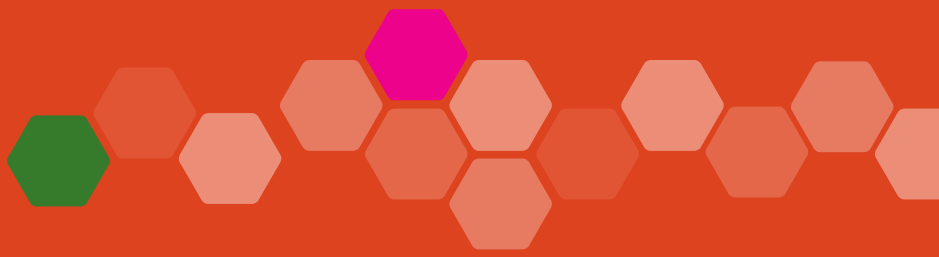
Scottish Government
Riaghaltas na h-Alba

Domestic Homicide Reviews - Evidence Briefing



CRIME AND JUSTICE

social research

Contents

Abbreviations

CPR	Child Practice Review
DA	Domestic Abuse
DHR	Domestic Homicide Review
DVDRT	Domestic Violence Death Review Team
EHM	European Homicide Monitor
EIGE	European Institute for Gender Equality
EQIA	Equality Impact Assessment
FHM	Finnish Homicide Monitor
NADVFRT	Native American Domestic Violence Fatality Review Team
NSW	New South Wales
UN	United Nations
USA	United States of America

Summary

This evidence briefing has been prepared to inform the initial stage of thinking around the development of a Domestic Homicide Review (DHR) model for Scotland.

A DHR is a multi-agency review that aims to identify trends and patterns, reduce domestic homicides, improve agencies' responses to domestic abuse and, in some cases, give a voice to victims and their families.

The DHR model of 17 jurisdictions (across seven countries) was considered for this briefing. While the overall aim and approach is very similar across jurisdictions, there is variation in the scope and implementation of DHRs, for example:

- Legislation and governance of the process differ, with most jurisdictions having established specific legislation, but some establishing DHR under coronial mandate as part of the remit of an Ombudsman or as a pilot to review historical cases.
- While all jurisdictions include intimate partner homicide within case selection criteria, there is variation in the inclusion of family homicide, suicide, bystander or near deaths.
- Multi-agency panels can be established at jurisdictions level or at a local level, with some panels consisting of dedicated permanent teams, while others are established ad-hoc.
- There are different ways and levels of inclusion of family and friends of the victim (and perpetrator) in the DHR process.
- Reports can be written for each case, annually or biennially. Sometimes reporting is more ad hoc.

In-depth analysis of the DHR methodologies and data was not the focus of this briefing, but some clear similarities were found across jurisdictions, with a focus on building case chronologies, scoping out involvement of agencies and evaluating information sharing and collaboration. More critical gendered analysis of the overall system (and society) appears limited.

Important aspects to take into account when considering a Scottish DHR model include:

- Clarity of purpose and aim, and an appropriate process that can address these, for example a Theory of Change;

- Clarity of inclusion criteria and justifications for the case selection process;
- Clarity on the roles, responsibilities and oversight of the DHR;
- Consideration of including family (and friends) in the review process and what their contribution will look like, taking into account concerns around the family's experience of loss and the risk of further traumatisation.
- Establishment of a common and regularly collated data set, and systematic data collection and analysis, to enable the identification of developing trends and patterns;
- Clear recommendations targeted at individual and collective agency level, and inter-agency working/communication, with an agreed action plan and a body responsible for monitoring progress in response;
- An approach to evaluation of the DHR model and its outcomes, to understand its impact and allow improvements to be made.

Apart from domestic homicide reviews, there are other initiatives that do not include a multi-agency review, but instead gather systematic data on domestic homicides and identify trends, such as Homicide Monitors in Finland, Sweden and the Netherlands, and the 'delegation for victims' report in France.

1. Introduction

Domestic abuse is a pervasive societal problem across geographies. At its most extreme domestic abuse can lead to a fatality, also called a domestic homicide. There are multiple definitions of domestic homicide but it will always include intimate partner homicide[1]. Intimate partner homicides are perpetrated predominantly against women (femicide) (Beguja et al. 2017). Some definitions might also include wider family violence – homicides in the context of family relations – or any homicide (including the death of bystanders) where there was a domestic abuse context. In Scotland, domestic abuse is defined in the Domestic Abuse (Scotland) Act 2018 as[2]:

Person ("A") engages in a course of behaviour which is abusive of A's partner or ex-partner ("B"), and both of the further conditions are met:

- That a reasonable person would consider the course of behaviour to be likely to cause B to suffer physical or psychological harm,
- That either—
    - A intends by the course of behaviour to cause B to suffer physical or psychological harm, or
    - A is reckless as to whether the course of behaviour causes B to suffer physical or psychological harm.

In the further conditions, the references to psychological harm include fear, alarm and distress.

One mechanism to address domestic homicides is a Domestic Homicide Review (DHR). The first domestic homicide reviews were established in the United States, and have since been implemented in other countries such as England, Canada, Australia and New Zealand. A DHR is a multi-agency review that aims to reduce domestic homicides and improve agencies' responses to domestic abuse. It offers "*the opportunity for systemic and structural changes, as well as increased public awareness, particularly in the local areas where the domestic homicide occurred, although [DHRs] have utility beyond the local context*" (Jones et al. 2022). While there is variation in how a DHR is conducted in different jurisdictions, in general there seem to be three common elements to a domestic homicide review:

[1] Intimate partner homicide refers to a homicide where the victim and offender have a current or former intimate relationship.

[2] Domestic Abuse (Scotland) Act 2018

1. Gathering data on all domestic homicides to understand trends, such as the gender and age of those involved in a homicide, where homicides take place and whether victims and perpetrators had contact with any agencies leading up to the homicide.
2. Undertaking an in-depth review of (a selection of) cases to understand the timeline and background leading up to a homicide. The process focuses on tracking the way a case flows through systems focusing not on apportioning blame but on improving collaboration and learning across agencies.
3. Centre the victim's story by "*offering an alternative to the 'forensic narrative*'" (Rowlands 2020a p. 25), providing an account from the victim's perspective.

1.1 Current context in Scotland

While England, Wales and Northern Ireland all conduct DHRs, in Scotland there currently is no established multi-agency DHR process. Equally Safe, Scotland's strategy for preventing and eradicating violence against women and girls, includes within the Delivery Plan, a commitment to "*develop multi-agency domestic homicide reviews with Police Scotland and partners learning from practice in other jurisdictions which have allowed for improvements in practice"*[3].

Police Scotland have undertaken reviews in the case of domestic homicides[4] since 2014. The process originally instigated a full review on every occasion. Currently, an initial internal review will be undertaken to scrutinize any prior police contact with either the victim or the perpetrator. It will be completed within 7 days after every domestic homicide and determine whether or not a full review is required. Where there has been prior police contact, this will almost always result in a full review. A full review will include partner agency engagement where it is established the victim or perpetrator was in contact with them. Whilst there is no statutory obligation to participate, the partners have always elected to provide information to capture learning. The reviews are aimed at identifying learning and delivering recommendations which are recorded and actioned.

[3] Equally Safe: Year One Update Report

[4] Homicides in the context of intimate partner relationships.

Scotland's homicide statistics[5] shows that in 2021-2022 there were 11 victims of intimate partner violence: nine female victims and two male victims. There were 8 victims of wider family violence. Of these, four victims (all male) were killed by their child and four (3 female and one male) by another relative. All victims were 16 or over.

In the last ten years (2012-2022) the largest proportion of female victims of homicide have been killed by their (ex)partner: 62 of 148 female victims (42%). 28 of 148 female victims were killed by a relative (19%). Men are most likely to be killed by an acquaintance (253 of 454 victims or 56%), although in the last ten years there were 21 male victims killed by their (ex)partner (5% of total male victims) and 35 by a relative (8%). Of those victims (both female and male) that were killed by a relative, 20 were younger than 16 (9 female, all killed by their parent; and 11 male, 10 killed by their parent, one by another relative).

To understand these homicide figures better and help in the prevention of domestic homicides a DHR model for Scotland is being considered. This evidence briefing aims to inform the discussion and develop the evidence base from which to develop a Domestic Homicide Review model for Scotland.

It is also worth noting that in Scotland there are a number of death review processes already in place such as Child Protection Committee Learning Reviews and Alcohol Deaths Reviews. The approach taken in Scotland will need to be cognisant of these to ensure the DHR model dovetails with pre-existing (non-accidental) death review models.

1.2 Methodology

This evidence briefing supports the initial stage of thinking around a DHR model for Scotland. At the time of writing, the scope of the Scottish domestic homicide review has not yet been defined and as such this evidence briefing approaches DHR in its widest sense, to support refining the definition for Scotland as the model develops. To understand the diversity in DHR models and to review good practice, this evidence briefing focuses on three areas:

1. **International comparison:** A high-level comparison was made of 17 different jurisdictions' models to domestic homicide reviews[6].

[5] Homicide in Scotland 2021-22

[6] The jurisdictions that are included are: Australia – South Australia, Western Australia and New South Wales; Canada – British Columbia, Saskatchewan, Ontario; England; New

Information was sought on legislation, aim of the DHR, case selection criteria, the process and governance of the DHR, timeframes, dissemination of the reviews, monitoring and evaluation, and costs. The sources that were used were government websites, websites of the relevant DHR, and publicly available DHR reports in different jurisdictions (see Annex 2). The information is presented in Annex 1, and a summary of each theme is provided in sections 2 to 5 of this report.

2. **Academic research and recommendations:** Academic literature of research conducted into different DHR models was reviewed. A literature search was conducted using the KandE search engine, searching for literature on DHRs published between 2015-2022[7]. This led to two different types of studies: those focused on evaluating the DHR process and different types of models, and those focused on using DHRs to analyse domestic homicide/abuse. As the aim of this evidence briefing was to support thinking around a DHR model for Scotland, only the first type of studies, evaluating (aspects of) the DHR process, were included. In total 14 academic journals or book chapters were considered, which included (systematic) reviews of DHR models, studies interviewing practitioners, (case) studies of specific DHR models and reflections from both academic and practitioners working in the field. An overview of the literature can be found in Annex 2. The findings and recommendations from these studies are included throughout sections 2 to 5.
3. **Alternative models:** Information on alternative frameworks with similar aims as a DHR was considered. To determine whether there were other approaches to understanding domestic homicides, a quick scan was carried out, using “domestic homicide monitoring” and “femicide monitoring” search terms. The website of the European Institute for Gender Equality (EIGE)[8] provided an overview of approaches in different countries, of which the Homicide monitor and the Délégation

Zealand; Northern Ireland, Portugal, USA – Colorado, Delaware, Maryland, Montana, Vermont and Washington; Wales.

The selection of states in Australia, Canada and the USA is based on available information, comparable population size to Scotland and comparable domestic homicide numbers to Scotland. A mix was also sought in different types of legislative approaches.

[7] Initial search terms included “domestic homicide review”; “domestic violence fatality review” or “family death review”. This gave limited results, and a wider search was conducted with the search terms “Domestic Homicide” AND “Death review” OR “Review”. Suggestions were also provided by James Rowlands, an academic in the field of DHR research.

[8] European Institute for Gender Equality

aux Victimes Intimate Partner Violence reporting showed similar aims as the DHR. These are discussed in section 6.

1.3 Scope and limitations

This evidence briefing aims to provide a high-level overview of different DHR models as well as lessons learned identified in the academic literature. It does not provide in-depth analysis of all DHR models in use internationally. The briefing also does not provide a systematic review of all academic literature on this topic. The briefing included literature discussing the DHR *process*, and particularly focused on discussions of strengths and weaknesses of the process and suggestions for improvement.

The description of the DHR models are generic and limited to the available information online. Some of the processes that are described in official documents might in practice play out slightly differently. There was a specific lack of information found on monitoring and evaluation of DHRs, however, that does not mean that none of the jurisdictions have processes in place and models might have been internally reviewed. The themes across the academic literature and the country-specific findings are nevertheless similar, which suggests that the high-level overview provided in this briefing does provide an up to date picture of a range of different DHR models and the potential strengths and risks to consider.

The briefing also discusses some other approaches to gathering and analysing domestic homicide data, although no substantial literature research was carried out given the specific scope of this work.

2. The purpose of a Domestic Homicide Review (DHR)

Key findings:

The overall aim of a DHR is similar across the 17 jurisdictions covered in this briefing, which is to understand the system's response to domestic abuse to learn from and prevent domestic homicide deaths. To reach this overarching goal jurisdictions conduct a multi-agency review to understand patterns and trends, identify learnings and provide recommendations for improving policy and services.

The evidence suggests that there is , however, a lack of awareness on some of the assumptions underlying DHRs. Differences in understanding of the purpose of a DHR can affect the kind of learning and recommendations produced. To ensure a shared understanding of the purpose of the DHR, the literature recommends to articulate a Theory of Change to underpin the DHR model.

Although there are different approaches to DHRs internationally, the purpose is generally the same: to understand the system's response to domestic abuse and prevent and/or reduce domestic homicide deaths in the future. A description of the aims of DHRs in each jurisdiction is given in table 1 in Annex 1.

One of the overaching goals of the Australian Domestic and Family Violence Death Review Network includes: "identifying practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths"

Source: Australian Domestic and Family Violence Death Review Network Data Report – Intimate partner violence homicides 2010-2018

The Domestic Violence Fatality Review of Washington (US) states its purpose as: "To understand how systems and communities are or are not effective in responding to domestic violence victims and abusers. Through deeply examining one individual victim's experience, review teams bring to light how systems respond to all survivors and abusers."

Source: Washington State Domestic Violence Fatality Review

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The purpose of the DHR in England is defined as:

a) “to establish lessons to be learned (..) for the way local professionals and organisations can work individually and together to safeguard victims;
b) identify lessons both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
c) apply these lessons to improve service responses;
d) prevent domestic violence homicide and improve service responses (…) by developing a co-ordinated multi-agency approach (…);
e) contribute to a better understanding of the nature of domestic violence and abuse;
f) highlight good practice.”

Source: Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, UK Government

Although often not specifically mentioned in the legislation or DHR guidance, one underlying reason for establishing a DHR is to give victims (and their families) a voice. Some reports for example start with an “in memoriam”, remembering the victims of domestic homicide.

A DHR allows for multi-agency communication and in-depth understanding of the (events leading up to the) incident. The literature points out, however, that there can be a lack of awareness of some of the assumptions underlying DHRs. Reviewing the DHR process in England, Rowlands (2020a) concluded that it is for example not clear “*how the narrative of a homicide is generated during the DHR process and then represented in the final published documents”.* (p. 25). Rowlands (2021) examined UK Government policy documents to understand the justifications for the implementation of DHRs. In his analysis, Rowlands points out that DHRs were rendered as common-sense and “a taken-for-granted good”. This might mean that “*the risks and opportunities of DHRs are left unrecognized*” (Rowlands 2021 p. 13), for example in understanding how panels operate and make sense of the deaths that are reviewed.

Rowlands’ (2021) analysis also suggests that while victims were viewed as the object of concern, they were presented “*as the “Other” and, for the most part, rendered silent and denuded of subjectivity and agency*” (Rowlands 2021 p. 7). Yet, one of the aims of the DHR across several of the 17 jurisdictions, is

that the victim's story is central, and that the DHR can offer an alternative narrative to the forensic one (Rowlands 2020). Rowlands (2021) argues that if the main aim is to increase understanding of victim and perpetrator characteristics and to improve system responses, then the focus of a DHR can be on agency and professional learning. However, he points out that if there is also the aim to challenge the forensic narrative of domestic homicide, the DHR will need to take a more victim-centred approach (Rowlands 2021).

Differences in understanding of the purpose of a DHR can affect the kind of learning and recommendations produced. To ensure that there is a shared understanding, Rowlands (2020) recommends that a Theory of Change[9] is developed to underpin the DHR process. A clearly articulated Theory of Change would "*require interrogation so that how and why an intervention work can be clearly articulated*" (Rowlands and Cook 2022, p. 560).

[9] A theory of change is a process of thinking through, and providing a description on, how a program or intervention is supposed to work, why it will work, who it will benefit, and in what way, and the conditions required for success. It provides a description (or illustration) of the context, the activities involved, and how these interlink and will produce results to achieve the intended impact.

3. Legislating Domestic Homicide Reviews and Selecting Cases

3.1 Legislation

Key findings:

Legislation has been established for the DHR in 11 out of 17 jurisdictions specific. Responsibility for the overall DHR process tends to sit within national/state government or specific aspects of the justice sector (e.g. the coroner's office or the Attorney General's office).

The most common approach for establishing DHRs is by legislation. 11 out of 17 jurisdictions examined for this briefing have specific legislation in place. England, Wales, Northern-Ireland, New Zealand and Portugal all have national legislation governing the process. In the USA, Canada and Australia the reviews are managed at state/territory level, with some states having established specific legislation while others have provided a mandate to either the Coroner's office or Ombudsman to carry out DHRs. The different statutory approaches are listed in Table 1.

Table 1: Legislative approaches to DHR

Legislative Approach	Number of Jurisdictions
Specific legislation (Act) establishing DHR	11
Legislation establishing death reviews in general	1
Under Coronial Mandate	3
As part of the remit of the Ombudsman	1
As a pilot	1

For a description of the legislation for each jurisdiction, please see table 1 in Annex 1.

In a literature review conducted in 2015, Bugeja et al. (2015) showed that of the 25 jurisdictions[10] they identified as implementing DHRs, 13 had a statute,

[10] The study identified 25 jurisdictions that had a DHR process in place either at a national or state/territory level. It does, however, not specify which 25 jurisdictions these are. In total there were 18 USA jurisdictions identified, three Australian jurisdictions, two Canadian

code, or executive order to establish a DHR. Five jurisdictions had a statute, code or executive order which enabled the establishment of DHRs but did not require it. The remaining 7 jurisdictions had no statute, code or executive order.

Responsibility for the overall DHR process tends to sit within national/state government or specific aspects of the justice sector (e.g. the coroner's office or the Attorney General's office). In some cases a specific commission, board or council has been established that governs the review process.

3.2 Case selection

Key findings:

There are differences in the type of homicide cases covered by DHRs amongst jurisdictions. All jurisdictions include intimate partner homicide, but there is variation in the inclusion of homicide by family members, homicide-suicide cases, death of bystanders, near deaths and suicide.

There is also a difference in whether all cases that meet the criteria are reviewed, or only a selection. When a selection is made for in-depth case review, the review team does gather basic quantitative data (e.g. demographic data) on all cases to establish trends over time.

The literature highlights that it is important that the selection criteria are clear and the process of selecting cases transparent.

With or without specific legislation, next to a clear established aim of the DHR, the literature highlights the importance of jurisdictions clearly defining which cases are eligible for conducting a review. How case selection criteria are defined varies across the 17 jurisdictions considered in this briefing (see table 2 in Annex 1 for the criteria for each jurisdiction). Similar to Bugeja et al. (2015) research findings, the dominant focus of domestic homicide reviews in the 17 countries covered is on intimate partner homicides.

In 10 of the 17 jurisdictions reviewed, homicide by family members was also included (although some exclude child deaths). In seven jurisdictions there was a specific mention of including homicide-suicide cases (where the perpetrator commits suicide after committing murder or assault). Six jurisdictions included death of bystanders, for example when a police officer or

jurisdictions as well as New Zealand and the UK. The jurisdictions that did not have legislation in place were either in the USA (four jurisdictions), Australia (two jurisdictions) or Canada (one jurisdiction).

professional intervened. Near deaths were mentioned in five jurisdictions. It should be noted that some of these numbers could be higher, as case selection may be more flexible in practice.

In Ontario, Canada, the Domestic Violence Death Review Committee covers domestic violence death, which are defined as "all homicides that involve the death of a person, and/or his or her child(ren) committed by the person's partner or ex-partner from an intimate relationship." However, at the discretion of the chair, the review team may also look at near-deaths.

New Zealand has a broader definition, and their Family Violence Death Review Committee looks at "family violence deaths", which are defined as: "the unnatural death of a person (adult or child) where the suspected offender(s) is a family or extended family member, caregiver, intimate partner, previous partner of the victim, or previous partner of the victim's current partner, and where the death was an episode of family violence and/or there is an identifiable history of family violence". Excluded from this definition are: non-family member bystanders or interveners, suicides, suicide-assisted deaths, and deaths from chronic illness associated with family violence.

In Delaware, USA, cases can cover both homicides and suicides resulting from domestic violence. The victim can be the domestic violence victim, perpetrator, or a by-stander as long as the death or near death (life-threatening injuries) was a result of domestic violence, meaning either intimate partner violence or violence between family members.

Some reviews have started to incorporate suicide (in a domestic abuse context), including five of the jurisdictions analysed for this briefing. However, as Jones et al. (2022) point out, establishing domestic abuse as causal in suicide can be difficult, as is obtaining a verdict of suicide. They argue that there is a need to further develop our understanding of the relationship between suicide and victims of domestic abuse (Jones et al. 2022).

Bugeja et al. (2015) mention that the broader the criteria (and the more deaths that are included in a review), the greater the likelihood that system gaps will be identified and addressed. Fairnbairn et al. (2017) add that any definition should strive to represent a full picture of domestic homicides, although it is inevitable that boundaries are drawn. On the other hand, broader inclusion criteria (e.g. family relationships instead of only intimate partner homicide) could lead to overlap with other types of reviews (see Section 4.4).

Regardless of the specific criteria, Fairnbairn et al. (2017) point out that the inclusion criteria of cases and justification for the selection process should be clear, and the case selection process should be transparent. They argue that while these criteria are often specified on paper, in practice it is not always clear how choices of inclusion and exclusion are made (Fairnbairn et al. 2017).

In many jurisdictions, due to legislated mandates, data availability, or resource availability, only a selection of all domestic homicides is considered for review. Moreover, while some jurisdictions review cases that are still being processed through the justice system, others only review 'cold cases'. When a selection is made for in-depth case review, the review team does gather basic quantitative data (e.g. demographic data) on all cases to establish trends over time. In a pilot that ran from 2015 to 2018 in Saskatchewan, Canada, for example, of the 48 deaths identified, 6 were reviewed in-depth. Other examples are New Zealand, where three to four cases are reviewed per year and Montana, USA, where two review committees each review two cases per year[11]. Cases are usually selected based on their learning potential (Dale et al. 2017). This raises an ethical dilemma, why some deaths are considered and others not (Rowlands 2020a). Jones et al (2022 p. 4) draw attention to the importance of ensuring that the selection "*is representative of different types of domestic homicide in diverse communities*". They recommend that reviews should aim to include a sample that is both representative and embraces diversity (Jones et al. 2022).

[11] In New Zealand the Sixth Report of the review committee shows that between 2009-2017 there were 230 family violence deaths (average of 29 per year).

Montana recorded 200 fatalities between 2000-2018 (average of 11 per year) due to intimate partner violence (See Montana Domestic Violence Fatality Review Commissions Report to the Legislature (2019))

4. The Process of Conducting a Review

Implementing a DHR and establishing its process requires consideration of several aspects, including the setup of the panel, who is included, what methodology is used, whether family will be involved and how other death reviews might interact with the DHR. The following sections will address these questions. Table 3 in Annex 1 provides an overview of the DHR process for each jurisdiction.

4.1 Review panels

Key findings:

Most jurisdictions work with a multi-agency panel, with representation by police, ministerial departments, health providers, domestic abuse service providers, victim advocates and domestic abuse experts. The panel can be established at jurisdiction or local level and can be a permanent team or created ad hoc.

The literature suggests that membership of these multi-disciplinary panels should be inclusive and culturally sensitive. Moreover, clarity on roles and responsibilities and, especially where there are multiple local panels operating under the same model, of the DHR process is important. Lack of clear guidance might lead to differences in how DHRs are conducted, what type of information is gathered and what is reported upon.

Most jurisdictions' DHRs operate on a multi-agency basis, with the majority including representation by police, ministerial departments, health providers, domestic abuse service providers, victim advocates and domestic abuse experts (e.g. academics). Other approaches include South Australia, for example, where a research officer is responsible for gathering information on domestic homicides, which can lead to a coronial inquest, where different agencies will be called to 'give evidence'. In West Australia the Ombudsman is responsible for DHRs. The office of the ombudsman will work with all agencies involved and is supported by an advisory panel.

Multi-agency teams can be established at a jurisdiction-wide or at a local level, and can either be dedicated, permanent teams or established ad-hoc as required. The literature suggests that permanent panels can allow for a good team dynamic to develop and skill development, while ad hoc panels can allow for a greater number of professionals to gain experience with DHRs (Rowlands 2020a). In most cases where teams operate on a local level, there is an overall team or board that pulls together the results of the different

reviews at jurisdiction level. The literature suggests that an overarching body to draw together all the learning of local teams and identify recommendations is important for understanding the overall impact of the DHRs. In the cases of Australia, Canada and the USA, where DHRs are regulated at state-level, there is a country-wide network to support cross-jurisdiction learning.

Either permanent or ad hoc, at local or jurisdiction level, the literature suggests that membership of these multi-disciplinary panels should be "*inclusive rather than exclusive*" (Websdale 2020) and should be culturally sensitive. This latter point is important, as often wider factors such as discrimination, stereotypes and structural oppression might play a role and it is important to consider these (Jones et al. 2022). Rowlands (2020a) and Websdale (2020) point out there is a critical role for domestic violence specialists in helping panel members to understand the complexity of domestic violence.

Haines-Delmont et al. (2022) showed that in England and Wales, some professionals felt there was a lack of diversity and input, particularly from third sector specialist domestic abuse agencies. Jones et al. (2022) point out that setting up a multi-agency team will require transparency and honesty about tensions that can arise between members of a review team, acknowledging different organisational priorities and practices. They point out the need for a shared language and standardised terminology (Jones et al. 2022).

The literature also highlights the need for clarity on the roles and processes of the DHRs. Boughton (2021) point out that in England, the Home Office guidance for example states that the DHR panel must meet "an appropriate number of times", but no further commentary is made what is considered appropriate. Boughton's study showed that the role of the panel member and the Individual Management Review author in the English model also remain unclear. The guidance states who should be considered for the roles, but there is very little reference to the responsibilities of the role (Boughton 2021). Rowlands (2020a) argues that when reviews are implemented by multiple local teams this lack of clear guidance might lead to differences in how DHRs are conducted, what type of information is gathered and what is reported upon. For example, in England and Wales the timeframe that a review covers (i.e. how far a review looks back) seem to vary (Jones et al. 2022).

In several jurisdictions guidance stipulates that members of the panel should be of an 'appropriate level of seniority'. Reviewing this guidance in England

and Wales, Boughton (2021) suggest that this has however led to participants being concerned that senior members might not have the knowledge of 'on the ground' processes. Other reviews, such as the Welsh Child Practice Review (CPR), recognise this and take a different approach, with CPRs holding at least two Learning Events per review, one for management and one for practitioners directly involved in the case (Boughton 2021). A core philosophy of the DHR is that it should not blame and shame individuals. However, in practice it has been reported that professionals can be defensive and try to shift responsibility, as there can be "*a tension for representatives from organisations between what their organisation will allow them to say, the shifting of blame and the Chair's final report*" (Haines-Delmont et al. 2022).

In most of the jurisdictions, the chair of the review team/committee has a significant role to play. The chair's skills and experience in dealing with sensitive and contentious issues are therefore important enablers of the DHR process (Haines-Delmont et al. 2020). Haines-Delmont et al. (2020) point out that it can be advantageous to have an independent chair, although this might require significant resources, and the chair might lack some knowledge on the local context.

4.2 Review process and methodologies

Key findings:

Broadly speaking the different jurisdictions tend to follow the same general process and use similar methodologies. These includes constructing a timeline, identifying agencies and individuals that the victim (and perpetrator) had contact with, and evaluating the sharing of information and collaboration between agencies.

Addressing privacy and confidentiality is an important aspect to consider when establishing a DHR. The literature suggests that teams should follow the "do no harm" principle and accessing information should not undermine confidence of victims in advocacy services.

Other aspects that are considered important, particularly for sustainability of the DHR, are review teams' capacity and resources as well as effective oversight and leadership.

Although there is variation in the exact process followed by the DHR models in different jurisdictions, in general the process will observe the following steps:

- Team or those responsible for deciding whether a DHR takes place receives information on domestic homicides;

- A DHR is initiated (if a jurisdiction works with ad hoc teams, a DHR team is established and a terms of reference is produced);
- Information is gathered from records and requested from agencies who have had contact with the victim and/or perpetrator;
- Family and friends are asked to provide information about the victim's (and perpetrator's) life;
- A meeting is called, bringing together the review team;
- The team reviews the information, establishing a time-line of events leading up to the homicide;
- Recommendations are formulated and reported on.

Often jurisdiction-wide panels will work with a two-tiered mixed methods data collection process: collecting standardised quantitative data on all domestic homicide cases and conducting in-depth qualitative reviews on a selection of cases.

In New South Wales, Australia, the Domestic Violence Death Review Team (DVDRT) is a multi-agency committee convened by the State Coroner, bringing together representatives from key government agencies, non-government service providers and sector experts.

The DVDRT reviews individual closed cases and identifies systemic issues; it understands domestic and family violence as a complex, intergenerational and 'wicked' problem that requires complex responses that reach across government, non-government and community actors. It takes a two-tiered approach to analyse the cases:

- Tier 1: 'real time' domestic violence homicide dataset (for quantitative data analysis)
- Tier 2: Examination of in-depth case reviews (qualitative data analysis), following a comprehensive examination and analysis of all available case material. The secretariat prepares a case review report, which is examined by the team in a series of workshops. Recommendations are developed in consultation with agencies.

Broadly speaking, most DHR models use the same methodologies for in-depth reviews. In general a timeline is constructed, agencies and individuals identified that the victim (and perpetrator) had contact with, and information sharing and collaboration between agencies is evaluated (Dale et al. 2017; Rowlands 2020a; Websdale 2020). Teams "*identify 'red flags' or risk markers*

in the relationship [between the victim and perpetrator] that may have indicated an elevated level of danger" (Dale et al. 2017 p. 230). Some reviews will consider a broader context such as situational factors, broader social structures and cultural values and beliefs (Rowlands 2020a, Websdale 2020).

To conduct a DHR the review panel is dependent on receiving information from agencies, which will include personal information on victim and perpetrator. There are different approaches taken to confidentiality and privacy and how individual case information is accessed and shared. The literature suggests that teams should follow the "do no harm" principle and accessing information should not undermine general confidence of victims in service providers. Dale et al. (2017) point out that absolute confidentiality is seen as important, during the review process. In a number of jurisdictions panel members will sign confidentiality agreements to ensure privacy is protected and an open discussion is guaranteed. Many reviews will also only report aggregated data and learning, to protect the privacy of those involved. This may create a tension, however, with giving the victim's voice a central role which could mean that "*the uniqueness of each person's story is lost*" (Rowlands 2020a p.32).

Review teams' capacity and resources are key issues for sustainability, as are effective oversight and leadership. DHRs are resource intensive and unstable funding has led in some jurisdictions to difficulties in producing reports consistently (Jones et al. 2022). Jones et al. (2022) note a tension between speed and thoroughness, and with little known about how proposed timeframes play out in practice, there is a need to better understand these (Rowlands 2020a). Boughton (2021) found that due to Community Safety Partnerships in England and Wales (who conduct the DHRs) having to continuously balance their finances, it can sometimes lead to the decision to not review a case, even though the case would fall within the selection criteria.

4.2.1 A gendered approach

Key findings:

Domestic abuse and domestic homicide is a gendered issue.The literature suggests the need for a focus on the gendered dynamics of domestic homicides.

Establishment of DHRs have often come about through involvement of feminist advocacy and in several jurisdictions the DHR is embedded in the government's strategy for tackling violence against women.

It is less clear if a gendered approach is taken when conducting a DHR. In the 17 jurisdictions included in this briefing data is presented disaggregated by sex. However, other studies pointed out that a feminist perspective or methodology seems almost entirely absent from the process. While some reports highlight gendered drivers and impacts of domestic abuse, most recommendations tend to focus on service provision or risk assessment rather than on structural inequalities.

Domestic abuse and domestic homicide is a gendered issue. While the majority of homicide victims are men, most victims of intimate partner homicide are women (Haines-Delmont et al. 2022). Moreover, a UN study showed that in 2021 women and girls were most likely to be killed by a member of their own family (UNODC and UN Women 2022)[12]. With this in mind, Sheeny (2017) argues that a feminist lens of analysis is necessary which focuses on the gendered dynamics of domestic homicide and societal barriers to change.

Although an in-depth analysis of the DHR methodologies and data representation is out of the scope of this briefing, a quick scan of the 17 jurisdictions did show an acknowledgement of the gendered dimension of domestic abuse and homicides, especially when establishing a DHR model. The establishment of DHRs often came about through involvement of feminist advocacy, and in several jurisdictions it is embedded in government's strategy tackling violence against women.

[12] Of the 81100 women intentionally killed in 2021, approximately 56% were killed by intimate partners or family members. It is compared to male homicides, where only 11% is perpetrated in the private sphere.

In Scotland, in the last ten years (2012-2022) female victims are most often killed by their (ex)partner, 62 of 148 female victims (42%). 28 of 148 female victims were killed by a relative (19%). Men are most likely to be killed by an acquaintance and in the last ten years there were 21 male victims killed by their (ex)partner (5% of total male victims) and 35 by a relative (8%). See Homicide in Scotland 2021-22

When conducting a DHR, however, it is less clear whether a gendered approach is taken. In the 17 jurisdictions covered, data was presented disaggregated by sex, showing the gendered nature of the homicides. Moreover, in New Zealand part of the DHR methodology is to use a structural analysis, taking an intersectional approach to the data and consider domestic abuse as a complex societal problem and acknowledge gender inequality (Rowlands 2020a). However, in a review of (a limited number of) DHRs in Canada, Sheeny (2017) points out that analysis from a feminist perspective seems almost entirely absent from the process. The UK Government has received some criticism from those who consider that they have failed to recognize the gendered nature of domestic abuse in the DHR model (Rowlands 2021).

The aim of many DHRs is to share information and evidence relating to the identification of domestic and family violence risk indicators and/or case characteristics. This analysis and presentation of data trends and patterns opens the possibility to highlight gendered impacts. In New South Wales the 2017-2019 DHR report, for example, mentions men's behaviour, its gendered drivers and societal attitudes towards women, and acknowledges the impact of power-imbalances and gendered structures in society. The sixth report of New Zealand's review committee includes a discussion on the reduction of men's use of violence, providing recommendations on healthy masculine norms and reconnecting men with positive forms of social support. Most often, however, recommendations tend to focus on service provision, coordination between agencies or risk assessment rather than on structural gender inequalities.

Other inequalities might also play a role in understanding domestic homicides. An intersectional approach to domestic homicides could take into account both the gendered nature of the issue as well as potential other (structural) inequalities that may play a role. In Montana for example, there is a specific Native American Domestic Violence Fatality Review Team (NADVFRT), focused on domestic homicides in Montana's Indian Country. This team aims to recommend culturally sensitive, proactive changes to prevent domestic homicides in the future. In the Scottish context, a DHR policy will be subject to an Equality Impact Assessment (EQIA) which will allow to flag potential inequality impacts.

4.3 Family involvement

Key findings:

Some review teams will include testimonies from family and friends of the victim (and sometimes perpetrator) to inform the DHR, and the literature recommends to include family (and friends) in the review process.

It is suggested that a DHR can provide families with a sense of healing, and give them a critical role in the process. The literature also notes that DHR teams recognise that there are challenges, both practical as well as concerns around the family's experience of loss and the risk of further traumatisation.

There is still limited understanding on how family engagement is undertaken and whether intended outcomes are met.

To conduct a DHR, review teams will draw on administrative data (e.g. police and court records) and data received from agencies involved. Some teams will also include testimonies from family and friends of the victim (and sometimes perpetrator). Not all jurisdictions covered in this briefing include family and friends, and those that do include them can differ in the level of engagement. In New Zealand the review committee has acknowledged for example that the current approach is not reciprocal, and they would like to embed the family more fully in the review process. In the 2017-2019 report of the New South Wales review, the review team states that while they are currently using document reviews to analyse a case, opportunities to engage with surviving friends and family are being explored.

In England, guidance for DHR panel states that "the review panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances, for example, where there are suspicions of 'honour'-based violence".

The guidance mentions that one of the benefits of this approach includes "assisting the family with the healing process which links in with the objectives of the new National Homicide Service - supporting victims for as long as they need after homicide."

The review panel is, however, made aware of sensitivities and the need for confidentiality.

The literature recommends to include family (and friends) in the review process to provide their perspective and experiences. Mullane (2017) argues that families should be integral to the review process, as "*the review is a journey for the family (…) and should allow the family to contribute, receive and review information*" (p. 262). Rowlands (2020b) notes that family and friends can help provide a more victim-centred story, and it is important to treat their accounts with the same status as agency information, as well as facilitate multiple opportunities for meaningful involvement.

Rowlands and Cook (2022) point out that DHR teams increasingly recognise the input of families as valuable. However, the teams also recognise challenges, with both practical concerns (e.g. on confidentiality) as well as "the emotional burdens of contributing" (Rowlands and Cook 2022, p. 560). This includes concerns around the family's experience of loss and the risk of further traumatisation. Mullane (2017) points out, for example, that sometimes sensitive information previously unknown to the families might be revealed in a review. He suggests that a specialist advocate, preferably peer support, can help families to understand the DHR process, assist with coordinating the family's contribution, managing expectations, as well as supporting the family with discussing the review outcomes and report with the chair/panel (Mullane 2017).

In an analysis of family involvement in the DHR process in England and Wales, Rowlands and Cook (2022) argue that family involvement is often framed as offering two outcomes: contributing to the diagnosis and identification of any system-failures (and formulating possible solutions); and enabling relational-repair for families through their participation in a DHR. However, there is still limited understanding on how family engagement is undertaken and whether these outcomes are reached (Rowlands and Cook 2022). Dale et al. (2017) point out that when and how a family is approached is important, as well as ensuring that, in cases where family and friends are interviewed, there are trained interviewers to do so. Follow-up for family and friends should also be addressed, both in offering care and information on the DHR.

Jones et al. (2022) states that there is limited involvement of children, "*despite their active role in experiencing [Domestic Violence and Abuse], witnessing the homicide and calling for help*" (Jones et al. 2022 p.4).

4.4 Other death reviews

Key findings:

Apart from a DHR a jurisdiction might have other (death) review processes in place. It appears that often there is no clear process in place to coordinate multiple review processes. This can lead to several reviews being conducted on the same case.

In a couple of jurisdictions there was specific mention of other review processes, such as child death reviews, and how the DHR should interact with those. In England, for example, the case selection criteria include a note that where the victim is between 16 and 18 years old, both a Serious Case Review and a DHR are required. These may be run in parallel, and some aspects can be commissioned jointly.

Often however, there does not appear to be a clear process in place to coordinate multiple review processes and this can lead to several reviews being conducted on one case simultaneously. In Wales, for example, one case was identified where seven different reviews took place (not including the police investigation and coroner's inquest). It shows the need to streamline these processes, as "*the duplication of evidence gathering, where single incidents trigger numerous reviews (…) would seem to be unwieldy, unfair to family and not in the spirit of multi-professional, inter-agency working*" (Robinson et al. 2018 p. 11). In Wales, this led to commissioning an evaluation of its review process (Robinson et al. 2018). The evaluation focused in particular on the overlap between DHRs and other death reviews, in order to improve coordination between these reviews. It led to the design of a new unified review process. The Single Unified Safeguarding Review model in Wales is currently being finalised and is expected to be rolled out across Wales in 2023.

5. Reporting, Monitoring and Measuring Impact

A DHR will include recommendations to improve the system's response to domestic homicides. Table 4 in Annex 1 gives an overview of how each jurisdiction reports on the findings and recommendations of the DHR, and how progress is monitored.

5.1 Types of reporting

Key findings:

In most jurisdictions reports were written either for each case, annually or biennially. When reports include a number of case reviews, data is usually aggregated and the report discusses trends rather than individual homicides.

All reports include recommendations. The literature suggest that recommendations are often targeted at individual agency level, and recommendations that focus on relationships between agencies and community responses could be more widely utilized.

The academic literature highlights that a common dataset would ensure systematic collection of data and learning. The literature also suggests there is a need for more consistency in reporting.

The 17 jurisdictions show that reports can be written for each case (e.g. in England, Wales, Northern Ireland and Portugal), annually (e.g. Western Australia, Ontario, Maryland and Delaware) or biennially (New South Wales, Montana and Washington). Sometimes reporting is more ad hoc (e.g. British Colombia), or, for example in Saskatchewan, Canada, there is one report presenting all findings of the pilot DHR, analysing cases from 2005-2014. In some of the jurisdictions the reporting is required by and presented to parliament, or parliament committees, for example in New South Wales (Australia), Colorado (USA), Montana (USA) and Vermont (USA).

When reports include a number of case reviews, data is usually aggregated and the report discusses trends rather than individual homicides. Often reports also include a section on the victims, which comprises of either a message to commemorate them or the inclusion of all the names of those that were killed. As noted in the previous section, many reviews report aggregated data and learning to protect the privacy of those involved. This could, however, prevent a victim's story being told, putting an emphasis on "counting" over "memorialisation" (Rowlands 2020a).

In England and Wales the DHRs are implemented by Community Safety Partnerships at a local level. For every DHR conducted, the Community Safety Partnership will produce a report. The recommendations of the report are therefore focused on the local context, with for example specific suggestions for the police, local authorities, domestic abuse services or health services.

New South Wales (NSW), Australia, reports biennially to the NSW parliament, with more general recommendations derived from both individual case analysis and wider quantitative data analysis. The recommendations cover legislation, policies, practices and services, covered by themes that were identified in the data. Every report is followed by a response from the NSW government, addressing these recommendations.

In New Zealand the committee reports regularly, with each report reflecting on the themes discussed in the previous ones, and adding to the body of knowledge. Early reports focused on how individual agencies or components of the system responded to cases, while more recent reports reflect on wider systemic processes or structures that work to reinforce the violence experienced. Each report provide recommendations to improve the system and agency responses, but they are not directed to individual agencies and are seen as applying to all agencies.

The academic literature highlights the need for a common data set, especially when DHRs are undertaken locally, to ensure the systematic collection of data and learning. This allows data, as well as recommendations from multiple case reviews, to be aggregated. Rowlands (2020a) points out that the absence of a national standardized data collection can lead to a lack of understanding of wider (country-wide) trends, as well as lack of suggestions or engagement with recommendations that should be implemented on a national level. This national collection could include a central repository to hold all reports, as Wales has for example implemented, as well as an overarching body that can collate reviews and synthesize and disseminate learning (Robinson et al. 2018).

All reports of the 17 jurisdictions covered in this briefing have recommendations listed, some might be more general (drawn from multiple cases), while others might address specific cases and specific agencies. Haines-Delmont et al. (2022) point out that it is important to formulate actions that are ‘specific, tangible, achievable and realistic’. Jones et al. (2022) add

that recommendations are often targeted at individual agency level. They argue that a focus on relationships between agencies and recommendations to address these could be a helpful inclusion. Additionally, their study highlighted that recommendations that target a community response are currently underutilized (Jones et al. 2022). These type of recommendations would be valuable, especially as analysis has shown that "*the room for error seemed to increase when boundaries are 'crossed' or where there is a transition between one type of service user to another, from one service to another, or from one geographic area to another*" (Robinson et al. 2018 p. 5).

The literature also addresses the need for consistency in reporting. Studying the Welsh DHR process, Robinson et al. (2018) noted that the quality and scope of reports often differed markedly, with some reports "*of far better quality in terms of their level of detail and analysis than others and writer of reviews would benefit from guidelines, training and a consistent standard and benchmarking*" (Robinson et al. 2018 p. 12).

5.2 Implementing review recommendations

Key findings:

In some jurisdictions annual reports address recommendations from previous reports and how they were followed-up. Often, however, it is not clear who is responsible for implementing recommendations, or how they are addressed and used in practice.

Policy development is likely to remain a challenge when there is no clear mechanism for monitoring the implementation of recommendations.

There is a lack of information on whether and/or how recommendations are implemented and evaluated (Rowlands 2020a, Jones et al. 2022). Bugeja et al. (2015) show in their review that only about a third of the domestic homicide reviews examined reported changes had occurred in service systems as a result of the recommendations made in the review process. Moreover, they showed that of 35 DHR models that made recommendations, only seven of them had specific mechanisms for monitoring actions taken and outcomes achieved. These mechanisms included: recommendations being assigned to an appropriate member of the DHR team who takes the recommendation to the agency that is capable of responding; a mandatory response regime in which recommendations are tracked by the DHR team members for completion; a focus on following up on recommendations made in previous

years when no new DHRs were conducted in that year; and a symposium to synthesise and prioritise previous recommendations and develop a strategic plan for implementation (Bugeja et al. 2015).

In some jurisdictions annual reports address recommendations from previous reports and how they were followed-up. In New South Wales, the government publishes a response to the recommendations made in each biennial report. Often, however, it is not clear, who is responsible for implementing recommendations, or how they are addressed and used in practice.

Policy development is likely to remain a challenge when there is no accountability or mandate to respond to recommendations or to develop a mechanism for monitoring their implementation (Bugeja et al. 2015). The literature suggests that it is important to "*make the shift from prioritization to implementation of recommendations*" (Jones et al. 2022 p. 11) and organisations might need incentives to implement recommendations including support and training. In England and Wales for example, there is a statutory requirement to carry out a DHR, but no statutory requirement to report on whether recommendations have been implemented (or what the barriers to implementation are) (Jones et al. 2022).

5.3 Evaluation and evidencing impact

Key findings:

It is difficult to evidence impact and attribute changes to DHRs alone. Moreover, little information was found in the literature on evaluation processes in the 17 jurisdictions covered in this briefing.

The literature highlights that there are several common themes in the recommendations made in DHR reports and these themes are often repeated in consecutive reports, which raises the question of what the impact of DHR recommendations is in practice.

Suggestions from the literature to deliver impact are to clearly articulate the purpose, aims and processes of a review and ensure consistency between reviews is established. A DHR should be viewed as a continuously evolving practice that includes auditing, monitoring and evaluating recommendations and overall impact.

There is a consistent challenge in evidencing impact of DHRs. It is difficult to make causal links between actions taken as a result of a DHR and homicide figures (Beguja et al. 2015, Jones et al. 2022). It may be more useful to focus

on whether reviews lead to organisational change (Rowlands 2020). Websdale (2020) suggests that one common outcome of review work is "*an increase in social networking, communication, coordination, and collaboration among those agencies and stakeholders handling domestic violence cases*" (p. 15).

It is, however, difficult to attribute changes to the DHR work alone as reviews take place in a context with many other possible influences. Evaluating a coordinated community response is difficult "*due to the complex and localised nature, as well as different understanding of what constitutes 'success'*" (Jones et al. 2022 p.11). Haines-Delmont et al. (2022) argues that to ensure impact can be understood and reported upon, the purpose, aims and processes of a review should be clearly articulated and consistency between reviews established. One way to do this is by developing shared concepts and clearly define the theories and terms that underpin the review process. Moreover, in Haines-Delmont et al. (2022) study, professionals suggested that a DHR should be a continual process of 'evolving practice' and include auditing, monitoring and evaluating recommendations.

In terms of evaluations, there often does not seem to be a systematic evaluation process in place once a DHR is established. In their study, Bugeja et al. (2017) did not find any independent evaluations that looked at the effectiveness of a DHR process. They point out that with the absence of any evaluation of best practice, there is a lack of useful guidance to support newly forming DHR teams.

It is unclear from the reports and available information online whether the 17 jurisdictions covered in this briefing have evaluative processes in place to review their approach to DHRs. An exception is Wales, which has conducted an evaluation to support the development of a more holistic review process (see Robinson et al. 2018). Moreover, there are some academic research projects (in some cases commissioned by government or DHR review boards) that have formulated suggestions for improvements for specific countries (see Rowlands (2020) for a review of the approach in England). It might be the case that evaluations are carried out internally or are ongoing, and no documentation is (yet) publicly available. For example, the Home Office guidance, which has been in place for 11 years, is currently under review with the revised guidance anticipated to be published in 2023.

The literature highlights several common themes in the recommendations made in DHR reports[13]. Often these themes are repeated in consecutive reports. For example, the recommendation to provide professional training for staff of services coming in contact with victims of domestic abuse has been a common recommendation for over a decade (Jones et al. 2022). Moreover, there is a substantial body of literature that has identified risk factors and interventions to prevent domestic homicides (for an overview, see Kim and Merlo 2021). This raises the question of what the impact of recommendations from DHRs is, whether further DHRs will provide any new insight, or whether substantial systemic change is needed (Haines-Delmont 2022).

The value of a DHR, however, is not only in the recommendations it provides. It also creates the opportunity for practitioners to make new connections with (local) partners and directly address any flagged issues in their organisation. In Haines-Delmont et al. (2022) research professionals in Wales described the learning event (where lessons learnt are shared) as powerful in improving practice.

6. Other Initiatives Analysing Domestic Homicides

Key findings:

There are other initiatives that involve the gathering of systematic data on domestic homicides and identifying trends.

Two examples are the Homicide Monitor in place in several European countries and the delegation for victims (La délégation aux victims) in France. The homicide monitor includes information on victims of homicides and can be used as a data source to identify trends in domestic homicide. The delegation for victims produces an annual report on statistics of intimate partner homicide (and its effect on children), including the consideration of (long-term) trends.

Domestic Homicide Reviews are currently implemented, or in the process of being implemented in seven countries, either at a national, sub-national or

[13] Jones et al (2022) found common themes in the recommendations of DHR reports, including: Improving awareness and understanding of the dynamics of DA and providing training; improving the provision of services and inter-agency coordination; addressing the needs of children (see also Jaffe et al. 2017). Other common issues that have been identified in multiple DHRs are 'faulty assessments', often not taking into account multiple aspects of behaviour or problems; and tunnel vision, where practices are often shaped to fit a particular narrative and changes over time not always recognised (Robinson et al. 2018).

local level[14]. Other countries, however, might also have death review processes, for example when children or adults who are supported by mental health services are involved, and in some instances this will also include a domestic abuse context. The difference between these and a DHR is that these might be single agency rather than multi-agency reviews, and they do not necessarily gather systematic data on domestic homicides. There are other initiatives however, that might not include an agency review, but do gather systematic data on domestic homicides and identify trends. Below two of these initiatives are discussed. This is not an exhaustive list, but serves to illustrate potential alternative approaches to gathering and monitoring domestic homicide or femicide data for the purposes of learning from these deaths.

6.1 Homicide monitors

Finland established the Finnish homicide monitor (FHM) in 2002, maintained by the University of Helsinki (Institute of Criminology and Legal Policy), the National Police Board and the Police College Research Unit. The aim of the monitor is "*to create a data base for in-depth research, and to serve crime prevention and prevention targeting purposes*" (EIGE nd). The aim is similar to DHRs, with a focus on prevention, although not necessarily specific to domestic abuse. Nevertheless, the database does contain information on the relationship between the victim and perpetrator as well as demographic variables and characteristics of the homicides committed. It is used by organisations working on gender-based violence as a data source, and has also served as evidence for research on domestic homicide (see for example Kivivuori and Lehti 2012).

The information included in the FHM is defined by researchers and uses a 'victim-based data architecture', with about 90 variables for each victim being collected (EIGE n.d.a). These variables include information about prior criminal justice contacts of the victim and offender. The data is collected from the chief investigator of each homicide case on a standard electronic form. This form is filled in after the investigation has been concluded or one year after the initiation of the investigation if a case is not concluded within a reasonable time frame. It is compulsory for the investigating officers to fill in the questionnaire.

[14] These countries include: Australia (at state level), Canada (at state level), Ireland (in process of being implemented), Portugal, New Zealand, United Kingdom (England, Wales and Northern Ireland) and Unites States (at state or local level).

The FHM is used as the basis for the European homicide monitor (EHM). The EHM partners include Finland, the Netherlands, Sweden, Norway, Estonia and Switzerland. The EHM consists of 85 variables, with each country having their own system of gathering data to include in the monitor. Sweden for example uses police files, verdicts from the court and forensic psychiatric records, while the Netherlands also includes media reports (University of Leiden n.d.).

6.2 France's Delegation for Victims

The delegation for victims (La délégation aux victims) sits with the Ministry of the Interior in France. It is responsible for monitoring policies for supporting victims, proposing actions and assisting victim associations (EIGE n.d. b). The delegation covers all victims of crime, but domestic violence is a key focus. A report is produced annually, together with the Police Nationale and Gendarmerie Nationale, covering intimate partner homicide (Ministère de L'intérieur 2021). It reports on statistics of intimate partner homicide (and its effect on children), including trends and a list of measures taken by the Ministry of Interior to combat domestic violence.

Information for the report is collected by the 'delegation for victims', who issue a questionnaire to the relevant services. Information that is collected includes relationship between victim and perpetrator, where the homicide took place, whether substance abuse was involved and whether there had been a record of previous violence between the victim and perpetrator (Ministère de L'intérieur 2021).

7. Conclusion

Domestic Homicide Reviews are implemented in a range of ways across different jurisdictions, with variation in the number and type of cases that are reviewed, how review panels operate, and the way findings are reported. Nevertheless, there are some common characteristics across jurisdictions, particularly in the aims and methods of the DHRs.

DHRs can provide insight into domestic homicides which are relevant to the prevention of new fatalities, mainly through focusing on improvement of service provision and collaboration across agencies. DHRs usually consider the victim's (and perpetrator's) story and construct a timeline to understand the events leading up to a domestic homicide.

When considering a DHR model for Scotland, academic reviews of the DHR process identified some useful lessons learned. Clarity of purpose, aim and process are important, including having clear inclusion criteria and justifications for the case selection process. Clarity on the roles, responsibilities and oversight of the DHR is important, especially if multiple (local) teams conduct reviews, to ensure consistency and a clear line of accountability. To enable the identification of trends and patterns a common data set and systematic data collection and analysis is recommended. Other aspects that warrant consideration are: the level of analysis and type of methodology, including taking a gendered and intersectional approach; confidentiality and privacy and how case information is shared and reported; and, resources and capacity of the team, including responsibility and budget for taking forward recommendations. Annex 3 gives an overview of recommendations Rowlands (2020a) formulated for improvement of the English and Welsh DHR process, which may be useful to consider in the Scottish context.

Some aspects of DHRs seem less developed, such as the inclusion of family and friends, although there are differences between jurisdictions. Overall, research underlines the importance of considering how the purpose of the DHR is reflected in the process. The articulation of a Theory of Change can help provide clarity about how and why a DHR is expected to work. Moreover, whilst all DHRs make recommendations to improve the system, there is less clarity in how these recommendations are followed-up. Monitoring and evaluation processes are important to ensure that DHRs fulfil their intended purpose. A better understanding of certain aspects of domestic homicides, for

example suicide in a domestic abuse context and the impact of domestic abuse on children, can also further support and inform thinking about the DHR design.

References

Boughton, G.A. (2021). *Investigating Investigations: A Critical Evaluation of the England and Wales Domestic Homicide Review (DHR) Process*. PhD Thesis, University of South Wales. Available at: https://pure.southwales.ac.uk/en/studentTheses/investigating-investigations-a-critical-evaluation-of-the-england

Bugeja, L., Dawson, M., McIntyre, SJ. & Poon, J. (2017). Domestic/Family Violence Death Reviews: An International Comparison. In: Dawson (eds), *Domestic Homicides and Death Reviews*, London: Palgrave Macmillan. p. 3-26. DOI 10.1057/978-1-137-56276-0_1

Bugeja, L., Dawson, M., McIntyre, SJ. & Walsh, C. (2015). Domestic/Family Violence Death Reviews: An International Comparison. *Trauma, Violence, & Abuse* 16, 179-187. DOI: 10.1177/1524838013517561

Dale, M., Celaya, A. & Mayer, S.J. (2017). Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews. In: Dawson (eds), *Domestic Homicides and Death Reviews*, London: Palgrave Macmillan. p. 229-256. DOI 10.1057/978-1-137-56276-0_1

EIGE (nd a). Finnish Homicide Monitor (FHM). Website accessed on 27 September 2022. Finnish Homicide Monitor (FHM) | European Institute for Gender Equality (europa.eu)

EIGE (nd b). La délégation aux victimes (DAV). Website accessed on 27 September 2022. La délégation aux victimes (DAV) - Delegation for victims. | European Institute for Gender Equality (europa.eu)

Fairbairn, J., Jaffe. P. & Dawson, M. (2017). Challenges in Defining Domestic Homicide: Considerations for Research and Practice. In: Dawson (eds), *Domestic Homicides and Death Reviews*, London: Palgrave Macmillan. p. 201-228. DOI 10.1057/978-1-137-56276-0_1

Haines-Delmont, A., Bracewell, K. & Chantler, K. (2022). Negotiating organisational blame to foster learning: Professionals' perspectives about Domestic Homicide Reviews. *Health & Social Care in the Community* 30, p. e2818-e2826. https://doi.org/10.1111/hsc.13725

Jones, C., Bracewell, K., Clegg, A., Stanley, N. & Chantler, K. (2022). Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review. *Homicide Studies* 00, 1-12. https://doi.org/10.1177/10887679221081788

Kim, B., & Merlo, A.V. (2021). Domestic Homicide: A Synthesis of Systematic Review Evidence. Trauma, violence & abuse. https://doi.org/10.1177/15248380211043812

Kivivuori, J. & Lehti, M. (2012). Social Correlates of Intimate Partner Homicide in Finland: Distinct or Shared with other Homicide Types? *Homicide Studies* 16, 60–77. https://doi.org/10.1177/1088767911428815

Ministère de L'intérieur (2021). *Étude Nationale sure les morts violentes au sein du couple 2020*. etude-nationale-sur-les-morts-violentes-au-sein-du-couple-chiffres-2020.pdf

Mullane, F. (2017). The Impact of Family Members' Involvement in the Domestic Violence Death Review Process. In: Dawson (eds)*, Domestic Homicides and Death Reviews*, London: Palgrave Macmillan. p. 257-286. DOI 10.1057/978-1-137-56276-0_1

Robinson, A.L., Rees, A. & Dehaghani, R. (2018). *Findings from a thematic analysis of reviews into adult deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews*. Cardiff University. Available at: https://orca.cardiff.ac.uk/id/eprint/111010/
Rowlands, J. (2021). Constructing Fatality Review: A Policy Analysis of the Emergence of Domestic Homicide Reviews in England and Wales. *Violence Against Women*, 00, 1-24. https://doi.org/10.1177/10778012211068064

Rowlands, J. and Cook, E.A. (2022). Navigating Family Involvement in Domestic Violence Fatality Review: Conceptualising Prospects for Systems and Relational Repair. *Journal of Family Violence* 37, 559-572. https://doi.org/10.1007/s10896-021-00309-x

Rowlands, J. (2020a). *Reviewing domestic homicide – International practice and perspectives*. Technical Report, Winston Churchill Memorial Trust. DOI: 10.13140/RG.2.2.12897.12646

Rowlands, J. (2020b) The ethics of victim voice in Domestic Homicide Reviews. *Sentio* 2, 34-41. ISSN 2632-2455

Sheehy, E. (2017). A Feminist Reflection on Domestic Violence Death Reviews. In: Dawson (eds)*, Domestic Homicides and Death Reviews*, London: Palgrave Macmillan. p. 373-402. DOI 10.1057/978-1-137-56276-0_1

UNODC and UN Women. (2022). Gender-related killings of women and girls (femicide/feminicide), available at: Gender-related-killings-of-women-and-girls-improving-data-to-improve-responses-to-femicide-feminicide-en.pdf (unwomen.org)

University of Leiden (nd). European Homicide Monitor. Website accessed on 27 September 2022 European Homicide Monitor - Leiden University (universiteitleiden.nl)

Websdale, N. (2020). Domestic Violence Fatality Review: The State of the Art. In: Geffner, R., White, J.W., Hamberger, L.K., Rosenbaum, A., Vaughan-Eden, V., Vieth, V.I. (eds) *Handbook of Interpersonal Violence and Abuse Across the Lifespan,* Springer, Cham, p. 1-23. https://doi.org/10.1007/978-3-319-62122-7_133-2

Annex 1 – Country comparison tables

Table 1: Legislation and aim

Jurisdiction	DHR establishment	Legislative approach to DHR	Aim of DHR
Australia	Overarching Network was established in 2011	In Australia DHRs are established at state/territory level. The National Plan to Reduce Violence against Women and their Children 2010–2022 (Strategy 5.2) mandates states and territories to "drive continuous improvement through sharing outcomes of reviews into deaths and homicides related to domestic violence". The Australian Domestic and Family Violence Death Review Network was established to share outcomes.	The goals of the Review Network are to: Analyse domestic and family violence deaths, the DHR findings and recommendations of all states, and identify practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths
South Australia	January 2011	No specific legislation, established under coronial mandate. The Office for Women established, in partnership with the South Australian Coroner's Office, the role of senior researcher to research and investigate open and closed deaths related to domestic violence. Depending on the investigation, a coronial inquest may follow.	To research and investigate domestic-violence-related deaths.

Jurisdiction	DHR establishment	Legislative approach to DHR	Aim of DHR
Western Australia	July 2012	No specific legislation, embedded in the role of the Ombudsman. The Ombudsman has all the powers provided for in the Parliamentary Commissioner Act 1971 (WA) (the Act) and all of the powers of a standing Royal Commission.	To identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities The Ombudsman will: 1) review circumstances of deaths; 2) identify patterns and trends; and 3) make recommendations to public authorities.
New South Wales	2010	The Domestic Violence Death Review Team (DVDRT) was established with the Coroners Amendment (Domestic Violence Death Review Team) Act 2010 (NSW), inserting Chapter 9A into the Coroners Act 2009 (NSW) and establishing the Domestic Violence Death Review Team. Reviews are convened by the coroner, which operates independently within Department of Justice	The DVDRT aims to develop and promote domestic violence intervention and prevention strategies so as to reduce the likelihood of deaths occurring in similar circumstances in the future, and to improve the response to domestic violence more generally. The functions of the Team are to 1) review and analyse individual closed cases; 2) maintain a database and identify patterns and trends; and 3) develop recommendations
Canada	The first Canadian review was established in 2003 in Ontario	Reviews are established at province/territory level but the Canadian Domestic Homicide Prevention Initiative (CDHPI) was developed to share information. It is a partnership between Western University and the University of Guelph. Funding for the	The CDHPI hosts information and reports on the reviews as well as provide resources to support implementation

Jurisdiction	DHR establishment	Legislative approach to DHR	Aim of DHR
		CDHPI was provided by the Canadian Women's Foundation.	
British Columbia	One review conducted in 2010 and one in 2016 (covering the period 2010-2015)	No specific legislation, established under coronial mandate. The Coroners Act provides the chief coroner with the discretion to establish death review panels to review the facts and circumstances of deaths. Hosted by British Columbia Coroners Service. Panel members are appointed by the chief coroner under Section 49 of the Coroners Act.	Death reviews are held to provide the chief coroner with advice on medical, legal, social welfare and other matters that may impact public health and safety and prevention of deaths. A death review panel may review one or more deaths before, during or after a coroner's investigation or inquest.
Saskatchewan	Established in 2015, as a pilot	No specific legislation, the review was set up as a pilot, to review historical cases. A steering committee was set up, with representation from ministry divisions that deal with domestic violence situations and the police. This committee oversaw the development of the review process.	Examine specific cases to 1) identify trends, risk factors and patterns, to inform risk management; 2) identify barriers, gaps and points of intervention in community and systemic responses; 3) recommend prevention and intervention strategies; and 4) facilitate systemic and inter-agency communication and coordination
Ontario	2003	No specific legislation, established under coronial mandate (Section 15(4) of the	The purpose of the Domestic Violence Death Review Committee (DVDRC) is to assist the Office of the

Jurisdiction	DHR establishment	Legislative approach to DHR	Aim of DHR
		Coroners Act, R.S.O. 1990, Chapter c. 37, as amended). The Chief Coroner is authorized, when seen as necessary, to use experts to provide comprehensive examinations and analyses of deaths, to highlight areas for future inquiry, and/or to identify potential recommendations for enhancing prevention	Chief Coroner in the investigation and review of deaths of persons that occur as a result of domestic violence, and to make recommendations to help prevent such deaths in similar circumstances. Tasks include to maintain a database; to help identify systemic issues, problems or shortcomings; to help identify trends, risk factors and patterns; to conduct research where appropriate; to make recommendations and promote educational activities.
England	13 April 2011	DHRs were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004, section 9(3). The Act's provision came into force in 2011. There is a statutory requirement for local areas to conduct a Domestic Homicide Review (DHR) following a domestic homicide that meets the criteria. National statutory guidance sets out how DHRs should be conducted and reported on. Guidance and (online) training is produced by the Home Office.	A Domestic Homicide Review (DHR) is a multi-agency review that aims to 1) establish lessons to be learned both within and between agencies; 2) apply these lessons and improve service responses; 3) prevent domestic violence homicide by developing a co-ordinated multi-agency approach; 4) contribute to a better understanding of the nature of domestic violence and abuse; and 5) highlight good practice

Jurisdiction	DHR establishment	Legislative approach to DHR	Aim of DHR
New Zealand	2008 As of 2023, the 5 mortality committees, including one with a focus on family deaths will be disestablished, with one committee taking its place	New Zealand Public Health and Disability Act 2000 enables creation of mortality committees. The New Zealand Family Violence Death Review Committee (FVDRC) established as a ministerial committee in 2008 under this mandate to address family violence. In April 2011, following the New Zealand Public Health and Disability Amendment Act of 2010, the Committee became the responsibility of the Health Quality and Safety Commission (HQSC).	The focus of the FVDRC is to reduce family violence deaths by 1) reviewing and reporting family violence deaths to the Health Quality & Safety Commission; 2) developing strategies to reduce family violence. The FVDRC aims to collect a standard set of information on every family violence death. Local and national review of this information helps identify patterns and trends in family violence deaths over time and establish policy and practice improvements that can contribute to the reduction of family violence deaths.
Northern Ireland	10 December 2020	Legislation: the Domestic Violence, Crime and Victims Act 2004, section 9(3), see England Guidance was developed by Ministry of Justice, taking into account the UK Home Office Multi-Agency Statutory Guidance, as well as the experiences and learnings in England and the outcomes of a consultation process	See England The overarching purpose of a review is to prevent future domestic homicides by learning any lessons from the death and improving responses to domestic abuse victims (and their family and children) as a result of lessons learnt.

Jurisdiction	DHR establishment	Legislative approach to DHR	Aim of DHR
Portugal	Established in 2015 and started analysing cases in 2017	Article 4a of the Domestic Violence Act (No. 129/2015) and Ordinance 280/2016 establish and regulate the 'Equipa de Analise Retrospectiva de Homicidio em Violencia Domestica' (Retrospective Analysis Team of Domestic Violence Homicide)	The aim of the EARHVD is the retrospective analysis of domestic violence homicide, to make recommendations on the implementation of new preventative procedures and measures. The analysis aims to understand the reasons, circumstances and context in which the murder occurred, with a view to improve intervention methodologies, prevent/correct errors and guide the action of public and private agencies.
USA	Domestic Violence Fatality Reviews were established early to mid-1990s.	Fatality reviews are established at a state, regional or local level. The National Domestic Violence Fatality Review Initiative was established to share information (NDVFRI). It is funded by the Office on Violence Against Women (US Department of Justice), through the Violence Against Women Act. It is housed at Northern Arizona University	The NDVFRI acts as a national repository hosting information and reports and it provides training and technical assistance around implementation and delivery.
Colorado	The Denver Metro Domestic Violence Fatality Review established in	Senate Bill 2017-126, created the Domestic Violence Fatality Review Board (DVFRB) chaired by the Colorado Attorney General.	Gain a deeper understanding of the dynamics related to domestic violence fatalities and develop meaningful policy and practice recommendation aimed at improving domestic violence prevention and response services.

Jurisdiction	DHR establishment	Legislative approach to DHR	Aim of DHR
	1996. In 2017 Colorado Domestic Violence Fatality Review Board was established	It enables local governments across Colorado to form DVFRTs in order to enhance existing efforts to prevent domestic violence fatalities.	The (CDVFRB), is charged to: 1) examine collected data; 2) identify measures to help prevent domestic violence fatalities; 3) establish uniform methods for collecting, analysing, and storing data; and 4) make annual policy recommendations
Delaware	1996. It is the first jurisdiction wide review team established in the United States.	By statue: Title 13 Section 2105 It established a permanent Domestic Violence Coordinating Council. The council is given the power to investigate and review domestic homicide deaths, through a review panel, the Fatal Incident Review Team (FIRT)	Primary purpose is to decrease the incidence of domestic violence deaths by reviewing the facts and circumstances of all deaths and near deaths that occur in Delaware as a result of domestic violence. The reviews focus on 1) identifying trends, patterns and obstacles in services; 2) assessing agency interventions; and 3) developing practical recommendations aimed at improving the system
Maryland	Local (voluntary) teams established in 2003 and 2004. In 2005 Local Domestic Violence Fatality Review Teams	Legislation: the Maryland Code of Family Law Section 4-703, which details the purpose and membership of the review teams Section 4-704 provides the activities the Local Teams should perform Legislation allowed the two already established review teams to access more information	A multifaceted purpose, to prevent domestic violence deaths by: 1) enhancing coordination and cooperation between agencies; 2) deliver crucial services and support to domestic violence victims and their families as well as abusers; and 3) conceive and deliver recommendations for improving investigation and support of domestic violence.

Jurisdiction	DHR establishment	Legislative approach to DHR	Aim of DHR
	were signed into law.	(initially they relied on public records and interviews)	
Montana	2003. The Native American fatality review team was added in 2014.	The Fatality Review Commission is described in the Montana Code, Title 2, Chapter 15, Part 20 The commission sits within the Department of Justice. Next to the Montana Domestic Violence Fatality Review Commission (MDVFRC), there is also the Native American Domestic Violence Fatality Review Team (NADVFRT), focused on domestic homicides in Montana's Indian Country.	The commission seeks to reduce homicides caused by family violence. The MDVFRC seeks to identify gaps in Montana's system for protecting domestic violence victims and better coordinate multi-agency efforts to protect those most at risk of domestic homicide. The NADVFRT seeks to deeply understand what leads to domestic violence fatalities in Montana's Indian Country, and to recommend culturally sensitive, proactive changes to prevent them in the future
Vermont	2002	Legislation: Statue 15 VSA § 1140(b), establishing a Domestic Violence Fatality Review Commission (DVFRC) within the Office of the Attorney General, in consultation with the Council on Domestic Violence	To collect data and conduct in-depth reviews of domestic violence related fatalities to better understand how the fatalities occurred and what can be done to prevent them The purpose of the DVFRC is to 1) examine trends and patterns; 2) to identify barriers, the strengths and weaknesses in communities and systemic responses; 3) to educate the public, service providers, and policymakers; and 4) to make recommendations

Jurisdiction	DHR establishment	Legislative approach to DHR	Aim of DHR
Washington	1998	Revised Code of Washington (RCW 43.235.020). It authorizes the Department of Social and Health Services to make grants available for a DA agency to gather and maintain data and coordinate domestic violence fatality reviews (the Washington State Coalition Against Domestic Violence - WSCADV). The reviews are carried out by regional panels.	The purpose of the Domestic Violence Fatality Review is to understand how systems and communities are or are not effective in responding to domestic violence victims and abusers. The Domestic Violence Fatality Review seeks to: 1) increase safety and self-determination for victims and accountability for perpetrators; 2) foster communication and collaboration; 3) identify patterns in and; 4 generate information useful to policy makers, practitioners, advocates and educators.
Wales	2011	Legislation: the Domestic Violence, Crime and Victims Act 2004, section 9(3), see England Next to DHRs, two other types of reviews are established in Welsh law: Child or Adult Practice Reviews (CPRs or APRs) and Mental Health Homicide Reviews (MHHRs)	See England The DHR will be included in the newly established Single Unified Safeguarding Review (SUSR). This is one single review to include the multiple different reviews in UK and Welsh legislation. The SUSR will allow practitioners to appreciate and address the whole picture and identify key cross cutting areas to learn and develop

Table 2: Case selection

Jurisdiction	Domestic Homicide Statistics	Case Selection
Australia	In 2021 there were 105 victims of family and domestic violence (FDV) related homicide nationally. The majority of FDV related homicide victims were female (58% or 61 victims). FDV include (ex)partner, parents, other family members and non-family members that are carer, guardian or kinship relationships	The Network collates information from the DHRs conducted by the different States and Territories and compares reporting. As such they define minimum case inclusion criteria and developed a standardised minimum data set. Exact case selection criteria are, however, determined by each state or territory.
South Australia	In 2021 there were 14 family and domestic violence (FDV) related homicides recorded, including five children (under 18). Ten victims (71%) were female, four victims were male (29%). Four were intimate partners of the perpetrator, six were other family members. Of four victims relationship was not registered.	The scope of the review includes: single fatality homicide, single fatality suicides and multiple fatality (e.g. homicide–suicide) incidents where there is a context of domestic or family violence. It includes both child and adult victims. Open coronial and closed criminal cases are considered.
Western Australia	In 2021 there were 13 family and domestic violence (FDV) related homicides recorded (all adults). Ten victims were female (77%) and three victims were male (23%).	A FDV fatality is a death that is caused directly or indirectly by a person who was in a family or domestic relationship with the deceased. This include (ex)partners, parents, children or other relatives. Both open and closed coronial and criminal cases are considered.

Jurisdiction	Domestic Homicide Statistics	Case Selection
New South Wales	In 2021 there were 26 victims of family and domestic violence (FDV) related homicide, including four children (under 18). Seven victims were female (27%) and 19 victims were male (73%).	All domestic violence related deaths including intimate partner homicides and adult family homicides as well as domestic violence related suicides and fatal accidents that are caused by domestic violence (e.g. including bystanders) Review team will only consider closed coronial and criminal cases.
Canada	In 2017 there were 76 intimate partner homicides In total 933 intimate partner homicides occurred between 2007 and 2017, a large majority (79%) involved female victims.	
British Columbia	Between 2010 and 2015, 75 fatal intimate partner violence incidents occurred, resulting in 100 deaths (73 IPV victims, 27 IPV perpetrators) 78% of the victims were women, 22% were men. Almost two-thirds of all IPV victims had a known history of IPV, but fewer than one third of all victims had reported the violence to police.	The 2010 Review covered domestic violence, closed cases that were selected by the chair because the cases were illustrations of the most compelling and significant domestic violence risk factors and systemic gaps. The 2016 Review covered intimate partner violence related deaths, including victims who were former or current partners, bystanders (e.g. new partners or children) and also perpetrator's suicide
Saskatchewan	Between 2005-2014 there were 48 domestic homicides (intimate partner violence and parent-child relationships) with nine related suicides.	Domestic violence death is defined as a homicide or a related suicide that occurs in circumstances involving persons in an intimate relationship and their families. It often involves conflict between intimate partners or ex-

Jurisdiction	Domestic Homicide Statistics	Case Selection
Ontario	One third (15) of the victims were under age 21. Of the adult victims 19 were female (58%) and 14 were male (42%). Of the perpetrators 32 (70%), were male and 14 (30%) were female.	partners, including situations which lead to the death of a child or familial member. Quantitative information was gathered on all cases, 6 cases reviewed in-depth (selected to represent diversity of situations)
	In 2017 there were 20 victims of domestic violence death (intimate partner violence, including death of any children). It included 17 female adult victims (85%), one male adult victim (5%) and two male children (10%). There were 3 perpetrator suicides related to domestic homicide cases (all adult male).	Domestic violence deaths are defined as “all homicides that involve the death of a person, and/or his or her child(ren) committed by the person’s partner or ex-partner from an intimate relationship.” At the discretion of the Chair, review team may also look at near-deaths or cases where there was the possibility that the victim and the perpetrator were involved in an intimate relationship.
England	In 2020-2021 there were 114 domestic homicides including adults in England and Wales. Of the 114 domestic homicides, 67 victims were killed by a partner or ex-partner, 27 were killed by a parent, son or daughter and 20 were killed by another family member. 75 (66%) of the victims were female, 39 of the victims were male (34%). Of the 75 female victims, 72 were killed by a male suspect.	A DHR is considered when a case include an adult (aged 16 or over) death that has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself. Reviews can be conducted in cases of suicide where

Jurisdiction	Domestic Homicide Statistics	Case Selection
	Domestic homicide includes intimate partners as well as family relations	"circumstances give rise to concern" (although operationalisation remains somewhat unclear) A DHR is held when a review may result in identifying lessons to be learnt
New Zealand	In 2018 there were 15 victims killed by their partner, 4 were killed by their child, 5 by their parent and 3 by other family members. Of those 27 victims, 16 were female (59%) and 11 (41%) were male. Between 2007 and 2018, approximately 136 homicide victims were killed by their partner, of which 74% were female.	A family violence death is defined as: the unnatural death of a person (adult or child) where the suspected offender(s) is a family or extended family member, caregiver, intimate partner, previous partner of the victim, or previous partner of the victim's current partner, and where the death was an episode of family violence and/or there is an identifiable history of family violence. Excluded from this definition are: non-family member bystanders or interveners, suicides, suicide-assisted deaths, deaths from chronic illness associated with family violence.
Northern Ireland	In 2020/2021 there were 9 homicides with a domestic abuse motivation (intimate partner violence and incidents between family members). 7 victims were partner or ex-partner of the perpetrator, and 2 victims were other family relations. 8 victims were female (89%), and 1 victim was male (11%).	Similar to England, a DHR is considered when: - the deceased person is aged 16 or over - the death has or appears to have resulted from violence, abuse or neglect - the perpetrator was related to the victim, was in an intimate personal relationship with the victim, or lived in the

Jurisdiction	Domestic Homicide Statistics	Case Selection
	Between 2010-2021 there were 65 domestic abuse homicides. 36 victims were the partner or ex-partner of the perpetrator, and 29 victims were other family relations. 45 victims (69%) were female, 20 victims were male (31%).	same household as a victim A DHR is held when a review may result in identifying lessons to be learnt
Portugal	In 2019 there were 41 homicides in a domestic violence context, of which 26 were intimate partner homicides (22 women and 4 men).	Closed cases of homicides, and near deaths, in a domestic violence context, which includes intentional homicide and attempted homicide, directly or indirectly related to the sociological context and or interpersonal relationships referred to in Article 152 of the Penal Code. It includes intimate partner relations, family members or relatives as well as people co-habiting or being economically dependent of the accused. It also includes death of DA professionals where the crime was motivated by, directly or indirectly, exercising of such functions.
USA		
Colorado	In 2018, 43 individuals were killed as a result of domestic violence (intimate partner homicides and collateral victims in this context). 26 were the primary victim of domestic violence, 2 were collateral children, 4 were collateral adults, and 11 were the primary perpetrator of domestic violence. The largest group (20, or 47%) were women killed by a	Cases that are considered are intimate partner homicide, including near-misses, perpetrator suicide and collateral victims. Cases for in-depth review are selected based on several factors, including status of the case (must be closed with no

Jurisdiction	Domestic Homicide Statistics	Case Selection
	current or former male partner. 5 men were killed by their female (ex)partner.	civil action pending), availability of records, recommendations by DVFRT members, and incident location.
Delaware	In 2019 there were 8 domestic violence homicide (intimate partner homicide and homicide between family members) victims and 1 near-death victim. 4 were female and 5 were male. 3 female victims were (ex)partner of the offender. 1 of the victims was a minor child, and 2 were adult children, 1 was an uncle and 1 was the former boyfriend of offender's current partner.	Cases include both homicides and suicides resulting from domestic violence. The victim can be the domestic violence victim, perpetrator, or a by-stander as long as the death or near death (suffered life-threatening injuries) was a result of domestic violence, meaning either intimate partner violence or violence between family members. The victim must have been a Delaware resident at the time of the incident leading up to the death
Maryland	In 2020, 56 people lost their lives to domestic violence. This included 38 victims killed by their intimate partner (34 women, one teen girl and three men), 3 bystanders and 4 men lost their life due to DA violence with unknown case details. 11 abusive partners died, nine men and two women in attempted or completed murder-suicides	Local teams review and assess their county data for any domestic violence that resulted in death or near-death (serious physical injury), including suicides. The local teams may only review criminal cases after conclusion of the court case or suicide investigation.
Montana	In 2021 there were 15 domestic homicides (homicide offenses involving partners or family members) in Montana.	The commissions review closed domestic homicide cases selected by the attorney general. The cases that are included are of intimate partner homicide as well as homicide-suicide cases.

Jurisdiction	Domestic Homicide Statistics	Case Selection
		The NADVFRT looks at cases of family fatalities related to domestic violence on or near Reservations.
Vermont	There were 8 domestic violence related homicides in 2020; 5 involved intimate partner relationships, 3 involved family members who lived in the same household. 7 of the deceased were male, 1 was female. In 2019 there were 8 domestic violence related homicides. 6 involved intimate partner relationships and 2 involved family members. 5 deceased were female and 3 were male.	The (quantitative) data the DVFRC includes only those cases the Office of the Chief Medical Examiner ruled as homicide. in-depth reviews can be held for any domestic violence related fatality, which can be homicides, murder-suicides, suicides (with a documented history of DA) and substance abuse related deaths (with a history of DA). It includes family members, household member, estranged partner's current household member, or a current partner's or family member's estranged "household member" and bystanders
Washington	In 2020 there were 47 domestic homicides (homicides in intimate partner violence context), 18 perpetrator suicides (of abusers in context of intimate partner homicide or assault) and 8 perpetrators killed by police intervention In 2021 there were 29 domestic homicides, 3 perpetrator suicides (of abusers in context of intimate partner homicide or assault) and 1 perpetrator killed by police intervention	Cases look at intimate partner violence, including: current or former intimate partner; friends, family, new partners, or police officers killed by abusers in the context of intimate partner abuse; abusers killed by victims, police, or someone intervening; and suicides of abusers following a domestic violence homicide or assault.

Jurisdiction	Domestic Homicide Statistics	Case Selection
Wales	National statistics are provided by ONS on both England and Wales (see England). Since 2014, there have been 37 DHRs commissioned	For DHR see England APRs take place after an 'adult at risk' has died or sustained life threatening injury. An adult at risk is defined as a person who is experiencing or at risk of abuse or neglect, has need for care and support and as a result of those needs is unable to protect themselves against abuse or neglect MHHRs are carried out after homicides are committed by individuals known to mental health services in Wales. The decision to undertake a review is made on a case by case basis.

Table 3: Process of conducting a DHR

Jurisdiction	DHR Process	Time scale of DHR
Australia	The Network comprises of members of each of the death review teams from all of the Australian states and territories. Members of the Network have specialist expertise in domestic and family violence-related issues and are able to access information from coroner’s courts, ombudsman’s offices and government agencies. The Network had an MoU with ANROWS (Australia's National Research Organisation for Women's Safety) to research national trends (from 2020-2022).	Meetings are held at least four times per year. The second iteration of the Network's report was an 18 month research project

Jurisdiction	DHR Process	Time scale of DHR
	The data used for this research is sourced through death review teams in each Australian jurisdiction, and is extracted into a national minimum dataset.	
South Australia	The Senior Research Officer (Domestic Violence) is based within the South Australian Coroner's Office and works as part of the Coronial investigation team and will: - Identify deaths with a domestic violence context - Review files, provide interim reports and have specific input into Coronial Inquests which relate to domestic violence. - Conduct specific retrospective research projects relevant to building the domestic violence death review evidence base. - Develop data collection systems: including the Coronial Domestic Violence Information System (CDVIS), incorporating over 120 different perpetrator and victim-specific variables and providing the capacity to record data and track trends.	No information found
Western Australia	The WA Police Force informs the Ombudsman of all family and domestic violence fatalities. A review will be undertaken if the relationship between victim and suspected perpetrator meets the case selection criteria. The extend of the review depends on the circumstances of the death and the level of involvement of relevant agencies. The review team includes an assistant Ombudsman, a Director, a Principal Aboriginal Liaison Officer and a number of investigating research officers. After the Ombudsman has been informed the team will start the review process: - Demographic information, circumstances and issues are identified, analysed and	The annual report of the Ombudsman notes that a timely review for family and domestic violence fatalities is important. It reports that 41% of all reviews were completed within six months and 68% of reviews were completed within 12 months

Jurisdiction	DHR Process	Time scale of DHR
	reported - Patterns and trends are identified, analysed and reported To review this, the team liaises with public authorities and agencies that interact with or deliver services to those at risk of domestic violence. There is an Advisory Panel (including government representatives and domestic abuse specialists) that provides independent advice to the Ombudsman on issues and trends.	In 2020-2021 the Advisory Panel met two times
New South Wales	The DVDRT is a multi-agency committee and includes a secretariat, constituting of a Manager and a Research Analyst. The team is convened by the State Coroner and brings together representatives from key government agencies and non-government service provides and sector experts. The DVDRT reviews individual closed cases and identifies systemic issues. It understands domestic and family violence as a complex, intergenerational and 'wicked' problem that requires complex responses that reach across government, non-government and community. It takes a two-tiered approach to analysis the cases: - Tier 1: 'real time' domestic violence homicide dataset (for quantitative data analysis) - Tier 2: Examination of in-depth case reviews (qualitative data analysis), following a comprehensive examination and analysis of all available case material. The secretariat prepares a case review report, which is examined by the team in a series of workshops. Recommendations are developed in consultation with agencies.	Unclear how long the DHRs take, but the aim of the DHR specifies that the team looks at closed cases, meaning they are reviewed after the court process has finished.

Jurisdiction	DHR Process	Time scale of DHR
	It includes a document review, although the 2017-2019 report states opportunities to engage with surviving friends and family is being explored.	
Canada		
British Columbia	Ad hoc panels that include government and non-government representatives. In 2010 the panel convened on March 9, 10 and 11, at the Office of the Chief Coroner in Burnaby to examine the circumstances surrounding 11 incidents of domestic violence. The 11 incidents that are the subject of this report were selected from a review of over 100 coroner case files dating back to 1995. After examining the circumstances related to the fatal incidents, the panel made several findings and recommended strategies for preventing similar deaths in the future. The panel's findings and conclusions were reported to the chief coroner by the chair. The 2016 Review was held on June 8-9, and included deaths resulting from intimate partner violence. The circumstances of 100 deaths as a result of IPV incidents were reviewed in aggregate. The panel reviewed the coroners investigative findings, academic literature, information provided by panel members, public policies and strategies and discussed environmental, social and medial factors associated with the deaths, possible trends or themes and existing challenges.	The first review was held during the course of 3 days, the second review was held during the course of 2 days. It is unclear how much preparation time preceded these sessions, or how much time was needed for writing the report.
Saskatchewan	The Ministry of Justice compiled a list of domestic violence deaths in Saskatchewan between 2005 and 2014 by examining closed files from the Office of the Chief Coroner. Of all these death some general characteristics were gathered (gender,	The pilot started in 2015, with its final report published in 2018

Jurisdiction	DHR Process	Time scale of DHR
	age, relationship between victim and perpetrator, where the death occurred etc.). Of the 48 deaths identified, 6 were chosen to review in-depth. The in-depth review was conducted by a multi-disciplinary panel. The Panel tested a standardized assessment process that used risk and victim consideration matrices to examine cases. The review led to a recommendations presented in a report for the Government of Saskatchewan	The multi-disciplinary Review Panel met for seven days over a number of months
Ontario	The Domestic Violence Death Review Committee (DVDRC) consists of multi-agency representatives. In some cases, external expertise on specific issues is sought if necessary. When a domestic violence homicide or homicide-suicide takes place in Ontario, the Executive Lead of the DVDRC is notified and basic case information is recorded in a database. Reviews are conducted by the DVDRC only after all other investigations and proceedings – including appeals – have been completed – the executive lead will verify the status periodically. Once it has been determined that a case is ready for review, the case file is assigned to a reviewer (or reviewers). Each reviewer conducts an examination and analysis of facts within individual cases and presents their findings to the DVDRC as a whole. Information considered within this examination includes the history, circumstances and conduct of the perpetrators, the victims and their families, and community and systemic responses. They are examined to determine primary risk factors, to identify possible points of intervention and develop recommendations.	As the committee only investigates a case after all investigations and proceedings have been completed the timescale before a DHR starts can vary. Unclear how long the process takes once a review commences

Jurisdiction	DHR Process	Time scale of DHR
	Family members and other stakeholders can provide input to the DVDRC through the Regional Supervising Coroner responsible for the area where the homicide or homicide-suicide took place. Information is provided through the course of the initial coroner's investigation.	
England	Reviews are initiated by Community Safety Partnerships (CSPs). CSPs are local partnerships between the police, local authorities, probation service and voluntary agencies, that develop and implement strategies to protect local communities from crime. The police informs the relevant Community Safety Partnership in writing on a domestic homicide. The chair of the CSP is responsible for establishing whether a case is to be subject of a domestic homicide review (as set out by the guidelines). When it is decided a review should take place CSP will request a panel to be set up. The review panel can either have a fixed, standing membership or can be tailored for the purpose of a particular homicide review. The panel should include individuals from both statutory agencies (listed under section 9 of the 2004 Act) and voluntary/community sector organisations. The panel must also include specialist/local domestic abuse service representation. Family, friends and colleagues do not sit on the panel, although guidance advices to invite them to participate/contribute to the review. The review panel appoints an Independent Chair to co-ordinate the review process and producing the final report. The panel will consider the scope of the review and draw up a terms of reference. A case review follows.	The decision to hold a review should be taken within 1 month of a case coming to the attention of the CSP. The overview report should be completed within a further 6 months of the date the decision to proceed is taken. (could be delayed in case of restrictions due to criminal case) In practice the average time between a homicide occurring and a DHR report being considered by the quality assurance panel is longer. Rowlands (2020) reported an average of 2.4 years.

Jurisdiction	DHR Process	Time scale of DHR
	The Home Office produces multiagency statutory guidance to lay out the review process in detail. A quality assurance panel is installed to oversee the DHR system as a whole, and approves reports submitted by CSPs to be published. Where the victim is between 16 and 18 years old, both a Serious Case Review and a DHR are required. These may be run in parallel, and some aspects can be commissioned jointly	
New Zealand	The FVDRC is an interagency and multi-disciplinary committee. It has a maximum of eight members, appointed by the HQSC for three years, covering diverse knowledge and expertise on family violence The FVDRC has a twin-track data collection system: 1. collecting a standard set of data on each family violence death event over time, which the Committee aggregate and report on regularly. Data comes from police and coronial information 2. conducting in-depth reviews of death events to identify the unique details of each event, gain insights into the functioning of the multi-agency family violence system and ways to prevent future deaths. Four regional review panels conduct the death reviews. Three to four in-depth reviews are held per year. The regional panels include representatives from the key agencies involved in the family violence response along with family violence and cultural experts. The review includes: (i) a traumagram to	Originally the FVDRC was expected to review each family violence death within six months of the death event. However, the judicial process can take over two years to complete, and the information collected through this process is considered of value, therefore the in-depth reviews are now only conducted after this process has been completed.

Jurisdiction	DHR Process	Time scale of DHR
	map experiences of trauma for the families and whānau involved (often over four generations), (ii) collation of narrative life stories of the people involved and (iii) a multi-chronology timeline of key events, agency practice and collaborative work. Analysis is aligned with understanding family violence response as a complex adaptive system. The committee has started to speak with friends and family, but the families do not engage with the agency representatives present for each review. The committee acknowledges that this creates a non-reciprocal approach, and would like to fully embed the family in a “healing” review process.	
Northern Ireland	The Police Service of Northern Ireland (PSNI) sends a notification to the Senior Oversight Forum (SOF) when there is a (suspected) domestic homicide of a person aged 16 or older. If a death can reasonably be judged to fit the case selection criteria, the SOF commissions a DHR. The SOF is chaired by the Department of Justice and comprising representatives from the Police Service of Northern Ireland (PSNI), the Probation Board for Northern Ireland (PBNI) and the Health and Social Care Board (HSCB). The Department of Justice appoints three Independent Chairs for a period of three years. Each review will be allocated to one of the Independent Chairs from the pool of three (on a rota basis). The Independent Chair will request initial information from relevant agencies. A panel will be formed by SOF and the Independent Chair. The members of the	A decision on whether or not to commission a DHR will be taken as soon as practicable and within six weeks of a death. The length of time completion of a DHR will take, depends on the specifics of the case and criminal proceedings. Expected time frames are: establishing a panel and undertaking internal learning reviews - 8 to 12 weeks; Analysing information and drafting report - 10-

Jurisdiction	DHR Process	Time scale of DHR
	panel include statutory, as well as voluntary and community sectors organisations. They should be independent of line management of staff involved in the case. During a DHR process relevant information is requested from a variety of sources, including commissioning of Internal Learning Review from statutory bodies, community and voluntary sector organisations. There will also be engagement with family and friends. The information will be analysed by the panel and a DHR report will be written. A DHR Secretariat provides administrative support to the DHR process. When a victim is between 16 and 18 years old, the Independent Chair should engage with the Child Case Management Review (CMR) process to agree whether one process could be adopted (and one report published), to avoid duplication.	12 weeks; Finishing/submitting report - 4-6 weeks. Completion of review (including publication or report) is expected within 26 to 39 weeks
Portugal	Centralized review team, housed at the General Secretariat of the Ministry of Internal Affairs. The team is made up of a coordinator and a case analysis unit (Unidade de Análise e Estudos de Casos). The team coordinator is a magistrate of the Public Prosecutor's Office, appointed for three years. The analysis unit consists of permanent and non-permanent members. The permanent members include government representatives. The team determines the methodology that is adopted to do a DHR, identify cases that are in their remit, obtain information on these cases, prepare a case dossier, and prepare a final report for each case that includes recommendations.	Decision to review a case taken within 10 days Unclear if there is a timeline for the analysis phase, but the 2020 activity report presents findings of three cases all from 2018. The four case dossiers that were opened in 2020 were still pending analysis. This might be due to the fact that

Jurisdiction	DHR Process	Time scale of DHR
	Information that is analysed includes court documents and health records. The team can request information from agencies that potentially had contact with victim or perpetrator, as well as statements from family and friends. Per year a maximum of 10 cases will be reviewed (as more than 10 homicide can fit the case selection criteria, priority is given to cases where the victim is a minor and/or where a previous identical situations is known). When a case is selected for analysis, a member of the team will be made the case manager. The case manager is responsible for proposing the appointment of non-permanent and occasional members, arranging technical support, scheduling the team meeting to analyse the case, and prepare the final report	the review is done after criminal proceedings have finished. The centralized review team meets at least once a month, and designs an action plan for each year.
USA		
Colorado	Local review teams conduct in-depth reviews. In 2018 there were three active local review teams in Colorado. Case information is compiled with the cooperation of respective law enforcement agencies and/or prosecutors' offices, as well as any other entities authorized to release information related to the case. The compiled cases are presented and discussed by members of the respective review team. The Denver team has 25 members, from a broad range of professional expertise and is coordinated by the Rose Andom Center, which researches and analyses the data and together with the review team develops recommendations.	No information found on specific time-lines In 2018 there were 37 incidents in Colorado, 11 were reviewed in-depth. The Denver Metro Domestic Violence Fatality Review Team annually reviews 6-10 DA fatality or near fatality incidents in-depth.

Jurisdiction	DHR Process	Time scale of DHR
	The CDVFRB collects basic information on all domestic violence fatalities as well as more detailed data from the local reviews. The CDVFRB reports on this collated information and gives policy recommendations. The board together with the Denver team establishes uniform methods for collecting, analysing and storing data	
Delaware	Delaware has one state-wide team (the Domestic Violence Coordinating Council's Fatal Incident Review Team (FIRT)). The team consists of core members (of government agencies and victim services), who can invite other people to the panel for each review. The core team includes three members of the Domestic Violence Coordinating Council (who are co-chairs). Each core member has a specific role, set out in a Policy and Procedures document. The Attorney general gives approval to review a case. When a case is approved to be reviewed, each team member will receive a Cover Sheet, to fill in information about the case. Local agencies that had contact with the victim/perpetrator/family are identified and join the panel. Information will also be requested from them. Once all information has been received a review meeting will be scheduled, led by one of the co-chairs. Findings and recommendations are formulated by the panel and are only adopted upon a sixty percent (60%) vote of participating members of the review panel. The review team will issue an annual report to the Domestic Violence Coordinating	The review team will meet on a monthly basis, provided there are cases eligible for review. Unclear how long it takes to gather all information. The policies and procedure document states that two week before the review meeting takes place all information should be sent to the coordinator. If during the review meeting it becomes clear there is a lack of information, the panel members should gather the needed information and reschedule the review. The interview with the victim in near

Jurisdiction	DHR Process	Time scale of DHR
	Council summarizing aggregated findings and recommendations made over the year by each review panel. Case specific information is confidential. In case of a near-death incident, the victim will be asked to participate in a victim interview. When the victim is a minor, the case is reviewed jointly by the regional panel of the Child Death, Near Death and Stillborn Commission and the FIRT.	death cases is held before the review meeting
Maryland	Maryland has 18 county-based domestic violence fatality review teams. The members of a local team will come from a variety of organisations, backgrounds and areas of expertise. The Maryland Network Against Domestic Violence coordinates the teams and provide training and technical assistance. Each local team creates their own protocols to govern their operations, using a model protocol as a guide (based on the legislation, best practices and experiences from teams around the state). The teams must meet at least once a year to review county data on domestic homicides and near deaths and give recommendations to improve coordination and reduce deaths. Some teams have a case screening selection committee, others receive cases from prosecutor or law enforcement or a team consensus selection process by the team itself. When a case will be reviewed, information is gathered from all agencies	No information found

Jurisdiction	DHR Process	Time scale of DHR
	involved, and interviews can be conducted with family members, friends and/or the perpetrator. This information is reviewed and recommendations are made.	
Montana	The teams consist of 16-18 members and are led by a facilitator. They include government and non-government representatives Each team reviews two cases a year in-depth (an “inch side, mile deep” approach). Quantitative data is captured on all cases of domestic homicides to allow identification of trends. In each case the teams review all available information, including law enforcement reports, criminal histories, medical and autopsy records, presentence investigations, newspaper stories and criminal justice records. They will also interview family, co-workers, school personnel, friends, shelter staff and all other relevant individuals to learn more about the victim and the perpetrator. The team then travels to the community where the death occurred, reviewing the case with local partners and compiling a timeline of events leading up to the deaths. The timeline indicates involvement with agencies and services, as well as missed opportunities, things that worked well and gaps in services.	Unclear how much time is spent on information gathering. Once in the local community, the team takes two days per case
Vermont	Vermont has one commission comprised of 17 members, including Commissioners of several state departments, Attorney, Defender General, members of DA agencies, representative of law enforcement, victim-survivor of DA, physician and a judge.	The commission meets 6 times a year. The legislation states: upon written

Jurisdiction	DHR Process	Time scale of DHR
	(Quantitative) Data is gathered on all cases, but a selection will be reviewed in-depth. The commission reviews data provided by the Medical Examiner and law enforcement records for all homicides to determine if they are domestic violence related. Of these, the Commission selects one or two cases to review in depth. The cases selected will be fatalities that are not under investigation or are post adjudication. When a case will be reviewed, the commission will request information from relevant agencies. The commission will meets bi-monthly to discuss all DA related homicide, the in-depth review of one or two cases, trends and recommendations. Recommendations are reported annually and made based on common threads in the case reviews, although occasionally recommendations are based on a single case review	request of the Commission, a person who possesses information or records that are necessary and relevant to a domestic violence fatality review shall, as soon as practicable, provide the Commission with the information and records.
Washington	DHRs are implemented by regional multi-agency panels, convened in fifteen counties. Panels can also invite people on ad hoc basis, for a particular in-depth review. The local panels allow for people who are closely involved in the community response to DA to be actively involved. The panels review a selection of all cases (between 1998-2010 84 cases were reviewed). Data is collected on all domestic violence related homicide and suicide deaths in the	No information found

Jurisdiction	DHR Process	Time scale of DHR
	state, using a standard from, and is combined with other state-wide data sources such as death certificates, court records, census data. Research and data analysis include: the connection between domestic violence history and suicide; disproportionate rates of domestic violence homicide by race; domestic violence homicide victims' use of child support enforcement; and pregnancy rates among victims killed by intimate partners.	
Wales	In Wales DHRs are, similar to England, implemented on a local level, either through a Community Safety Partnership or a Public Service Board (PSB). The other two homicide reviews in Wales are commissioned either by regional Safeguarding Boards (the CPRs/APRs) or the Health Inspectorate Wales (the MHHRs). In some cases multiple reviews (e.g. both MHHR and DHR) will be carried out for the same case, which can lead to duplication of evidence gathering. At the moment the process of initiating a review, reporting to the Home Office, setting up the panel and producing the report is similar to England. However, after reviewing the process, the Welsh Government is implementing changes. It has decided to join all types of reviews together under a Single Unified Safeguarding Review (SUSR). Regional Safeguarding Boards will coordinate Regional Case Review Groups, which will consider all referrals for CPRs, APRs and DHRs. It will recommend whether a SUSR is necessary or an alternative service review can be carried out. New guidance to deliver reviews under a single system whilst delivering against devolved and non-devolved legislation is being prepared. A SUSR Coordination Hub will provide a secretariat, hold a list of approved chairs, and liaise with regional	See England Under review (changing to Single Unified Safeguarding Review. SUSR have the aim to complete each review within 12 months, with as many meetings of the panel as necessary)

Jurisdiction	DHR Process	Time scale of DHR
	partnership boards on progress against recommendations and actions. Training will be offered to practitioners. There is central repository (Wales Safeguarding Repository), established in 2021 at Cardiff University (including all past reviews as well).	

Table 4: Reporting, monitoring and evaluation

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
Australia	The Australian Review Network shares and collates findings of the different states/territories It published their first Death Review Network Data Report in 2018 which provided national data with respect to all intimate partner homicides that occurred in a domestic violence context between 2010 and 2014.		The budget of the ANROWS and network's research project (2020-2022) was AUD $129,664 (about £76,000)
South Australia	Coronial inquests will give recommendations relating to domestic violence systems improvement, which are published. Since 2015 there is a Coronial Domestic Violence Information System (CDVIS) that incorporates over 120 different perpetrator and victim-specific variables. It is built to support evidence-based decision making in	The nine Coronial inquests led to 43 recommendations. Unclear how the recommendations are followed up	No information found

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
	policies and programs to reduce violence against women and their children.		
Western Australia	The annual report (to the government) of the Ombudsman includes a section on Family and Domestic Violence Fatality Reviews, providing statistics of the victims and perpetrators and circumstances of the homicides of that year. The report also provide a discussion of patterns and trend collating data from previous years. Recommendations following the reviews of that year are included. The reviews led to the Ombudsman's major own motion investigation: "Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities". This was published in 2015, and tabled in Parliament.	The Ombudsman monitors recommendations. In their annual report, implementation of previous recommendations are highlighted (including those mentioned in the major own motion investigation) The implementation of the recommendations discussed in their major own motion investigation (of 2015) were reported upon (to Parliament) in a second report published in 2016	No information found
New South Wales	The DVDRT reports to the NSW Parliament biennially, and includes recommendations derived from individual (tier 2 - or qualitative analysis) and groups (tier 1 - or quantitative analyses) of cases. The recommendations cover legislation, policies, practices and services. Every biennial report is followed by a report from the	Recommendations are expected to be implemented by government and non-government agencies. The DVDRT undertakes public monitoring of its recommendations and the responses to these. Information of	No information found

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
	NSW government responding to the recommendations Both reports are made available on the website of the NSW Coroners Court.	implementation is recorded in its reports and on its website.	
Canada			
British Columbia	Ad hoc reporting In the 2010 report recommendations were made to specific ministers and government agencies. In the 2016 report the panel put forward 3 (more general) recommendations that would be taken up/led by the Provincial Office of Domestic Violence. The two current reports are published on the website of the BC Coroners Service.	Unclear whether there is a monitoring process/follow-up on the recommendations listed in the reports. The 2010 report states: "The panel submits the following recommendations for review, consideration and distribution, as deemed appropriate by the chief coroner"	The Coroners Service organises Death Review Panels regularly, which are not just specific to domestic abuse (there was for example also one on illicit drug deaths and on heath mortality). On average the cost per Panel is CAD $2-3,000 to cover travel, meeting and printing costs (£1300-2000)
Saskatchewan	An interim report was published in 2017, and a final report published in 2018. The report includes quantitative data on domestic	In 2019 the ministry released a response which outlined the ongoing government-	No information found

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
	homicides, a description of the review process and recommendations. No specific information on the in-depth reviewed cases were included.	wide initiatives that address the 19 recommendations of the report . One of the recommendations included in the report was that all domestic violence deaths should be reviewed using the methodology the pilot panel set up. The Panel also recommended that the review should be mandated through legislation or amendments to existing legislation. The government response did not address these recommendations.	
Ontario	Annual reporting, covering trends, risk factors, patterns identified through the reviews, and recommendations to prevent deaths in similar circumstances. Trends are mainly reported in a statistical overview. Short summaries of each case are included in the appendix of the report. Recommendations are distributed to relevant organizations and agencies through the Chair of the DVDRC. If a case identifies issues/recommendations that have already been addressed by previous reviews, they might be recorded for information purposes only, or the report might list 'no new recommendations'.	The recommendations developed by the DVDRC are not legally binding and there is no obligation for agencies and organizations to implement or respond to them. However, organisations and agencies are asked to respond back to the Executive Lead of the DVDRC on the status of implementation of recommendations within six months of distribution. Organizations are encouraged to “self-evaluate” the status of their response to the recommendations. The Office of the	Within coroner’s budget. Annual cost CAN $14-26K (£9-17K)

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
	All reports and recommendations are distributed electronically	Chief Coroner does not challenge or question responses received. Responses to recommendations are available to the public upon request	
England	All relevant agencies produce a comprehensive individual management review (IMR) of their full involvement with the victim and alleged perpetrator. The lessons to be learned and proposals for addressing these are drawn out from the IMRs and are presented in an overview report, published for each case. The report also includes any risk factors for domestic violence and abuse that were identified during the review and recommendations for future action (presented in a SMART action plan). The Home Office Quality Assurance Panel gives permission for the overview report (and executive summary of each review) to be published. When the quality assurance panel approves publication, the CSP publishes an anonymised overview report and executive summary on the CSPs website. In terms of collecting the overall learning of all DHRs, there is an absence of a common data set, making	The statutory guidance refers to the need to follow-up on the established action plans: "*To derive value from the DHR process and prevent further abuse and homicide, CSPs should satisfy themselves that there are appropriate governance mechanisms in place for monitoring delivery against DHR action plans*" Research has pointed out, however, that there is very little known about implementation of the recommendations. In a review of the English system Rowlands (2020) point out that a particular challenge is that some local authority teams may no longer have a specialist DVA or VAWG lead officer, which might mean that CSPs do not	Limited information found Research by Boughton (2021) showed that CSPs can struggle with the financial investment of doing a DHR. Participants involved in DHRs reported that DHRs are an expensive resource and a single DHR can ran into thousands of pounds.

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
	comparison difficult. There is no routine analysis across DHRs, although the Home Office has published (ad-hoc) reports presenting key findings form analysis of DHRs across England and Wales.	have the right skills, expertise or time to follow-up on the recommendations.	
New Zealand	The committee reports regularly, with each report reflecting on the previous ones. Each report might therefore have a slightly different focus, with early reports focusing on how individual agencies or components of the system responded to cases and more recent reports reflecting on wider systemic processes or structures that work to reinforce violence experiences. Each report provides recommendations to improve agencies responses and to improve the overall system. They are not directed to individual agencies but are seen as applying to all agencies.	The FVDRC reports on the implementation of past recommendations. This is done by requesting a detailed update on progress from the agency responsible for implementing the recommendation. Reports reflect on key recommendations of previous reports and how work towards implementing the recommendations has progressed (or not). In the latest report by the FVDRC, the committee acknowledged that little has changed for those experiencing violence in New Zealand.	No information found
Northern Ireland	For each DHR a report will be drafted by the Independent Chair. The Chair will also ensure the findings and suggested actions are translated into	The SOF is responsible of the implementation of actions and lessons learned. The Secretariat collates a	No information found

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
	measurable change (in an Action Plan, attached to the report). The draft report and action plan will be shared with the panel, who have 10 working days to consider it, after which a meeting takes place to formally sign off the report. Reports completed by the independent chairs will be considered by the SOF (for quality assurance). When a report is signed off by SOF it will be made publicly available on the DHR website. The SOF will also drive dissemination of the lessons identified. It commissions the pool of Independent Chairs to work together to produce a thematic report, at least once every two years, to collate information of all the DHRs within that period and reflect on what has been learned from the cases collectively. The thematic repot will be published on the DHR website.	regular action plan update, for SOF's consideration. SOF will hold a quarterly meeting to monitor progress against the various action plans for all completed DHRs. Each review will remain as a standing item on the agenda until all of the actions in its action plan have been implemented.	
Portugal	For each case that is reviewed a report is written. The report consists of the following parts: a) Composition of the Team; b) Summary of the case under analysis; c) Review of the information gathered; d) Description of the facts found; e) Analysis/discussion of the case; f) Conclusions; and g) Recommendations	The team interacts with relevant agencies to follow up on recommendations (unclear to what extent), and has also provided training. The methodology used for the DHR is	No information found

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
	The reports are published (anonymised) on the website of the review team. The report will also be send to any agencies involved in the case, or that are linked to any of the recommendations. Each year the team will produce an annual (activity) report, noting all the recommendations that were included in the reports published that year.	regularly evaluation (biennially), and the manual updated.	
USA			
Colorado	An annual report is written, and submitted to the Health and Human Services and Judiciary Committees of the Colorado Senate and the Public Health Care and Human Services and Judiciary Committees of Colorado House of Representatives. The board will examine data collected by review teams and identify measures to help prevent domestic violence fatalities and near-death incidents.	Unclear whether there is a monitoring process for the recommendations listed in the reports. A 2022 Bill introduced to the Colorado General Assembly reviews the DVFRB tasks and will require the board to pursue and implement any recommendations, with a focus on improving communication and information-sharing between agencies, as well as provide coordination and technical assistance and training.	No information found

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
Delaware	Annual report, including aggregated findings and statistics, and recommendations.	The annual report includes responses to the recommendations of that year as well as follow up of recommendations from previous years	No information found
Maryland	Each team prepares an annual report that compiles the recommendations. These reports are public and anonymised (findings are not ascribed to particular cases). The state-wide team (MDADV) provides an annual report, the DV Homicide Prevention Report, which includes state-wide domestic homicide statistics, information on the review process and their activities (including providing technical support) to support review teams.	All team members will take back any recommendation to their individual organisation with a request for consideration and action. At a subsequent meeting team member may provide feedback from their agency and report on any actions taken. Follow-ups can also be included in the teams' annual reports If the recommendation applies to laws, community practices, or entities other than those represented by the members, the team will create an action plan to effectuate the recommendations, often with the assistance and guidance of the MNADV.	No information found
Montana	Biannual reporting to the Law and Justice Interim Committee, the Attorney General, Governor, Chief Justice of the Montana Supreme Court and the people	The teams monitor the progress of the recommendations that are identified.	Paid for by the Violence Against Women Act budget

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
	of Montana. The Commission meetings and records are confidential, but state law requires it to publish a report detailing (general) findings and recommendations.	The Montana teams are recognized as a model for fatality review in the USA. Representatives from other stated an tribal jurisdictions come to observe the review process.	Commission members volunteer their time
Vermont	Commission proceedings and meetings are confidential by statute. The Commission reports its findings and recommendations annually to the Governor, the General Assembly, the Chief Justice of the Supreme Court and the Vermont Council on Domestic Violence. Reports of the commission are publicly available on the Attorney General's website's Reports page	The 2018 report states that the Chair of the Commission and the Coordinator of the Vermont Council of Domestic Violence met monthly to work on implementing the past recommendations. The annual reports also includes updates on recommendations and successes	No specifics found. A grant was received in 2014 from the Office on Violence Against Women (federal government)
Washington	A biennial state-wide report is published by the WSCADV, as well as issue briefs and summaries of review recommendations. There are statistics available of fatalities by county, aimed to be updated every 6 months.	The initial legislation called for a recommendation to be made in 2010 as to whether the process should continue. A recommendation was provided to continue the review, and to expand the work to include supporting communities to implement the recommendations made. The WSCADV have a page on their website "how to use fatality reviews",	No information found

Jurisdiction	Reporting	Monitoring and Evaluation	Costs
		which includes examples of how recommendations are used by agencies. Unclear whether there is a systematic follow-up on recommendations	
Wales	See England A national safeguarding repository was established in 2021, and will hold the SUSRs and all previous DHRs, CPRs, APRs, MHHRs	The Minister for Violence against Women and Girls and Sexual Violence commissioned a review of the DHR process, to assess the effectiveness of CSP and other public services to respond to DHR recommendations. It resulted in a change to work with regional safeguarding boards on single unified safeguarding reviews. A coordination hub will be established to liaise with partners on the progress against recommendations	Chairs are paid on average 10-15K

Annex 2 – Literature and Evidence Sources

Overview of the literature included in this evidence briefing

Document and websites accessed by jurisdiction

Jurisdiction	Literature
Australia	Australian Bureau of Statistics: Recorded Crime - Victims, 2021 | Australian Bureau of Statistics (abs.gov.au) Office for Women – Government of South Australia: Office for Women - Coroner's research position ANROWS: Australian Domestic and Family Violence Death Review Network national data update - ANROWS - Australia's National Research Organisation for Women's Safety
Australia – South Australia	Australian Bureau of Statistics: Recorded Crime - Victims, 2021 | Australian Bureau of Statistics (abs.gov.au) Office for Women – Government of South Australia: Office for Women - Coroner's research position Report "Second Action Plan 2013-2016: Moving Ahead. Of the National Plan to Reduce Violence Against Women and their Children 2010-2022", available at: Second action plan 2013-2016 – moving ahead – of the national plan to reduce violence against women and their children 2010-2022 (1library.net) Courts Administration Authority of South Australia: Inquests - CAA (courts.sa.gov.au)
Australia – Western Australia	Australian Bureau of Statistics: Recorded Crime - Victims, 2021 | Australian Bureau of Statistics (abs.gov.au) Ombudsman Western Australia: Ombudsman Western Australia Annual Report 2021, Ombudsman: Ombudsman WA Annual Report 2020-21 Family and Domestic Violence Fatality Review
Australia – New South Wales	Australian Bureau of Statistics: Recorded Crime - Victims, 2021 | Australian Bureau of Statistics (abs.gov.au) Coroners Court New South Wales: Domestic violence death review (nsw.gov.au)
Canada	Statistics Canada: Domestic Homicide Numbers: Section 2: Police-reported intimate partner violence in Canada, 2017 (statcan.gc.ca)

	Canadian Domestic Homicide Prevention Initiative: DVDRC Committees | Canadian Domestic Homicide Prevention Initiative (cdhpi.ca)
Canada – British Columbia	Province of British Columbia: Death Review Panel Reports & Information - Province of British Columbia (gov.bc.ca) 2010 Review report: Findings and Recommendations of the Domestic Violence Death Review Panel - May 2010 (gov.bc.ca) 2016 Review report: Death Review Panel Report on Intimate Partner Violence Deaths from 2010-2015 (gov.bc.ca)
Canada – Saskatchewan	Domestic Violence Death Review Final Report: Domestic Violence Death Review Final Report Released | News and Media | Government of Saskatchewan Response to the Domestic Violence Death Review 2019: Publications Centre (saskatchewan.ca)
Canada - Ontario	2018 Annual Report: Domestic Violence Death Review Committee 2018 Annual Report | Ontario.ca
England	Office for National Statistics: Homicide in England and Wales - Office for National Statistics (ons.gov.uk) Home Office – DHR Statutory Guidance: DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk) Home Office – online learning: Conducting a domestic homicide review: online learning - GOV.UK (www.gov.uk) Home Office – Criteria for reports: criteria-DHR-web-v2.pdf (publishing.service.gov.uk) Report – Key findings form analysis of domestic homicide reviews: Key findings from analysis of domestic homicide reviews - GOV.UK (www.gov.uk) Rowlands 2020a
New Zealand	New Zealand Police: homicide victims (police.govt.nz) Health Quality & Safety Commission New Zealand: Family Violence Death Review Committee | Health Quality & Safety Commission (hqsc.govt.nz) Family Violence Death Review Committee Terms of Reference: Microsoft Word - FVDRC Terms of Reference FINAL - May 2021 (updated July 2022).docx (hqsc.govt.nz) Short et al. 2019: Thinking differently: Re-framing family violence responsiveness in the mental health and addictions health care context - Short - 2019 - International Journal of Mental Health Nursing - Wiley Online Library

Northern Ireland	Police Service of Northern Ireland: Trends in Domestic Abuse Incidents and Crimes Recorded by the Police in Northern Ireland 2004/05 to 2020/21 (psni.police.uk) Department of Justice – DHR guidance: multi-agency dhr guidance.pdf (justice-ni.gov.uk) NI direct – government services: Domestic Homicide Reviews (DHRs) | nidirect Irish Legal News: NI: Domestic homicide reviews introduced in Northern Ireland | Irish Legal News
Portugal	Observer: APAV supported 99 people following attempted or consummated homicides – Observer (observador.pt) EIGE femicide fact sheet: Femicide | European Institute for Gender Equality (europa.eu) Equipa de Analise Retrospectiva de Homicidio em Violencia Domestica (EARHVD): EARHVD (mai.gov.pt)
USA	NDVFRI: ABOUT - National Domestic Violence Fatality Review Initiative (ndvfri.org)
USA – Colorado	DHR Report: Colorado Domestic Violence Fatality Review Board Report - DocsLib Colorado General Assembly: Continue Domestic Violence Fatality Review Board | Colorado General Assembly Rose Andom Center: Domestic Violence Fatality Review – Rose Andom Center
USA – Delaware	Fatal Incident Review Team 2020 Annual Report: Fatal Incident Review Team 2020 Annual Report (delaware.gov) The Delaware Code Online: Delaware Code Online Domestic Violence Coordination Council: Fatal Incident Review Team - Domestic Violence Coordinating Council (DVCC) - State of Delaware
USA – Maryland	MNADV Fatality Statistics Graphic: MD-DV-2019-Fatality-Statistics-Graphic-8.7.2020.jpg (2550×1650) (mnadv.org) MNADV 2020 Annual Report: 2020-DV-Homicide-Prevention-Report.pdf (mnadv.org) Schlaich & Thompson – Harford County Trial Lawyers: Local Domestic Violence Fatality Review Teams in Maryland (stclaw.net)
USA – Montana	Montana Board of Crime Control: MBCC - Montana Crime Data (mt.gov)

	Montana Code (annotated 2021): 2-15-2017. Domestic violence fatality review commission -- confidentiality of meetings and records -- criminal liability for unauthorized disclosure -- report to legislature, MCA (mt.gov) Department of Justice: Domestic Violence Fatality Review Commission - Montana Department of Justice (dojmt.gov)
USA – Vermont	2021 DHR Report: Domestic Violence Fatality Review Commission (vermont.gov) 2018 DHR Report: 2018-Final-DV-Report.pdf (vermont.gov) Vermont General Assembly: Vermont Laws
USA – Washington	WSCADV: Washington State Domestic Violence Fatality Review – Washington State Coalition Against Domestic Violence (WSCADV) and Overview of the Washington State Domestic Violence Fatality Review – Washington State Coalition Against Domestic Violence (WSCADV) WSCADV Statistics: fatalities by county through 12-31-2021 DRAFT.xlsx (wscadv.org) Washington State Legislature: Chapter 43.235 RCW: DOMESTIC VIOLENCE FATALITY REVIEW PANELS (wa.gov)
Wales	Office for National Statistics: Homicide in England and Wales - Office for National Statistics (ons.gov.uk) Internal report (James 2018) Robinson 2018 Report Domestic Homicide Review using Adult Practice Review Methodology: D-APR-English.pdf (monmouthshire.gov.uk) Wales Safer Communities Network: Safeguarding Reviews and Domestic Homicide Reviews - Wales Safer Communities

Academic literature on DHR process

Author	Title	Aim and method of review
Jones et al. 2022	Domestic Homicide Review Committees' Recommendations and Impacts: A Systemic Review	Systematic review of research examining DHR processes Method: systematic review of research. The studies are identified through 11 electronic databases and selected using eligibility criteria
Haines-Delmont et al. 2022	Negotiating organisational blame to foster learning: Professionals'	Exploring barriers and facilitators to the impact of DHRs

	perspectives about Domestic Homicide Reviews	Method: interviews with practitioners
Boughton 2021	Investigation Investigations: A Critical Evaluation of the England and Wales Domestic Homicide Review (DHR) Process	To examine the principles and operation of DHRs in England and Wales Method: interviews, observations and (internal) document analysis
Rowlands and Cook 2022	Navigating Family Involvement in Domestic Violence Fatality Review: Conceptualising Prospects for Systems and Relational Repair.	Conceptual article discussing family involvement within DHRs. Method: synthesis of policy, practice and academic literature
Rowlands 2021	Constructing Fatality Review: A Policy Analysis of the Emergence of Domestic Homicide Reviews in England and Wales	To understand policy discourse of DHRs in UK (government) Method: Analysis of policy documents
Rowlands 2020	Reviewing domestic homicide - International practice and perspectives	Review of approaches taken to DHRs, with recommendations to improve the English system Method: Conversations with (selection of) DHR teams, drawing on scholarly research, and own experience
Rowlands 2020	The ethics of victim voice in Domestic Homicide Reviews	Reflections on the ethics of DHRs, specifically when it comes to the aim of a DHR to centre the victim's voice. Method: Based on scholarly research and own experiences
Websdale 2020	Domestic Violence Fatality Review: The State of the Art	Providing an overview of what DHR entails (definition, approach, governance etc.) Method: drawing on scholarly research, primary (DHR) reports and own experience
Robinson et al 2018	Findings from a thematic analysis of reviews into adult	Comparing different review process in Wales. Although most of the

	deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews	report focuses on outcomes of reviews, it also includes a reflection on overlap of different processes. Method: analysis of a sample of review documents and focus groups with practitioners
Fairbairn et al. 2017	Challenges in Defining Domestic Homicide: Considerations for research and Practice	Reviewing the definition of domestic homicide (in DHRs) Method: drawing on scholarly research and comparing jurisdictions
Dale et al. 2017	Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews	Overview of ethical considerations in DHR processes. Method: drawing on scholarly research and own experience
Mullane 2017	The Impact of Family Members' Involvement in the Domestic Violence Death Review Process	Reflection on family involvement in the DHR process Method: drawing on own experience.
Sheehy 2017	A Feminist Reflection on Domestic Violence Death Reviews	A critical reflection on the need to take a gendered approach. Theoretical (feminist) lens
Bugeja et al. 2015	Domestic/Family Violence Death Reviews: An International Comparison	International comparison of DHR in 25 jurisdictions Method: identification of jurisdictions through search engine. Use of legislation documents, terms of reference and most recently released (DHR) report

Annex 3 – Recommendations by Rowlands (2020a)

Overview of the recommendations Rowlands (2020a) formulated in his report that may be useful to consider in the Scottish context of establishing a DHR process.

1. Articulate a Theory of Change to underpin the DHR process
2. Facilitate a dialogue about the multiple, sometimes conflicting purposes of DHRs
3. Develop a set of principles to inform the DHR process, addressing the roles and responsibilities of key stakeholders, as well as decision making and conduct
4. Develop a shared set of consistent definitions
5. Ensure that decision-making process concerning DHRs is robust and transparent
6. Enable flexibility in the DHR model (rather than 'one size fits all') depending on the case circumstances
7. Develop a competencies framework for panel members
8. Develop an induction/training programme for multi-agency review panel members
9. Provide opportunities in individual DHRs to reflect on the purposes of DHRs, as well as how multi-agency review panel members will work together
10. Ensure specialist representation from domestic violence and abuse and community services are valued, heard and recompensed
11. Address ethical and methodological challenges in undertaking DHRs
12. Enable the routine collection and analysis of a minimum data set
13. Develop a mechanism to collate emerging learning from across DHRs
14. Enable a national programme to provide technical expertise
15. Establish a regular reporting system, underpinned by the aggregation of case data, learning and recommendations, at a regional and national level
16. Clarify the purpose of publication, with reference to responsibilities, aim(s) and audience(s)
17. Establish a national repository to act as a clearinghouse for all completed DHRs

How to access background or source data

The data collected for this <statistical bulletin / social research publication>:

☐ are available in more detail through Scottish Neighbourhood Statistics

☐ are available via an alternative route <specify or delete this text>

☐ may be made available on request, subject to consideration of legal and ethical factors. Please contact <email address> for further information.

☒ cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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