Centre for Research & Education
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Multi Disciplinary Perspectives on Preventing Domestic Homicides:

A Discussion Paper from a Canadian Think-Tank

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Background

This discussion paper is the result of a think-tank on the review of Canadian domestic homicides held in London Ontario on October 20-21, 2008. The think-tank brought together social scientists, coroners, policy makers, social service/mental health professionals, police, and crown attorneys from five different Canadian provinces (British Columbia, Manitoba, Ontario, Quebec and New Brunswick). The think-tank was funded by the Department of Justice Canada, the Ontario government (Attorney General, Ontario Women's Directorate), University of New Brunswick and the University of Western Ontario (Research Western, The Faculty of Education) (See the list of participants in Appendix A). Although we have tried to capture and summarize some of key themes from the think-tank, the opinions expressed in this paper are those of the authors and may not represent the views of the funders or the individual participants.

The think-tank was structured around the exploration of challenges and promising practices in reviewing domestic homicides. Background information was provided by the United States Fatality Review Project, Ontario's Domestic Violence Death Review Annual Reports and a recent research paper on the domestic violence death review process.[1]

The overall objective of the think-tank was to bring together multi-disciplinary perspectives from different Canadian provinces, representing various regions of the country, to share experiences in reviewing domestic homicides. The two senior authors of this paper are members of the Domestic Violence Death Review Committee, Office of the Chief Coroner of Ontario, and had initiated the think-tank in response to the expressed interest in different provinces to examine the variety of methods and data collection in reviewing domestic homicides. The purpose of the think-tank was to discuss future practices and policies that provinces and communities can consider implementing to enhance death reviews and to expand the research to help prevent future domestic homicides. Specifically, the goal was to bring experts in the field of domestic violence and/or homicide together to discuss potential strategies for review and data collection in regards to domestic homicides.

[1] Information about the United States Fatality Review Project can be found at www.ndvfri.org and the, Ontario's Domestic Violence Death Review Annual Reports can be found at http://www.mcscs.jus.gov.on.ca/english/publications/pubs.html. The discussion paper was written by Kelly Watt and Nicole Allen as a summary of the former's doctoral dissertation in the Department of Psychology at the University of Illinois at Urbana-Champaign and is found in Appendix B.

Long-term objectives for the think-tank were: (1) To explore the feasibility of a national conference on this topic; (2) To develop common database containing information on domestic homicides across Canada beyond existing Statistics Canada reports; and (3) To discuss the funding possibilities that would support the enhancement of research and practice partnerships in this area. Research into domestic homicides has for the most part been fragmented, both in terms of the issues focused upon and in the locations in which research has been conducted with some areas in Canada and other countries receiving more attention than others. Notwithstanding the interconnections among research focus and region, there has been little opportunity for bringing insights together from various provinces that are facing the same issues when responding to domestic violence and homicide. The think-tank provided an excellent opportunity to bring researchers, government and community partners, and policy makers together to determine what is similar, what is different, what works, and what needs attention in such efforts. By documenting progress and identifying what needs to be done, the think-tank was intended to create a platform for future research and to contribute to the knowledge base for effective prevention and intervention in domestic homicides.

This discussion paper outlines the development of the domestic violence death review process in the United States and Canada. In addition, this paper will summarize the challenges to the death review process identified in discussions from the think-tank, and will describe how current promising practices respond to these challenges.

History of Domestic Violence Death Review Process in the United States & Canada

At one time, the common perception of a domestic homicide was a 'crime of passion' for which there was little warning and thus little possibility of prevention and/or intervention. Today, most who work within the field or conduct research in this area recognize that domestic homicides may be both predictable and preventable because they are often preceded by a number of risk indicators well documented in the literature (for reviews, see Campbell et al. 2007; Jaffe & Dawson 2004). As a result, the importance of risk assessment involving both the victim and the perpetrator has become a crucial issue in the prevention of and intervention in domestic homicides in a number of sectors including community agencies, police, the courts and corrections.

The Government of Canada has committed to preventing family violence through its Family Violence Initiative (FVI). This initiative promotes "public awareness of the risk factors of family violence and the need for public involvement in responding to them; strengthening the criminal justice, housing, and health systems to respond; and supporting data collection, research and evaluation efforts to identify effective interventions." These FVI commitments represent the foundation of what domestic violence death reviews are all about. Further, the FVI emphasizes the importance of what is the key mandate of domestic violence death review committees which is to understand how to intervene in cases of domestic violence before they become lethal. Such a goal is vital, not only for the individuals involved, but for their families, their communities and society at large. It has long been recognized that a lack of coordination and communication among the many agencies and individuals involved in responding to

these cases is a major issue when it comes to preventing domestic homicides. Determining how to increase collaboration and communication among the key stakeholders therefore is required in the ongoing development of policies and initiatives that seek to respond to domestic violence.

Over the past two decades the United States has witnessed a rapid growth in the death review mechanism used to address the issue of community and agency coordination, collaboration and communication (see http://www.baylor.edu/ndvfri/index.php). The first domestic violence death review occurred in San Francisco, California after the 1990 murder-suicide case involving Veena and Joseph Charan (Websdale, 1999). Veena and Joseph Charan were married but separated at the time of the homicide. About 15 months prior to her death, Veena Charan was seeking support from several government agencies and made numerous reports to police about Joseph Charan's abusive behaviour. She had obtained a restraining order against her husband and obtained full custody of their nine-year old son. Joseph. Charan was eventually arrested for assaulting his wife and placed on probation. He was ordered to attend domestic violence counseling and to stay away from Veena Charan. He violated the restraining order several times and eventually killed Veena Charan at the front of their son's school before taking his own life.

Due to this horrific crime, the San Francisco Domestic Violence Consortium commissioned the "Charan investigation." The results of the investigation identified several key elements that would aid in the prediction and prevention of future domestic homicides. Specifically, crucial gaps in service delivery needed to be rectified, such as providing better communication and coordination between government agencies, providing better means of data collection for institutions investigating domestic homicides, providing better access to services for victims and perpetrators, and implementing more thorough training programs for frontline workers. It was this investigation that revealed the importance of a domestic violence death review when trying to understand and to prevent domestic homicides.

Clearly, the importance of these death review teams has been recognized because there are now approximately 75 domestic violence death review teams across the United States and the number continues to grow (Watt & Allen, 2008). Ontario is the only province in Canada that conducts a systematic review of these homicides using a review committee which is conducted by the Domestic Violence Death Review Committee (DVDRC), Office of the Chief Coroner of Ontario. This DVDRC is a multi-disciplinary advisory committee of experts that was established in 2003 in response to recommendations made from two major inquests of the domestic homicides of Arlene May by Randy Iles and Gillian Hadley by Ralph Hadley. Currently, other provinces are looking to expand their domestic homicide review process, such as inquests, and include a domestic violence death review committee.

What are Domestic Violence Fatality Reviews?

A domestic violence fatality review brings together community agencies, service providers, and government representatives with expertise in domestic violence to

investigate and review homicides and/or homicide-suicides that involve domestic violence. The purpose of the review is to create recommendations aimed at preventing deaths in similar circumstances and reducing domestic violence in general.
By conducting a thorough and detailed examination and analysis of the facts within domestic homicide cases, the review strives to develop a comprehensive understanding of why domestic homicides occur and how they might be prevented. The recommendations are ideally created through the examination of the risk factors identified in the cases and the responses to these factors by different community and government systems. The recommendations are generally aimed at public education, professional development in many service sectors, enhanced legislation, better coordination of services and resource development.

The above discussion underscores the importance of domestic violence death review committees, but like any large multi-disciplinary project, the process of creating and implementing such a committee can be challenging. In this regard, we held a think-tank with the purpose of collecting individual perspectives on the challenges and benefits of a domestic homicide death review process. Below, we describe the challenges raised by think-tank participants regarding domestic violence death review, and the promising practices of committees in the U.S. and Canada that respond to each of these challenges. The challenges identified fell under five major themes: a) the formation of a committee, b) resources, c) sharing information and confidentiality, d) accountability, and e) central versus local reviews.

An Examination of Challenges and Promising Practices in DV Death Review

a) Forming a Death Review Committee
How a domestic violence death review committee is formed will determine how formal or informal the committee will be. Constructing a death review committee can bring about significant challenges, such as how the committee will be regulated and committee membership. Below is further discussion regarding these challenges and committee responses.

Government vs. Private

There are a few challenges that arise when attempting to establish a domestic violence fatality committee. First, it needs to be determined what agency or governing body will form the committee.

> Domestic violence fatality review committees can be formed under legislative mandate, by a domestic violence victim service provider or under the sponsorship of a domestic violence council or task force, or separately from a domestic violence council or task force. Other methods of formation include through a research project, through grant funding, by requirement of a federal Violence Against Women grant, by administrative order of the court, or by commission of a governor. It is also possible to establish informal reviews which do not require the

formation of a committee but rather individuals working to end violence against women" (McHardy & Hofford, 1999, pg. 3).

Many committees in the United States are formed under legislative mandate. "Several committees believe that a legislative mandate would help address problems of access to information, provide authority for the reviewing body, create a funding mechanism for the committee's work, send a clear message about the importance of the work, mandate participation of key players, and address confidentiality and liability issues" (McHardy & Hofford, 1999, pg. 3). Examples of those states in which the committees have been formed under a legislative mandate are California, Delaware, Maine, Nevada, and Tennessee. Currently, the Domestic Violence Death Review Committee of Ontario is not formed under specialized government legislation; rather it falls under existing rules and regulations for the Office of the Chief Coroner.

In addition to establishing a governing body for the committee, it needs to be determined what agency or organization will house the committee. In making such a decision, it is important to think about "whether there is an official mandate, the potential for ongoing funding, political climate, diversity, relationships with law enforcement, health and service agencies, and the presence of initial start-up funds" (McHardy & Hofford, 1999, pg. 4). The DVDRC is housed by the Office of the Chief Coroner which is located in Toronto, ON. The Ontario Ministry of Community Safety and Correctional Services established special funding in the Office of the Chief Coroner for the committee. The committee accesses information through police services (after court proceedings are completed) through existing legislation (Coroners' Act). Inquests are still held on individual cases when appropriate.

Membership

Third, deciding on membership for the committee can present challenges. It is key that a committee has representation from all sectors that deal directly with domestic violence situations. Moreover, it is important that the committee have representation from diverse communities. However, such committees must also remain at a workable size. A promising practice for some committees is to have an established roster of members and invite other individuals on a provisional basis for representation on specific and complex cases. As one example, California created legislation that outlined the membership of a domestic violence fatality review committee (Websdale et al., 2001), stating that a committee should be comprised of, but not limited to:

1. Experts in the field of forensic pathology.
2. Medical personnel with expertise in domestic violence abuse.
3. Coroners and medical examiners.
4. Criminologists.
5. District attorneys and city attorneys.
6. Domestic violence shelter service staff and battered women's advocates.
7. Law enforcement personnel.

8. Representatives of local agencies that are involved with domestic violence abuse reporting.
9. County health department staff who deal with domestic violence victims' health issues.
10. Representatives of local child abuse agencies.

b) Resources

Valuable resources are required when implementing and sustaining a domestic violence death review committee. There is a particular concern around financial resources and determining how a committee will be funded. Furthermore, the allocation of resources and a cost-benefit analysis need to be considered. These concerns are discussed below.

Financial resources

Another difficult challenge in creating a domestic violence fatality review committee is accessing appropriate and sufficient resources, particularly financial resources. The question that comes up during any discussion around fatality review committee formation is how the committee will be funded? Some committees are funded directly through their government. For example, the Domestic Violence Death Review Committee of Ontario is funded through the Office of the Chief Coroner, while Iowa receives funding from the Department of Public Health, and the Miami/Dade Fatality Review Team is funded by their county. Other committees can be funded through organizations that work directly to end violence against women. For example, the Minnesota Fatality Review committee is funded through WATCH, an organization that monitors how courts handle cases of violence against women and children and the Dayton, Ohio Fatality Review Committee receives funding from the Family Violence Collaborative (Websdale et al., 2001). Many committees apply for government grants and some committees receive no funding and rely on volunteers.

Case resources

There is some concern in creating a domestic violence fatality review in jurisdictions that have low numbers of domestic violence fatalities because it may be a waste of scarce resources. In short, is it worth the work and resources to conduct a review on only one or two deaths? However, where numbers are low, a fatality review can take a "biographical" approach to a review in which detailed information is gathered on a small number of cases with the goal of obtaining in-depth knowledge of the dynamics in a single case (Watt & Allen, 2008). For example, Knox County, Tennessee has a population of less than 500,000 yet they established the Knox County Domestic Violence Fatality Review Committee (see http://www.baylor.edu/content/services/document.php/61713.pdf.). In 2004, this committee reviewed two cases of domestic homicide, resulting in four recommendations that focused on legislation, the identification of high risk cases, and how to deal with issues of animal abuse. In contrast, Santa Clara County, California has a population of almost two million yet in 2007, they had only four identified domestic violence fatalities.

In their annual report the committee stated that their previous recommendations had reduced the number of domestic homicides. (see http://www.baylor.edu/content/services/document.php/63543.pdf.).
Thus, although the number of domestic violence fatalities may be small, the benefits of a review appeared to outweigh the costs.

c) Sharing Information/Confidentiality

Information is a key component in any domestic violence fatality review. The review committee requires any information on a particular case that will help them create accurate and detailed recommendations that will promote change in specific agencies and/or systems to prevent similar tragedies from occurring in the future. However, it is acknowledged that sharing personal and private information can lead to some difficult challenges around confidentiality, respecting the privacy of an individual or an agency, and the amount of information shared. These issues are discussed in more detail below.

Sharing confidential information

Confidentiality is important in any death review. A domestic violence fatality review committee may receive information from several sources about the victim and the perpetrator of a particular case. Although these committees value shared information because it creates a more accurate perspective in the review process, committees also respect the privacy and confidentiality of the individuals involved in the cases, including family members, friends, the victim and the perpetrator. Thus, the best practice for death review committees is to maintain the privacy of individuals involved by not sharing information on the cases being reviewed to those outside of the committee and by not providing any identifying information for each case in the annual reports. However, there continues to be a challenge with confidentiality when the information needed is about a victim or a perpetrator who is not deceased.

Confidential information and consent

The Domestic Violence Death Review Committee of Ontario is not permitted to obtain information on perpetrators or victims who are not deceased without consent from the individual. Examples of victim information shared with the committee, in which consent from the victim was given, are interviews with police or information from an agency that has a signed consent form. Information on perpetrators that are not deceased can be accessed through police interviews or public record (e.g., trial transcripts with sworn evidence and psychiatric assessments presented in court). However, this does limit the committee's access to information, resulting in a more difficult review process. For information on Ontario's Freedom of Information and Protection of Privacy Act, follow the link: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f31_e.htm.

Agencies code of confidentiality

The issue of confidentiality can also create a challenge when the committee is encouraging a single agency to share information and that agency has a representative on

the committee who feels that this would violate an individual's and an agency's right to privacy, even if the individual is deceased. For example, several U.S. committees reported that committee members who represent women's shelters felt that sharing information about the victim without the victim's consent was a violation of her privacy and a violation of the information sharing guidelines of the shelter (Watt & Allen, 2008). A shelter is considered a safe place for a woman to escape domestic violence and it is understood that what occurs in that shelter is kept in confidence. With the shelter sharing this woman's information with the committee, some shelters feel that they are disrespecting their code of confidentiality. Other service providers may share similar ideas and formal policies which may limit accurate and comprehensive recommendations (Watt & Allen, 2008).

Amount of information needed

Finally, it is obvious that a domestic violence fatality review team needs to acquire both the necessary and sufficient information about the victim and the perpetrator in domestic homicide cases to make educated and accurate recommendations. However, how does a committee know when they have enough information? How can the quality or comprehensiveness of the information be assessed? When a committee conducts a review, they analyze information shared by agencies, police interviews, and other gathered evidence but, at times, it seems that there is more information that can be obtained to further enhance the review. Yet, how far can a committee go before it turns from a review process to an investigative process?

One promising practice that addresses all of these particular challenges related to confidentiality is establishing domestic violence fatality review committees under legislative authority. "Governmental authorization allows committees to have access to confidential information related to a review of a death, prevents information reviewed from being subject to subpoena or discovery, and provides immunity for each member of the committee from civil or criminal liability" (Websdale, Sheeran, & Johnson as cited in Watts & Allen, 2008, pg. 7). Further, government legislation can outline the process that needs to be followed to obtain shared information, quantify and qualify the information necessary for a review, and create universal/provincial assessment and investigative tools for domestic homicide cases that will ensure the comprehensiveness and quality of the information. For those committees that are unable or choose not to be established under legislative authority the common practice is to establish confidentiality agreements between agencies and the committee that allows the sharing of confidential information.

d) Accountability

The role of accountability within a domestic violence death review committee can take two forms. First, a committee advocates for accountability from agencies and systems involved with a domestic violence fatality; however this can be a very sensitive issue which may result in those that attempted to help feeling blamed for the case outcome. Second, a committee needs to be accountable for their recommendations regarding individual cases. The role of accountability is discussed in detail below.

Blaming and shaming

Accountability or the state of being accountable, liable, or answerable, is an important element of the domestic violence fatality review process. Accountability is seen as a philosophy in the review process that encourages agencies and systems to take responsibility for particular behaviours that were seen to have a direct impact on the outcome of the case reviewed. By holding oneself accountable, lessons can be learned and changes can be made to create responses that are hopefully free of error in the future. However, due to the sensitivity of all case reviews, accountability can sometimes turn into, or appear to be, finger-pointing and laying blame. The challenge is to maintain the philosophy of accountability without appearing to be "blaming and shaming" particular individuals, agencies, or systems. The approach of accountability, if not handled sensitively, can deter individuals from coming forward and sharing information regarding specific cases out of a fear that they will be blamed and ridiculed for the fatality. For some committees, a best practice in dealing with the challenge of accountability is to address the issue privately with the agency or system involved beforehand and/or to ask the agency or system to help with the construction of the recommendation that addresses the particular issue (Watt & Allen, 2008).

Accountability of the committee

Another challenge involving accountability within a domestic violence fatality review is determining where the responsibility lay for tracking the outcome or result of recommendations made by the committee. A domestic violence fatality review committee examines and investigates domestic homicide cases for the purpose of creating recommendations aimed at service providers, community agencies, and government systems. It is hoped that these recommendations will be implemented to foster change for future intervention and prevention of domestic homicides. However, without someone taking responsibility for tracking these recommendations, the committee and the community cannot hold themselves accountable for the recommendations that have and/or have not been implemented. Some promising practices in dealing with this challenge including committees creating an independent task force to monitor the implementation of recommendations or creating independent review committees who summarize recommendations made over the past year, noting any systemic changes implemented as a result of the recommendations (Websdale et al., 2001).

e) Community level of a review: central versus local reviews

Domestic homicides occur in a broad range of contexts such as remote rural communities and large urban centres. Recommendations from one community may not have relevance for other communities or represent a defined pattern of problems such as lack of training or resources. It is uncertain if it is most beneficial and efficient to review domestic homicides on a local level or on a broader central level. Challenges have been identified with both types of reviews and discussed in further detail below.

A central review committee is one that is formed at a state or provincial level and includes members that represent particular sectors of the domestic violence community.

A central review committee is not directly involved with the case review but rather uses their expertise to analyze and evaluate responses made by the agencies and systems from the community that was involved. The committee then creates recommendations that are aimed at programs, services, and systems throughout specific jurisdictions. The Domestic Violence Death Review Committee of Ontario is considered a central review committee in that it is formed at a provincial level and directs recommendations to provincial programs, services, and systems. However, some committees are formed at a local level, such as a county, regional, or city level. These committees are composed of community residents who often had direct involvement with the victim and the perpetrator prior to the homicide. In addition, local review committees will bring family members and friends of the victim and/or perpetrator into the review process to provide further information. A local level review committee forms recommendations aimed at improving local community programs, services, and systems that respond to domestic violence situations.

Challenges are posed by both types of review committees. One major concern regarding the central review committee is that by not including individuals who had direct involvement with the case in the review, the committee will not have access to additional pertinent information. Usually it is those people who are closest to the victim and/or the perpetrator who possess valuable insider information that may be important to the committee when identifying needed changes and recommendations. In addition, allowing these individuals a voice in the review process can be therapeutic for the individual and the community and can be seen as a debriefing mechanism where personal concerns are addressed. However, local review committees that are comprised of individuals who had direct involvement with the case can be risky if an individual's privacy is inadvertently violated. Further, although the review process may be therapeutic to some individuals who had direct involvement with the case, the review process may be difficult for others. By discussing the details of the case, unresolved and oppressed feelings may resurface and an individual may be propelled back to a state of anguish and upset.

A promising practice that deals with the challenges involved with both central and local review committees is creating a committee that incorporates positive aspects of both. For example, Washington State has created a central review committee that is formed at the state level but includes local reviews that are conducted at a municipal or county level (see http://www.baylor.edu/content/services/document.php/29322.pdf.). Specifically, the Washington State Domestic Violence Fatality Review team features local review panels, comprised of community members who may have had direct involvement with the case, which identify recommendations for domestic homicide cases that occurred in a particular city or county. These recommendations are then forwarded to the centralized committee to be refined for publication in the annual report. Within the local review committees, several best practices have emerged to deal with specific challenges. For example, to maintain confidentiality, the local review committee has confidentiality agreements signed by all committee members. Further, rather than inviting family members or friends to attend the review process, the committee will assign a trained professional/therapist to interview these individuals and present the information to the committee.

Recommendations for the Future

In summary, discussions during the think-tank identified several challenges regarding implementing a domestic violence death review team. However, many of these challenges have been met with promising practices from U.S. committees and the Ontario Domestic Violence Death Review Committee. With continuous communication and collaboration between Canadian provinces, the process of domestic violence death reviews can be enhanced significantly, increasing the likelihood that the goal of predicting and preventing future domestic homicides will be reached.

While Ontario currently has the only domestic violence fatality review committee in Canada, both Manitoba and New Brunswick are in the process of developing a domestic violence death review committee and other provinces are exploring ways to work within their existing frameworks for death reviews to examine domestic homicides more closely, moving beyond the inquest process. A promising future for Canada is to have several review committees across the country that can provide in-depth information on domestic violence fatalities across the nation and make Canada a leader in understanding and preventing domestic homicides. Several challenges have been identified in terms of forming domestic violence fatality review committees. Thus, it is recommended that provinces continue to learn from each other and from other countries that are acquainted with the fatality review process so as to identify challenges and promising practices in domestic violence fatality review.

Our initial think-tank was limited to five provinces based on available funds, however four other provinces have expressed an interest in expanding their knowledge on domestic violence fatality reviews. Therefore, the next practical step is to create a national conference on domestic homicide prevention based on lessons learned from tragedies and promising practices identified both in research and in the field. The general goal in holding a national conference is to enhance networking and partnerships among social science researchers, policy makers and practitioners (coroners, medical examiners, police, crown attorneys, anti-violence community agencies) in their review of domestic homicides across Canadian provinces and territories. The conference will focus on common risk factors and systemic gaps in policies, training and resources that are related to domestic homicides. Invited guests could include researchers, policy makers and service providers from across the globe that are familiar with the fatality review process. Plans for a conference in London, Ontario from June 14-16, 2009 are underway.

Collaboration between researchers should be established to identify key factors involved in domestic violence fatalities, such as risk factors, assessment tools and forms of intervention, to educate the public about the dangers of domestic violence and risk for fatality. Further, research involving inter-regional comparisons can point out unique issues in review processes and legislation across provinces that may or may not be effective in fatality review. Many of the individuals that attended the think-tank are members of an already-existing national alliance aimed at building community and academic partnerships to carry out research and public education to eliminate violence

against women. By expanding this alliance and the breadth of research on domestic violence fatalities, Canada will continue to be a leader in intervention and prevention of violence against women and children.

Potential areas for future projects include inter-disciplinary and community/government collaborative research on a) the risk of domestic violence on children as victims and witnesses of domestic homicide, b) safety planning for women who are leaving abusive relationships, c) risk reduction and treatment of perpetrators of domestic violence, d) risk assessment of domestic violence by different sectors (health, justice, police, social service, mental health), e) public education strategies for friends, families and neighbours in regards to warning signs for lethal domestic violence, f) the role of the workplace in addressing the needs of victims of domestic violence and g) the benefits as well as limitations of local and centralized death reviews. It is hoped that a national conference will be a springboard to enhanced collaboration and research in these areas.

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Appendix A

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APPENDIX B

Domestic Violence Fatality Review Teams: Critical Tensions and Promising Practices

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Author Notes

This paper was prepared for the Think Tank on Canadian Domestic Violence Death Reviews. It was based on research conducted in partial fulfillment for a doctoral degree in the Clinical/Community Division of the Department of Psychology at the University of Illinois at Urbana-Champaign. This research was made possible in part by a Social Sciences and Humanities Research Council of Canada Doctoral Fellowship. The authors would like to thank all of the Domestic Violence Fatality Review Teams that took part in the study.

Over the last fifteen years, domestic violence fatality review teams have emerged in North America as an innovative and promising means of understanding and preventing domestic violence deaths, homicides and suicides resulting from domestic violence (Websdale, 2003). As of 2006, twenty-eight states in the United States and one province in Canada had established at least one domestic violence fatality review team (Watt and Allen, 2008). However, given there is often more than one team in each state or province, the total number of domestic violence fatality review teams far exceeds this number, amounting to approximately seventy-five teams in total. For instance, at the time this estimate of the prevalence of domestic violence fatality review teams was made, the state of California alone had twenty-two county wide teams. The total number of domestic violence fatality review teams operating in North America continues to grow at a rapid pace and very few teams have disbanded over the years, which is likely a reflection of the perceived need and effectiveness of these efforts.

Domestic violence fatality review teams involve a collaboration among stakeholders from a variety of agencies (e.g., law enforcement, health care, social services, education) to identify and review cases of domestic violence deaths and to develop strategies to prevent or reduce future fatalities. The process used by these teams to review cases is reminiscent of mortality reviews that routinely occurred in the fields of medicine, aviation, and nuclear fuels (Websdale, 2003). Specifically, teams typically conduct a systematic analysis of the events leading up to a series of domestic violence deaths to determine what risk factors were present and how the system could have responded differently to prevent their occurrence (Websdale, 1999). Following this review process the vast majority of teams publish a report that describes the work of the

team, summarizes their findings, and outlines their recommendations for systems change (Thompson, 2006). In general, recommendations aim to prevent or reduce future domestic violence deaths by promoting public awareness and education, increasing coordination and communication across existing services, improving practices, procedures, and policies in the system response, and creating additional funding or resources (Watt & Allen, 2008).

Anecdotal evidence suggests that patterns identified by domestic violence fatality review teams could contribute to a wide variety of changes to the system response and ultimately prevent future deaths (Thomson, 2006; Websdale, 2003). For example, the Washington State Domestic Violence Fatality Review (2004) reported increased public awareness regarding domestic violence homicides by disseminating their reports widely to community stakeholders and generating media attention through press releases. In addition, the State of New Hampshire Governor's Commission on Domestic and Sexual Violence Domestic Violence Fatality Review Committee (2002) witnessed better coordination between courts and crisis centers following the implementation of one of their recommendations. Improvements to practice were observed by the Maine Domestic Abuse Homicide Review Panel (2004) when one of their recommendations resulted in changes to law enforcement policies related to weapons removal in cases of domestic violence. Lastly, the Ontario Domestic Violence Death Review Committee (2004) noted increased funding for domestic violence when the provincial government announced a sixty-six million dollar action plan to address a range of needs outlined in their report.

Although domestic violence fatality review teams share an overarching goal of understanding and preventing domestic violence deaths, how they go about reaching this

goal varies widely across teams. For instance, teams differ with respect to their underlying philosophy, where they are established, who is included as members, how they review cases, and what recommendations they make (Watt, 2006). These differences are often a reflection of important tensions faced by teams in the course off their development. Tensions refer to dilemmas or tradeoffs teams encounter when making a choice between alternative courses of action that each has their relative costs or benefits (Stake, 1995).

This paper reviews five critical tensions commonly faced by domestic violence fatality review teams. These tensions were developed based on discussions with experts in the field, review of the literature on coordinated community responses to domestic violence, attendance to national and regional domestic violence fatality review team conferences, and interviews with thirty five domestic violence fatality review teams as part of a national study of their efforts. Identifying tensions is critical in the examination of domestic violence fatality review teams because it highlights how the dilemmas teams face and the choices they make shape how these teams operate and position themselves to affect change. Furthermore, tensions within teams often stimulate the development of promising practices as teams attempt to resolve conflicts or solve problems.

No Blame or Shame versus Accountability

The vast majority of domestic violence fatality review teams initially adopt a philosophy of *no blame or shame* to guide their work in order to make stakeholders feel more comfortable coming to the table and sharing information about their involvement in a case prior to a fatality (Websdale, 2003). Team members are encouraged to focus on

building trust and relationships between members as opposed to placing blame on any single individual and agency for a domestic violence death. Risk and error as inevitable aspects of coordinated delivery of complex services and perpetrators are ultimately held responsible for the deaths of their victims (Websdale, Town, & Johnson, 1999). This approach contrasts with the philosophy of *accountability* that underlies traditional strategies for reviewing domestic violence deaths (e.g., agency reviews, public inquests) which emphasizes holding individuals or agencies accountable for past behaviour and future change (Watt, 2008). This philosophy encourages the identification and correction of specific gaps or failures in the system response and places little to no emphasis on relationship building.

Tension sometimes arises between the philosophies of *no blame or shame* and *accountability* when domestic violence fatality review teams begin to review cases. This tension may become particularly strong when teams observe a clear failure in the system response or desire to make more specific and targeted recommendations than a *no blame or shame* approach allows. During these times, some teams report feeling that it is important to hold individuals, agencies, or systems responsible for past behaviour and for future change and believe that their philosophy of no blame or shame prevents them from doing so. Although emphasizing a philosophy of *accountability* may make stakeholders feel uncomfortable coming to the table and discussing past mistakes, some teams feel that holding others accountable is critical for making change.

> *"No blame or shame was important in terms of creating the right atmosphere for our discussions and encouraging people to come to the table. It was important for people to know that they were not going into this process to be attacked in the course of the meeting or knifed publicly as a result."*

> *"The cost of promoting no blame or shame is that sometimes you really want to blame someone. I think we honestly had to back off in some cases so that we would not play the blame/shame game."*

Several promising practices have emerged as a result of the tension between *no blame or shame* and *accountability*. Teams that traditionally emphasized *no blame or shame* as their underlying philosophy have considered several strategies to hold individual and agencies *accountable* without harming carefully fostered relationships. For instance, if teams choose to make targeted or specific recommendations for system change, they may first inform the agency privately of the observed system failure or ask the agency for their input into the wording of the recommendation.

Freedom of Information versus Confidentiality

Domestic violence fatality review teams also differ with respect to what type or amount of information is shared among members. Teams tend to emphasize *freedom of information* inside the team and believe that sharing information is critical to better understand the risk factors and system failures contributing to domestic violence deaths. Teams often collect private information and place no restriction on the amount or type of information shared among team members. In contrast they tend to emphasize confidentiality of their proceedings outside the team and strong restrictions are often placed on the amount or type of information shared. Teams rarely inform people outside the team which cases they are reviewing (e.g., family members and service providers) or include information in the report that may identify the case reviewed (e.g., names of victims, case scenarios).

Tension between *freedom of information* and *confidentiality* tends to emerge

within domestic violence fatality review teams when the information sharing guidelines of the team conflicts with those of a single agency represented by one of the members. As a consequence disagreements may emerge regarding what type or amount of information should be shared. In these cases, instead of emphasizing *freedom of information* a team member may emphasize the victim, perpetrator, or agency's right to privacy and limit the information they are willing to share. For instance, several teams reported that members from domestic violence shelters were not willing or able to share information with the team because they felt they had not obtained the victim's consent to do so and as a consequence believed this constitute a violation of this person's right to privacy. However, the lack of information from shelters was often seen by other team members as a lost opportunity to evaluate potential gaps in the system response to domestic violence.

> *"I think we can really identify the issues that need to be addressed and help make significant improvements to the system by sharing the information honestly and openly within the group."*

> *"The shelters perspective was that if you share information about a woman who died after being in the shelter that is the ultimate form of violating that women's sovereignty. They just flat out refused to share information."*

The establishment of domestic violence fatality review teams under legislative or statutory authority and executive orders is one very important promising practice that has emerged to allow teams to both share information and maintain the confidentiality of information shared. Formal authorization allows the teams to have access to confidential information related to review of a death, prevents information reviewed from being subject to subpoena or discovery, and provides immunity for each member of the team from civil or criminal liability (Websdale, Sheeran, & Johnson, 2001). When formal authorization and protections have not been obtained, teams often establish interagency

and confidentiality agreements to allow agencies to share information with one another.

Betterment versus Empowerment

Most teams have been structured based on a *betterment* model in which teams have been formed at a state level where agency leaders shape the development of the team (Himmelman, 2001). The members of the team are typically not directly involved in providing services to the perpetrators or victims prior the fatality. As a consequence of the membership of the team and where it is based, improvements to programs, services, systems and polices tend to be directed at a state level. In contrast to the *betterment* model, a minority of teams are based on an *empowerment* model in which teams have been formed at a county or regional level, where community residents (e.g., local service providers, family members, victims) shape the development of the team (Himmelman, 2001). The members of the team are often directly involved in providing services to the perpetrators or victims prior the fatality. As a result, improvements to programs, services, systems and polices tend to be directed at a county or regional level.

One of the ways the tension between the *betterment* and *empowerment* model emerges is with respect to who is included as a member of a team. Many teams that have traditionally been based on a *betterment* model have debated about including community residents who were more directly involved in the cases reviewed, which would be more consistent with an *empowerment* model. For instance, teams have considered including family members of victims of domestic violence deaths as part of their efforts. The primary reason for doing so was often to gain access to additional information and out of respect for the victim and their surviving family. However, some members have argued

against the inclusion of family members due to concerns about the possibility of violating confidentiality, the quality of the information that would be obtained, the potential harm to family members by opening up old wounds, and the inability to provide follow up services due to lack of expertise or resources.

> *"We want the family's permission to review the case because we do not want to offend them by making them feel like the government is sneaking around and prying into their affairs. We also want them to participate by coming in and talking to us because we gain enormous amounts of information that our file does not reflect."*

> *"We do not contact families to ask them for additional information. We really hold true to the fact our value of confidentiality and I do not think we could insure that if we included family."*

Although the structure of most teams continues to be heavily influenced by a *betterment* model, many teams have attempted to incorporate elements of an *empowerment* model by including community residents in a variety of innovative ways and several promising practices have emerged. Specifically, teams have invited victims of domestic violence to be members of their team, interviewed surviving family and friends about their experiences and perspectives, and conducted focus groups with community residents related to specific issues that arise.

Biography versus Epidemiology

Domestic violence fatality review teams have chosen diverse methods to collect and analyze information. Most teams use some form of a *biographical* approach in which detailed information is collected about a small number of cases, sometimes referred to as a case specific or systems approach (Websdale et al., 1999). The primary goal of this approach is to obtain an in depth understanding of the dynamics of a single case. For

instance, teams may spend several days collecting and reviewing information about one death. Fewer teams use some form of an *epidemiological* approach in which general information is collecting about a large number of cases, sometimes referred to wide-angle or investigative model (Websdale et al., 1999). The primary goal of this approach is to obtain an understanding of trends across cases. Therefore, teams may spend as few as ten minutes collecting and reviewing information per death.

Tension most frequently emerges within domestic violence fatality review teams about *biography* and *epidemiology* when initially selecting a method to analyze cases. However, tension may also arise over the course of reviewing cases if the costs of the approach they are using begin to outweigh the benefits. Proponents of the *biographical* approach argue that in depth information is critical for revealing the complex dynamics of each case and the gaps or failures in the system response that could have potential implications for informing system change. In contrast, proponents of the *epidemiological* approach warn against the dangers of basing any decisions about system change on a single case. They argue that any recommendation for systems change should be based on trends observed across cases.

> *"Because domestic violence is such a complex issue, we really need to gather a lot of information and take an in depth look to get at the complexities and the uniqueness of each case. It gives you the opportunity to really identify gaps and increase cooperation and collaboration. If you do not dig deep into a specific case the likelihood that you are going to be able to identify these things is pretty slim."*

> *"We worry about making recommendations based on six to ten cases. While those are very well researched cases, how much of the patterns that we have seen are indicative of the other twenty or thirty cases we have not reviewed? If we can gather more data it will help substantiate some of the policy recommendations we are trying to make."*

Many teams that have debated about the costs and benefits of *biographical* and

epidemiological approaches to collecting and analyzing data have resolved this tension by adopting a mixed methods approach. For instance, teams may collect a limited amount of information about all cases of domestic violence deaths and in depth information about a subset of these fatalities. As a consequence they are able to capitalize on the benefits of both approaches with respect to identifying system failures and making recommendations for system change.

Understanding versus Action

Domestic violence fatality review teams appear to have very different models regarding how to promote systems change. Some teams approach systems change by emphasizing *understanding*. They tend to view themselves as independent fact finding bodies whose responsibility it is to educate others about changes that need to be made to policies, procedures, and practices. They may make recommendations for systems change but are not involved in monitoring or implementation of those recommendations. In contrast, other teams approach systems change by emphasizing *action*. These teams see themselves as part of the system response and believe it is their responsibility to implement changes to policies, procedures, and practices. In addition to making recommendations for systems change they are involved in monitoring or implementing those recommendations.

Tension typically emerges within domestic violence fatality review teams between *understanding* and *action* when teams consider the extent to which they should be involved in promoting systems change. Initially many teams emphasize increasing understanding as their primary means of promoting systems change. However, over time tension arises in some teams when they begin to examine whether their recommendations

were being implemented by others and observe that very few changes are being made to the system response. This finding emphasizes to these teams that in order to more effectively promote systems change they needed to become more actively involved in the implementation of recommendations.

> *"The most teams can do is point out the problem and make suggestions about how to make a difference. It is up to other people to act."*

> *"The team never expected to have to follow up with implementation of recommendations. It learned, however, that its efforts were futile otherwise."*

The increased recognition of the limitations of solely relying on increasing *understanding* as a means of promoting systems change has led many domestic violence fatality review teams to make changes to their practices to increase the likelihood their recommendations will be put into *action*. For example, teams have followed up with agencies to monitor whether recommendations were implemented, to assist agencies with implementation of the recommendations, and to document improvements made to the agencies practices or policies subsequent reports.

Domestic violence fatality review teams are very promising venues for promoting system change. Increasing understanding of the tensions faced by teams in the course of their work may help to explain the diversity of their goals, structures, processes, and outcomes. Furthermore, actively grappling with these tensions could stimulate teams to establish promising ways to improve policies, procedures, and practices. Although this discussion is by no means an exhaustive list of all the tensions encountered by teams or the many ways they impact on the operations of the team, hopefully it will stimulating thinking about how choices made by teams about these types of issues may have important implications for what they ultimately accomplish.

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