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Domestic homicide review processes as a method of learning

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Introduction
Domestic violence remains a pervasive social problem across socio-economic, geographical, age, cultural, and religious boundaries (United Nations Office of Drugs and Crime, 2018). Overwhelmingly, when domestic violence turns lethal, women are killed by male partners and, globally, it is one of the leading causes of death for women (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; UNODC, 2018). Research has developed extensively over the last several decades to understand risk and protective factors for domestic homicide (Porter & Gavin, 2010; Campbell, Glass, Sharps, Laughon, & Bloom, 2007). The findings from this research have been drawn upon to develop prevention initiatives which have led to systemic, structural transformations and increased public education and awareness about the dynamics of domestic violence and the deaths that result (Dobash & Dobash, 2015; Johnson & Dawson, 2011; Monckton-Smith & Williams, 2014; van Wormer & Roberts, 2009).

One specific mechanism for conducting research and informing prevention has been domestic violence death reviews (DVDR), originating in the United States in the 1990s, and now operating in six high-income countries (Dawson, 2017a; Websdale, Ferraro, & Barger, 2019). Following a brief discussion of the rise of these initiatives and their overall objectives, this chapter will describe how models vary across jurisdictions, including key decisions faced when establishing such initiatives which have implications for research. Key challenges that continue to face DVDRs are also discussed, including innovative responses. Finally, the opportunities that DVDRs continue to present for strengthening prevention efforts are highlighted, including actual and potential impacts for strengthening policy and practice as well as contributing to education and awareness. This chapter uses the term ‘domestic violence death review’ to describe the initiatives in general, but it is acknowledged that there is within- and cross-country terminology used.

Evolution and objectives of DVDRs
The first DVDR was conducted in San Francisco into a high-profile domestic homicide-suicide in 1990. The female victim, Veena Charan, had been seeking help for months from various agencies, but her efforts were in vain. She was shot and killed by her husband in front of...
students and teachers at her son's elementary school. Her death resulted in an ad hoc review which is seen as a watershed moment for the beginning of domestic violence death reviews in the United States (Websdale et al., 2017). Resulting in a series of recommendations, the Charan review highlighted gaps in service delivery, communication and coordination, data collection, access to services, and training (Websdale et al., 2017). Today, between 175–200 review teams operate in the US (Websdale et al., 2017) and the National Domestic Violence Fatality Review Initiative (www.ndvfrl.org) continues to provide support to these initiatives.

Canada was next to follow with the establishment of a DVDR in Ontario in 2002 after coroner’s inquests into two high-profile domestic homicides of women by their male partners. Six Canadian provinces have now established DVDRs with several in progress (Dawson, Jaffe, Campbell, Lucas, & Kerr, 2017). New Zealand established its Family Violence Death Review Committee in 2008 (Tolmie, Wilson, & Smith, 2017), followed closely by Australia in 2009 with its first Domestic and Family Violence Death Review in Victoria (Butler et al., 2017). Australia currently has initiatives operating in five states and the Northern Territory. Their work is supported by the Australian Domestic and Family Violence Death Review Network. In 2011, the United Kingdom introduced legislation in England and Wales to allow for the implementation of multi-agency domestic homicide reviews (Payton, Robinson, & Brookman, 2017). Most recently, in 2017, Portugal implemented a death review mechanism focusing on domestic homicide (Websdale et al., 2019).

While variations exist across DVDRs, their overall goal is to retrospectively examine system and human factors prior to and surrounding domestic homicides with the aim of reducing similar future deaths. Most review teams compile descriptive data to identify: (1) victim, perpetrator, relationship, and incident characteristics; (2) history of system contacts and possible points of intervention; (3) gaps or failures in service delivery; (4) policy or program inadequacies; and (5) opportunities and strategies for system and legislative reform. In addressing core goals, DVDRs often differ in structure and mechanisms of governance, case inclusion criteria, review measures, and outputs. Next, some key decisions involved in establishing or operating DVDRs are discussed.

Discussion and analysis

Establishment and governance of DVDRs

The impetus for DVDRs has largely been driven by feminist and violence against women activists/advocates whose consistent voices are heard most acutely following high-profile killings of women and/or their children by male partners. The Charan review largely grew from efforts by a coalition of frontline women’s organizations who pressed for a full investigation into her death and the role played by sectors who did not respond adequately to her pleas for help (Sheehy, 2017). In Canada, building on ground-breaking research on intimate femicide spearheaded by a group of feminist frontline workers in Ontario (Crawford, Gartner, & Women We Honour Action Committee, 1992; Crawford, Gartner, Dawson, & Women We Honour Action Committee, 1997), women and feminist activism/advocacy played a role in two pivotal coroner’s inquests. Similarly, in Australia and New Zealand, women’s advocacy groups, including frontline workers, were active in pushing for change during panel reviews and task force activities (Bugeja et al., 2013). Recommendations generated from these inquests, panels, or task forces included recommendations to establish DVDRs.

Most DVDRs typically have some type of government endorsement enabling varying types of support (i.e. funding, resources, agency engagement), however, the degree of formalized
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Government support varies significantly (Bugeja, Dawson, McIntyre, & Poon, 2017). Some jurisdictions enacted a statute, code, or executive order to establish or mandate a review initiative. Others used already-existing legislative mechanisms in coroner or medical examiner acts (e.g., Coroner’s Court of Victoria used their coroner’s act). Finally, some jurisdictions had no formalized mechanism, but were able to set up initiatives using localized, regional, and national efforts of civil society members and/or organizations.

It is argued there are benefits to having a legislative framework for the reviews (Dale, Celaya, & Mayer, 2017; Sheehy, 2017). Legislation can help ensure transparency and accountability and identify an authoritative body that provides legitimacy and guidelines for governance, processes, and outputs (Dale et al., 2017; Sheehy, 2017). Statutes also provide frameworks to ensure reviews are confidential and may formalize team philosophies, membership, and protocols. However, there is no evidence-based support for the benefits of legislation, compared to those operating without such legislation, particularly for achieving social change. Regardless, a transparent, guiding framework is arguably crucial for the reasons identified and vital when bringing together a diverse set of actors with individual and group concerns about confidentiality and accountability. These concerns are significant and impact collaborations despite the ‘no blame, no shame’ guiding philosophy that is often foundational to review teams.

The ‘no blame, no shame’ philosophy has the underlying goal of achieving reviews that are collaborative and consultative, maintain independence, and ensure strict confidentiality and privacy protections. Largely universal and voluntary, this philosophy is not without its inherent challenges. In her review of 35 DVDR initiatives, Watt (2010) identified tensions between ensuring ‘no blame’ and achieving accountability for actions leading to domestic homicides. Her study showed 17 percent of the 35 DVDRs stated they tried to enforce accountability while simultaneously and cooperatively engaging with agencies to identify recommendations for improvement. This was done without publicly blaming those involved. New Zealand’s committee reportedly adopts this approach to ensure feasibility of recommendations and to encourage a commitment to implementation by those responsible (Tolmie et al., 2017).

Sheehy (2017) questions whether the ‘no blame, no shame’ philosophy can produce change, however, asking “if the errors of specific individuals and agencies are not criticized, exposed to public view, and translated into consequences, is it realistic to expect change?” (p. 389). Providing some support for this argument, DVDR annual reports frequently contain recommendations that repeat the need for improvements already identified in earlier reviews (often more than once) or indicate ‘no new recommendations’ meaning that what would have been recommended has already been recommended. Sheehy (2017) argues that repeating recommendations highlights that change has yet to occur and the decision not to repeat recommendations may mean DVDR teams feel that it “has done its best to urge change but that the same problems persist” (p. 389).

Team composition of DVDRs

Team composition varies significantly, often depending on whether there is existing legislation or an order including membership requirements. Some teams are comprised of individuals who all work within the same organization (e.g., coroner’s office, Victoria, Australia); however, more often representatives from more than one agency are invited to sit on reviews. If eligibility criteria exist, they often identify government representatives (i.e., police, prosecution, corrections, parole, child welfare, and family services), but some DVDRs have requirements for domestic violence advocates, service providers, representatives from diverse communities, particularly if overrepresented among victims and perpetrators. The New South Wales team, for example, has
various government representatives, but legislation stipulates that at least one member must be Aboriginal or Torres Strait Islander and one representative must be from Aboriginal Affairs in the Department of Education and Communities (Wilson, 2017). Similarly, two US jurisdictions have legislation that require representation from American Indian/Native American tribal organizations (Websdale et al., 2017). Although fewer, other DVDRs involve family members or survivors such as in the United Kingdom where, largely due to efforts by Advocacy After Fatal Domestic Violence (AAFDA), family members play a key role in review processes (Mul-lane, 2017).

Some committees have the capacity to grant ad hoc membership to individuals with specific expertise – important for DVDRs with limited, permanent membership. The Coroner’s Court of Victoria review initiative has a permanent team located in the Violence Prevention Unit, along with a diverse advisory committee with varying expertise (Bugeja et al., 2013; Butler et al., 2017). Therefore, if a case involves immigration and there is no permanent team member with this expertise, an outside immigration expert from the advisory committee can be brought into the review. In jurisdictions without advisory committees, outside experts can and have been brought onto reviews for specific cases. If a DVDR is national in scope, its representatives may represent higher-level government peak bodies or agencies. If more regional or local in scope, it might have representation from more diverse organizations who regularly interact with those experiencing domestic violence. An initiative can have both types of teams in play simultaneously. In New Zealand, there is a two-tier system that allows for both national and regional/local reviews, each with varying team representation. The national review team has a wide range of expertise, including two Māori (the Indigenous peoples) and representation from the non-governmental family violence sector (Tolmie et al., 2017). The four regional review panels who conduct in-depth local reviews across the country provide a safe space for team members to learn from each other’s experiences within a regional context (Tolmie et al., 2017).

Team composition is one of the most critical decisions in establishing a DVDR because it impacts resulting deliberations, analyses, recommendations, and, ultimately, the knowledge generated (Sheehy, 2017). A key consideration is the degree to which members represent the community in which they operate, including racial/ethnic groups, age, disability status, and religion, among other potential subgroups and populations (Dale et al., 2017). One challenge is identifying who community representatives should be, particularly at the national level, given that one or two ‘token’ individuals cannot speak for entire communities or minority groups (Bent-Goodley, 2013). In the United States, the New Mexico team formed a Native American subcommittee to review cases on or off tribal land involving Native American victims and/or perpetrators (Websdale et al., 2017). However, given the overrepresentation of racial/ethnic groups among domestic violence victims and perpetrators, there is still much work to be done (Bent-Goodley, 2013; Sheehy, 2017; Websdale et al., 2017).

Second, review teams must have core experts in the field of intimate partner and domestic violence with related policy, program, and practice expertise. This should include individuals with knowledge and awareness of state/provincial and national policies which is particularly relevant if the teams engage in policy reform. However, core expertise is often found in non-governmental communities as well, including those working in violence against women organizations as well as mental health and addictions agencies. These professionals and advocates often hold crucial information about domestic violence in their communities and there needs to be more effort to capture these expert voices. Without their participation only a partial understanding of the circumstances leading to the domestic homicide is possible.
**Scope of DVDR reviews**

Review scopes vary from a narrow focus on women killed by current/former male partners to a broader focus on all domestic violence-related deaths, including children, other relatives, bystanders, and/or near-fatalities (Bugeja et al., 2017). Some DVDRs have recently broadened their scope to capture domestic violence victims who die by suicide (Bugeja et al., 2017). However, the primary focus of most teams remains intimate partner homicide (including homicide-suicide) and, specifically, women killed by male partners, but there are good reasons to go beyond such cases. There have been many ‘secondary’ or ‘collateral’ fatal victims whose deaths should be counted (Fairbairn, Jaffe, & Dawson, 2017) and others who did not die, but were targeted, which supports focusing on attempted homicides (e.g. New Jersey, Florida, and Georgia in the United States). Of specific importance are those children killed in the context of domestic violence and whether and how DVDRs operate with, or alongside of, child death reviews which have existed much longer (Jaffe, Campbell, Reif, Fairbairn, & David, 2017). While some jurisdictions are developing protocols to deal with the overlapping scope of these two types of reviews, DVDRs have developed parallel to child death reviews for the most part. However, many of the risk factors are similar and families experiencing violence are often facing similar obstacles and challenges that integrated reviews may be able to address more adequately (Jaffe et al., 2017). The review scope often depends on available resources, however.

A second consideration is whether all deaths meeting review criteria are examined or only a subset of cases and, if the latter, how the subset will be selected. Reviewing all deaths allows for accumulated knowledge about patterns over time and across subtypes (e.g. familicide, domestic-violence related filicide, homicide-suicide). This information is crucial to understanding emerging priorities for system improvements as well as practice, professional, and research concerns. However, breadth may mean that depth is lost (i.e. fewer details collected) which might mean vital nuances for assessing risk and safety are missed. Further, information required to understand differing contexts within which domestic homicides occur may also be missed, crucial for understanding risk and safety for marginalized or vulnerable populations (e.g. Indigenous, immigrant/refugee, and/or rural/remote victims). This approach also has the potential for prioritizing some victims over others and these more marginalized, and subsequently, vulnerable populations may be ignored, particularly if numbers are smaller. The best-case scenario, then, is to conduct both aggregate, quantitative analyses and more nuanced, context-based qualitative reviews to achieve a comprehensive understanding, which is the goal of such reviews.

**What is reviewed and whose voices are represented?**

There are variations in what is reviewed for each death, including the types of documents accessed and, ultimately, whose voices are heard – whether on paper or in person. Victims cannot speak for themselves, so who speaks for them, if anyone, and how this is determined by review committees is crucial but has received minimal attention. This is concerning because who gets to construct these events and what materials are used to do so has significant implications for understanding what happened which informs recommendations. In England and Wales, the involvement of the victim’s family, friends, and/or colleagues is specified in their review policy because it is recognized these individuals often have important information about barriers and shortfalls that contributed to the death of someone close to them (Mullane, 2017; Regan, Kelly, Morris, & Dibb, 2007). The decision to involve family and friends remains
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controversial, however, for at least three reasons. First, ethical issues are identified that stem from approaching and speaking with surviving family or friends who may be re-traumatized as a result, particularly if those conducting their interviews are not adequately trained (Mullane, 2017). Second, involving those close to victims requires additional time for team members, most of whom are volunteers. Finally, the time between domestic homicides and the reviews is often lengthy, meaning it can be difficult to locate surviving family members, which has both ethical and practical implications (Mullane, 2017).

Few disagree, however, that family members and friends may have the most information about the events leading to domestic homicides because victims do not always seek help from formal agencies or have access to the resources to do so even if they wished (particularly in rural and remote locations). Therefore, the voices of family and friends can be crucial to understanding a woman’s decisions about seeking help or not and understanding the responses she received if she did so. DVDRs are often the only forum, apart from a criminal trial if there is one, in which those significantly impacted by the death of a loved one can participate and seek answers about the domestic homicide. While many are often interviewed by police immediately after the incident, these same people may not get another chance to speak upon recovering from shock and reflecting on the circumstances. It is only then that they may be able to think more clearly about possible contributors, including system responses (or lack thereof) of which they may be aware, and the loss of this knowledge can weaken the review and recommendations that result.

There are several issues to consider if involving family and friends in the review process. First, there may be difficulties identifying whether and whom is the most reliable person to speak for the victim. Family is often narrowly defined to include close biological/kin connections rather than the often broader ‘family-like’ connections valued by women experiencing violence and/or who may be estranged from their biological/kin families. Second, there are ethical and social-psychological challenges to working with those who have experienced the loss of a loved one. These may include emotions about their own perceived failure to help the victim, their potential defensiveness, and their protectiveness of formal agencies. The latter may be due, in part, to their own intimidation by state and other professionals whom they may see as more of an authority. In the UK, AAFDA responds to these issues by supporting and guiding family members involved in domestic homicide reviews and is seen as an international best practice in involving family/friends in reviews.

What and how is information disseminated?

Two key types of outputs are common from DVDRs. First, descriptive data on all or a subset of domestic homicides that have occurred during the review period and, in some cases, historical statistical data from the time the DVDR was established (e.g. Ontario; Bugeja et al., 2017). The objective of doing so is to document common precursors or ‘red flags’ in domestic homicides which are often represented as risk factors. It is acknowledged that most initiatives do not conduct systematic research, including a comparison or reference group of non-lethal domestic violence cases, to discern whether a specific factor is a real risk or simply frequently present in cases reviewed (Websdale et al., 2017). Regardless, understanding common factors that precede killings or common characteristics of those involved can improve future responses.

The second key output of DVDRs are recommendations meant to facilitate system change, although the quality and quantity of those recommendations vary. For example, while some teams target all recommendations to specific organizations or agencies, other teams target just some or none at all. A few DVDRs direct recommendations to lead agencies who liaise with
various sectors to implement recommendations. At the very least, it is recognized that DVDRs must have the capacity to make recommendations which is a necessary, but not a sufficient, condition for system and social change. They must also have the capacity to monitor recommendation uptake and implementation.

Reports produced by DVDR teams are often made available to the public and released either annually, biannually, or at varying times throughout the review process (Bugeja et al., 2017). These reports typically contain information about how the DVDR functions, the number of deaths reviewed including descriptive data summarizing the characteristics of domestic homicides and those involved. The reports also frequently contain the recommendations generated from each case or collection of cases. While information varies across reports, most recognize it is essential that lessons learned from reviews are transmitted to the broader public which is done using recommendations and public reporting mechanisms.

Tracking and monitoring recommendations for update and implementation

Despite recommendations being the most concrete and tangible outcomes of DVDRs, there is a dearth of systematic research that sheds light on what improvements or changes have been recommended, how often similar recommendations are made, what sectors or organizations are tasked with implementing recommendations, or what outcomes and impacts have developed, if any, as a result. The lack of research can be attributed, in part, to the fact that few jurisdictions mandate responses to recommendations which makes monitoring implementation difficult (Bugeja, Dawson, McIntyre, & Walsh, 2015; Bugeja et al., 2017). This means that there is also a dearth of systematic knowledge about overall impacts of DVDRs, including accountability of agencies/organizations/sectors meant to improve responses.

Some DVDRs assign team members to take recommendations to organizations targeted whereas others report holding symposiums to synthesize and prioritize recommendations to facilitate the development of implementation plans. There is little information as to what are the outcomes of these two approaches or others that may be adopted. One exception is Victoria, Australia, who monitors recommendations through mechanisms in place for coronial investigations and their accompanying coroner’s act. Specifically, statutory bodies and entities must provide a response to recommendations within 90 days although their response can be a refusal or a decision to put the recommendation on hold (Coroner’s Court of Victoria, 2014). A second exception is the state of Iowa where legislation is enacted for this purpose. Other jurisdictions request, but do not mandate responses, including the District of Columbia and Ontario, Canada, where directors of agencies are asked to respond to recommendations within 60 days (Bugeja et al., 2017; Office of the Chief Coroner of Ontario, 2018).

One approach to increasing the uptake of recommendations by those targeted has been adopted by New Zealand (Tolmie et al., 2017). This review team reportedly undergoes extensive stakeholder engagement with agencies and sectors identified or targeted, including meetings with senior staff. The goal is to seek organizational feedback about how recommendations can be constructed to account for system constraints that may not be amenable to change because it involves multiple agencies with different processes, procedures, tools, disciplinary understandings, and resources. The philosophy of the New Zealand approach is that engaging with agencies prior to making recommendations, or during the construction of recommendations, ensures what is generated is practical and based on a solid understanding of the agency’s current processes (Tolmie et al., 2017). Obtaining prior agreement to a recommendation also increases agency buy-in and subsequent uptake. It is reported that this approach has contributed
to their initiative having a fair measure of success in recommendation implementation (Tolmie et al., 2017). Further, in this jurisdiction, in addition to the national recommendations, each death review results in local recommendations which are actioned at that level.

**Key ongoing challenges facing DVDRs**

**Accounting for and responding to intersecting oppressions**

Despite overall declines in domestic homicide in some world regions (e.g. North America), some groups of victims remain at high risk with little evidence of corresponding declines. Indigenous populations subject to historical and ongoing impacts of colonization, discrimination, and racism are disproportionately represented in domestic violence-related deaths, compared to non-Indigenous groups living in Australia, Canada, New Zealand, and the United States (Wilson, 2017). Similarly, African Americans in the United States (Bent-Goodley, 2013) and some regions of other countries, including Canada, also face high risk of domestic violence. Women living in rural and remote regions face higher risks than their urban counterparts (Dawson et al., 2018). Finally, immigrant and refugee women face unique challenges when experiencing violence which contributes to their marginalization and vulnerability (Dawson et al., 2018).

Given increased vulnerability to domestic homicide of these and other groups, it is crucial that DVDRs consider and speak to the intersecting oppressions experienced by many victims, perpetrators and their families. Specifically, Hobart (2004) argues that specific attention is needed to whether responses to varying experiences of violence are shaped by “institutional biases regarding race, poverty, literacy, language, immigration status, disability, age, culture, gender or sexual orientation” (p. 5). For example, among 43 DVDRs examined by Sheehy (2017), three required the committee composition to reflect the diversity of the jurisdiction, and another six required specific numbers of diversity appointees, sometimes naming the specific groups.

Given the vast overrepresentation of Indigenous women among victims of domestic homicide in Canada, Australia, New Zealand, and the US, more concerted efforts must be made by DVDRs to understand how colonialism and racism contributes to their increased marginalization and vulnerability. Some Indigenous communities have strategic ways of responding to domestic violence and have insights into the realities of Indigenous women’s lives that will be crucial to crafting recommendations. The New Zealand committee has reported to have adopted an inter-generational approach to domestic homicide, drawing upon the expertise of Māori communities, recognizing reviews must include both historical victims and those who follow and, specifically, the children left behind (Tolmie et al., 2017).

**The role of feminists and women’s advocates**

An ongoing criticism of many DVDRs is that there is little to no representation from a core group of experts who arguably have the greatest wealth of knowledge about domestic violence – feminist and/or frontline women’s advocates. In most jurisdictions, feminist and grassroots violence against women agencies were largely responsible for lobbying for the establishment of these initiatives. It is perplexing, then, their voices are not represented to a greater degree (Sheehy, 2017). Some teams recognize their actual and potential contributions and have ensured that their expert voices are at the table or, at least, in an advisory capacity. Such appointees are
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required in many US jurisdictions with some orders or statutes stipulating the eligibility of “a certified domestic violence center” (Alabama, 2009), “a domestic violence victim service agency” (Alaska, 2012), “domestic violence shelter service staff and battered women’s advocates” (California, 2012), or a “victim advocate” (Delaware, 2013) (Sheehy, 2017). However, Sheehy (2017) has argued that the proportion of total team members who are feminists or frontline advocates/workers remains small overall, meaning review teams may not have a clear or comprehensive understanding of the root causes of male violence against women.

Women’s advocates are also often better equipped than government and criminal justice representatives to speak to intersecting oppressions in women’s lives because they work directly for, and with, victims/survivors. Feminists and women’s advocates who work with women living in poverty and/or confronting racism are often able to underscore the role played by “class dimensions of patriarchy and white domination” (Richie, 2000). Similarly, feminist advocates can contribute to reviews’ considerations of other inequalities such as women with disabilities (Healey, Howe, Humphreys, Jennings, & Julian, 2008) and immigrant and refugee women fleeing male violence (Zannettino et al., 2013). The most urgent need for DVDRs, then, is to include the voices and expertise of Indigenous and racialized populations as well as feminist women’s advocates as permanent members of DVDRs so that particular cultural or community perspectives can fully inform the development of review processes and provide insight on individual reviews.

Documenting impacts

One of the key challenges moving forward is the limited systematic research examining the impact of DVDRs on prevention (Dawson, 2017a; Websdale et al., 2017). There is little to no evidence-based research examining associations among reviews, socio-legal change, and declining rates of domestic violence or homicide. There have been no large-scale environmental scans of the large number of reports produced internationally, capturing type, frequency, and content of recommendations generated by these review teams (but see Dawson, 2017a). Further, no research has followed up with those involved with DVDRs and the communities in which they operate to determine if changes have occurred as a result. Finally, there have been no matched, case-control studies that compare jurisdictions with and without DVDRs over an extended time period to determine if there has been system or social change.

In an earlier review, Watt (2010) reported anecdotal evidence that DVDRs have produced change through increased public education, media coverage of the release or dissemination of annual reports, improved cooperation across multiple sectors involved in responding to these cases, changes in law enforcement practices, and increasing funding for services. Some countries have also witnessed new laws, growing public disapproval of domestic violence, promising agency protocols and/or practices, more intensive and/or comprehensive coordinated community responses, and the emergence of risk and safety initiatives (Dawson, 2017a; Websdale et al., 2017). Many of these changes may be attributable to DVDRs, but it is not possible to know for sure given few efforts to track their impacts.

Most DVDRs indicate reducing domestic homicide is a core goal, but few teams report whether this has been achieved (Bugeja et al., 2015, 2017). In part, this is due to the inability to establish a causal relationship between the work of DVDRs and the incidence of subsequent domestic violence-related deaths. DVDRs are only one component of a larger set of reforms that have occurred which may, in turn, contribute to reducing domestic homicide. As such, isolating the independent contribution of DVDRs is difficult which raises the question of whether such a measure of success is appropriate and should be stated in the first place. Of course, the
long-term goal is to reduce such deaths, otherwise why conduct the reviews in the first place, but stating this as a primary outcome measure or overarching goal sets the initiatives up for failure if declines are not noted, or if increases are documented, particularly in the short term. Despite this complexity, many teams feel stating this goal remains important because it demonstrates domestic violence is unacceptable by society and it is preventable (Bugeja et al., 2015). In a sense, then, one of the more crucial roles played by DVDRs is that they send the message that domestic violence is an issue that requires attention and their existence, symbolically and practically, shows that responding to domestic violence requires all sectors and members of society to work collaboratively. The fact that findings of DVDRs regularly feature in local and national news strengthens this cultural effect, underscoring the preventable nature of such crimes rather than their more common representation as ‘isolated and episodic’ events that defy prevention. This raises the status of domestic violence as a serious social issue (Mullane, 2017).

**Opportunities**

The cultural transformation in how individuals and society think about domestic violence that led to the development of DVDRs has taken decades to achieve and, while there is much work left to be done, progress is undeniable. It may take a significant period of time before we understand the contributions of DVDRs to the prevention of domestic violence and homicide. Until then, the stated goal of DVDRs should be to strengthen domestic violence service systems through the development and implementation of recommendations and to monitor their impacts on systems over time. The research emphasis should be to describe what improvements are identified by reviews, examine uptake and implementation of recommendations, and to examine subsequent impacts on the systems they were meant to change. Only then will it be possible to determine what the impacts have been on the experiences of victims, perpetrators, and communities. In the meantime, various opportunities continue to present themselves through DVDRs which have had current and immediate impacts.

First, simply by establishing a DVDR, jurisdictions bring together a diverse set of actors who may not typically come together in a collaborative and consultative manner thereby becoming more familiar with each other and the constraints they work within. Ultimately, a better understanding of the roles they play separately and together is achieved by all involved. This educational aspect is built upon by the New Zealand team who regularly uses information from the death reviews to provide feedback to agencies on key practice issues as well as professional training (Wilson, Smith, Tolmie, & Haan, 2015). Second, DVDRs provide a unique opportunity to identify deficiencies in, and to work out mechanisms for enhancing, information. Third, the work of the DVDRs produces better data that can be disaggregated to more clearly understand the circumstances surrounding these deaths and those involved. The previous dearth of information in most countries has underscored the need for more accurate tracking of these cases and the violence prevention role that may be played by domestic violence death review teams (Bugeja et al., 2017). This need has been reiterated time and again by the United Nations Special Rapporteur on violence against women who urges countries to collect more data that can be disaggregated, especially by sex, and that can be standardized and aggregated over time (Vincent, 2014).

**Conclusion**

There have been significant social, cultural, and legal transformations in recent decades in how society perceives and responds to domestic violence and the rise of DVDRs which indicate a
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shift from reactive to preventative approaches. Historically, criminal investigations have been perceived as the primary mechanism for responding to domestic violence and homicide and, while they continue to be crucial, it is recognized that they do not act alone. Further, the work of DVDRs means that the role of responding sectors is now enhanced by information and knowledge gained from similar preceding deaths thereby learning from patterns and trends over time.

Currently, these initiatives exist largely in high-income countries, despite domestic violence being a serious social issue in low- to middle-income countries. Although child death reviews have been implemented more extensively across the world, it is not yet clear whether DVDRs can be usefully transferred to middle- and low-income countries, to different cultural milieus, or to countries with vastly different governance structures (Dawson, Mathews, Abrahams, & Campbell, 2017; Jaffe et al., 2017). The wholesale adoption of any of the current DVDR models may not be possible, and even the applicability of the process itself may have limited utility unless certain criteria within a country’s sociopolitical infrastructure are met. Perhaps the most significant factor influencing transferability is whether the systems of governance maintain and advance the philosophical position that violence against women is unacceptable. Where the systems of governance do not operate from this fundamental standpoint, individual death reviews would do little to ameliorate the experiences of domestic violence. In addition, other relevant considerations would be whether countries recognize that, as a public health problem, domestic violence is preventable; whether they have the infrastructure required to conduct such reviews (e.g. resources, means of data collection, legal governance); and whether they have the ability or power to implement any recommendations made.

Since DVDRs are largely in their infancy in terms of evolution in most of the jurisdictions in which they operate, there are valuable opportunities for international dialogues on good practices that have evolved and how we might better understand their impacts on the populations they are meant to help. Currently, DVDRs are the only mechanism available to review these deaths, particularly those ending in the suicide of the perpetrator. Arguably, however, investigations with the goal of solving a crime and proceeding to trial have different mandates than the reviews themselves – the latter of which is focused solely on prevention – and so their potential for reducing all domestic-violence related deaths is clear. Only with systematic research on their processes and impacts can DVDRs achieve their potential and this should be the research and practice priority as they head into the next decade.

Critical findings

• Key considerations for the establishment and operation of domestic violence death reviews (DVDRs) and the research that results are governance models, team composition, review scope, whose voices are represented what and how information is disseminated, and how recommendations generated will be tracked and monitored.
• Key challenges of these initiatives are accounting for and responding to victims, perpetrators and communities experiencing violence who have intersecting oppressions; ensuring the diversity and inclusiveness of voices in the reviews; and documenting outcomes and impacts of recommendations and their ability to achieve system and social change.
• Key opportunities are the cultural transformation facilitated by the rise of these initiatives both practically and symbolically; their ability to bring together a diverse set of individuals and groups who respond to domestic violence; enhancement of information sharing across groups and sectors to allow for better responses to those experiencing violence; and better data on domestic violence-related deaths, given they are currently the only mechanism with such a mandate.
Implications for practice, policy, and research

- While similar in many ways, DVDRs differ along important dimensions that make it difficult to identify good practices; therefore, it is imperative to begin more systematically sharing existing knowledge by expanding networks across national and international jurisdictions.
- Policy development will remain a challenge until jurisdictions begin to mandate responses to recommendations and develop mechanisms for tracking and monitoring responses to recommendations by the agencies targeted.
- Future research to provide a more comprehensive understanding of the core elements of death review initiatives, move recommendations from the development to implementation stage, and ensure systematic examination of their impacts on systems and social change is a priority.

Note

1 The terms ‘domestic violence’ and ‘domestic homicide’ are used, given they are the most commonly referenced in related death review initiatives. It is acknowledged, however, that other terms may be more accurate such as intimate partner femicide, given that most of the cases reviewed are women killed by current or former male partners.

References

Domestic homicide review processes


Watt, K. E. (2010). Domestic violence fatality review teams: Collaborative efforts to end intimate partner femicide (D Phil Psychology). University of Illinois, Urbana–Champaign.


