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Domestic/Family Violence Death Reviews: An International Comparison

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Abstract

Domestic/Family Violence Death Reviews (D/FVDRs) have been established in a number of high-income countries since 1990 as a mechanism to inform prevention-focused interventions to reduce domestic/family violence. D/FVDRs differ in their structure, governance, case identification processes and inclusion criteria, review measures, and outputs. Outside of the United States, the extent of heterogeneity across and within countries has not been explored. This study comprised an international comparison of D/FVDRs and their core elements to inform the establishment of D/FVDRs in other developed countries, and potentially low- and middle-income countries where violence is a leading cause of death. Such a review is also a necessary foundation for any future evaluation D/FVDRs. The review identified 71 jurisdictions where a D/FVDRs had been established in the past two decades, 25 of which met the inclusion criteria. All D/FVDRs examined stated a reduction in deaths as a goal of the review process; however, none reported an actual reduction. The focus of the D/FVDRs examined was on intimate partner homicides; however, more recently established D/FVDRs include other familial relationships. Almost one third of the D/FVDRs examined reported changes to the domestic/family system that occurred as a result of recommendations made from the review process. While similar in many ways, D/FVDRs differ along a number of important dimensions that make it difficult to identify best practices for jurisdictions considering the establishment of such an initiative. To share knowledge, existing networks should be expanded nationally and internationally to include jurisdictions that may be considering this initiative.

Keywords

domestic violence, family violence, homicide, death/fatality review

Key Findings

- The dominant focus of reviews for existing Domestic/Family Violence Death Reviews (D/FVDRs) is on intimate partner homicides and intimate partner homicide–suicides, but more recently established D/FVDRs have expanded this definition to include other familial relationships.
- Almost one third of the D/FVDRs examined reported changes to the domestic/family system that occurred as a direct result of recommendations made from the review process.
- Although a reduction in deaths and strengthening service systems are common goals of D/FVDRs, success was only reported with respect to the latter, which may be because it is a more concrete and measureable outcome.

Introduction

Domestic/family violence is a pervasive and resilient social problem which crosses socioeconomic, geographical, age, cultural, and religious boundaries (World Health Organization, 2002). Estimates of the economic impact of domestic/family violence in high-income countries extends into many millions and, in some countries, billions of dollars (Access Economics, 2004; Centers for Disease Control and Prevention, 2003; Taylor et al., 2008; Walby, 2004; Wilson & Websdale, 2006). Although the economic impact of domestic/family violence is not as well researched in low- and middle-income countries, there is evidence to suggest that these developing countries are disproportionately affected by such violence. Comparatively, estimates of the cost of domestic/family violence in these low- and middle-income countries are reported to be a higher percentage of the gross domestic product (World Health Organization [WHO], 2004).

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At its most extreme, domestic/family violence results in fatalities. Overwhelmingly, this occurs between intimate partners and is perpetrated against women by men (referred to by some as femicide or intimate partner femicide). Globally, intimate partner femicide has been established as one of the leading causes of death among women (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Wilson & Websdale, 2006). In response to the growing recognition of this problem, research has developed extensively over the last two decades to identify and understand risk factors for domestic/family violence homicide (Campbell, Glass, Sharps, Laughon, & Bloom, 2007; Dawson, Bunge, & Balde, 2009; Porter & Gavin, 2010). The findings from this research have been drawn upon to develop prevention interventions. These interventions have lead to systemic and structural changes and increased public awareness about the dynamics of this violence and the deaths that often result (Brookman & Maguire, 2005; Home Office, 2006; Johnson & Dawson, 2011). One specific mechanism for conducting this research and informing these interventions has been the establishment of Domestic/Family Violence Death Reviews (D/FVDRs).

The establishment of the first D/FVDR followed the 1990 Charan Investigation conducted in San Francisco in response to a high-profile homicide–suicide (David, 2007). Since that time, D/FVDRs have been established in varying forms across a number of high-income countries (McHardy & Hofford, 1999; Wilson & Websdale, 2006). D/FVDRs function by retrospectively examining system and human factors as they occur within the circumstances of domestic/family violence-related deaths. They have a shared aim of reducing fatal and nonfatal forms of domestic/family violence. To achieve this, most review teams compile demographic and descriptive data on domestic/family violence deaths to identify environmental and human risk factors, history of system contact and possible points of intervention, gaps or failures in service delivery, policy inadequacies, and opportunities and strategies for system and legislative reform. Outside of these core activities, D/FVDRs often differ in their structure and mechanisms of governance, case identification processes and inclusion criteria, review measures, and outputs. However, the extent of this heterogeneity across and within countries has not been explored outside the United States (Watt, 2010).

Existing international literature on these death review teams generally appears to have endorsed this interdisciplinary and prevention-focused model (Onwuachi-Saunders, Forjuoh, West, & Brooks, 1999). However, this study was not able to identify any independent program evaluation that has sought to demonstrate their effectiveness in improving service responses to domestic/family violence or their impact on the reduction of family violence-related deaths (David, 2007; Johnson & Dawson, 2011; Wilson & Websdale, 2006). Such evidence would provide useful guidance to newly forming D/FVDRs across other developed countries, and potentially low- and middle-income countries where violence is also a leading cause of death. In the absence of any evaluation that might identify, at least generally, best practice approaches for D/FVDRs, a comparative appraisal was undertaken to examine four core elements of models internationally: (1) governance and structure, (2) case inclusion criteria, (3) outputs, and (4) achievements and outcomes. This international comparison of current D/FVDRs and their core elements is the necessary foundation for any evaluation of their effectiveness and is intended to inform the establishment of future D/FVDRs.

Method

Inclusion and Exclusion Criteria

D/FVDRs were included in the study if they met the following conditions: (1) a report detailing the governance, structure, and/or terms of reference was publicly available; (2) it was operational jurisdiction-wide (see definitions in Table 1); (3) it was operational as of January 1, 2012; and (4) it was ongoing. The definitions adopted for the purpose of this study are shown in Table 1. As shown, subjurisdictional D/FVDRs were excluded from the study. The decision to exclude subjurisdictional D/FVDRs stemmed from the fact that these types of initiatives were primarily located in the United States, whereas the jurisdiction-wide Level 1 and 2 initiatives teams were more common cross nationally and, therefore, determined to be the most valid for international comparisons. However, future research will seek to include these review initiatives because they are equally important in many ways and may be the most logical structure to be adopted in various jurisdictions.

Review Identification Strategy

A search was conducted using the search engine Google to identify countries in which a D/FVDR, in any form, had been operational. The search comprised a combination of the following terms: "domestic violence;" OR "family violence;" OR "intimate partner;" AND "fatality;" OR "homicide;" OR "death;" AND "review;" OR "team;" OR "committee;" OR "panel." Countries identified through this process were reviewed to determine whether there was a national D/FVDR in operation. If no D/FVDR was operating at the national level, a search was conducted at the next largest governmental subdivision within that country (e.g., states in the United States; provinces/territories in Canada, etc.). This search was conducted using the terms outlined previously in conjunction with the name of each identified jurisdiction in turn. In addition, the National Domestic Violence Fatality Review Initiative website (2011) and the Compendium of State Statutes and Policies on Domestic Violence and Health Care (Durborow, Lizdas, O'Flaherty, & Marjavi, 2010) were also reviewed.

Data Collection and Analysis

For all jurisdictions, a core set of variables were recorded in a unit record format in Microsoft Excel. For each review that met the inclusion criteria, two researchers reviewed legislation and executive orders, terms of reference, and the most recently released report to identify and record 62 variables of interest.[1]

Table 1. Definitions for Inclusion and Exclusion Criteria for D/FVDRs.

Term	Level	Definition
Jurisdiction-wide D/FVDR		Any D/FVDR operational either nationally or at the next largest governmental level (e.g., states in the United States). Jurisdictions in which a number of D/FVDRs were operational but which had a jurisdiction-wide governance structure were also included within the purview of "Jurisdiction-wide D/FVDR."[a]
	Level 1	Any D/FVDR governed at a national level.
	Level 2	Any D/FVDR not governed at the national level, but at the next largest governmental level.
Subjurisdictional D/FVDR	Not applicable	Any D/FVDR which operates neither at a national level nor the next largest governmental level (e.g., County in the United States).

Note. D/FVDR = Domestic/Family Violence Death Reviews.
[a]For example, the Washington State Domestic Violence Fatality Review convenes review panels on an ad hoc basis because "The best information and analysis about fatalities are generated at the local level, by people who are closely involved in the community response to domestic violence." Factors that were considered in determining whether a review had a jurisdiction-wide governance structure include whether the D/FVDRs shared common terms of reference/protocols; had standardized composition or procedures for the review process; were trained or otherwise supported at a jurisdiction-wide level; whether data, recommendations and findings were reported jurisdiction-wide; and whether all subjurisdictions within the jurisdictions are, or are anticipated, or desired to have a D/FVDR.

Where variables were missing information for some jurisdictions following the review of these primary documents, supplementary information was sought from older reports and the D/FVDR website if available. A series of descriptive and bivariate analyses were performed on the data collected.

Limitations

A number of limitations relating to the available data sources may have impacted the findings reported in this study. The major limitation was that the D/FVDR process is often iterative and evolves over time. As a result, the most recently released report may not accurately reflect the current status. Ideally, each jurisdiction should have been contacted to validate the information collected; however, this was beyond the resource capacity of the current study. Second, a D/FVDR may have been operational in a jurisdiction, but it did not have a public, online presence. In these circumstances, the total frequency of international D/FVDRs may have been underreported. Despite these limitations, to our knowledge, the data collected in this study represent the first systematic international analysis of existing D/FVDRs and their characteristics.

Results

From the searches conducted, five countries were identified as having some form of D/FVDR. Two countries had a jurisdiction-wide, Level 1 D/FVDR (United Kingdom and New Zealand; Family Violence Death Review Committee, 2009). The remaining three countries were divided into smaller jurisdictions as follow: United States ($n = 50$ states); Canada ($n =$ 13 provinces and territories); and Australia ($n = 8$ states and territories). Following a review of these 71 jurisdictions, 24 were excluded because no D/FVDR was identified. A further 21 jurisdictions were excluded because the only D/FVDRs identified were subjurisdictional. A further two jurisdictions were excluded because the jurisdiction-wide death review was not operational as of January 1, 2012. One was excluded because a report detailing the governance, structure, and/or terms of reference was not publicly available. The remaining 23 jurisdictions had a jurisdiction-wide, Level 2 D/FVDR. In total, 25 D/FVDRs met the inclusion criteria (see Figure 1).

Governance and Structure

The following data relate to the processes, structures, and organizational traditions that determined how reviews were established and how they conduct their work. With respect to the jurisdiction level, of the 25 D/FVDRs that met the inclusion criteria, as noted above, Table 2 shows that two were Level 1 D/FVDRs (United Kingdom and New Zealand). Of the 23 Level 2 D/FVDRs identified, 18 were in the United States, 3 in Australia, and 2 in Canada.

Statute/code/executive order. Table 3 shows that, in 12 of the 25 D/FVDRs that met the inclusion criteria, the jurisdiction had enacted statute or code, or had made an executive order, to establish the D/FVDR. In a further jurisdiction, the effect of the statute, code, or executive order was to mandate the establishment of a D/FVDR. Five jurisdictions had enacted statute, code, or executive order which enabled the establishment of a D/FVDR but did not require it. In the remaining seven jurisdictions, no statute, code, or executive order specifically mentioning the D/FVDR was identified. In three of these seven jurisdictions, the D/FVDR was able to function through existing legislative mechanisms; for example, within the ambit of a Coroner's Court. It is possible that this was the case for other jurisdictions, but this was not possible to determine from the searches conducted.

Year of establishment. Following the Charan Review in the early 1990s, the concept of D/FVDRs began to gain momentum in the United States. The first jurisdiction-wide D/FVDR included in this study was established in Delaware in 1996. From here,

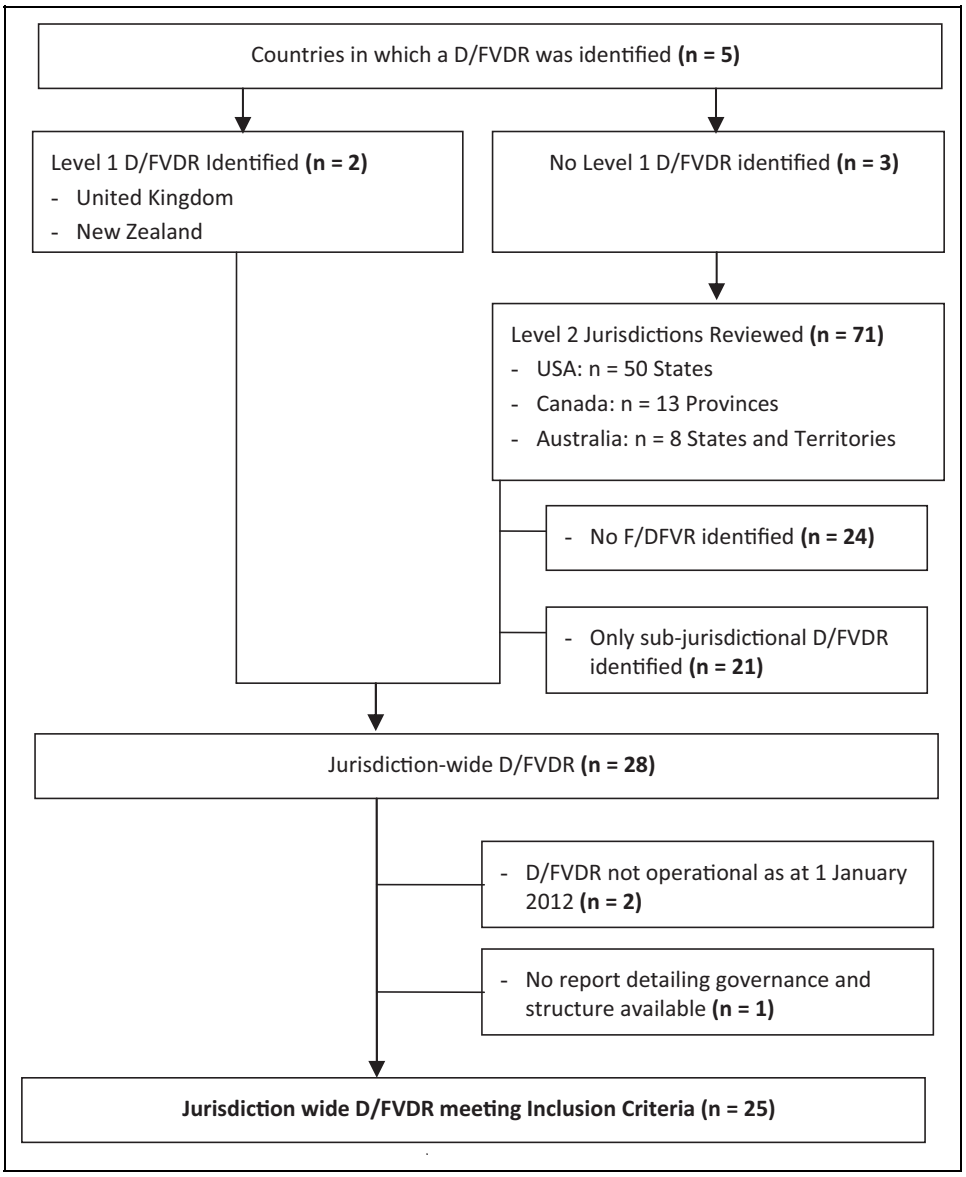

Figure 1. Method for identifying D/FVDRs meeting the inclusion criteria.

Table 2. Level of Jurisdiction for D/FVDR by Country.

Level	USA	Aus	Can	UK	NZ	Total
1	—	—	—	1	1	2
2	18	3	2	—	—	23
Total	18	3	2	1	1	25

Note. D/FVDR = Domestic/Family Violence Death Reviews.

Table 3. Presence and Impact of Statutes, Codes, or Executive Orders for Each Jurisdiction by Country.

	USA	Aus	Can	UK	NZ	Total
Establishes	9	1	1	1	—	12
Mandates establishment	1	—	—	—	—	1
Enables establishment	4	—	—	—	1	5
None	4	2	1	—	—	7
Total	18	3	2	1	1	25

Note. D/FVDR = Domestic/Family Violence Death Reviews.

the number of jurisdiction-wide reviews increased steadily by two or three every year in this country. Canada was the second country to implement specialized systems for reviewing domestic/family violence deaths, beginning in Ontario in 2003 (Office of the Chief Coroner of Ontario, 2009). New Zealand followed in 2008, and Victoria established the first Australian review in 2009. The most recently established review mechanism is in the United Kingdom whose legislation came into effect in 2011. Figure 2 shows the steady international growth of these initiatives during this period, although this growth has been driven largely by U.S. jurisdictions.

Governing body. It is common practice to have an established body govern the review initiative or to nominate an agency

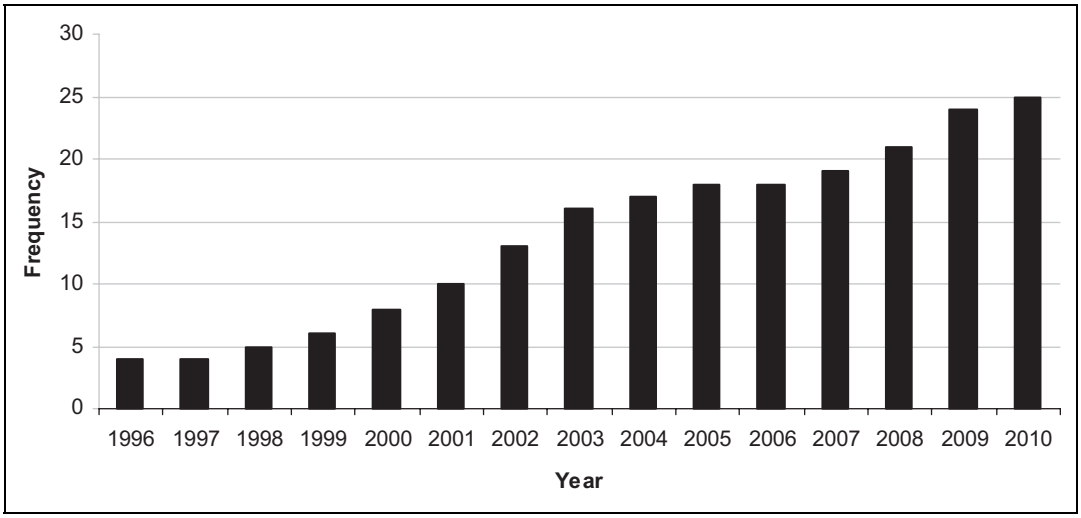

Figure 2. Number of jurisdiction-wide D/FVDRs by year.

Table 4. Nature of the Governing Body for each D/FVDR by Country.

	USA	Aus	Can	UK	NZ	Total
Other government department/s	6	—	1	1	1	9
D/FV representative organization	7	—	—	—	—	7
Coroner's Office/OME	1	3	1	—	—	5
Combination	3	—	—	—	—	3
University	1	—	—	—	—	1
Total	18	3	2	1	1	25

Note. OME = Office of the Medical Examiner; D/FVDR = Domestic/Family Violence Death Reviews.

to lead the review process. As Table 4 demonstrates, the body most commonly responsible for governing D/FVDRs was a government department (not including a Coroner's Office or Office of the Medical Examiner [OME]; n = 9). Both national jurisdictions and seven other jurisdictions adopted this governance mechanism. A representative organization from the domestic/family violence industry- or sector-groups governed the D/FVDRs in seven jurisdictions in the United States. The Coroner's Office was the governing body in five jurisdictions.

Review team composition. The composition of D/FVDRs varied across jurisdictions. In most jurisdictions (n = 20), only one team was involved in reviewing deaths in each jurisdiction. However, five jurisdictions had more than one team in operation. In these jurisdictions, teams were organized and trained by a jurisdiction-wide body and reported to that body for the purposes of collecting and reporting jurisdiction-wide data. The majority of D/FVDRs comprised individuals from more than one agency (n = 23). Only two D/FVDRs comprised individuals who all worked within the same agency. These D/FVDRs were both Australian and the agency was the Coroner's Court. Eight D/FVDRs have the capacity to grant ad hoc membership to individuals with particular expertise on a case-by-case basis. For example, the Delaware Fatal Incident Review Team can invite sector representatives who had contact with the deceased to sit on the panel for that death review only. Five D/FVDRs have an associated group of individuals who act as an advisory body or reference group but do not actively participate in the review process. In the other 20 D/FVDRs, the study did not identify such a body.

Determination of scope. Table 5 shows that legislation and executive orders were the most common ways by which D/FVDRs determined their scope. In the absence of legislation referring specifically to the D/FVDR, scope was defined instead by the review team through protocols, policy documents, and terms of reference.

Case Inclusion Criteria

Types of fatalities/near fatalities reviewed. Although the types of relationships considered family or domestic differed across D/FVDRs, the general case types reviewed were relatively homogenous (see Table 6). All D/FVDRs identified that they examined fatalities involving intimate partners. Most also examined fatalities between nonintimate partners (n = 20). It should be noted that 5 of these 20 D/FVDRs only review nonintimate partner fatalities that occur in the context of intimate partner violence (e.g., where a bystander intervenes or a child is killed in revenge).

All identified D/FVDRs examine homicides. Homicide–suicides are reviewed by 23 D/FVDRs. Suicides only are examined by 15 of the D/FVDRs, primarily focusing on the suicide of victims of domestic or family violence; however, two D/FVDRs identified included the suicide of domestic/family violence perpetrators. Four reviews also consider near-deaths to be within their review scope.

Table 5. Mechanism by Which the Scope of the D/FVDR Is Determined.

Mechanism of Determination	Frequency	%
Legislation only	9	36.0
Legislation and terms of reference	2	8.0
Determined principally by the team	2	8.0
Resources and terms of reference	1	4.0
Terms of reference only	1	4.0
Resources only	3	12.0
Not recorded	7	28.0
Total	25	100.0

Note. D/FVDR = Domestic/Family Violence Death Reviews.

Table 6. Types of Fatalities or Near Fatalities Reviewed by D/FVDRs.

Type of Relationship and Case Reviewed	Yes	No	Unknown
Relationship type			
Intimate partner fatalities	24	—	1
Nonintimate partner fatalities	20	3	2
Case type			
Homicides	24	—	1
Suicides	15	8	2
Homicide–suicides	23	—	2
Near fatalities	4	20	1

Note. D/FVDR = Domestic/Family Violence Death Reviews.

Proportion of relevant deaths reviewed. One significant difference among D/FVDRs is whether all deaths meeting the criteria of a domestic or family violence death are examined. In 7 of the 25 D/FVDRs, it was indicated that all deaths meeting the inclusion criteria are reviewed. Of the remaining 18 D/FVDRs, 13 reported how a subset is selected. In three jurisdictions, cases reviewed are determined by referral (from coroners, community members, review members, or government ministries) and 10 are determined on the basis of specified characteristics such as the date of death (with a preference for more recent cases) or demographic factors (such as age, race/ethnicity, and locality). Although locality was used as a characteristic for determining case reviews, DFVDRs differed in whether they chose to review incidents occurring in locations not previously examined, or only review incidents occurring in the one location (e.g., in one specified county).

Death review timing. Overall, as shown in Table 7, the most common time to commence reviewing a death is after both the criminal and coronial/OME investigations are completed. This was the case for 15 of the 25 D/FVDRs and for two thirds of the jurisdictions within the United States (12 of the 18). Two of the D/FVDRs (both in Australia) reviewed deaths as part of the coronial investigation, following the completion of the criminal proceedings. In one U.S. jurisdiction, the D/FVDR commenced before the criminal proceedings had concluded and, for two D/FVDRs, the review timing was not dependent on the criminal or coronial investigations.

Average annual frequency of incidents reviewed. Where possible, the average number of incidents reviewed per year was calculated by dividing the number of deaths reviewed by the number of years covered in the reporting period. The average number ranged from 1 review (three jurisdictions) to above 30 (two jurisdictions). The majority reviewed between 1 and 10 incidents per year.

Outputs

Reporting. Reports are typically available to the public and released either annually (n = 12) or biannually (n = 5). Of the remaining jurisdictions, two D/FVDRs report at variable times and, for the remaining six, information about the frequency of reports is unknown. Reports often contain information about how the D/FVDR functions, the number of deaths reviewed, the findings and recommendations following the reviews, and overall data with respect to domestic/family violence fatalities.

Recommendations. All 25 of the D/FVDRs make, or indicate that they will make, recommendations that are to facilitate system change. In this study, 19 had done so as of January 1, 2012. Seven of these teams did not target their recommendations to specific organizations or agencies whereas eight D/FVDRs targeted all of their recommendations and four targeted some of their recommendations to specific organizations or agencies. One of the D/FVDRs located in the United States directed their recommendations to the lead agency of the D/FVDR who then liaised with the various sectors to implement the recommendations. Of the 12 jurisdictions in which agencies/organizations were targeted in recommendations, only 2 jurisdictions appeared to mandate that the agencies respond. Victoria, Australia, does so through the mechanisms in place for coronial investigations and Iowa does so through the legislation enacted for the purpose of the D/FVDR.

Responses and tracking/follow up of recommendations. Five D/FVDRs reported the content of responses they had received from the agencies/organizations with respect to the recommendations made. Seven of the D/FVDRs specified the mechanism they used for tracking and/or following up on responses to, or the implementation of, recommendations. These mechanisms are follows:

- A recommendation is assigned to an appropriate member of the D/FVDR who takes the recommendation to the agency that is capable of responding to and/or implementing that recommendation (n = 3);
- A mandatory response regime in which recommendations are tracked by D/FVDR team members for completion (n = 2).
- A focus on following up on recommendations made in previous years when a particular county did not review a death in that year (n = 1); and
- A symposium to synthesize and prioritize previous recommendations and develop strategic plan for their implementation (n = 1).

Table 7. Timing of Review Commencement Relative to Criminal and Coronial/medical Examiner Investigations.

	USA	Aus	Can	UK	NZ	Total
After criminal proceedings and coronial/OME investigation are complete	12	1	2	—	—	15
After criminal proceedings but before coronial/OME investigation is complete	—	2	—	—	—	2
Before criminal proceedings are complete	1		—	1	1	3
Other (i.e., not dependent upon criminal or coronial/OME proceedings)	2	—	—	—	—	2
Unknown	3	—	—	—	—	3
Total	18	3	2	1	1	25

Note. OME = Office of the Medical Examiner.

Achievements and Outcomes

Although all 25 D/FVDRs specified a reduction in domestic/family violence deaths as a goal, not one reported that this had been achieved. A number of review teams identified that a reduction had not occurred or that it was impossible to measure such an outcome. This issue will be returned to in the Discussion section. All 25 D/FVDRs specified that strengthening the domestic/family violence service system was a key goal. Eleven of these D/FVDRs reported that they had been successful in strengthening the service system and all of them used the implementation of recommendations as the measure for this success. Of the 11 D/FVDRs reporting success in the form of implementation of recommendations, 7 specified that the changes to the system occurred as a direct result of the recommendations they made. In the remaining four, it was unclear, or the D/FVDR was unable to specify, whether the changes to the system came about because of the recommendations or some other mechanism.

Discussion

Summary of Key Findings

This international review identified 71 jurisdictions in which D/FVDRs had been established in the past two decades. Of these, 25 had a jurisdiction-wide D/FVDR with publicly available material detailing the governance, structure, and/or terms of reference. The major findings from an examination of these 25 D/FVDRs showed that there was a focus on intimate partner homicides and intimate partner homicide–suicides. This may be a function of the time period of establishment, whereby the definition of domestic/family violence centered on these types of fatalities. More recently established D/FVDRs have expanded this definition to include other familial relationships. While this may lead to overlap in some jurisdictions that also have specialist Child Death/Fatality Reviews, the more deaths subject to such in-depth prevention orientated processes, the greater the likelihood that system gaps will be identified and addressed. Almost one third of the D/FVDRs examined reported changes to the domestic/family system that occurred as a direct result of recommendations made from the review process.

One significant point of difference among D/FVDRs is whether all deaths meeting the criteria of a domestic or family violence death are examined. While criminal investigations are often considered in isolation, D/FVDRs have the ability to consider each death in light of similar preceding deaths and, thus, are able to accumulate knowledge of trends across deaths and patterns over time. D/FVDRs that examine multiple deaths in a review period can take a holistic, rather than a fragmented, approach that strategically positions them to make recommendations focused on system reform. On the other hand, reviewing a selected number of deaths in more detail may lead to a deeper understanding of underlying factors which result in domestic/family violence deaths. The approach taken may be, in part, dependent upon the composition of the D/FVDRs (i.e., single agency vs. multiagency) and available resources.

All D/FVDRs examined in this study stated *a reduction in deaths* as a goal of the review process, however, none reported an actual reduction. The likely explanation for this is the inability to establish a causal relationship between the existence of D/FVDRs, recommendations generated from D/FVDRs, and the incidence of deaths. D/FVDRs are only one component of a larger set of reforms that may be necessary to contribute to any reduction in deaths and, as such, isolating their independent contribution is difficult. This raises the question of whether or not such an aim may be an inappropriate measure of the impact of D/FVDRs because it essentially sets them up to fail to meet their stated aims. This becomes particularly problematic in the event of an evaluation. Despite this complexity, stating such an aim remains important and demonstrates that domestic/family violence is now recognized as (1) unacceptable by the community and society, (2) requiring a response from the criminal justice and civil administration system, and (3) preventable. This cultural shift has taken generations to achieve and it may be the case that the contribution of D/FVDRs will also take more time to be realized. Until such time, the goal of strengthening the domestic/family violence service system can become a more concrete focus of research to examine the development, uptake, and success of recommendations made by these committees over a period of time.

Strengths and Limitations

This study extends the body of work of Watt (2010) and Websdale (2003) by providing the first international comparison of D/FVDR models. It furthers the knowledge base on similarities and points of difference across and between countries. This analysis provides a basis upon which an examination of best practices may be conducted although we recognize that best practices will often vary depending upon the characteristics of the jurisdictions in which such teams are located. The findings of this study are limited to

those D/FVDRs that have an online presence and for which material about the D/FVDR process was publicly available. As noted previously, this method may have failed to identify the existence of D/FVDRs in countries where English was not the native language. In addition, to ensure a systematic approach (but within resource constraints), D/FVDR models included in the study were restricted to those operational jurisdiction-wide. As a result, the value of subjurisdictional models was not considered and is an important goal for future research given that there may be benefits to having more localized committees compared to broader, more centralized reviews (Jaffe, Dawson, & Campbell, 2011).

Finally, coding of the variables was reliant on the D/FVDR having specified the information of interest in publicly available reports; however, this was not always the case. For example, in three of the seven jurisdictions in which no specific legislation was identified, the D/FVDR was known (by the researchers) to be able to function through existing legislative mechanisms (e.g., within the ambit of a Coroner's Court). It is possible that this was the case for other jurisdictions.

Conclusion and Future Directions

To date, the establishment of D/FVDRs appears to be limited to high-income, English-speaking countries. Although Child Death/Fatality Reviews have been implemented more extensively across the world, D/FVDRs currently exist in only five countries but may have as yet unrealized potential in other countries with similar socioeconomic statuses. What is less clear is whether D/FVDRs can be usefully transferred to middle- and low-income countries, to different cultural milieus, and to countries with vastly different governance structures. The wholesale adoption of any of the current models of D/FVDR may not be possible, and even the applicability of the process itself may have limited utility unless certain criteria within the countries sociopolitical infrastructure are met.

The prerequisites of effectively establishing D/FVDRs in low- and middle-income countries have not been widely considered. Perhaps the most significant factor influencing transferability is whether the systems of governance maintain and advance the philosophical position that violence against women is unacceptable. Where the systems of governance do not operate from this fundamental standpoint, individual death reviews would do little to ameliorate the experiences of domestic/family violence victims. In such countries, the overarching prevention-focused interventions are usually readily apparent and change needs to occur at a broader foundational level before case-specific recommendations will be useful. In addition, other relevant considerations would be whether countries recognize that, as a public health problem, domestic/family violence is preventable; whether they have the infrastructure required to conduct fatality reviews (e.g., resources, means of data collection, legal governance, etc; see Jaffe, Dawson, & Campbell, 2013); and whether they have the ability or power to implement any recommendations made.

To achieve the above, it may be that the WHO would be an appropriate surveillance body given that most D/FVDRs inherently recognize the ecological framework adopted by WHO in understanding violence and its prevention. In their *World Report on Health and Violence,* it was stated that "no single factor explains why some individuals behave violently toward others or why violence is more prevalent in some communities than in others. Violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors" (Krug et al., 2002, p. 12). The WHO report highlights how various factors at similar and multiple levels of society have direct, indirect, and reciprocal effects on each other and, as a result, their interaction or combination can produce varying levels of violence. It follows that no one sector or discipline can address violence on its own. The work of D/FVDRs recognizes this and, as such, takes a holistic approach to understanding violence prevention. Given that WHO has a strong agenda related to violence prevention and a particular focus on low- and middle-income countries, the work of currently existing models could be used as a foundation for discussions about how varying models need to be modified to fit particular political, cultural, and social contexts in other countries. More rigorous research, however, needs to examine the effectiveness of current models, as they exist before understanding how they might benefit other populations.

Implications for Practice, Policy, and Research

- While similar in many ways, D/FVDRs differ along a number of important dimensions that make it difficult to identify best practices. Nevertheless, it is important to share existing knowledge by expanding networks across national and international jurisdictions.
- Policy development is likely to remain a challenge, given that few jurisdictions mandate a response to recommendations and/or have developed mechanisms for tracking and monitoring responses to recommendations by the agencies targeted.
- Future research is needed to provide a more comprehensive understanding of the core elements of death review initiatives, in particular efforts to move recommendations from the development to implementation stage.

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1. Data collection instrument is available upon request.

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