from the outset and have maintained that involvement. I have also been as vocal, helpful and supportive as possible in trying to ensure that there has been deep engagement with local expert partners, but there has been less of that engagement than I would have hoped for.

From COSLA's point of view, our members have been looking at the issue relatively frequently, in the context of their business, as a really important piece of business that is being developed. The thoughts that I am reflecting are as you outlined: we are concerned about implementation and making the process work in order to achieve, in the best possible way, the improvement that we are all seeking. We feel that the process of co-design has been quite challenging.

Sharon Dowe: There have been a lot of meetings. The bill has been produced in a short timescale. Perhaps you have not been listened to, and not everything that you wanted to be in the bill has been taken on board. Perhaps you did not have the chance to mention it.

Katie Brown: Within my capacity, I have raised issues. Those have been responded to but have not necessarily worked through into part 2 of the bill.

Sharon Dowe: Graeme Simpson, do you want to comment?

Graeme Simpson: I am sorry, but I cannot answer the question on the volume of

communication. I sit as Social Work Scotland's rep on the domestic homicide and suicide review working group, which has met monthly since September last year; it has moved at a fair pace. I echo what Katie has just said. Some of our suggestions and discussions have not been listened to to the extent that we feel was necessary.

Sharon Dowey: The Social Work Scotland submission mentions that a key organisation—Child Protection Committees Scotland—has not been engaged with. Are you aware of any other key groups that have not been engaged with?

Graeme Simpson: The point is about how we ensure that children's voices feature. There is further work to do around that. The United Nations Convention on the Rights of the Child is now incorporated into Scots law, so any review process will have to ensure that the child's voice is at the heart. Have we engaged to the necessary extent with children? I accept that that is not an easy task but there is learning from organisations that are already capturing the voices of children that could have been helpful to shaping some of the bill.

Sharon Dowey: Some of the evidence that we have received has raised concerns about adding new system reviews to an already complex review landscape. Katie Brown, if you have not already explained the issues or concerns that you have, will you give us a wee bit more detail on that? Could the review framework in the bill be revised and amended to address your concerns and reduce any potential strain on local authorities?

Katie Brown: I will pass that over to Graeme Simpson because it requires specialist knowledge of how things operate in the local system and I am representing the voice of the politicians. You will get more sense from him.

Graeme Simpson: I will take the starting point of a review process. As I and as Social Work Scotland understand it, the process for domestic homicide and suicide reviews will be triggered by a referral from the Crown Office or Police Scotland to a minister, who will approve the commencement of a review.

That is based on other systems. For example, in my role, I get a weekly email from Health Improvement Scotland about every child who has died in my area and I have to respond as to whether we are undertaking a review in relation to that child's death. A child protection committee also has responsibilities in relation to whether we instigate a learning review in relation to a child who has died and whether we have had involvement with that child.

It is critical to think about how we align the mechanics of each of the reviewing processes that exist to ensure that we communicate clearly,

concisely and consistently with families. The same applies to the workforce. If we decide locally that a learning review is not required in a particular instance but, several weeks or months down the line, a decision is made that a homicide review should take place, how do we manage and support the workforce through those complex reviewing landscapes?

Sharon Dowey: Do we just need to review and refine what we have already, rather than implement the bill? Do we need to legislate or to refine what we already have? I have a concern that everybody is spending all their time doing reviews, but nobody is implementing the actions from that work so we do not get the outcome that we need.

Graeme Simpson: There is validity to your concern. We could do better as a nation at collating the findings of reviews and supporting system change more consistently.

Sharon Dowey: Do you have any comments on that, Dr Fletcher?

Dr Fletcher: No.

Sharon Dowey: That is fine—thank you.

Katy Clark: You have all made the case very strongly about the resource and financial pressures on the system, in local government and health and across the public sector. You have also made a powerful case in relation to duplication. It seems to me that the multilayered review system, as you describe it, exists in some cases—we perhaps need to deal with that—but there are other situations where that is not a feature. An example is the situation, as we understand it, in relation to Fiona Drouet's daughter. I am involved in a case where, as far as I am aware, there is no review process. There are cases where there are no drugs issues, or no children are involved, or there is no social work involvement already. Is it fair to say that we need to look at those scenarios in different ways?

The committee's role is to scrutinise what is in the bill. I appreciate and completely understand that you are not draftspeople, but are you saying that, in terms of the policy that we are trying to achieve, we perhaps need to ensure that those different scenarios are dealt with in different ways, in the bill and in the regulations that will come thereafter? Are you saying that you accept that there is a gap that needs to be addressed, but that there are other situations where there are already a range of review processes?

Graeme Simpson: I agree with your observation. It is difficult to write a bill that will cover every scenario. I have some knowledge of Fiona's circumstances, given that her daughter died in Aberdeen. We have worked with the

universities on that through our violence against women partnership. That scenario would probably not have fallen into existing review arrangements, so I acknowledge that the gap exists and that we have to take account of that in thinking about and framing the bill. That is important to acknowledge.

We need to define more clearly what a domestic homicide review is, and to fully categorise what that means. A narrow area within that is that the bill as it stands refers to children up to the age of 16. Increasingly, we are referring children up to the age of 18. Ensuring alignment is important and it would help with some of the consistency factors that I am flagging to the committee.

Katie Brown: That has not been part of what has been discussed with our members in respect of the development of the domestic homicide and suicide reviews, so I cannot really comment on it, except to say that, where harm is done, local government would want to ensure that there is more than lessons learned. It is vital, when we do not have the systems in place, to capture harms. Suicide is particularly challenging in that respect. As far as I am aware and am informed, we do not yet know what that might look like, and we do not have the data in place to provide a clear understanding. We would not want in any way to undermine ensuring that everyone in our communities lives the life that they have a right to live and is safe and secure in their life. We are dedicated to ensuring that.

In response to the second part of your question, I repeat that we believe that there is more work to be done.

Katy Clark: Is it your understanding from all the meetings that you have been to that the policy intention is to have a review in every case where there is a death that meets the definition?

Katie Brown: From the meetings that I have been to, I would say that the power in relation to making that decision sits with the systems that are being set up to assess that.

Katy Clark: That suggests that you are asking us to look at the circumstances in which a referral is made. You are saying that there might be situations in which there is no need for a full review process because there have been many multilayered reviews that have already captured much of that information. Are you saying that we need to be aware of that and look at whether the bill delivers on it? Is that fair?

11:45

Katie Brown: Again, I pass that question to Graeme Simpson because of his technical and professional knowledge of the way that things work within the environment.

Graeme Simpson: A significant learning review is not undertaken in relation to every child who dies. We will look at the death as an individual circumstance and determine whether additional learning and system change are to be gained from doing a review. The circumstances of the child's death might be so significant that we want to take that approach, but we do not review every child's death in the detail that is required in a learning review process.

Katy Clark: You are saying that, in relation to the proposed legislation, you believe that there is a gap in domestic homicide and suicide reviews, but there might be some cases in which that work has already been done so a review will not be needed, and that will be taken into account in deciding whether a referral is made. I understand the resource points that you are making. I fully understand those and I am more than sympathetic to them. I have listened carefully and I am extremely concerned, as I am sure we all are. However, if there is a gap, the Parliament needs to decide whether to legislate. Emma, will you comment on that?

Dr Fletcher: There is a gap that needs to be addressed. I am very reflective about how the process will align. For example, will it have primacy over local suicide reviews that happen in local areas? I suggest that it will. Does that need to be made explicit in the bill? I do not know. I am also reflective about how we optimise the system such that we have clear actions that need to be taken on a for-Scotland basis, because that is critical. How do we bolster the impact of the review process, whichever area that is in, and how do we share learning from the review process? That is clearly outwith the scope of the bill, but it would be a superb position to get to.

My other reflection is on the local and national interface. I apologise again if this is in the bill and I am just missing it, but I am unclear about the context in which a national review committee will be set up. Will that vary depending on the local area that is impacted or will it stay constant with local contributors feeding into a standardised process? I am not sure whether I am reading that correctly. That is just a thought.

Fulton MacGregor: Good morning and thank you for your evidence so far. Before I come to my main question, I will pick up on the three previous questions. I do not know that I would use the words "negative" or "barriers", but I think it is fair to say that Katie Brown and Graeme Simpson have expressed the most concerns about this part of the bill of all the witnesses that we have spoken to.

As Rona Mackay pointed out, one of the reasons that the Government introduced the bill is because there has been that gap. I do not want to go over the whole conversation again, because

you have answered colleagues' questions quite well, but how many of your concerns about this part of the bill relate to the ability or capacity of the workforce to deal with it?

Graeme Simpson: There is a workforce capacity challenge—there is no doubt at all that that has to be considered as a factor. However, there is no reluctance from the workforce to learn, or to reflect on and be curious about whether we could have done things differently and been more proactive in supporting and intervening to prevent tragic events from happening. There is a capacity challenge, but there is also a coherence challenge with regard to the various policies and pieces of legislation that currently exist, including in relation to reviews. For me, it is about coherence. We want to ensure that, where learning is required, we capture that clearly once, and that that system change for Scotland takes place.

Katie Brown: I whole-heartedly agree with that, but I will add a point about the embedding and ownership of learning. As somebody who works for COSLA in this field, I know about the impact of tragedies resulting from domestic abuse and other forms of violence against women and girls in local areas and in local authorities. There is definitely no reluctance to do better, to learn and to implement that learning. However, that learning is better owned and driven locally, with local knowledge, and embedded in and across the very complex local systems and relationships. In that way, it brings those relationships and systems together to ensure that the best outcomes are achieved.

Fulton MacGregor: On a similar theme, with regard to multiple proceedings, the bill would allow reviews to be carried out in parallel with other proceedings, which would potentially include criminal proceedings. Of course, the Lord Advocate would have the power to pause or end the review to prevent any prejudice. What are your views on that, if you have any?

Graeme Simpson: It is an arrangement that we already encounter, so we work with that. In doing so, we always seek to have an opinion from the Crown before instigating a learning review where a child has died and there are potential criminal proceedings to be undertaken. We would always seek the view of the Crown, and that arrangement is well embedded and accepted. It is sometimes frustrating because, as a system, we want to learn and improve, and to be enabled to do that as timeously as possible. However, while it can be frustrating, public agencies are committed to working with that arrangement.

Fulton MacGregor: Katie, do you want to comment on that?

Katie Brown: I have nothing to add.

Fulton MacGregor: I will bring in Dr Fletcher, but first I note the views of Dr Marsha Scott, who was on the previous panel. I do not know whether you heard her evidence. She expressed support for the measure, similarly to Graeme Simpson, but she said that the power to pause or end a review should be used only in exceptional circumstances and that the processes should run in parallel as a matter of course. Do you have any thoughts on the overall provision in the bill?

Dr Fletcher: Again, that is a very technical area. I think that it reflects what I said in my opening remarks about how we create an environment in which the reviews can be conducted in a full and transparent way, with everyone who is round the table being supported to maximise the learning. The interplay with criminal justice proceedings has been recognised as a consideration, but I am not sure how a balance between the interests of everyone involved can best be achieved.

The Convener: I do not think that any other members want to come back in. I have a couple of questions as we come to the end of the meeting.

My first question relates to a point that was made in the previous evidence session about the publication of reports following a review process. Fiona Drouet offered some words of caution about the publication of reports, specifically with regard to the potential impact on families, and Katy Clark brought up the suggestion of redacting reports. There is almost a duty of care in that regard. I am interested in hearing your views on that.

Graeme Simpson: I share the concerns that Fiona Drouet raised in that respect. We need to think carefully about publishing reviews, because of the real risk of retraumatising children and family members who are impacted. That said, there has to be a way of providing transparency and openness. There is also a need to build a relationship with family members and children as we undertake the review and to use that relationship to ensure that they are kept apprised and informed, because their understanding of the learning is important. From my experience of engaging with families before and after reviews, I know that what they are most concerned about is that the learning is embedded and that change takes effect. That is also the really important part for me.

Dr Fletcher: The annual reports that we provide following our local drug death reviews are all presented in a way that is non-person identifiable. Numbers fewer than five are suppressed and we ensure that there is no person-identifiable information in them.

With regard to providing assurance to the people involved, which Graeme Simpson talked about, we have taken on the learning and

considered how it will be actioned. It is important that we create reports that describe thematic learning and how that can be taken forward. I am also aware of processes that are used elsewhere in the United Kingdom and how we can use that wider information to create the changes that we need to make.

The Convener: Thank you—that is helpful.

My final question concerns an issue that we discussed with the previous panel—you may have been in the room when we talked about training. I am interested in your views on getting that balance whereby we have a body of experts and knowledgeable individuals who can undertake reviews. Are there points about training that you are keen to make? Staff working across public services get abstracted to go on lots of training, and I am interested in your views on that aspect of the preparatory work around the introduction of a review process.

Graeme Simpson: The child protection guidance for undertaking learning reviews contains what is almost a person specification that sets out the skills, knowledge and, more important, personal qualities that a chair who is leading a review needs to have. Something in that process could be captured and replicated. Again, there is a question about who has those skills. We are drawing from a small pond when we are trying to identify people with those skills and with the necessary time and energy—the time commitment can be quite onerous, too, and we need to recognise that aspect.

There is training that could be delivered. One of the questions that we have to ask is which review model will be adopted. Previously, the Scottish Government's child protection improvement programme referred to the Welsh model. We have trialled that and supported others to be trained in understanding it. However, we must recognise that it is not only the model that is important, but also the individual's knowledge, skills and capacity to undertake a review. There is training out there, but we need to keep that fresh, current and revised.

Dr Fletcher: The only thing that I have to add is that we need to think about how we provide support to people and staff who are involved in the review. The process can be incredibly impactful for all the reasons that we have talked about, and it can have an impact on the people who are involved. When you undertake those reviews, you cannot dissociate yourself fully from that, so that is an important consideration.

Katie Brown: It is important to ensure that the training reflects the deep-rootedness of our approach nationally through the equally safe framework and lens. The systems need to be trauma informed, gender competent and informed

about violence against women and girls, particularly domestic abuse and coercive control, and they need to be supported in the context of the knowledge that will inform the decisions that people will make when they are sitting in those positions.

The Convener: That is a helpful reminder and a valuable point.

Thank you all very much. As members and witnesses have no further questions or comments, I will bring the public part of the meeting to a close.

12:01

Meeting continued in private until 12:18.

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