Reviewing domestic homicide – International practice and perspectives

James Rowlands

2019 Churchill Fellow

WINSTON CHURCHILL MEMORIAL TRUST

In memory of those who have been killed, and in acknowledgement of their families and friends who have to navigate the aftermath of homicide.

This report is dedicated to my father, Keith Rowlands. A keen reader of history, he would have been thrilled to know I had been awarded a Churchill Fellowship.

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Acknowledgements

Travelling to research a topic you care about is a wonderful, inspiring opportunity but it can bring challenges. I would like to thank my family and friends for their support over the last year. Thank you too to Sam Oliver.

Thank you as well to the people who have been there at crucial points in my career, providing support that helped me on my way, in particular Jan Pickles and Davina James-Hanman. Thank you also to Linda Beanlands and Charlotte Farrell, who worked alongside me when I first became involved with Domestic Homicide Reviews (DHRs) as a local authority commissioner. Your knowledge, passion and good humour, even in the hardest times, was invaluable.

As I have worked more on DHRs, I have benefited from the advice of many people, including Frank Mullane and Dr Neil Websdale. I am also grateful to have had the opportunity to work as an Independent Chair with my colleagues at Standing Together Against Domestic Violence (STADV). My particular thanks to Althea Cribb and Laura Croom.

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Biography

James Rowlands has been working in the Domestic Violence and Abuse (DVA) and wider Violence Against Women and Girls (VAWG) sector since 2004. He is currently a Doctoral Researcher at Sussex University where he is completing an Economic and Social Research Council (ESRC) funded PhD looking at DHRs in England and Wales. Specifically, he is researching the part DHRs play in the coordinated community response and the difference they make, including whether they bring about system change and reduce the likelihood of future homicides. For more information, go to https://profiles.sussex.ac.uk/p450624-james-rowlands. James also works as a consultant. In this capacity, he is an Independent Chair of DHRs. For more information, go to https://www.jhrowlands.co.uk/about.

[1] https://www.wcmt.org.uk

[2] See *Appendix Three* for a list of organisations and individuals involved by country.

Executive Summary

My 2019 Churchill Fellowship investigated how other countries review domestic homicides, with the intention of using this learning to improve practice in the UK. Over nearly eight weeks, in three legs, I was able to visit the USA, New Zealand, Australia and then Canada. During my travels, I gathered information about how domestic homicides were reviewed in these countries and was able to talk with activists, practitioners and academics about their experiences.

Drawing on my dual roles as a practitioner and a researcher, this report summarises what I learnt. It focuses on the principles which underpin the review of domestic homicides internationally, as well as considering issues like establishment, cases selection, membership, sense-making, and the production of learning and recommendations. It then considers the implications for DHRs in England and Wales, both nationally as a system and during the conduct of individual case reviews, in light of the strengths and weaknesses of current arrangements. A thread running through this report is that despite the appearance of being national in scope, in practice the DHR system is a localised endeavour. This means there is the potential for differences in both understanding the purposes and the practice of DHRs, with this potential being exacerbated by issues with both implementation and oversight to date.

In response, this report poses 12 questions and makes recommendations in response. These will be relevant to a range of stakeholders, in particular those with a responsibility for the delivery of the DHR system nationally, now or in the future, as well as those involved in DHRs when they are conducted into an individual death. I hope the questions and recommendations contribute to a dialogue about how we might embed, develop or expand best practice in the DHR system in England and Wales.

While this report raises many questions about DHRs, both as a system and in terms of individual case review, a note of caution is important. First, the current weaknesses of the DHR system should not distract from its strengths, the hard work and commitment of many of those involved, or its potential. Second, the answer to the questions I ask in this report is surely not that we should stop doing DHRs, nor that we should narrow their scope or ambition. It is also important to resist the lure of simple or expedient solutions which lead to the same result through the back door. Instead, I believe reviewing domestic homicides is a necessary if challenging endeavour. Our task is to ensure we have a DHR system that is fit for purpose. That is, it can honour those who have died and also challenge narratives that excuse or minimise the actions of those who caused their deaths. At the same time, it must also be able to increase our understanding of the circumstances of domestic homicide at a case and aggregate level, as well as identifying learning and recommendations, in order to improve our individual and collective responses.

The questions this report poses, and recommendations it makes in response, are as follows:

Questions	Recommendations
1. How can we develop and sustain a shared understanding of the purposes of DHRs?	1a. Articulate a Theory of Change to underpin the DHR process 1b. Facilitate a dialogue about the multiple, sometimes conflicting purposes of DHRs 1c. 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 1d. Develop a shared set of consistent definitions 1e. Identify opportunities to collaborate with other aligned initiatives e.g. the Femicide Census
2. How can we ensure that there is effective oversight of the DHR system at a local, regional and national level? In answering this question, what constitutes effective oversight and what is its purpose?	2a. Evaluate the effectiveness and impact of the current arrangements for oversight of the DHR system, including existing local (through CSPs) and national (by the Home Office) arrangements 2b. Consider whether national oversight of the DHR system should be transferred to the Domestic Abuse Commissioner 2c. Identify best practice and make recommendations to ensure that CSPs are discharging their responsibilities effectively 2d. Develop regional oversight by formalising the role of Police & Crime Commissioners (PCCs) through a co-commissioning model
3. What is the best way to commission and deliver DHRs, while continuing to recognise the unique significance of each homicide?	3a. Ensure that the decision-making process concerning DHRs is robust and transparent 3b. Enable flexibility in the DHR model (rather than 'one size fits all') depending on case circumstances
4. How can multi-agency review panel members be supported to take part in DHRs?	4a. Develop a competencies framework for panel members 4b. Develop an induction/training programme for multi-agency review panel members 4c. Provide opportunities in individual DHRs to reflect on the purposes of DHRs, as well as how multi-agency review panel members will work together 4d. Ensure specialist representation from DVA / community services is valued, heard and recompensed

5. What is the best way to ensure that Independent Chairs have the right skills to lead DHRs?	5a. Develop a competencies framework for Independent Chairs and Report Authors 5b. Develop an induction/training programme for Independent Chairs and Report Authors and develop an accreditation or quality mark 5c. Establish an Independent Chairs and Report Authors Network to share best practice
6. What have we learnt after nearly a decade of DHRs about best practices around methodology?	6a. Drawing on best practice – in the context of DHRs to date, international fatality review systems and other statutory review models in the UK – review the methodology used to undertake DHRs 6b. Review existing guidance around information sharing during the DHR process 6c. Address ethical and methodological challenges in undertaking DHRs
7. How can the DHR system ensure it can 'see the big picture?'	7a. Develop the existing data collection form to enable the routine collection and analysis of a minimum data set 7b. Develop a mechanism to collate emerging learning from across DHRs
8. What is the best way to deliver an oversight function to ensure the quality of individual DHRs and system integrity?	8a. Restructure the quality assurance model by: • Establishing regional panels, to be responsible for the scrutiny of DHRs and regional learning/action • Refocus the national panel, to be responsible for the aggregation of learning and process integrity nationally 8b. Review the composition of the quality assurance panel: • Fill through a public appointment process with panel members serving for fixed terms • Include survivor and community voice, specialist sector and academic representation
9. What is the most consistent and cost-effective way to support best practice?	9a. Establish a national programme to provide technical expertise
10. How can learning be shared across the DHR system?	10a. Establish a regular reporting system, underpinned by the aggregation of case data, learning and recommendations, at a regional and national level 10b. Clarify the purpose of publication, with reference to responsibilities, aim(s) and audience(s)

	10c. Establish a national repository to act as a clearinghouse for all completed DHRs
11. How can the impact of the DHR system be evidenced and sustained?	11a. Given it is the 10th anniversary of the implementation of DHRs in 2021, commission an independent evaluation of the DHR system 11b. In due course, reflecting the outcomes of an independent evaluation, amend legislation and review the statutory guidance to ensure the DHR system is fit for purpose
12. What are the opportunities presented by international collaboration?	12a. Explore opportunities for continued international collaboration to share practice approaches, learning and data

Chapter One: Introduction

This introductory chapter sets out the background to and rationale for my Fellowship, before describing its objectives and my itinerary. It also addresses some of the limitations of this report, as well as clarifying some issues around terminology.

1.1 Background and rationale for the Fellowship

In England and Wales, there were 366 domestic homicides recorded for the year ending March 2016 to the year ending March 2018; of these, 74% involved women being killed by men, usually by a former or current partner (Office for National Statistics 2019, p.19). Reflecting the appalling scale of domestic homicide, DHRs have sadly become all too familiar. Between April 2011 and March 2018, around 500 DHRs were completed (Mullins and Cordy 2018). Our increasing familiarity with DHRs means it can be easy to forget that they are a recent innovation, having only been routinely undertaken since 2011. Their relative infancy in England and Wales means that our knowledge of the 'doing' of DHRs (a term I used to describe the operational and discursive practices involved) is limited. In addition to the doing of DHRs, we also need to consider how they are utilised, both as reviews of individual cases and collectively. How we make use of DHRs will vary depending on our perspective. Those who use DHRs include people who knew a victim personally (like family and friends), as well as professionals, researchers and policymakers. Our use of DHRs may be orientated towards the victim of the homicide (for example, as an act of memorialisation, or as a way to try to answer questions about what happened). Alternatively, our use of DHRs may be orientated elsewhere, including using them to better understand the circumstances of homicide, identifying what works and what does not, and then using any learning to improve individual, agency and system responses. The best DHRs manage to achieve all these things.

Yet, the manner in which DHRs were rolled out – with an emphasis on local implementation, a relative lack of national leadership, too few efforts to systematically aggregate data and learning, no consistent mechanism to monitor recommendations, and the absence of a national repository to store and share published DHRs – has arguably impeded their doing and use. In drawing attention to these issues, I do not want to dismiss the hard work and commitment of those involved in DHRs. Nor do I want to minimise the challenges of implementing and then maintaining a new system over the last decade, particularly in the context of austerity and localism.[3] However, because of the legacy of these issues, there is uncertainty about whether the DHR system as a whole is effective and, critically, what contribution it has and can make towards improved responses to DVA and the reduction of future homicides.

[3] These issues are explored in section 4.2.

1.2 Objectives of the Fellowship

This report will raise many questions about DHRs, both as a process of individual case review but also as a whole system. Nonetheless, as a practitioner and researcher, I believe reviewing domestic homicides is a necessary if challenging endeavour. As a result, my Fellowship focused on investigating international practice in fatality reviewing with a view to improving the existing DHR system in England and Wales. It focused on the principles of fatality reviews and how they are established, as well as considering their doing (including case selection, membership, and how they make sense of homicides) and the production and use of learning and recommendations. Chapter four explores issues about the DHR system, with associated questions and recommendations for its development. I have chosen not to direct these at any one agency, although they will be particularly relevant to the Home Office, which currently 'owns' the DHRs system. They will also be relevant to the Domestic Abuse Commissioner for England and Wales,[4] who is likely to play a key role in DHRs in the future. There are a range of other key stakeholders in DHRs, including those involved in their delivery, as well as the Community Safety Partnerships (CSPs) that commission them.[5] The questions and recommendations will also be relevant to them, particularly around decision making, as well as training and how to support partnership working and information sharing during DHRs. Given this, I hope the questions and recommendations will be considered widely, and perhaps be a starting point for conversations between different stakeholders about the future shape of DHRs.

1.3 Fellowship itinerary

June 2019	United States of America (USA)	• Attended a national summit from the 24 - 26 June organised by the National Domestic Violence Fatality Review Initiative (NDVFRI) • Contact with Florida's Statewide Domestic Violence Fatality Review Team, Montana's Domestic Violence Fatality Review Commission and Oklahoma's Domestic Violence Fatality Review Board
August 2019	New Zealand	• Visits to Wellington and Auckland, including meetings with the Family Violence Death Review Committee (FVDRC) and other stakeholders

[4] The Domestic Abuse Commissioner will be tasked with encouraging good practice in preventing domestic abuse; identifying victims and survivors, and perpetrators of domestic abuse, as well as children affected by domestic abuse; and improving the protection and provision of support to people affected by domestic abuse. https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-abuse-commissioner-factsheet.

[5] CSPs, more formally known as 'Crime and Disorder Reduction Partnerships', bring together a range of local agencies and have a statutory responsibility for reducing crime and disorder, substance misuse and re-offending in a local area. There are about 300 CSPs in England and 22 in Wales. CSPs are responsible for commissioning DHRs.

	Australia	• Visits to South Australia, the Victorian Systematic Review of Family Violence Deaths (VSRFVD) and the New South Wales Domestic Violence Death Review Team • Attended a femicide roundtable organised by Monash University's Gender and Family Violence Prevention Centre[6] • Presented on my PhD research at Monash University, and also at a seminar hosted by the Melbourne Alliance to End Violence Against Women And Their Children (MAEVe) and Melbourne University[7]
December 2019	Canada	• Visits to British Columbia's Death Review Panel and Ontario's Domestic Violence Death Review Committee (DVDRC) and other stakeholders • Visit to the Canadian Domestic Homicide Prevention Initiative (CDHPI) at Western University, where I also presented a webinar on DHRs in the context of vulnerable populations[8]

1.4 Limitations

This report is a snapshot and it is based on my experience of a small number of fatality reviews internationally, albeit those reviews were located in the few countries that have well-established fatality review systems. This report also reflects my perspective. I am without doubt an 'insider'; I commissioned DHRs when I worked for a local authority, while I currently practice as an Independent Chair and am also researching them. As a result, while I hope this report will be of interest and use to others, the views and opinions expressed draw heavily on my own experience of, as well as hopes and concerns for, the DHR system. I have referenced a range of documents and research throughout the report. Readers may find this a useful reading list, although it is by no means comprehensive.

1.5 A note on language

What we call DHRs in England and Wales are described in different ways in different countries. Any references to 'DHR' refers specifically to the system in England and Wales and, when referring to other countries, this report uses the terminology used by the review system being discussed. When referring to reviews collectively, the term 'fatality review' is used.

[6] https://www.monash.edu/arts/gender-and-family-violence/news-and-events/articles/national-roundtable-on-femicide-data-collection.
[7] https://socialequity.unimelb.edu.au/news/events/domestic-homicide-reviews.
[8] http://cdhpi.ca/upcoming-webinar-introduction-domestic-homicide-reviews-england-and-wales.

Additionally, this report uses the term ‘domestic homicide’. Reflecting practice in England and Wales, this refers to both Intimate Partner Homicide (IPH) and Adult Family Homicide (AFH), although in the international context not all fatality reviews include the latter.

Lastly, women are disproportionally the victims of domestic homicide (UNODC 2018). As a result, using the term ‘homicide’ in this context has been problematised because it renders the gender-based context of killings of women invisible (Weil 2016). To address this, the killing of women in domestic homicide can be described as an example of femicide. This can be defined as ‘…the intentional killing of women and girls because of their gender’ (Weil et al. 2018, p.1). However, there are challenges with this definition, not least the difficulty of ascribing or measuring intent (Corradi et al. 2016, p.980). As a result, some have argued for a more cautious approach, for example, by defining femicide as ‘…killings of all women, regardless of motive or perpetrator status’ (Campbell and Runyan 1998, p.348). As most fatality reviews do not routinely use this terminology, it is not used in this report, but all fatality review systems recognise the gendered nature of domestic homicide.

Chapter Two: What are Fatality Reviews and what models exist?

This chapter provides an overview of domestic homicide fatality review. It then describes the current arrangements for DHRs in England and Wales and the different fatality review systems in operation internationally.

2.1 Fatality Reviews

Fatality reviews were first conducted into child and infant deaths in the USA and, from the 1990s, as a response to domestic violence related deaths (Dawson 2013). Since then, a recent estimate identified 38 jurisdiction-wide fatality reviews (Bugeja et al. 2017), although this total includes fatality reviews that operate at a state, regional and local level. The countries where fatality reviews operate, in addition to the UK (albeit only in England and Wales), include Australia, Canada, New Zealand and the United States (Dawson 2017). Portugal has also established a national fatality review team (Castanho 2017), with DHRs in the process of being introduced in Northern Ireland (Department of Justice 2018) and under consideration in the Republic of Ireland (Study on Familicide and Domestic Homicide Reviews 2019).

This report will not describe in detail the history of fatality review systems or the journeys that individual countries have taken. Country specific accounts are available for the USA (McHardy and Hofford 1999; Wilson and Websdale 2006), Canada (Jaffe et al. 2008), Australia (David 2007; Australian Human Rights Commission 2016) and New Zealand (Family Violence Death Review Committee 2014). Most recently, Dawson has edited a comprehensive overview (2017).

In explaining why fatality reviews have emerged in these countries, Websdale (2020a) has identified some shared characteristics. These include public concern about domestic homicide *and* state/community infrastructure that is responsive to DVA, as well as a wider context of concern about crime, victim rights, and broader changes in women's status that have been driven by feminism. Websdale also highlights that fatality reviews have emerged in 'functioning democracies' (ibid., p.4), suggesting that this is important because it allows that 'however meagrely, [the state] might be willing to accommodate self-criticism and reflexivity' (Websdale 2020b).

Specific fatality review systems have often emerged in the aftermath of a particular domestic homicide. Indeed, the investigations into these deaths might be described, with the benefit of hindsight, as 'inquir[ies] of note' (Stanley and Manthorpe 2004a, p.4). The 'Charan Review' in San Francisco, conducted after the murder of Veena Charan and subsequent suicide of her husband, is commonly cited in the USA (Websdale et al. 1999). Similar cases can be identified in Canada (Dawson et al. 2017) and Australia (Fitz-Gibbon 2016). Meanwhile, the 'Pemberton Review' – conducted after DHRs were introduced into legislation but before they were implemented –

considered the homicides of Julia and William Pemberton in 2003 (Walker et al. 2008) and went on to have a formative impact on the DHR system in England and Wales.[9]

While there are considerable differences between fatality review systems in their geographical scope, the types of deaths considered, and the data collected (Walklate et al. 2020, p.23), fatality reviews have a shared philosophy. At their broadest, they are conducted into deaths '…caused by, related to, or somehow traceable to domestic violence' and aim to develop preventative interventions (Websdale 2020a, p.1).

2.2 The UK

The UK is made up of the four nations of England, Northern Ireland, Scotland and Wales. In England and Wales, a UK Government department (the Home Office) is responsible for DHRs. In Northern Ireland and Scotland, this responsibility rests with the Northern Ireland Executive and Scottish Government, respectively. While DHRs were implemented in England and Wales in 2011, they are only now being introduced in Northern Ireland. Scotland is an outlier; while DHRs are identified in its national strategy, there is currently no timetable for their introduction.

England and Wales

In theory, there is a single DHR system and all domestic homicides which meet the criteria should be subject to review, with this leading (in most cases) to the publication of an Overview Report and Executive Summary. Indeed, in the international literature, the English and Welsh model is usually treated or described as a single system (Bugeja et al. 2017; Jaffe et al. 2020b; Websdale 2020a). The description of the DHR system in these terms reflects the manner of its establishment. First, it has a legislative mandate, as set out in Section 9 of the *Domestic Violence, Crime and Victims Act* (2004). Here, a DHR is described as a review into:

> 'the circumstances in which the death of a person aged 16 or over 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, held with a view to identifying the lessons to be learnt from the death'.

However, as set out in *Figure 1,* the roll-out of DHRs had a curious trajectory, with a considerable delay between the introduction of legislation (in 2004) and the enactment of this provision (it was not implemented until 2011).[10]

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[9] Frank Mullane, the brother of Julia and uncle to William, has provided a personal account of the murders and the establishment of the DHR (Monckton-Smith 2012).

[10] Although DHRs were implemented from 2011, some local area had developed review processes before this date, for example in London and South Wales (Richards 2006; Robinson 2006).

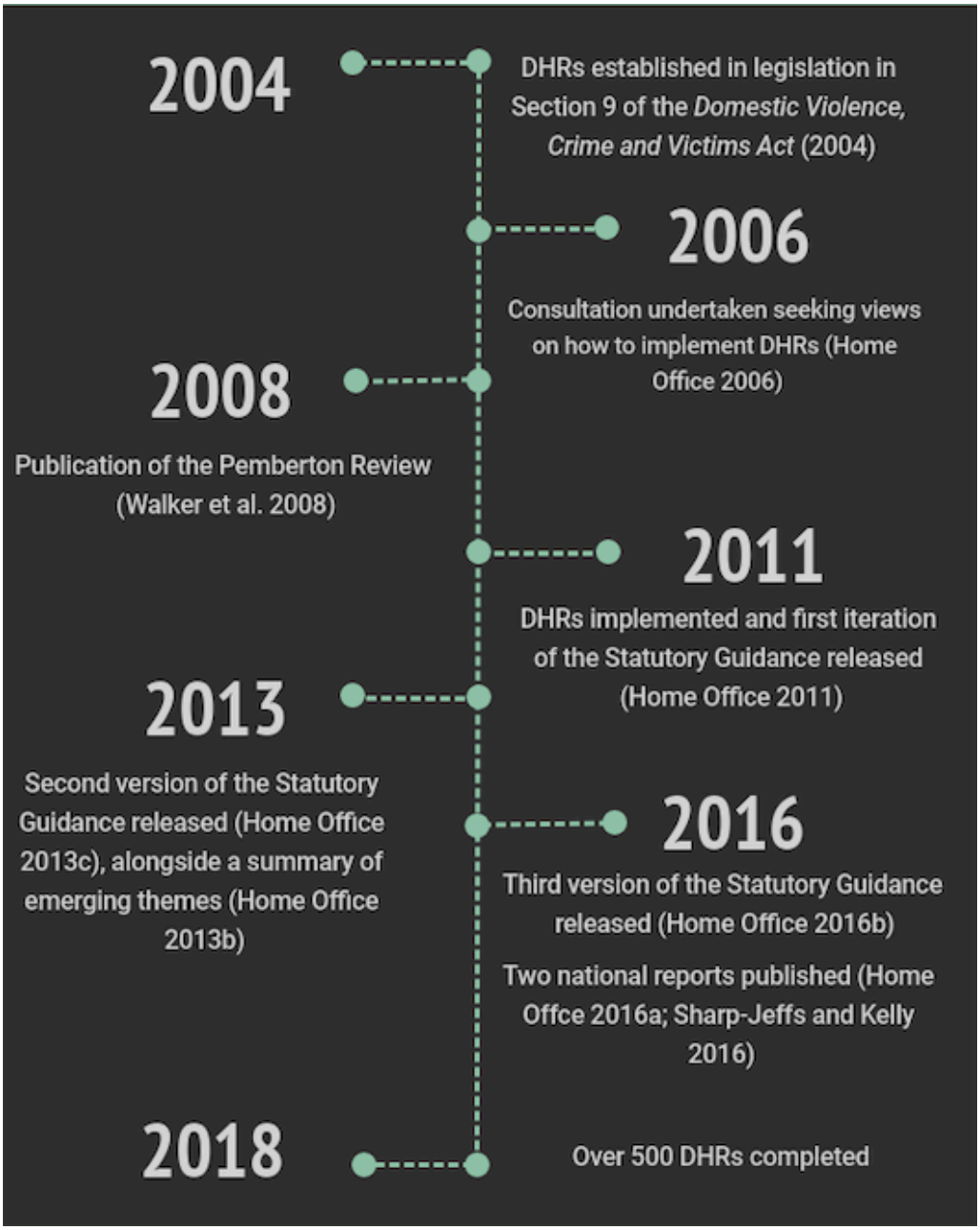

FIGURE 1: TIMELINE SHOWING THE IMPLEMENTATION OF THE DHR SYSTEM

Second, there is national statutory guidance, which sets out how DHRs should be conducted. This was first issued by the UK government in 2011, then updated in 2013 and 2016 (Home Office 2011; Home Office 2013c; Home Office 2016). Third, the Home Office has an oversight role, concerning both the decision to conduct DHRs in individual cases and for the DHR system as a whole. This latter role is primarily discharged through a quality assurance panel. At the conclusion of each DHR, the commissioning CSP must submit an Overview Report, Executive Summary and Action Plan (and since 2016, a simple data collection form)[11] to the Home Office. This is then

[11] This data form captures only limited information. The current template is available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/598585/DHR_management_information.odt.

considered by the quality assurance panel, which must approve the DHR before it can be published. An overview of the DHR process is set out in *Figure 2.*

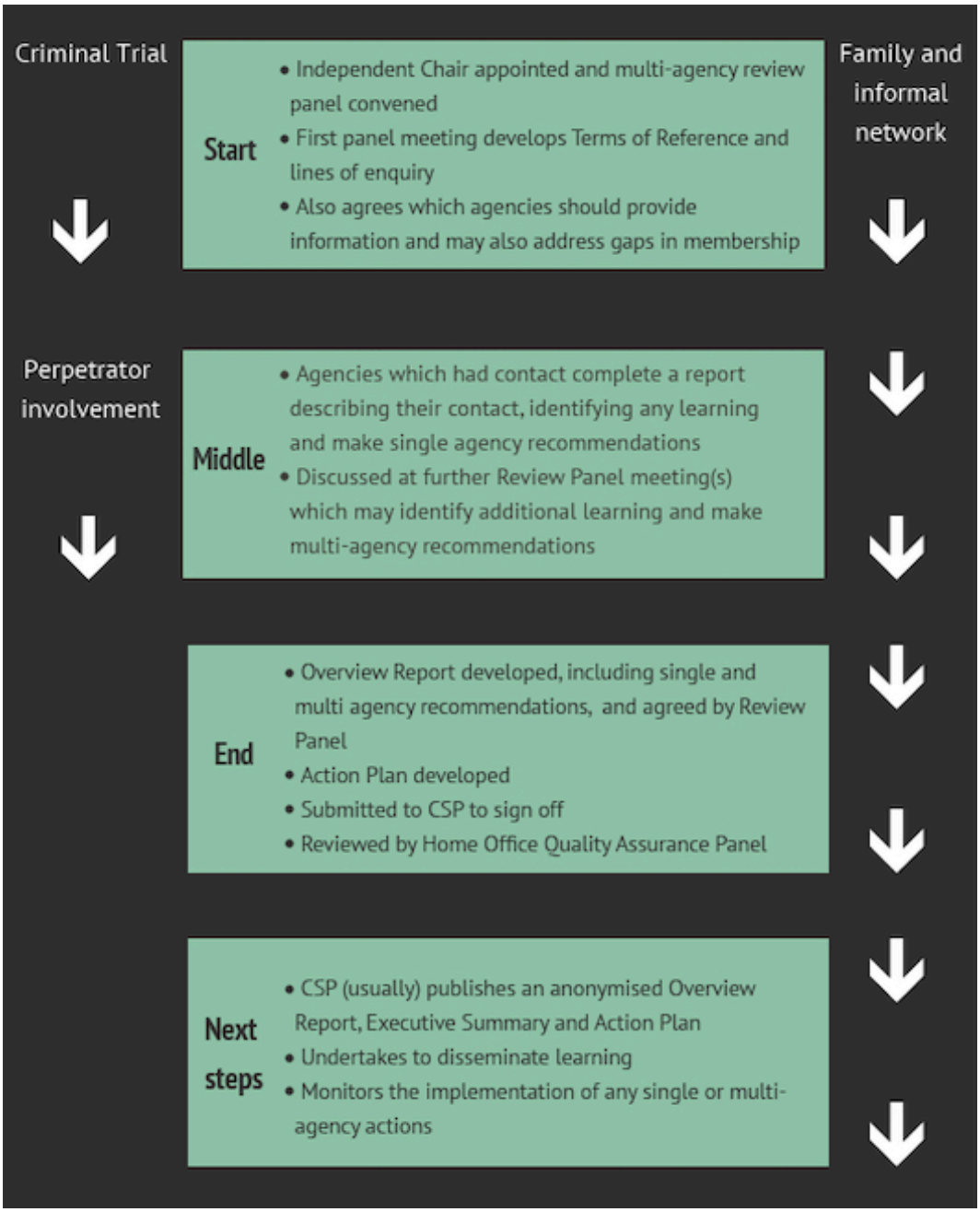

FIGURE 2: SUMMARY OF THE DHR PROCESS FOR INDIVIDUAL CASE REVIEWS

Yet, despite having the appearance of being a single system – afforded by legislation, statutory guidance and national oversight – the unity of the DHR system is superficial. It could be more accurately described as a multitude of parallel DHR systems of varying sizes, with more or less similarity or difference. This is because how the DHR system is delivered means that in operational terms it is a localised endeavour. Indeed, because DHRs are conducted into an individual case, the process is shaped by the

approach of the CSP that commissions each review;[12] the Independent Chair who is appointed to lead it and authors the report (unless there is a separate Report Author); and the multi-agency review panel with whom the Independent Chair works (themselves drawn from a host of different organisations and sectors).

Given this, there are a host of questions that can be asked about the DHR system. A non-exhaustive list might identify the following issues:

- It is unclear to what extent the statutory guidance is followed and, while there are criteria against which to assess quality,[13] there remains considerable variation in the style and quality of DHRs (Stanley et al. 2019, p.70);
- The statutory guidance states that DHRs should be completed in six months, not including any suspension to the process as a result of the criminal justice process (Home Office 2016, p.16). This timeframe is unrealistic, given it is rarely met. This is exacerbated by significant delays in terms of publication, including decisions by CSPs about when and how to publish (Bridger et al. 2017, p.95; Benbow et al. 2018, p.7; Stanley et al. 2019, p.62); and
- Little is known collectively about the profile of the cases reviewed, including demographics, risk factors and circumstances before the homicide, as well as the findings and recommendations arising. This is because there is no consistent mechanism to aggregate learning. As a result, our knowledge of what has been learnt from DHRs is piecemeal. It comes from two Home Office reports, of which only one is particularly robust (Home Office 2013b; Home Office 2016); a report commissioned by a non-governmental organisation (Sharp-Jeffs and Kelly 2016); and some regional learning summaries (Warren 2016; Harris 2017; Social Care Institute for Excellence 2020). This is increasingly being supplemented by academic research (Neville and Sanders-McDonagh 2014; Benbow et al. 2018; Chantler et al. 2019; Stanley et al. 2019).

Turning to the doing and use of DHRs more specifically, further issues include:

- How DHRs operate, including how multi-agency review panels are built and work together, how they make sense of the homicide and how this knowledge is used. This is particularly significant given it appears that some voices in reviews may be favoured over others (Robinson et al. 2018, p.22), while some behaviour, such as stalking, is not always explicitly identified (Monckton-Smith et al. 2017, p.9). More

[12] In placing the responsibility on CSPs to commission DHRs, it follows that they are also responsible for funding them. Although there will be opportunity costs, such as staff time, the largest direct cost is the commissioning of an Independent Chair/Report Author. Different funding models exist, which may include CSPs asking local statutory partners for contributions. However, anecdotally, the cost is commonly borne by the local community safety (and often specifically, VAWG or DVA) budget. The potential impact of this in terms of decision making is discussed in sections 4.2 and 4.3.

[13] https://www.gov.uk/government/publications/criteria-for-considering-domestic-homicide-review-reports.

generally, some commenters have identified concerns about victim-blaming[14] in DHRs (Ingala Smith 2017);

- The efficacy of the Home Office quality assurance process is unclear, both in terms of the impact of its work on the quality of individual DHRs and the DHR system as a whole. This is exacerbated by the time it takes for quality assurance to be completed;[15]
- The costs of being involved in DHRs, including the secondary trauma arising from participation, whether this has any effect on the doing of DHRs, and if and how this can be managed to promote 'emotional safety' (Williamson et al. 2020). How this concept is understood across different professional and organisational cultures is also relevant, particularly as this will have implications for if and how this issue is addressed within multi-agency review panels;
- Concerns about emotional safety are particularly important given the involvement of families (and others, like friends, neighbours and colleagues/employers) in DHRs. Some have highlighted how the claim that involvement in review processes brings catharsis has been little studied while noting that involvement demands considerable emotional labour (Ryan 2019). We also know little about family and others experience of DHRs, including feelings about, and satisfaction with, their involvement and the outcomes achieved. At the same time, this is a challenging area, not least because families and others who knew a victim may experience this concern as condescending, particularly if it is used to limit or contain their involvement; and
- How effectively any learning is captured and used, as well as whether the resulting recommendations lead to any changes (although there are accounts of impact, with individual CSPs and those involved in DHRs often being able to point to specific examples of changes).

While these are some of the questions that can be asked about the DHR system, it is important to note that there are many strengths. These are addressed throughout this report but are summarized in *Figure 3* alongside the weaknesses already described.

[14] Many studies of victim blaming draw on the concept of the 'ideal victim' (Christie 2018), exploring how victims of DVA may not be seen to meet this standard because of their intimate relationship with a perpetrator and the extent to which they are seen as accountable for their victimisation (Meyer 2016). A policy and practice example of this is the Domestic Violence Disclosure Scheme. Victims may experience victim blaming if, for example, it is assumed that they should or can make an application or respond in a certain way to any disclosures (Duggan 2018).

[15] These issues are explored in section 4.5.

FIGURE 3: STRENGTHS AND WEAKNESSES OF THE DHR SYSTEM

Northern Ireland

In 2018, the Department of Justice ran a consultation about the introduction of DHRs in Northern Ireland (Department of Justice 2018) and recently began the process of recruiting a cohort of Independent Chairs (Department of Justice 2020).

Scotland

In Scotland, the Scottish Government included a commitment to develop DHRs in its VAWG delivery plan (Scottish Government 2017). However, in the most recent annual report on progress, there is no reference to DHRs; it is unclear what, if any, progress has been made (Scottish Government 2019). Reflecting this, there are continuing calls being made for DHRs to be enacted from activists and practitioners (Goodwin 2018; Storrar 2019).

2.3 Countries visited as part of the Fellowship

An overview of the fatality review system in each country is included in *Appendix One*.

Australia: Fatality reviews are established at a state or territory level, operating in most Australian jurisdictions (Butler et al. 2017). The Australian Domestic and Family Violence Death Review Network was established in 2011 to share findings between state and territory fatality review teams and has reported on its work. It has also developed national data collection protocols (Australian Domestic and Family Violence Death Review Network 2018).

Canada: Fatality reviews are established at a province or territory level, operating in many Canadian jurisdictions (Campbell et al. 2016). The CDHPI acts as a national repository, hosting information on and reports by province or territory fatality reviews, as well as providing resources to support implementation.[16]

New Zealand: There is a single national fatality review, the FVDRC, which is supported by regional, multi-agency panels which conduct a small number of in-depth case studies. These case reviews are conducted by a Secretariat, which is based in the Health Quality and Safety Commission (HQSC). Oversight of the methods and findings is provided by the FVDRC, which also produces a regular report (Tolmie et al. 2017).

The USA: Fatality reviews are established at a state, regional or local level (Websdale et al. 2017). The NDVFRI acts as a national repository, hosting information and reports by state, regional or local fatality reviews. It also provides training and technical assistance around implementation and delivery, for example regularly running webinars on a variety of different aspects of the fatality review process.[17]

[16] http://cdhpi.ca/about-us/about-us.
[17] https://ndvfri.org/about/.

Chapter Three: Reflections on the DHR system

During my travels, I was often asked about how DHRs worked in England and Wales. This led to thought-provoking conversations about different approaches to fatality reviews. This chapter explores some of the things that stayed with me from those conversations, particularly where I was prompted to consider things that I had not thought about before or to look again at things I had taken for granted. My reflections are summarised into five themes and I identify some key issues for consideration, although any recommendations are made in the subsequent chapter.

3.1 Timeframes

A common concern in England and Wales is the length of time individual DHRs take. As noted above, the statutory guidance of six months is rarely met. To date, no research has been published on the time it takes to complete a DHR, although early findings from my PhD research suggest that the time between a homicide occurring and a DHR being considered by the Home Office quality assurance panel is a mean average of 2.4 years. It is important to note that this is not the same as the length of time it took a local area to complete and submit the DHR. That is because these data include an unknown time after DHRs were submitted but before they were considered by the quality assurance panel (the issue of time delays in quality assurance is discussed in section 4.5). Additionally, the average is pushed higher by a smaller number of cases that took far longer, with the mode average being 1.7 years.[18] To some extent, a lengthy timeframe is inherent to the DHR system, given it is built around an in-depth 'biographical' analysis of each death.[19] Inevitably, this means there is a tension between 'speed and thoroughness' (Benbow et al. 2018, p.21). The time taken to complete a DHR can also reflect case-specific issues. This can range from external factors like the duration of the criminal justice process,[20] to the complexity of the case and the number of agencies involved. Internal factors are likely to be influenced by the key milestones of a DHR's progression. For example, how promptly do CSPs decide to conduct the DHR? Other milestones might include the time taken to appoint an Independent Chair / Report Author; convene a multi-agency review panel; to prepare an Overview Report, Executive Summary and Action Plan; to engage with family; to go through Home Office quality assurance; or for publication, once the DHR has been completed. Little published research has explored these areas.

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[18] Based on a sample of 102 DHRs that were submitted to the Home Office Quality Assurance Panel in 2018.

[19] Websdale et al (1999, p.64) described two approaches to fatality review, including the close scrutiny of an individual case or alternatively a wider examination of a large number of deaths. Watt (2010, p.63) describes this as the difference between 'biographical' and 'epidemiological' approaches. The former enables in depth understanding and the latter aggregate trends.

[20] DHRs usually start relatively soon after a homicide. As a result, they often run alongside the criminal justice process and then continue after it has concluded. If these two processes are running concurrently, the criminal justice process takes precedence. For example, witnesses are not usually approached to participate in a DHR, and in some cases a DHR may be suspended, until after the criminal trial has concluded.

We need to better understand the timeframes for DHRs. This will help ensure the DHR process is run effectively and make it possible to manage the expectations of stakeholders about the duration of an individual DHR.

While there may be concerns about the timeframe for DHRs in England and Wales, it is relevant to note that the time it takes to complete a DHR does not necessarily mean that they are any less timely than in other jurisdictions. In contrast to DHRs, deaths considered by other fatality review systems are usually not reviewed until after the criminal justice or coronial process (including any appeals) has concluded. This means it can be several years before a case is reviewed.

3.2 Information sharing

In many other fatality reviews, requirements in their mandate and other protections around confidentiality and privacy (and associated concerns about liability) often means that some information cannot be accessed. For example, while DHRs routinely have access to a perpetrator's health information,[21] this can be less common in other jurisdictions. Although having access to more information may mean that DHRs can build a more holistic picture, it does mean that DHRs should be particularly mindful about how they use the information they collect, including what to include in the published Overview Report and Executive Summary. Anecdotally, this balance is not always achieved, with some DHRs including disproportionate information about the victim, perpetrator or any children. This is discussed further in section 4.5.

We need to consider what best practice looks like in terms of information sharing, including what information is collected and how it is used.

3.3 Publication

Reflecting differences in the approach to confidentiality and privacy, no other fatality review system directly publishes identifiable, individual case information. In contrast, in England and Wales, case-level data is shared publicly when a DHR is published at its conclusion. Although the statutory guidance requires DHRs to be 'fully anonymised' (Home Office 2016, p.22), in reality, this is only available to the subjects of DHRs if a decision is made not to publish. Once a DHR is published, its subjects are identifiable.[22] This is because the steps taken to anonymise DHRs are ultimately no more than smoke and mirrors: individual cases are easily identifiable given DHRs are published by the CSP in the area where the homicide occurred. It is relatively easy to unveil the subjects of a DHR by making the connection between the anonymised report and media reporting of the homicide event. Quite why this more permissive

[21] This may be with a perpetrator's consent. However, in circumstances where a perpetrator declines to take part in a DHR, the participation of health providers means there is still a mechanism to review any contact with health services. This will often include information about any relevant health concerns, treatment and disclosures.

[22] In a small number of cases, a victim's family has successfully advocated for a victim's real name to be used.

approach has developed in England and Wales is unclear. Websdale suggests that this may be because DHRs were established by the central government in England and Wales, whereas the USA is less centralised. He also identifies the importance of the concept of a 'public good', which is used to justify publication in England and Wales (2020a, pp.14–15). To illustrate this, Websdale points to the statutory guidance which sets out, when addressing concerns about sharing health information in DHRs, that the death of the victim means that the perpetrator's '…confidentiality should be set aside in the greater public interest' (Home Office 2016, p.27).

It is also important to note that DHRs did not emerge in isolation: they developed in the context of a wider history of reviewing serious incidents and deaths (Stanley and Manthorpe 2004b). As a result, DHRs exist alongside several different types of statutory review in the UK, many of which are also published.[23] Whatever the reason, there is a taken for granted assumption that placing this level of case detail into the public sphere has a value. Most often, this is explained as offering an alternative to the 'forensic narrative' by centring a victim's story. The forensic narrative is a term used to describe the account of a homicide that is generated by the criminal justice process and in media coverage. This is often problematic because it can reflect the perpetrator's account at the expense of the victim (Monckton-Smith 2012). The statutory guidance illustrates how this assumption is embedded into the doing of DHRs, with a call for DHRs to 'articulate the life through the eyes of the victim (and their children)' (Home Office 2016, p.7). However, as with many other aspects of the DHR system, little research has been conducted to test this assumption.

It is not clear how the narrative of a homicide is generated during the DHR process and then represented in the final published documents. Nor is it clear whether the narrative produced is an alternative to the forensic narrative, or in part or fully repeats it. It is also unclear what operational or discursive practices in the doing of DHRs might be critical in generating an alternative narrative (for example, the involvement of family and friends), how these narratives are used and the impact they have.

3.4 Family and community involvement

Many fatality reviews seek to involve family, as well as other members of 'informal networks' such as friends, neighbours and colleagues/employers (Sharp-Jeffs and Kelly 2016, p.45). Uniquely, DHRs do not just invite family involvement but, at least in theory, afford the family of the victim an equal status. While the family does not sit on the multi-agency review panel (although sometimes they may meet the panel), they have the right to participate in several ways, including having the opportunity to influence the Terms of Reference (which set the scope for an individual DHR) through to seeing and commenting on drafts of the Overview Report. The centrality of family involvement may reflect the conditions in which the DHR system developed, both

[23] These include Mental Health Homicide Review (now Independent Investigation Report); Safeguarding Adult Review / Adult Practice Review; and Serious Case Review (now Child Safeguarding Practice Review / Child Practice Review).

generally (there is a varying presumption of family involvement across the different types of statutory review in England and Wales) and specifically (as a legacy of the Pemberton Review). A consequence of this has also been the development of a model of specialist and expert advocacy specifically to support and facilitate family involvement, pioneered by Advocacy After Fatal Domestic Abuse (AAFDA).[24]

Evaluating the impact of specialist and expert advocacy is an opportunity to understand what benefit this brings, both in terms of DHRs access to a wider range of information, but also families experience of, and satisfaction with, DHRs.

3.5 The absence of data collection and aggregation, reporting, and a national repository

Most other fatality review systems routinely report on their findings, while national repositories often exist to share learning. Standardised data collection tools, and processes to aggregate learning regionally or nationally, are also in place or being developed. However, this is not reflected in England and Wales. Except for New Zealand, the DHR system is the only national-level fatality review system. That means, despite the concerns identified in this report, it is a unique model for the undertaking of systematic, in-depth fatality review. However, as noted in the previous chapter, it has a superficial unity, with its actual conduct being localised. One consequence is that there is no standardised data collection process (bar the simple data collection form that CSPs are required to submit)[25], nor critically is there a mechanism that would enable the routine analysis of data from across DHRs. Yet, as it is established at a national level, in theory if not in practice, England and Wales has the largest single fatality review system in the world. This means that DHRs can work as they do now, by seeking to tell the story of individual cases (using biographical case information and analysing case level interactions). However, they could also be used collectively to identify trends and patterns over time (by aggregating data and learning from across cases). That this has not happened consistently is a missed opportunity, which is exacerbated by the absence of a national repository.

The absence of a common data set, the systematic collection of data and learning, regular reporting, as well as a national repository, means that the opportunities to learn from DHRs are limited.

[24] https://aafda.org.uk.

[25] The Home Office requires CSPs to submit a data collect form, but this collects limited information: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/598585/DHR_management_information.odt.

Chapter Four: Learning for DHRs

This chapter considers six elements of any fatality review system, from principles, to how they are established, as well as their doing (including case selection, membership and how they make sense of homicides) and the production and use of learning and recommendations. Following the discussion of each element, recommendations are made that are relevant to the existing DHR system in England and Wales, and which could inform the development of the same in Northern Ireland and (possibly) Scotland.

4.1 Principles underpinning fatality reviews

While each fatality review system is unique, they share a common set of principles leading to three core functions, specifically identifying, reviewing and then reporting on homicides (Bugeja et al. 2015). As summarised in Australia, fatality reviews seek to:

> '… enhance our understanding of the primary risk factors leading to these deaths, improve system and service responses and inform policy designed to reduce rates of domestic-related homicide' (The National Council to Reduce Violence against Women and their Children 2019, p.115).

This means that fatality reviews consider precursors to a homicide, capturing data from individual killings and identifying gaps in and between service responses (Wilson and Websdale 2006; Bugeja et al. 2015). Critically, fatality reviews try to turn '…hindsight into foresight' (Jaffe et al. 2020b, p.xxi) and seek to use any learning to improve responses to DVA and so hopefully to reduce the likelihood of future homicides. Fatality reviews are part of the multi-agency, coordinated response to DVA (Payton et al. 2017, p.115; Websdale 2020a, pp.11–12). As a result, they commonly involve multiple stakeholders (including governmental and non-governmental agencies). Collaboration is underpinned by an ethos of enquiry, emphasising the idea of 'no blame/no shame' and instead the importance of accountability (Websdale 1999, p.234). *Figure 4* shows how purpose is articulated by different fatality review systems or their sponsoring body. Whilst the language varies, the commonality is evident. This applies to England and Wales too, where the overarching purpose of DHRs can be described as to: '…illuminate the past to make the future safer' (Mullane 2017, p.261).

Many other fatality review systems clearly articulate their purpose, not least because regular reporting provides an opportunity to reflect on activity and the issues arising in any given jurisdiction (the issue of reporting is discussed further in section 4.6 below). The existence of national networks and / or repositories – including the Australian Domestic and Family Violence Death Review Network, the CDHPI in Canada, and the NDVFRI in the USA – also provide mechanisms to share and build a collective understanding, albeit challenges remain. For example, the differences between local/regional fatality review systems around data collection and timeframes means

that building a national picture can be difficult (as will be discussed later, Australia has achieved this).

FIGURE 4: EXAMPLES OF STATEMENTS ABOUT FATALITY REVIEW SYSTEM PRINCIPLES

Reflections on the DHR system

In England and Wales, the purposes of DHRs are set out in the statutory guidance. This identifies the following: learning, acting on and applying lessons learnt from

domestic homicide; preventing domestic violence by improving service responses by intervening earlier; better understanding domestic violence and abuse; and highlighting good practice (Home Office 2016, p.6). However, little is known about how these purposes are understood (particularly where they interact, overlap or are in conflict). In particular, it is unclear how they are understood by those involved in the doing and use of DHRs. The potential for differences to arise may be exacerbated if the 'push' factors (that might lead to a divergence in understanding, or perhaps an emphasis on some purposes at the expense of others) are greater than the 'pull' factors (that promote a shared understanding). In England and Wales, there are likely considerable differences, because there is currently more that pushes the DHR system apart than pulls it together:

- As argued previously, there is a superficial unity to the DHR system, with individual DHRs being undertaken at a local level. This means there are multiple opportunities for divergence. In an individual case, that could be between the commissioning CSP, the Independent Chair / Report Author and / or the multi-agency review panel. In particular, the central role of the Independent Chair / Report Author means that their understanding of purpose (and the decisions they make as a result) will likely have a particular impact on any given DHR;
- There is no national training programme supporting the delivery of DHRs, including accredited training specifically for either Independent Chair / Report Authors or multi-agency review panel members. While training was provided during the initial implementation of DHRs, at a national level this has long since withered to a static e-learning package. [26] (the issue of training is discussed further in section 4.4); and
- While the Home Office quality assurance panel considers each DHR before publication, there are a range of questions about its functioning and impact. For example, the quality assurance panel has not published any 'lessons learnt', offering a bird's eye view of the strengths and weaknesses of DHRs to date. This kind of learning might help to pull (or keep) the DHR system together.

Any differences in the understanding of the purposes of DHRs is likely to have a considerable impact. There is some evidence that where there are differences between fatality reviews in terms of understanding, including the team's theory of change,[27] this can affect the kind of learning and recommendations produced (Watt 2010; McCarroll et al. 2020). That could have profound implications: one commentator has expressed concern about the narrowing of the focus of DHRs, describing this as a 'march towards complicity' (Mullane 2017, p.282) if their focus becomes restricted, thereby reducing their capacity to bring about system change.

[26] https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning.

[27] A theory of change is a tool to help you describe the need you are trying to address, the changes you want to make (your outcomes), and what you plan to do (your activities). For more information, go to https://www.thinknpc.org/resource-hub/creating-your-theory-of-change-npcs-practical-guide/.

Case study 1

The Australian Domestic Violence Death Review Network has developed principles that guide effective fatality review processes. Forming part of the Networks' Terms of Reference, these identify that review processes must:

- "Have government endorsement to ensure funding, resourcing and agency engagement;
- Be appropriately empowered to access information;
- Be supported by expertise in domestic and family violence policy;
- Have the capacity to make and monitor recommendations;
- Be empowered to conduct quantitative and qualitative analyses;
- Be empowered to contribute to the network (collaborate and share);
- Develop procedures and mechanisms for review which align with the work of other death review teams;
- Be collaborative and consultative but retain independence;
- Operate with knowledge and awareness of both state and national policies relevant to domestic and family violence;
- Be supported by confidentiality and privacy protections; and
- Reviews must operate in accordance with the overarching philosophy of death review processes, including conducting systemic reviews" (Australian Domestic and Family Violence Death Review Network 2019)

The Terms of Reference have also been reflected in other policy documents (Australian Human Rights Commission 2016, pp.42–49).

Shared concepts

One way to promote a shared understanding of fatality review is to develop shared concepts. Many other fatality review systems have taken steps to clearly define the terms and concepts that underpin their doing and use. The work of national repositories like the NDVFRI and CDHPI means that resources can be shared between local and regional fatality review teams. The importance of shared concepts is also driven by the need to collect reliable data across regional fatality reviews: it is not possible to build a common data set if one review team has a different understanding of a key term or concept. For example, the Australian Domestic and Family Violence Death Review Network has agreed Data Collection Protocols (2018, pp.44–45) which identify and define the data that is collected and have facilitated the reporting of national death review data. Perhaps the clearest example is the FVDRC in New Zealand, where defined concepts inform both data collection and the process of making sense of individual homicides.

Case study 2

The FVDRC defines many key concepts. As an example, one concept relates to roles in an abuse history. In some homicides, a victim of DVA uses retaliatory or self-defensive violence and in doing so kills an abuser (usually this involves a female victim of male violence). The FVDRC makes a distinction between the death event (where there will be a deceased person and an offender) while also considering patterns of violence and abuse in a relationship (which may reveal a predominant aggressor and a primary victim). The following definitions are used:

- "Abuse history: The ongoing patterns of coercive and controlling behaviours used throughout the intimate relationship, including after the relationship ceases;
- Predominant aggressor: The person who is the principal aggressor and has exercised coercive control against their intimate partner; and
- Primary victim: The person who has experienced ongoing coercive and controlling behaviours from their intimate partner" (Family Violence Death Review Committee 2017, p.29)

Another example is the issue of overkill, which is the use of violence far beyond what would be necessary to cause death. The FVDRC has identified the factors that it will consider when determining whether a killing constituted overkill. These include:

- "The number of injuries inflicted;
- Whether two or more of the injuries were fatal;
- The duration and ferocity of the attack;
- Whether violence was directed at multiple parts of the body (including vulnerable parts, such as the head, neck and chest); and
- Whether the attacker continued to exert potential lethal violence on the victim even after they presumably had become aware that possible lethal wounds had already been inflicted" (Family Violence Death Review Committee 2017, p.48).

In both these examples, clearly defining the concept enables increased attention to the context of a homicide.

Reflections on the DHR system

In contrast, in England and Wales, the stock of shared concepts is much less established although it is clear that some concepts are recognised as being important. For example, anecdotally, feedback from the quality assurance panel often highlights concern about victim-blaming language.

However, there are other examples where there is a lack of clarity built into the very structure of the DHR system. To expand on the example of a case where a victim kills an abuser using retaliatory or self-defensive violence, this can present a challenge when developing the lines of enquiry within a DHR. This is because a DHR is triggered by the death of a homicide victim. As a result, in these circumstances, there may be a focus on the experience of the homicide victim (who is also the perpetrator of DVA),

to the detriment of the offender (who is the victim of the DVA). If this happens, it means the focus of the DHR will be narrowed, and so the wider circumstances of the homicide are unlikely to be fully considered. To manage this, the commissioning CSP, the Independent Chair / Report Author and the multi-agency review panel, need to be able to both articulate this issue and then work with these two different concepts. In the absence of a consistent definition, it is hard to know whether this is happening or not.

A further example of the difficulties posed by the absence of a stock of shared concepts surrounds suicides. DHRs can be conducted in cases of suicide where the '…circumstances give rise to concern' (Home Office 2016, p.8). However, it is unclear what this means in operational terms, that is, what is the threshold for a circumstance of concern? For example, would a general history of DVA suffice (e.g. previous disclosure of DVA to family and friends or report(s) to services)? Or should these circumstances be underpinned by a more specific link (e.g. a previous suicide attempt linked to DVA), proximity in time (between a DVA incident and the death event) or a direct link (e.g. a suicide note)? This lack of clarity raises the potential for different decisions to be made by CSPs when considering if deaths by suicide meet the criteria for a DHR, meaning cases with a similar profile may be reviewed in one area but not another. Resolving this issue is important for two reasons. The first relates to the potential scale of suicides that might fall into the DHR process, given evidence of the extent of suicidality associated with DVA (Walby 2004, p.56; Munro and Aitken 2020). The second relates to the process of the identification of such cases, particularly if the criminal justice system begins to take domestic abuse related suicide more seriously and consider charges of manslaughter (Munro and Aitken 2018).

Memorialisation

Across fatality reviews, there is a common thread of hearing the voices of and honouring victims, although how this is done varies. However, reflecting concerns around confidentiality and privacy (as discussed in section 3.2), many fatality reviews only report aggregate data and learning. The result is that there can appear to be, at least in public-facing reporting, an emphasis on 'counting' over 'memorialisation'. Reflecting this, fatality reviews have been described as representing 'the most systematic and coordinated examples of counting femicides' (Walklate et al. 2020, p.23). The evident risk is that fatality reviews might appear to take a multitude of stories, reduce each victim to a case, before aggregating these cases, with the result that the uniqueness of each person's story is lost.

In some cases, fatality reviews attempt to mitigate this risk by seeking to draw attention to those who have died, sometimes specifically as an act of memorial. There are a range of different ways to do this. One example is Florida. Here the Statewide Domestic Violence Fatality Review Team's annual report, called 'Faces of Fatality', is now in its ninth iteration; it calls attention to the lives taken in its title (Florida Coalition Against Domestic Violence and Florida Office of the Attorney General 2019) (see

Figure 5). Many published reports include an acknowledgement to those who have died. For example, in New Zealand, a mihi ki te hunga mate – an acknowledgement to the dead – has been included at the start of reports (Family Violence Death Review Committee 2016, p.ii). Other examples include:

- In Montana, the names of those killed are included in the biannual report (Montana Department of Justice 2019, pp.21–25, 31);
- In New South Wales, the report includes anonymised summaries of the cases reviewed (Domestic Violence Death Review Team 2020, pp.20–50); and
- In New Zealand, case studies are used to illustrate problematic assumptions about cases and agency responses (Family Violence Death Review Committee 2016).

It is also worth considering whether memorialisation may operate beyond, or indeed regardless of, the written record produced by a fatality review. The issue of 'emotional safety' was noted earlier, but implicit in this concern is the assumption that those engaged in fatality reviews may be impacted by their encounter with the homicide (and other traumatic) event(s) as they are recounted in the course of a review. A consequence of this encounter may be that those involved in fatality review engage with the stories they hear, with these perhaps 'being 'etched' into the consciousness of reviewers' (Websdale 2020b). Whether and how this happens has been little explored, including the potential outcomes for those involved, from raised awareness, to changes in professional and multi-agency practice, to the impact on a participant's own life.

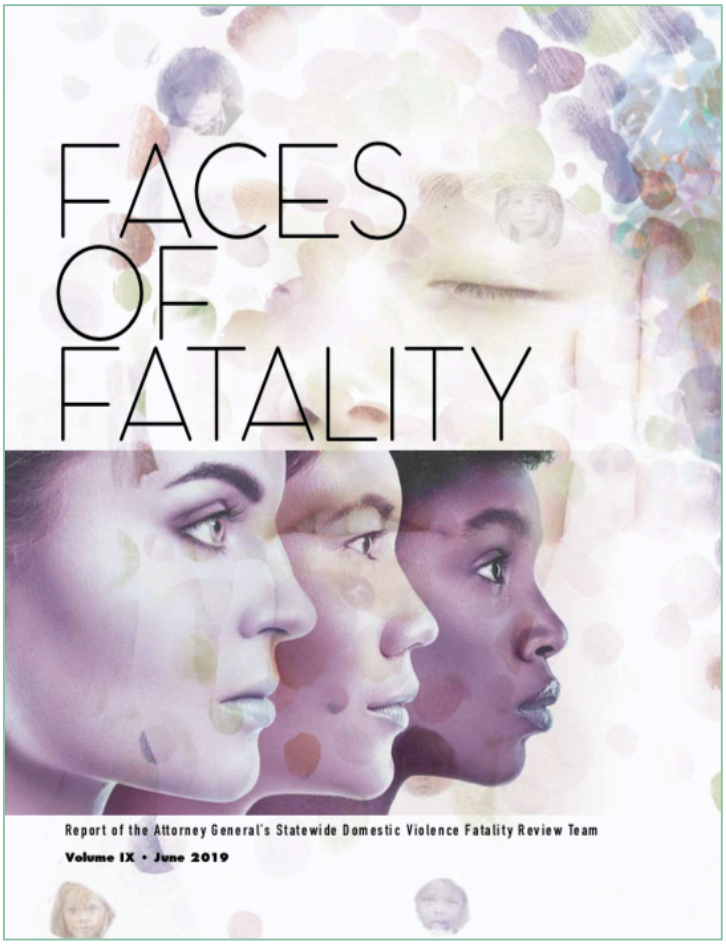

FIGURE 5: FLORIDA 2019 REPORT

Reflections on the DHR system

In contrast, because a biographical approach is used in DHRs and cases are usually published, there is an opportunity for each victim's story to be told. That, in turn, makes it easier, at least in theory, to keep victims at the centre of the narrative presented in a DHR.

In making this observation, it is important to note that, as with so many aspects of the DHR system, this is little researched: it is unclear how multi-agency review panels go about generating their account of a victim's story, or if there is a risk that these stories reinforce the forensic narrative, for example by blaming a victim or minimizing the responsibility of the perpetrator, or perhaps 'de-risking' agencies by underplaying their response(s).

The question of memorialisation also highlights a tension in the DHR process. While the statutory guidance emphasises that the '… narrative of each review should articulate the life through the eyes of the victim (and their children)' (Home Office 2016, p.7), this is not listed as one of the purposes of the DHR process. As noted above, the statutory guidance instead identifies learning, acting on and applying lessons; preventing and better understanding DVA; highlighting good practice. Moreover, the way victims are discussed in articulating these aims frames them as the recipients of multi-agency responses (either to be learnt from or better protected) rather than being subjects in their own right. There is, therefore, a need to clarify our collective understanding of the intended function of DHRs in this context, including whether they can and should seek to memorialise victims and, if so, how this could best be done.

Lastly, an area for further consideration is how fatality review systems overlap with observatories that monitor and collect data on femicides. Many countries have femicide observatories (sometimes known as 'femicide counts'), although forms vary, ranging from programmes hosted in academic institutions or non-governmental organisations to volunteer projects that monitor crime and media reporting. Fatality reviews and femicide observatories share some of the same underlying principles, including documenting and counting homicides and using this to advance practice, policy and legislative change. However, there may also be considerable differences, not least because femicide observatories are concerned with killings where the victim was a woman. This means that, at the same time, femicide counts both consider a broader range of killings than are in scope for fatality reviews (e.g. killings of women by men outside of intimate or familial relationships) but also exclude some cases (i.e. men). While this exclusion is reasonable given the purpose of femicide counts, it does mean that some killings that could be contextualised differently through a gendered lens may be overlooked (e.g. the killing of men by women where the victim was the primary perpetrator). Femicide counts also rarely have an explicit government mandate, which can affect how they operate; for example, in contrast to fatality reviews, they are often reliant on publicly available data. Nonetheless, despite these differences, there is a recognition of the value in ensuring that these distinct processes relate to each other (Corradi et al. 2018, p.156). An example of how this works in practice at a national level is the project between the Canadian Femicide Observatory

for Justice and Accountability (CFOJA)[28] and the CDHPI to develop a national homicide database.

In the UK, the Femicide Census collects data on femicides, including killings of women by men that would meet the criteria for a DHR.[29] Since 2016, it has published an annual report, providing an increasingly robust, longitudinal dataset about the profiles and circumstances of femicides. As a result, and in the absence of any mechanism for systematic data collection and reporting from DHRs in aggregate, the Femicide Census currently provides a more robust picture of domestic homicides in England and Wales than the DHR system, albeit with the self-evident exception of domestic homicides involving male victims.

Questions and recommendations for the DHR system

Question	Recommendations
1. How can we develop and sustain a shared understanding of the purposes of DHRs?	1a. Articulate a Theory of Change to underpin the DHR process 1b. Facilitate a dialogue about the multiple, sometimes conflicting purposes of DHRs 1c. 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 1d. Develop a shared set of consistent definitions 1e. Identify opportunities to collaborate with other aligned initiatives e.g. the Femicide Census

4.2 How fatality reviews are established

Since their early emergence in the USA, it has been recognised that fatality reviews require a clear mandate (McHardy and Hofford 1999, p.3). This allows for formation, while also shaping operational requirements (such as membership, confidentiality and disclosure, as well as reporting).

Websdale (2020a) has identified three different forms of fatality review in the USA, including those established within the justice system, ad hoc commissions that review a specific case, and aggregate reviews that consider killings within a given jurisdiction over time. Broadly speaking, this typology can be applied to fatality reviews internationally. For example, in Canada and Australia fatality reviews are largely mandated under a coronial jurisdiction, which is an independent part of the justice

[28] https://www.femicideincanada.ca.
[29] https://femicidescensus.org.

system. In the UK, DHRs effectively operate as a multitude of small-scale commissions, each reviewing a different case. Meanwhile, state-level repositories are increasingly seeking to bring together aggregative findings, although in doing so they may have to wrestle with how to share information across different jurisdictions (Australian Domestic and Family Violence Death Review Network 2018; Websdale et al. 2019).

The manner of establishment inevitably affects operation and differences can be observed across fatality reviews internationally. For example, in Australia, the VSRFVD and the fatality review process in South Australia both operate directly within the coronial jurisdiction, meaning they directly assist the coroner and recommendations are delivered via coronial findings. In contrast, in New South Wales, the Domestic Violence Death Review Team is convened by the coroner but operates independently (Bugeja et al. 2013).

A key issue evident across fatality review teams is capacity and resource. In his recent overview of fatality reviews internationally, Websdale notes that capacity can influence both the number and types of cases considered (2020a, p.6). At an extreme, fatality review processes may cease, perhaps because funding comes to an end or stakeholder engagement cannot be sustained. As an example, guidance issued in Florida notes that local fatality review teams may become inactive for a variety of reasons (Florida Coalition Against Domestic Violence 2017, p.26). In contrast, other fatality reviews have been able to operate continuously for a sustained period, often because they are hosted within a government agency. For example, the DVDRC in Ontario has been in operation continuously since 2003 and has consequently built a considerable track record: the most recent DVDRC report addressed both the cases it had reviewed in 2018 and trends since 2002 (Office of the Chief Coroner Province of Ontario 2019). However, the DVDRC (and other fatality reviews like the FVDRC in New Zealand), are dependent on a sponsoring governmental body, which may exert a direct or indirect influence over their functioning. For example, the FVDRC is a 'statutory advisor' to the body that hosts it (the HQSC). The FVDRC independently performs its functions, but the HQSC can exert an indirect influence as it sets the FVDRC's budget and scope, while the FVDRC's parameters are also determined by the relevant legislation.

Reflections on the DHR system

As previously noted, in England and Wales DHRs are established on a statutory footing, with the Home Office providing national oversight and individual DHRs being commissioned by CSPs at a local level. Any reflection of establishment then must consider both the national and local level.

At a national level, the curious trajectory associated with the implementation of DHRs, from their introduction in legislation in 2004 to implementation in 2011, encompassed

a change of government: A Labour Government was responsible for the former and a Conservative-Liberal Democrat Coalition Government for the latter. This report is not the place for an assessment of the respective record of these different administrations, but it is important to note that the implementation of DHRs by the Conservative-Liberal Democrat Coalition Government coincided with a period of austerity in public services (that is cuts in public spending after the 2007-2008 financial crisis) and a 'localism' agenda (a stated intention to devolve decisions from central to local government). The combined effect of these measures adversely affected domestic abuse service provision, with falls in government spending leading to cuts in specialist DVA services (Towers and Walby 2012; Sanders-McDonagh et al. 2016). Additionally, it has been suggested that austerity and localism also led to 'discord' between the national policy framework and local implementation (Ishkanian 2014, p.341). An example of this is refuge provision, which is commissioned locally but needs to operate regionally or nationally to work effectively (Bowstead 2015).

While the research cited above did not consider DHRs, it is not unreasonable to speculate whether localism and austerity affected their roll out and implementation. For example, austerity measures would have reduced staff capacity within the Home Office at a national level, while localism emphasised the role of CSPs at a time that local government (the bodies which host CSPs) were making cuts to both staff and services. Other infrastructure that may have supported the roll-out and implementation of DHRs, for example, regional Government Offices, was also abolished in this period (Ministry of Housing, Communities & Local Government 2010). Taken together, this may explain some of the relative lack of leadership that has been described in this report, with this also having been identified as a concern by practitioners (Neville and Sanders-McDonagh 2014, pp.51–52).

Several issues arise from the localised implementation of DHRs:

- There may be differences in decision making about whether to conduct a DHR. This may arise because of a lack of conceptual clarity (as discussed in 4.1 about cases where a primary perpetrator is killed, as well as in suicides). Or this may be because of different understandings of DVA, while, as the cost of DHRs is borne locally, resource or capacity may also play a part (these points are discussed further in section 4.3 below concerning case selection). On the matter of cost, those involved in DHRs have also voiced concern about the sustainability of the process (Sharp-Jeffs and Kelly 2016, p.78); and
- There is only anecdotal evidence about the involvement of, and influence by, Police and Crime Commissioners (PCCs).[30] Nonetheless, PCCs can have a direct impact.

[30] Since 2012, a PCC has been elected for each police force in England and Wales (expect in London, where the Mayor's Office for Policing and Crime is led by a Deputy Mayor for Policing and Crime appointed by the Mayor). PCCs have a number of powers, including appointing the Chief Constable; setting the police and crime objectives for their area through a police and crime plan; and setting the force budget. For more information, go to: https://www.gov.uk/government/collections/police-and-crime-commissioners-publications.

For example, some areas have commissioned regional learning (Neville and Sanders-McDonagh 2014; Warren 2016; Social Care Institute for Excellence 2020).

The introduction of a Domestic Abuse Commissioner is an opportunity to look afresh at current arrangements, particularly because the postholder will have the power to report to Parliament and make recommendations. However, as will be discussed in section 4.6, a key issue that has affected the ability to deliver nationally is capacity. If the Domestic Abuse Commissioner is to have a future role in relation to DHRs, this would need to be resourced as a specific function. Meanwhile, sharing responsibilities between CSPs and PCCs may help ensure greater sustainability and also promote opportunities to share best practice and learning at a regional level.

Questions and recommendations for the DHR system

Question	Recommendations
2. How can we ensure that there is effective oversight of the DHR system at a local, regional and national level? In answering this question, what constitutes effective oversight and what is its purpose?	2a. Evaluate the effectiveness and impact of the current arrangements for oversight of the DHR system, including existing local (through CSPs) and national (by the Home Office) arrangements 2b. Consider whether national oversight of the DHR system should be transferred to the Domestic Abuse Commissioner 2c. Identify best practice and make recommendations to ensure that CSPs are discharging their responsibilities effectively 2d. Develop regional oversight by formalising the role of Police & Crime Commissioners (PCCs) through a co-commissioning model

4.3 Identifying cases for review

Across fatality review systems there are differences in what constitutes a 'domestic homicide' (Albright et al. 2013, p.440; Fairbairn et al. 2017, p.213). Broadly, all fatality reviews consider cases of IPH (Dale et al. 2017, p.240). However, differences emerge around the inclusion of killings that occur outside of former or current spousal relationships, including dating relationships, corollary victims[31] (where another child or person is killed in the context of the homicide), as well as familial violence (Campbell et al. 2016, p.6). In some fatality reviews, suicides or near misses are also in scope.

[31] Although 'collateral' and 'secondary' are the more commonly used term in this context, following Smith et al (2014) I use corollary as it has less negative connotations.

To illustrate this, *Appendix Two* includes a summary of the scope of each of the fatality reviews visited.

Differences in case selection may reflect a fatality review's mandate (which can also carry through into other areas, such as membership, which is discussed in section 4.4). For example, all 'intimate partner violence' related deaths were considered in the most recent review in British Columbia, with this definition including victims who were former or current partners, bystanders (e.g, new partners, children) and also a perpetrator's suicide (British Columbia Coroners Service 2016, pp.8–9). In contrast, in Ontario, intimate partner deaths are considered, and cases include the death of a person and/or their children, as well as perpetrator suicides (Office of the Chief Coroner Province of Ontario 2019, p.5). Other fatality reviews have a more widely mandated remit. For example, they may include deaths where there was a DVA 'context', even if this was not an intimate or familial relationship. For example, if a bystander is killed while intervening, their death would be included in New South Wales (Domestic Violence Death Review Team 2020, p.18). However, this line is inevitably subjective, meaning some types of case may be considered while others are not, even where the degree of connection between the victim and perpetrator may seem similar. For example, in New Zealand, the FVDRC does not consider killings involving corollary victims who are not family members but does consider cases where the perpetrator is the previous partner of the victim's current partner (Family Violence Death Review Committee Terms of Reference 2015, p.2).

Some fatality review systems operate more broadly than their formal mandate. For example, on this basis, Oklahoma considers bystander or 'good Samaritan killings' (Oklahoma Domestic Violence Fatality Review Board 2019, p.32). Meanwhile, the relevant statute in Florida allows fatality reviews to be undertaken into killings in domestic relationships (including between former or current partners and spouses, but also family members). However, even though it did not fit this definition, one local team decided to review a case where the relationship in question '…had been of sufficient duration and the patterns were… similar' (Duval County Domestic Violence Fatality Review Team 2019, p.6).

Differences in case selection can also reflect capacity. For example, not all cases that fall within scope are necessarily reviewed by local teams in Florida; instead, specific cases will be chosen. Cases are selected based on a number of factors including the impact of a killing on the community and the potential to inform preventive strategies (Florida Coalition Against Domestic Violence 2017, p.16). Regional reviews in New Zealand operate in the same way, selecting cases based on learning potential (Family Violence Death Review Committee 2014, p.27).

Decisions on case selection have one consequence that is little discussed: only some homicides are considered, at least as part of any 'in-depth' review. This raises the ethical dilemma of why some deaths are considered and others are not (Albright et al.

2013). While this may seem reasonable in terms of a process, one cannot but help wonder what this may mean to the families of those whose cases are not subject to review, or if they are even aware of this decision.

Looking more broadly, it is also important to note that some cases may never be subject to a fatality review because they are not reported and / or identified as a domestic homicide. Some communities can be disproportionally affected by such absences, which are borne of several factors, including experiences of discrimination and structural oppression. For example, in Canada, the National Inquiry into Missing and Murdered Indigenous Women and Girls has helped document the number of Indigenous women who have either gone missing or been killed (National Inquiry Into Missing And Murdered Indigenous Women And Girls 2019). Similarly, in the context of Lesbian, Gay, Bi and Trans (LGBT+) homicides, several researchers have described how cases can be missed, not least because intimate relationships may not be acknowledged or identified (Messinger 2017, pp.80–83; Rossiter et al. 2020, pp.67–68). In other scenarios, some cases will be excluded because the homicides do not fit a particular definition of 'domestic homicide'. In Ontario, the DVDRC did not review the killing of eight gay men by serial killer Bruce McArthur (Hayes and Ha 2019). This decision has similarities with the killings by Stephen Port in London, into which a DHR has not been conducted (FOI Team 2019). In both examples, the issue revolves around whether the relationships were 'intimate enough' to merit consideration. Even if the homicide of victims from these communities reach a fatality review, this raises questions about the capacity of a review system to adequately consider the impact of discrimination and structural oppression in a homicide (Bent-Goodley 2013). (This is discussed further in relation to membership in section 4.4).

Case study 3

The Australian Domestic and Family Violence Death Review Network identified it was important to develop a National Minimum Data Set to ensure that the different fatality review teams have a shared understanding of what cases constitute a domestic homicide. It developed a Consensus Statement that states: "The definition of 'homicide' adopted by the Network is broader than the legal definition of the term. 'Homicide', as used by the Network, includes all circumstances in which an individual's intentional act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene provisions of the criminal law". This draws attention to:

- "Case type;
- The role of human purpose in the event resulting in a death (intent);
- The relationship between the parties (i.e. the deceased-offender relationship); and
- The domestic and family violence context (i.e. whether or not the homicide occurred in a context of domestic and family violence)" (Australian Domestic and Family Violence Death Review Network 2018, pp.38–42).

Reflections on the DHR system

The question of case selection affects the DHR system in England and Wales in a different way to most other fatality reviews. In some of the fatality reviews discussed above, decisions about case selection relate to a decision about *inclusion*, that is: which case(s) to review? In England and Wales, the decision making is arguably the other way around. It is instead concerned with *exclusion*. This is because in legislation and practice there is a presumption that a DHR should be conducted. This reflects the relatively low threshold that exists, with the legislation allowing for the review of any death that '…has, or appears to have…' occurred at the hands of a former or current partner, family member or someone they lived with. There are requirements about who should be involved in this decision-making process, while the victim's family should be informed and the Home Office notified (Home Office 2016, pp.9–10).[32] However, there is currently no obligation on CSPs to report on their decision making publicly, nor is there any research available in this area. As a result, it is not clear how decisions are made; who is involved (including the opportunity for families to challenge a decision not to conduct a DHR); and whether decision making varies by CSP or indeed by the type of case. In practice, this is most relevant to decisions not to conduct a DHR, with these cases effectively vanishing from view. Anecdotally, the decision not to review a domestic homicide could be based on resource (either fiscal or opportunity cost), or if a CSP feels that there is little or no learning to be identified (which normally means there was limited or no agency contact, which of course does not mean there is no opportunity to identify learning).

However, it could also be for two other reasons. First, there is a lack of clarity about decision making, with the example of suicide having already been discussed in section 4.1. Similarly, the statutory guidance is silent on dating relationships. Second, in some other scenarios, a case may not 'fit'. For example, it has been suggested that the killing of older adults may not always be subject to DHR because of stereotypes about ageing (Benbow et al. 2018, p.21). Additionally, although the criteria for DHRs is broad, it does still exclude some cases. For example, a literal reading would exclude a corollary victim who has not been in an intimate relationship, is not a family member or has not lived with the perpetrator. This means some killings which occur in a DVA context may not be considered. To illustrate this, consider the case of Cassie Hayes who was murdered in January 2018 by her girlfriend's male ex-partner. Threats had been made to Hayes by the perpetrator, including threats to kill himself or her, as well as to Hayes' girlfriend (BBC News 2018). However, the local CSP did not commission a DHR (Maxwell 2019).

[32] Decisions should be made within one month of the CSP being notified and involve local DVA specialists. They should also be communicated to the family, thereby giving them an opportunity to challenge the decision.

A final feature of the DHR system is worth noting, specifically its 'biographical approach', whereby a single case is reviewed in depth. This approach is more commonly used by fatality reviews where there are a relatively low number of domestic homicides per capita in a large state (e.g. Montana). In contrast, where all cases in scope are considered, this is usually at an aggregate level, although that does not mean detailed review work is not undertaken (e.g. Ontario, British Columbia). Even where there are specific mechanisms to undertake a more in-depth review of individual cases, this is normally targeted (such as in New Zealand, Oklahoma) or this function is delivered by a smaller specialist team (e.g. the VSRFVD and South Australia), although in some fatality reviews a multi-agency group then considers these findings (e.g. New South Wales Domestic Violence Death Review Team).

As a result, England and Wales have a unique approach which, bar the possible exclusions noted above, means every domestic homicide is subject to a DHR. Given what this means for the scale of the DHR system, some might ask whether all domestic homicides should be reviewed. For my part, I think there are legitimate questions about the doing and use of DHRs and it may be reasonable to ask about the best way to do this work. The diversity of approaches in other jurisdictions does highlight the fixity of the DHR model, which is very much 'one size fits all'. An alternative might be to introduce more flexibility to allow CSPs, in consultation with stakeholders including families, to decide on the best way to conduct DHRs. Additionally, there may be much to learn from other statutory review processes in England and Wales. This links to a broader issue of methodology, which is discussed in section 4.5. However, just because the DHR system could be improved, this does not mean we should stop reviewing each case. A DHR is an opportunity to look at individual and system responses, identify learning and improve our understanding of the circumstances of domestic homicide deaths. But, as I have suggested earlier, this process should also deliver a broader ambition: to memorialise victims; to include family as an equal stakeholder and try and answer their questions; and challenge the forensic narrative. That broader ambition is only possible where each case is reviewed.

Questions and recommendations for the DHR system

Question	Recommendations
3. What is the best way to commission and deliver DHRs, while continuing to recognise the unique significance of each homicide?	3a. Ensure that the decision-making process concerning DHRs is robust and transparent 3b. Enable flexibility in the DHR model (rather than 'one size fits all') depending on case circumstances

4.4 Fatality review membership

The fatality reviews explored in this report all have a given membership, which is set out in varying degrees of specificity in legislation or Terms of Reference. In most fatality reviews a range of stakeholders are involved. Broadly, this tends to include criminal justice, health, other service providers (including domestic abuse services), and community representation. Indeed, many emphasise the importance of a membership that is 'inclusive rather than exclusive' (Websdale 2020a, p.10).

In response to this breadth, and reflecting the principles that were discussed earlier, many fatality reviews place an emphasis on building and sustaining a team culture.

Case study 4

The Montana Domestic Violence Fatality Review emphasises the importance of dialogue, noting that its work "… provides the opportunity for individuals who seldom work with one another, or have traditional biases against each other, to proceed toward the common goal of understanding and preventing domestic violence deaths" (Montana Department of Justice 2019, p.8). It has also articulated its guiding principles:

1. "We offer each other support and compassion;
2. We conduct the Review in a positive manner with sensitivity and compassion;
3. We acknowledge, respect and learn from the expertise and wisdom of all who participate in the Review;
4. We work in honor of the victim and the victim's family;
5. We are committed to confidentiality;
6. We avoid accusations or faultfinding.
7. We operate in a professional manner; and
8. We share responsibilities and the workload" (Ibid. p. 12).

However, one common issue across all fatality reviews is that 'state' agencies make up the majority of team representatives, often because these agencies are specified in the enabling statute. Some have suggested that this might constrain the potential of fatality reviews (Sheehy 2017). Perhaps in response, many fatality reviews seek to ensure that their membership includes DVA specialists, and sometimes community members or experts by experience (including those affected directly by domestic homicide). In New Zealand, there is a different structure. While a Secretariat undertakes the actual reviews, it is overseen by the FVDRC. This is made up of experts from a range of disciplines, including DVA services, as well as service users/family members of those killed, with advisors from government agencies (Family Violence Death Review Committee Terms of Reference 2015).

There are other ways that fatality review systems try to ensure that their membership addresses specific knowledge or skills. For example, Bent-Goodley (2013) has explored why fatality review teams need to be culturally sensitive, and the pro-active

steps that are required to be culturally competent, not least to develop appropriate recommendations. To do this, fatality reviews adopt different approaches:

- One method is to ensure fatality reviews include representation. For example, in Florida there is a recognition that membership should reflect the local area's population (Florida Coalition Against Domestic Violence 2017, p.13);
- In New Zealand, the FVDRC is made up of experts from a range of disciplines, including representation from Māori and other ethnic groups (Family Violence Death Review Committee Terms of Reference 2015, p.4). When regional case reviews are undertaken, expertise is provided by a cultural advisor from the affected community and different agencies may also send staff with particular knowledge and skills; and
- Some other fatality review systems have developed mechanisms to consider the needs of specific communities. In Oklahoma, the Domestic Violence Fatality Review Board ensure that they review Native American cases since Oklahoma, along with California, have the largest Native American populations in the US. It has also established a sub-committee to consider '…the unique circumstances, challenges and barriers facing African American women' (Oklahoma Domestic Violence Fatality Review Board 2019, p.18). In Montana, a Native American fatality review was created in 2014 (Montana Department of Justice 2019, p.9).

While these different approaches may address cultural competence, for some communities there may only be a small number of homicides in any given jurisdiction, for example, LGBT+ victims. This may mean that it is not possible to aggregate case data, learning and recommendations specific to these communities. While there are risks associated with comparisons across jurisdictions, not least the risk of assuming the circumstances in one jurisdiction are the same as another or treating specific communities as homogenous, this means that national (or cross-national) data may be necessary if fatality review systems are going to identify trends and learning (Jaffe et al. 2020a, p.291).

Case study 5

Several state coalitions in the USA have produced guidance to help support professionals and agencies to participate in fatality reviews. This includes a guide in Florida that provides basic information on conducting a domestic violence fatality review. In particular, this empathises that 'discussions about team philosophy are central to the… process' (Florida Coalition Against Domestic Violence 2017, p.11).

Some fatality reviews have produced specific guidance for DVA services. For example, 'Guidelines for Advocates Participating in Domestic Violence Fatality Reviews' (Washington State Coalition Against Domestic Violence 2005). This emphasises the critical role of DVA specialists in review teams, including helping other panel members understand the complexity of DVA. This may help ensure the resulting recommendations are wide enough and also enable the fatality review to identify any unintended consequences.

A final point is that it is not uncommon for academics to be routinely included. For example, academics are explicitly included in the mandate for some fatality review systems. This includes the FVDRC in New Zealand, whose membership includes those with 'expertise in legal (criminal and family), medical, indigenous, social science and/or health research and practice' (Family Violence Death Review Committee Terms of Reference 2015, p.4). All the other fatality reviews considered in this report also included academic representation, although this is not necessarily explicitly stated in their Terms of Reference. The impact of the involvement of academics has not been explored, but one benefit may be to ensure that fatality reviews can draw on the latest research evidence with this complementing agency and family and informal network input.

Reflections on the DHR system

The issue of membership marks a further distinction between England and Wales and fatality reviews in other countries. Broadly speaking, other fatality review systems have a more stable committee or panel structures, and often a membership who are nominated or appointed. In contrast, in England and Wales, multi-agency panels are commonly 'bespoke', that is they tend to be convened anew for a particular case (although some local areas have standing panels. In London, at least half of panels are convened in this way (Montique 2019, p.10)).

This means that DHRs may face particular challenges in forming a multi-agency review panel, with implications for the process of selection/nomination, knowledge and skills of participants, and team dynamics (not least because a multi-agency review panel 'culture' will need to be developed anew in each DHR). Conversely, of course, there may be some benefits to this, not least as it may ensure a greater number of professionals have experience of DHRs over time, as well as avoiding some of the issues that may affect teams with consistent membership. The issue of emotional labour was noted in section 2.2; by regularly changing membership, the risk of secondary trauma may be reduced. Other benefits may include avoiding the issues that could come up as a result of a fixed membership (including entrenched tensions between members, or a risk of complacency).

Inevitably, smaller, non-governmental organisations, who are invited because they are DVA specialists or because they bring expertise in other areas (for example, concerning specific communities), may also need additional support to be involved (Benbow et al. 2018, p.16). Meanwhile, the involvement of academics may be more or less feasible in individual DHRs but could be recognised in the quality assurance process. This is discussed further in section 4.5.

As a final observation, all fatality reviews are dependent on specific individuals or teams to help drive the process, most commonly having a designated chair. In some cases, fatality reviews are dependent on a facilitator (in Montana, as well as the

regional reviews in New Zealand). However, the DHR process in England and Wales is unusually dependent on a single individual in the person of the Independent Chair / Report Author, who is/are appointed to lead the review. Yet, as with many other aspects of the DHR process, this has been little studied.

Questions and recommendations for the DHR system

Question	Recommendations
4. How can multi-agency review panel members be supported to take part in DHRs?	4a. Develop a competencies framework for panel members 4b. Develop an induction/training programme for multi-agency review panel members 4c. Provide opportunities in individual DHRs to reflect on the purposes of DHRs, as well as how multi-agency review panel members will work together 4d. Ensure specialist representation from DVA / community services is valued, heard and recompensed
5. What is the best way to ensure that Independent Chairs have the right skills to lead DHRs?	5a. Develop a competencies framework for Independent Chairs and Report Authors 5b. Develop an induction/training programme for Independent Chairs and Report Authors and develop an accreditation or quality mark 5c. Establish an Independent Chairs and Report Authors Network to share best practice

4.5 Making sense of homicides

Sources of information

All fatality reviews use information from the criminal justice process, often collected through the police or courts (Walklate et al. 2020, p.23), although many also look more broadly, drawing on a range of information from other sources (Websdale et al. 2019, p.2). This may include the media (for example, the New South Wales Domestic Violence Death Review Team), or social media (for example, the Domestic Violence Fatality Review Board in Oaklahoma).

Reflections on the DHR system

As discussed in section 3, although DHRs may have access to more information and so may find it easier to build a more holistic picture, it does mean that DHRs should be particularly mindful of the question that has been posed for other fatality reviews:

'how does a committee know when they have enough information?' (Jaffe et al. 2008, p.9). DHRs need to consider how to use the information they collect, for example, whether to include it as part of the Overview Report and Executive Summary. Anecdotally, this balance is not always achieved, with some DHRs including disproportionate information about the victim, perpetrator or children.

Media reporting tends not to be a key source of information for DHRs in England and Wales, although an Independent Chair / Report Author may consider media reporting at the start of a DHR. However, media reporting is used directly in research (Monckton-Smith et al. 2017) and the Femicide Census (Long and Harvey 2020).

Methodology and sense-making

Although fatality reviews operate differently, they broadly use the same toolkit to make sense of homicides. That is, by building case chronologies; identifying risk factors; scoping the involvement of agencies, and where possible, family and members of informal networks; and evaluating information sharing and collaboration (Websdale 2020a, p.2). To ensure that this is broadened beyond a focus on the individual, there is often a focus on the journey through the system. One fatality review summarises this simply as: '"Is there anything that could have been done differently to improve the systemic and/or community response to the victim and/or perpetrator?' (Oklahoma Domestic Violence Fatality Review Board 2019, p.33).

Another parallel approach is to consider individual experiences and encounters with agencies *and* a broader context still. Taken together, this includes considering someone's personal history (e.g. childhood), situational factors (e.g. family system), broader social structures (e.g. socioeconomic status) and cultural values and beliefs (e.g. gender roles) (Heise 1998). It may be that those fatality reviews that undertake in-depth biographical case reviews are particularly well placed to achieve this because they can consider the 'unique trajectories' of individual cases (Websdale et al. 2019, p.5).

Case study 6

The FDVRC in New Zealand has an explicit methodology, drawing on theories about both complexity (Fish et al. 2008) and also the Social Care Institute for Excellence (SCIE) methodology developed in the UK. There is an emphasis on 'thinking differently', and 'changing the narrative', about family violence. This includes recognising:

- "It is not appropriate to give victims the responsibility for keeping themselves and their children safe;
- Simply providing victims with a standard set of safety actions they can take is likely to be an ineffective response to their help-seeking;
- Victim safety requires systemic responses that focus on curtailing the abusive person's use of violence;

- Structural inequities and ineffective responses to family violence compound the entrapment of victims, and their families and whānau; and
- Victims responses to abuse are acts of resistance rather than acts of empowerment" (Family Violence Death Review Committee 2016, p.13).

Another aspect of thinking differently is the recognition that victims often receive a 'mis-matched' safety response. This can include being offered safety strategies that are relatively simple and which do not build on their resources / the strategies they are already using, recognise the realities of their lives, or include actions that practitioners can take (Family Violence Death Review Committee 2016, p.27).

The FVDRC explicitly adopts a structural analysis, recognising that social and economic resources are unequal in the population. There is also a focus on an intersectional approach. Taken together, this means there is a focus on challenging 'simple solutions' to what is a complex social problem, in particular by re-framing how violence and abuse are understood.

Case study 7

The FVDRC in New Zealand uses 'traumagrams' to help map an individual's (and their family's) experiences of trauma. This helps reviewers move away from focusing on specific incidents to consider patterns of harm, including 'historical trauma' that spans generations (Atkinson 2002). The development of traumagrams in New Zealand draws on previous work, including studies that linked the colonisation of Aboriginal lands in Australia to higher increased rates of family violence, child sexual abuse, and family breakdown in Australian indigenous society. This work has been extended to consider the experience of historical trauma by Mäori in New Zealand (Pihama et al. 2014).

Another way of sense-making employed by the FDRVC is the idea that Intimate Partner Violence (IPV) is a form of 'social entrapment'. The FVDRC takes this view of IPV and its model frames social entrapment as operating on three levels:

- "The social isolation, fear and coercion that the predominant aggressor's coercive and controlling behaviour creates in the victim's life; [33]
- The indifference of powerful institutions to the victim's suffering; and
- The exacerbation of coercive control by the structural inequities associated with gender, class, race and disability" (Tolmie et al. 2018, p.185).

These two different approaches encourage the review team to think about a victim's (and offender's) lived experience, including recognising how choices and decisions can be constrained or shaped by broader contextual factors. They also draw out the behaviour of other actors, including agencies.

[33] In the FVDRC's account of the social entrapment, IPV is framed solely as involving coercive control. It is not clear how this framework applies in cases of situational couple violence.

Reflections on the DHR system

The DHR system produces in-depth biographical case reviews, and this can generate a significant amount of learning. There is some evidence that DHRs do this and may also produce valuable broader learning, not least because they take a more holistic perspective than other agency-specific reviews (for example, into police contact) (Payton et al. 2017, p.110)

However, as is explored throughout this report, there can be any number of factors that may shape DHRs, including the sense-making process and so the story that is told and the learning that is generated. Much of this hinges on what have been called 'decision-making moments' in a fatality review process (Albright et al. 2013, p.437). These decisions may be contested by those involved, and in an English and Welsh context, by family. Further work is required to ensure that these moments (and other ethical issues) are recognised and their implications considered.

Data collection

Underpinning many fatality review processes is the aggregation of case data and learning, particularly where information is being shared across local or regional fatality reviews.

Case study 8

The Australian Domestic and Family Violence Death Review Network has developed a 'National Minimum Dataset' (Australian Domestic and Family Violence Death Review Network 2018). This brings together data from across Australian fatality reviews and includes:

- Details of the homicide event (fatal episode), including the manner, location and date of death;
- Socio-demographic characteristics of the homicide victim and homicide offender;
- Information regarding the relationship between the homicide victim and homicide offender, including the length of the relationship, details regarding separation, history of violence (reported and unreported), types of violence (physical, psychological, emotional, social and sexual violence), history of stalking, any criminal justice histories (including imprisonment, conviction, other offending);
- Criminal justice or coronial outcomes;
- Domestic Violence Order information; and
- Prevalence of surviving children (biological or stepchildren).

In the USA, work is ongoing to develop a uniform reporting system (URS) to enable data sharing between fatality reviews from across the country (Websdale et al. 2019). This would establish a national clearinghouse for domestic violence fatality review data. A summit in 2019 explored the types of information that could be collected, legal challenges in sharing information between fatality reviews, as well as the best way to share findings.

Reflections on the DHR system

As in other countries, early work on fatality reviews in England and Wales (before the introduction of DHRs) was instrumental in informing the development of risk tools (Richards 2006; Robinson 2006). Yet currently there is a very limited process for the collection of data. As a result, it is almost impossible to routinely gather data or learning from across DHRs. This means England and Wales cannot produce a 'real-time' dataset. This is in contrast to New South Wales for example, which collects and reports on quantitative data about all homicides occurring in a domestic violence context within a given period (Domestic Violence Death Review Team 2020, p.4). Additionally, the aggregation and analysis of case data and wider learning has, as described in section 2.2, been limited to date.

Questions and recommendations for the DHR system

Learning	Recommendations
6. What have we learnt after nearly a decade of DHRs about best practices around methodology?	6a. Drawing on best practice – in the context of DHRs to date, international fatality review systems and other statutory review models in the UK – review the methodology used to undertake DHRs 6b. Review existing guidance around information sharing during the DHR process 6c. Address ethical and methodological challenges in undertaking DHRs
7. How can the DHR system ensure it can 'see the big picture?'	7a. Develop the existing data collection form to enable the routine collection and analysis of a minimum data set 7b. Develop a mechanism to collate emerging learning from across DHRs

Quality Assurance

There is not a direct equivalent to the Home Office's quality assurance panel in other fatality review systems. The closest comparison is in those fatality review systems where local or regional fatality review teams undertake case review and a state-wide or national body then draws on these (e.g. Florida and New Zealand). However, it is important to note that these systems do not include a quality assurance function. Meanwhile, in some contexts, the concept of national oversight would raise specific issues. For example, in the USA, a quality assurance process undertaken at a national level would be inconsistent with the concept and practice of the separation of powers between federal/state and local government.

Reflections on the DHR system

In England and Wales, the Home Office has oversight of the DHR system, by way of its ability to issue statutory guidance but also via the national quality assurance panel. The quality assurance panel is a multi-agency panel, with representatives from statutory and non-governmental organisations, including specialist DVA services and other providers like Victim Support (Home Office 2013d). In having a diverse membership, the quality assurance panel shares many features with other fatality review teams.

The quality assurance panel has two broad functions. First, it 'bookends' the delivery of the DHR system in terms of individual cases: by reviewing decisions to conduct a DHR at the start and assuring the quality of the DHRs at the end. Second, it was conceived of as acting as a 'clearinghouse' for national learning and recommendations (Home Office 2013d, p.2; Home Office 2016, pp.28–29).

In terms of the first function, the decision to conduct DHRs is made by individual CSPs and, while the Home Office has oversight of this, little is known about how this works in practice (see section 4.3).

In terms of the second function, that of assuring quality, CSPs must submit a completed Overview Report, Executive Summary and Action Plan (and since 2016, a simple data collection form) to the quality assurance panel and require approval before publication. To support this function, in late 2019 the Home Office commissioned a 'readers' service'.[34] In summary, the process operates as follows:

- A 'reader' reviews each DHR, assessing it against a set criterion (Home Office 2013a);
- The reader assessment and the completed DHR are then considered by the quality assurance panel. The quality assurance panel decides whether any changes are required and whether the standard of the DHR is such that it can be published;
- Thereafter a letter is sent to the CSP with the quality assurance panel's decision. This either gives approval for publication or withholds it; it may also make recommendations about any aspect of the report. Where permission is given to publish, the CSP is expected to consider the recommendations and make any changes before publication. Where permission to publish is withheld, the CSP is expected to address any recommendations and then resubmit to the quality assurance panel.

[34] In addition to introducing a revised data collection form, which aims to collect more robust data and a wider range of information, the readers' service will produce an annual report on the DHRs reviewed over a 12-month period. This is a welcome step and will go some of the way to addressing the recommendations in this report around data collection and reporting.

When it commissioned a readers' service, the Home Office estimated that the quality assurance panel considers approximately 100 DHRs per year (Home Office 2019).

As has been noted elsewhere in this report, little is known about the quality assurance panel's functioning. Concerning its role regarding individual DHRs, it is not clear how consistent its feedback is, nor indeed whether this is then reflected in published reports. More critically, it is apparent that the volume of DHRs that are being considered exceeds its capacity, with the current arrangements producing a bottleneck. For example, based on personal experience as an Independent Chair / Report Author, the quality assurance process can take up to six months; ironically this is the timeframe in which the statutory guidance requires DHRs to be completed. The time taken for quality assurance is likely to have a significant impact. It means family are left waiting for the process to conclude, and it may also dilute the impact of the DHR when it is published, given the length of time that will have elapsed since the homicide.

The broader impact of the quality assurance panel is also unclear. In particular, in the absence of any regular reporting mechanism, it means that its ability to fulfil its role as a 'clearinghouse' – not least the consolidation of learning and recommendations – is circumscribed.

These are significant limitations. However, this should not be read as a criticism of those involved in the quality assurance process, given they are working within the confines of the system as it is currently conceived and resourced. Indeed, it is worth noting that members of the quality assurance panel are volunteers (and, as with individual DHR panels, this has a resource implication, with the opportunity cost being disproportionately felt by specialist DVA services).

It may be useful to consider how best to bridge the gap between local implementation and national oversight. This could include separating the current functions of the quality assurance panel, with regional panels undertaking oversight of quality assurance for individual DHRs, and a national quality assurance panel then delivering a clearinghouse function.

A common feature of many fatality reviews in their approach to membership is an appointment or nomination process. Adopting a similar approach in England and Wales may help ensure that the membership of the quality assurance panel is both regularly refreshed and seen as transparent. Although the quality assurance panel includes a range of specialist services currently, this could also be broadened to explicitly include other representatives, such as experts by experience and academics (as discussed in 4.4).

Looking more broadly than these operational issues, it may be useful to consider what 'quality assurance' means (in addition to the discussion here, this also links to the discussion in 4.2 regarding establishment). The existence of a national quality

assurance process is a good example of how the features of any given jurisdiction affects a fatality review's structure. For example, the UK has a highly centralised system of government (even allowing for devolution, as well as policy initiatives like localism) which means the idea that a central government department should have a quality assurance role may be taken for granted.[35] In contrast, as noted above, in the USA such a function would not be possible and, reflecting this, at a national level the focus is on technical advice as provided by the NDVFRI. Exploring this further is also relevant in practice, as it draws attention to the nature of the quality assurance panel's role, including how its functions are understood and delivered (i.e. the nature and scope of its scrutiny).

Questions and recommendations for the DHR system

Question	Recommendations
8. What is the best way to deliver an oversight function to ensure the quality of individual DHRs and system integrity?	8a. Restructure the quality assurance model by: • Establishing regional panels, to be responsible for the scrutiny of DHRs and regional learning/action • Refocus the national panel, to be responsible for the aggregation of learning and process integrity nationally 8b. Review the composition of the quality assurance panel: • Fill through a public appointment process with panel members serving for fixed terms • Include survivor and community voice, specialist sector and academic representation

Technical support

Other countries have recognised the value of technical support to facilitate the roll-out and development of fatality reviews systems, including collaboration across reviews. In some cases, this has been funded, for example, the CDHPI in Canada and the NDVFRI in the USA. In other cases, this is un-funded, as in the work of the Australian Domestic and Family Violence Death Review Network. As noted earlier, these arrangements provide mechanisms to share and build a collective understanding, supporting both implementation and delivery. For example, in addition to hosting a range of practical resources on its website, the NDVFRI regularly runs webinars on a variety of different aspects of the fatality review process in the USA.[36] In Canada, as a precursor to the development of province or territory level fatality reviews, there were a series of summits organised to explore implementation (Jaffe et al. 2008; Jaffe et al. 2011).

[35] Although it is of note that the quality assurance process for DHRs is different to the arrangements for other statutory reviews in England and Wales.

[36] https://ndvfri.org/resources/webinars/.

Reflections on the DHR system

In England and Wales there is no consistent mechanism for technical support. While the Home Office has produced statutory guidance and has oversight of the quality assurance process, its capacity and leadership in this area have been limited. Consequently, non-governmental organisations like AAFDA and STADV have filled the gap, while some CSPs and local partners have sought to promote best practice, as an example, by producing local DHR guidance.

Questions and recommendations for the DHR system

Question	Recommendations
9. What is the most consistent and cost-effective way to support best practice?	9a. Establish a national programme to provide technical expertise

4.6 Identifying learning and making recommendations

Most fatality reviews regularly report on their learning, commonly on an annual or biennial basis. Fatality reviews that produce regular reports are also able to use this information to mobilise political, media and community interest.

Reporting is usually in aggregate, identifying common risk factors, as well as trends and patterns. Although the frequency and format of reporting varies, all the fatality reviews discussed in this report have regular reporting mechanisms. Commonly, a focus of reporting is the circumstances of domestic homicides, in particular risk factors. The intention is that by identifying common risk factors, these can be used to inform risk identification and assessment, as well as risk management and safety planning. For example, the Ontario DVDRC reports annually on the frequency of 41 risk factors (Office of the Chief Coroner Province of Ontario 2019, pp.14–17).

In addition to the identification of risk factors, fatality reviews also report on wider learning. Other areas on which fatality reviews focus include:

- Missed opportunities for intervention and prevention;
- Barriers and gaps in service;
- Legislative reform; and
- Systemic and inter-agency communication and coordination (Campbell et al. 2016, pp.7–8).

The majority of fatality reviews make recommendations based on the learning identified. Within this, there are differences in approach. For example, in a recent

report, New Zealand's FVDRC focused on a 'dialogic' approach to change thinking (Family Violence Death Review Committee 2016, p.ii). Meanwhile, Ontario has a 'no new recommendations' rule which means it will not repeat recommendations that have already been made.

However, there is a consistent challenge in evidencing impact (Bugeja et al. 2017). This is in part an 'attribution problem' (Storer et al. 2013, p.422). That is, there is no current evidence showing if fatality reviews are achieving the overarching goal of reducing domestic homicides because of the difficulty of making a causal link between recommendation(s) and avoided deaths (Bugeja et al. 2015, p.185). As a result, it may be more useful to focus on whether fatality reviews lead to systemic change (Payton et al. 2017, p.112). However, even here the attribution problem is evident, not least because while fatality reviews may make recommendations and update on progress as part of regular reporting, others are responsible for delivery. Nonetheless, most fatality review systems can identify specific examples of the changes that have come about as a result of recommendations. There may also be broader impacts, for example, Websdale (2020a, p.15) has argued one benefit may be improvements in inter-agency working between those involved in fatality review and the handling of DVA cases in general.

As has been illustrated by this report, there are both significant differences and similarities between fatality review systems. Concerning learning and recommendations, there have been ongoing discussions between different jurisdictions. Most recently, this was reflected in an edited volume (Dawson 2017). However, developing opportunities for continued sharing of ideas, and even promoting international research and the sharing of data, may be fruitful.

Reflections on the DHR system

In contrast, England and Wales have a fragmented and inadequate reporting system. This reflects:

- The delegation of reporting to a local level, with CSPs being responsible for overseeing the implementation of recommendations. There is relatively little information available about progress against recommendations from individual DHRs. A particular challenge is that some local authority teams supporting CSPs may no longer have a specialist DVA or VAWG lead officer, with these functions being within a broader community safety or equivalent team. This may mean the postholder does not have the right skills, expertise or time to discharge this function;
- The absence of a standardised reporting mechanism, reflecting the previously noted lack of a common data collection tool or process for sharing learning; and
- Issues with the publication and accessibility of individual DHRs.

Meanwhile, at a national level, the absence of a national repository means the capacity to routinely produce aggregate data and learning is limited (HMIC 2015, p.105). As noted previously, few national reports have been produced, with significantly different levels of detail and analysis. The quality assurance panel's role in bringing together findings has also been limited (as discussed above in section 4.5).

Taken together, this significantly dilutes the ability of findings from DHRs to inform practice, policy, or influence public awareness. Fundamentally, it also means it is impossible to answer a key question: do the outcomes of the DHR system deliver its stated purposes?

Questions and recommendations for the DHR system

Question	Recommendations
10. How can learning be shared across the DHR system?	10a. Establish a regular reporting system, underpinned by the aggregation of case data, learning and recommendations, at a regional and national level 10b. Clarify the purpose of publication, with reference to responsibilities, aim(s) and audience(s) 10c. Establish a national repository to act as a clearinghouse for all completed DHRs
11. How can the impact of the DHR system be evidenced and sustained?	11a. Given it is the 10th anniversary of the implementation of DHRs in 2021, commission an independent evaluation of the DHR system 11b. In due course, reflecting the outcomes of an independent evaluation, amend legislation and review the statutory guidance to ensure the DHR system is fit for purpose
12. What are the opportunities presented by international collaboration?	12a. Explore opportunities for continued international collaboration to share practice approaches, learning and data

Chapter Five: Where next? Conclusion and the way forward

This concluding chapter starts by revisiting the aims of my Fellowship and discusses whether they were met, before addressing dissemination and recommendations.

5.1 Revisiting the aims of the Fellowship

My Fellowship focused on reviewing practice from international fatality reviews and using learning to improve the DHR system in England and Wales. This report has set out what I have learnt. In chapter two, I summarised different approaches to fatality reviews, before identifying some of the questions and issues about the DHR system. In chapter three, inspired by discussions with those I met, I explored aspects of the DHR system that I had not considered before or taken for granted. In chapter four, I addressed fatality review principles and establishment, before considering both their doing (including case selection, membership and how they make sense of homicides) and use (including the production of learning and recommendations). Throughout chapter four, I asked questions of and made recommendations to develop the DHR system (these are also brought together in one place at the end of this chapter). As I explained in chapter one, I have chosen not to direct these recommendations to any specific organisation, but they are relevant in England and Wales to the Home Office, the Domestic Abuse Commissioner and those involved in the doing and use of DHRs more broadly. I hope these recommendations will be a starting point for conversations with and between a range of different stakeholders about the future shape of DHRs.

5.2 Dissemination

In England and Wales, in addition to sharing this report with the Home Office and the Domestic Abuse Commissioner, I will share it with other key stakeholders including:

- Those involved in the delivery of DHRs, including CSPs and PCCs, Independent Chair / Report Authors and multi-agency review panel members;
- The specialist DVA sector, which has a vital if largely unfunded role to play, not least in ensuring DHRs hold the victim at the centre of their work; and
- The families of those affected by domestic homicide. In that context, AAFDA is a central stakeholder as the organisation that has worked to ensure that families are at the heart of the DHR system. Victim Support's Homicide Service also has a key role to play in this work.

I will also share this report with key stakeholders in Northern Ireland and Scotland.

More broadly, there is also an opportunity to engage with the research community, particularly around the doing and use of DHRs. My PhD research will explore some of

these issues but there is also research being conducted into different aspects of the DHR system at Cardiff University, the University of Central Lancashire (UCLAN), Manchester Metropolitan University (MMU) and the University of Gloucestershire. I will share this report with the Domestic Homicide Research Network, which brings together individuals from practice, policy and research in the UK and internationally.

5.2 Developing the DHR process in England and Wales

England and Wales nominally have a national-level review system, based on statute and national statutory guidance. In theory, this incorporates the best of both worlds. First, it enables a biographical analysis of individual deaths, as well as identifying local learning and recommendations. Second, as a national-level system, it should be possible to bring the learning from individual cases together in aggregate to identify common themes and issues, as well as to drive change and so reduce homicide. However, a thread running through this report is the argument that the DHR system is in practice localised, while its implementation and oversight have been problematic. In highlighting these issues, it is important to recognise the hard work and commitment of many of those involved in DHRs. Nonetheless, despite these efforts and because of the broader issues identified in this report, there remain many unanswered questions about the doing and use of DHRs, both individually and collectively. In short, if one critically appraises the DHR system as a whole, it is currently less than the sum of its parts. The challenge is to ensure we honour those who have died by making sure that the DHR system is as effective as possible. I hope that the recommendations in this report can play some part in making that possible, not least as we approach the 10th anniversary of the implementation of DHRs, with this being as good a time as any to step back and consider future directions.

5.3 Opportunities in Northern Ireland and Scotland

While neither Northern Ireland or Scotland currently undertake DHRs, the learning and recommendations in this report are relevant to both nations. Northern Ireland does not need to start from scratch: it has an opportunity to consider the learning from England and Wales, as well as other countries, as it starts to implement DHRs. Like New Zealand, Northern Ireland has a relatively small population and may find it more practicable to both undertake case-specific reviews but also bring together learning. Meanwhile, Scotland has yet to commit to implementing DHRs. In this, there are parallels to England and Wales, where it took seven years to implement DHRs after they were established in statute. Scotland appears to be following a not dissimilar trajectory, with its commitments to explore a DHR system as yet unfulfilled. While fatality reviews are a complex endeavour, they have an important role to play. Hopefully, this report will support the voices of specialist services, survivors and the families of those who have died in calling for the implementation of a fatality review system, so that Scotland is not an outlier in the UK.

5.4 Questions and Recommendations

Questions	Recommendations
1. How can we develop and sustain a shared understanding of the purposes of DHRs?	1a. Articulate a Theory of Change to underpin the DHR process 1b. Facilitate a dialogue about the multiple, sometimes conflicting purposes of DHRs 1c. 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 1d. Develop a shared set of consistent definitions 1e. Identify opportunities to collaborate with other aligned initiatives e.g. the Femicide Census
2. How can we ensure that there is effective oversight of the DHR system at a local, regional and national level? In answering this question, what constitutes effective oversight and what is its purpose?	2a. Evaluate the effectiveness and impact of the current arrangements for oversight of the DHR system, including existing local (through CSPs) and national (by the Home Office) arrangements 2b. Consider whether national oversight of the DHR system should be transferred to the Domestic Abuse Commissioner 2c. Identify best practice and make recommendations to ensure that CSPs are discharging their responsibilities effectively 2d. Develop regional oversight by formalising the role of Police & Crime Commissioners (PCCs) through a co-commissioning model
3. What is the best way to commission and deliver DHRs, while continuing to recognise the unique significance of each homicide?	3a. Ensure that the decision-making process concerning DHRs is robust and transparent 3b. Enable flexibility in the DHR model (rather than 'one size fits all') depending on case circumstances
4. How can multi-agency review panel members be supported to take part in DHRs?	4a. Develop a competencies framework for panel members 4b. Develop an induction/training programme for multi-agency review panel members 4c. Provide opportunities in individual DHRs to reflect on the purposes of DHRs, as well as how multi-agency review panel members will work together 4d. Ensure specialist representation from DVA / community services is valued, heard and recompensed

5. What is the best way to ensure that Independent Chairs have the right skills to lead DHRs?	5a. Develop a competencies framework for Independent Chairs and Report Authors 5b. Develop an induction/training programme for Independent Chairs and Report Authors and develop an accreditation or quality mark 5c. Establish an Independent Chairs and Report Authors Network to share best practice
6. What have we learnt after nearly a decade of DHRs about best practices around methodology?	6a. Drawing on best practice – in the context of DHRs to date, international fatality review systems and other statutory review models in the UK – review the methodology used to undertake DHRs 6b. Review existing guidance around information sharing during the DHR process 6c. Address ethical and methodological challenges in undertaking DHRs
7. How can the DHR system ensure it can 'see the big picture?'	7a. Develop the existing data collection form to enable the routine collection and analysis of a minimum data set 7b. Develop a mechanism to collate emerging learning from across DHRs
8. What is the best way to deliver an oversight function to ensure the quality of individual DHRs and system integrity?	8a. Restructure the quality assurance model by: • Establishing regional panels, to be responsible for the scrutiny of DHRs and regional learning/action • Refocus the national panel, to be responsible for the aggregation of learning and process integrity nationally 8b. Review the composition of the quality assurance panel: • Fill through a public appointment process with panel members serving for fixed terms • Include survivor and community voice, specialist sector and academic representation
9. What is the most consistent and cost-effective way to support best practice?	9a. Establish a national programme to provide technical expertise
10. How can learning be shared across the DHR system?	10a. Establish a regular reporting system, underpinned by the aggregation of case data, learning and recommendations, at a regional and national level 10b. Clarify the purpose of publication, with reference to responsibilities, aim(s) and audience(s)

	10c. Establish a national repository to act as a clearinghouse for all completed DHRs
11. How can the impact of the DHR system be evidenced and sustained?	11a. Given it is the 10th anniversary of the implementation of DHRs in 2021, commission an independent evaluation of the DHR system 11b. In due course, reflecting the outcomes of an independent evaluation, amend legislation and review the statutory guidance to ensure the DHR system is fit for purpose
12. What are the opportunities presented by international collaboration?	12a. Explore opportunities for continued international collaboration to share practice approaches, learning and data

Appendices

Appendix One: Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
AFH	Adult Family Homicide
CFOJA	Canadian Femicide Observatory for Justice and Accountability
CDHPI	Canadian Domestic Homicide Prevention Initiative
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
DVA	Domestic Violence and Abuse
DVDRC	Domestic Violence Death Review Committee
ESRC	Economic and Social Research Council
EVA	Ending Violence Association of BC
FCADV	Florida Coalition Against Domestic Violence
FVDRC	Family Violence Death Review Committee
HQSC	Health Quality & Safety Commission
IPH	Intimate Partner Homicide
IPV	Intimate Partner Violence
LGBT+	Lesbian, Gay, Bisexual and Trans
MAEVe	Melbourne Alliance to End Violence Against Women and Their Children
MMU	Manchester Metropolitan University
NDVFRI	National Domestic Violence Fatality Review Initiative
NEVR	Network to Eliminate Violence in Relationships
PCC	Police and Crime Commissioner
SCIE	Social Care Institute for Excellence
STADV	Standing Together Against Domestic Violence
UK	United Kingdom
URS	Uniform Reporting System
USA	United States of America
VAWG	Violence against Women and Girls
VSRFVD	Victorian Systemic Review of Family Violence Deaths
UCLAN	University of Central Lancashire
WCMT	Winston Churchill Memorial Trust

Appendix Two: Overview of fatality review processes in countries visited

Australia

Level		Establishment			Structure[37]					Cases in scope	Case Review		Reporting (most recent report)
		Mandate	Hosted by	Date	Secretariat or equivalent	Panel	Subject matter experts	Service user / family	Minority communities		Aggregate / quantitative	Biographical / qualitative	
State	New South Wales - Domestic Violence Death Review Team	Specific legislation	Convened by the coroner, operate independently within Department of Justice	2010	Manager and a Research Analyst	16 government, two non-government sector representatives and two non-government service providers	Y	N	Y	All 'domestic violence deaths', including IPH, AFH and 'other' homicides that occur in a domestic violence context	Data captured on all cases, allowing identification of trends over time	In-depth case reviews of all cases in reporting period (usually 2 years)	Biannual report (Domestic Violence Death Review Team 2020)

[37] Based on Terms of Reference and / or membership as listed in most recent report

State	South Australia	No specific legislation, established under coronial mandate	The Office for Women and the SA Coroner's Court	2011	Senior Research Officer	No formal arrangements but the Senior Research Officer can access advise from relevant government agencies and through the Office for Women.	-	-	-	Deaths where there is a domestic or family violence context	Data captured on all cases, allowing identification of trends over time	Reviews individual cases to inform coronial investigation. Published Coronial Inquests with a domestic violence context	Included in Coroner's annual report (Courts Administration Authority of South Australia 2018)
State	Victoria - VSRFVD	Specific legislation	Coroner's Court	2009	Team within the Coroners Court, headed by the State Coroner, including a manager, case investigators, lawyer, family liaison officer, registrar and project officer.	Reference Group with government and non-government representatives	Y	N	Y	'Family violence related homicides' i.e. deaths suspected to have resulted from family violence	Data captured on all cases, allowing identification of trends over time	Reviews individual cases to inform coronial investigation. Published Coronial Inquests and written findings having a family violence context	Included in Coroner's Annual Report (Coroners Court of Victoria 2019)

Canada

Level		Establishment			Structure[38]					Cases in scope	Case Review		Reporting (most recent report)
		Mandate	Hosted by	Date	Secretariat or equivalent	Panel	Subject matter experts	Service user / family	Minority communities		Aggregate / quantitative	Biographical / qualitative	
Provincial	British Columbia - Death Review Panel	No specific legislation, established under coronial mandate	British Columbia Coroners Service	2010	Coroners Service	Ad hoc and includes government and non-government representatives	Y	N	Y	Intimate-partner violence-related deaths	In 2016 conducted 6-year review of deaths	In 2010, conducted in-depth review of 11 cases	Ad hoc (British Columbia Coroners Service 2010; British Columbia Coroners Service 2016)
Provincial	Ontario - DVDRC	No specific legislation, established under coronial mandate	Office of the Chief Coroner Office	2003	Coroners Service	Includes government and non-government representatives	Y	N	N	Intimate-partner violence-related deaths	Data captured on all cases, allowing identification of trends over time	Individual case reviews completed	Annual (Office of the Chief Coroner Province of Ontario 2019).

[38] Based on Terms of Reference and / or membership as listed in most recent report

New Zealand

Level	Establishment			Structure					Cases in scope	Case Review		Reporting (most recent report)
	Mandate	Hosted by	Date	Secretariat or equivalent	Panel[39]	Subject matter experts	Service user / family	Minority communities		Aggregate / quantitative	Biographical / qualitative	
National FVDRC	New Zealand Public Health and Disability Act 2000 enables creation of mortality committees, with the FVDRC established under this mandate to address family violence[40]	HQSC	2008	Senior specialist based at HQSC	Experts from a range of disciplines Supported by advisors from government departments	Y	Y	Y	All cases of family homicide (including IPV, Child Abuse and Neglect, and Intrafamilial Violence).	Data captured on all cases	Small number of in-depth case studies	Regular reporting (Family Violence Death Review Committee 2016; Family Violence Death Review Committee 2017)

[39] Based on Terms of Reference and / or membership as listed in most recent report

[40] Between 2008 and 2010 the FVDRC was as an independent ministerial advisory committee hosted by the Ministry of Health.

The USA

Level		Establishment			Structure[41]					Cases in scope	Case Review		Reporting (most recent report)
		Mandate	Hosted by	Date	Secretariat or equivalent	Panel	Subject matter experts	Service user / family	Minority communities		Aggregate / quantitative	Biographical / qualitative	
State and local	Florida	Specific legislation	Office of the Attorney General and Florida Coalition Against Domestic Violence (FCADV) Effective 1st May 2020, the Florida Department of Children and Families Domestic Violence Program	2009	Co-chaired by the Florida Attorney General's Office and the (FCADV)	Includes government and non-government representatives	Y	N	Y	'Domestic relationships' (including IPH and AFH), with the potential to consider near misses	Local teams use a common data collection tool, with aggregate data used by statewide team.	Local teams conduct individual case reviews, the statewide team can also review cases	Annual (Florida Coalition Against Domestic Violence and Florida Office of the Attorney General 2019).
State	Montana - Domestic Violence Fatality Review	Specific legislation	Department of Justice	2003	Coordinator	Includes government and non-government representatives	Y	N	Y	Intimate-partner violence-related deaths	Data captured on all cases, allowing identification	Uses an 'inch wide, mile deep' methodology, with the two	Biannual reporting (Montana Department

[41] Based on Terms of Reference and / or membership as listed in most recent report.

	Commission; Native American Domestic Violence Fatality Review Team										of trends over time	fatality reviews considering two cases each per year	of Justice 2019)
State	Oklahoma - Domestic Violence Fatality Review Board	Specific legislation	Office of the Attorney General	2001	Program Manager	Includes government and non-government representatives	Y	Y	Y	'domestic violence-related homicides' including IPH and AFH, also domestic violence-related homicides where a non-family member is killed	Data captured on all cases, allowing identification of trends over time	In some cases, the Board will conduct an in-depth case review	Annual (Oklahoma Domestic Violence Fatality Review Board 2019)

Appendix Three: Organisation and individuals involved by country

Australia

South Australia

Organisation	Individuals
Coroners Court of South Australia / Australian Domestic and Family Violence Death Review Network	Heidi Ehrat
Office for Women	Ellie McEvoy and colleagues
Women's Safety Services SA	Maria Hagis

Victoria

Organisation	Individuals
Coroners Court of Victoria	Phoebe Marshall and Lauren Bedggood
Monash University – Gender and Family Violence Prevention Centre	Professor JaneMaree Maher Professor Jude Mcculloch Dr Lyndal Bujega Dr Silke Meyer
Monash Gender and Family Violence Prevention Centre	Femicide data collection roundtable event 23 July 2019
The University of Melbourne	Professor Cathy Humphreys Sian Harrison Dr Eva Elisic

New South Wales

Organisation	Individuals
ANROWS[42]	Cassandra Dawes Rebecca Goodbourn Helen Sowey
Domestic Violence Death Review Team	Anna Butler Emma Buxton-Namisnyk
Sydney Women's Domestic Violence Court Advocacy	Susan Smith
University of New South Wales	Dr Patricia Cullen

Canada

Ontario

Organisation	Individuals
The Office of the Chief Coroner for Ontario	Kathy Kerr and fatality review team members including Deborah Sinclair
Anova / London Coordinating Committee to End Women Abuse	Shelley Yeo

[42] An independent national research organization established by the Commonwealth and all state and territory governments of Australia. ANROWS is based in New South Wales.

Ontario Association of Interval & Transition Houses	Marlene Ham
Western University – Centre for Research and Education on Violence Against Women & Children / CDHPI	Professor Peter Jaffe, Barb MacQuarrie and colleagues

British Columbia

Organisation	Individuals
BC Society of Transition Houses	Amy FitzGerald and colleagues
Coroners Service of British Columbia	Michael Egilson Lori Moen
Ending Violence Association of BC (EVA BC) / Simon Fraser University – FREDA Centre for Research on Violence Against Women and Children / Kwantlen Polytechnic University – Network to Eliminate Violence in Relationships (NEVR)	Dr Kate Rossiter Dr Margaret Jackson The Honourable Donna Martinson Dr Balbir Gurm Sarah Yercich

New Zealand

Organisation	Individuals
FVDRC	Jane Koziol-McLain Irene De Haan
HQSC	Pauline Gulliver Denise Wilson [43]
New Zealand Family Violence Clearinghouse	Nicola Paton and colleagues
New Zealand Police	Inspector Fiona Roberts
Shine	Jane Drum Liz McAneny
University of Auckland	Professor Julia Tolmie
Women's Refuge	Natalie Thorbun

USA

Organisation	Individuals
Florida Coalition Against Domestic Violence	Cynthia Rubenstein and local fatality review team members
Montana Domestic Violence Fatality Review Commission	Joan Eliel
NDVFRI	Dr Neil Websdale Dr Kathleen Ferraro
Northern Arizona University, Family Violence Institute	National Clearinghouse for Domestic Violence Fatality Review Teams 1st Summit 24 – 26 June 2019
Oklahoma Domestic Violence Fatality Review Board	Jacqueline Steyn Dr Janet Wilson

[43] A past member of the FVDRC and has ongoing involvement with the HQSC.

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