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Peter G. Jaffe, Myrna Dawson, Marcie Campbell

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Developing a National Collaborative Approach to Prevent Domestic Homicides: Domestic Homicide Review Committees[1]

Peter G. Jaffe
Western University

Myrna Dawson
University of Guelph

Marcie Campbell
Western University

La perspective canadienne sur l'étude et la prévention des homicides au sein de la famille a été discutée par un groupe de réflexion rassemblé à London, Ontario, en 2010. Le groupe de réflexion a rassemblé des praticiens, des chercheurs et des représentants du gouvernement de 10 provinces et de deux territoires pour : partager leur expérience régionale en matière d'étude des homicides au sein de la famille, identifier les avantages et les défis d'effectuer des études pour la prévention de ces homicides et donner un aperçu des pratiques prometteuses qui ont été utilisées ou qui pourraient être utilisées pour surmonter ces défis. Les membres du groupe ont discuté des différences et des similitudes des processus d'étude au sein des provinces/territoires individuels ainsi que de nouvelles problématiques. Le résultat final de la rencontre était l'identification des prochaines étapes en matière d'étude et de prévention des homicides au sein de la famille par le biais de différentes recommandations qui appuient un cadre futur de recherche et de pratique.

Mots clés : étude sur les homicides au sein de la famille, cadre de prévention des homicides au sein de la famille, groupe de réflexion canadien

Canadian perspectives on domestic homicide review and prevention were discussed at a 2010 national think-tank held in London, Ontario. The think-tank brought together practitioners, researchers, and government officials from 10 provinces and two territories to share regional experiences with domestic homicide reviews, to identify benefits and challenges of conducting reviews for domestic homicide prevention, and to outline promising practices that have been or may be implemented to address challenges. Think-tank members discussed both the differences and similarities of death review processes within individual provinces/territories and emerging issues and concerns around

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domestic violence death reviews. The final outcome of the think-tank was the identification of next steps in domestic homicide death review and prevention through various recommendations that support the future framework for research and practice in this area.

Keywords: domestic homicide review, framework for domestic homicide prevention, Canadian think-tank

In Canada, the rate of spousal homicide was 3.5 victims per million spouses in 2009, which is a 44% decrease from the rate 30 years ago (Statistics Canada 2011). There are many theories about the reasons for the decrease in domestic homicides, one of which identifies the growth in existing and new resources (e.g., shelters, specialized domestic violence courts) that may prevent or reduce the likelihood of violence between intimate partners – a growth that has paralleled these declines (Dugan, Nagin, and Rosenfeld 2003). Among these resources are the domestic violence death review committees, which originated in the United States but have been implemented in Canada in the past decade. The present article begins by describing the history of the domestic violence death review process in Canada. Drawing from a 2010 national think-tank held in London, Ontario, the authors outline the benefits of a domestic violence death review committee, and then identify the challenges and possible responses as identified and discussed by think-tank participants. Participants included about 40 practitioners, researchers, and government officials from 10 provinces and two territories.[2] The article concludes by summarizing what next steps are required to create a national domestic homicide prevention initiative that will facilitate a future framework for research and practice in this area.

The history of the domestic violence death review process in Canada

Domestic violence death reviews have been conducted in North America since the early 1990s. The first review was conducted in San Francisco, California after the killing of Veena Charan by her husband (Websdale, Town, and Johnson 1999). This review identified several key issues and made recommendations that would help to predict and prevent similar killings. Since the Charan review, approximately 82 domestic violence death review committees have been created across the United States, and the number continues to grow (Wilson and Websdale 2006). The purpose of a domestic violence death review is to identify risk

factors that help predict potential lethality and to make recommendations aimed at preventing deaths in similar circumstances. Recommendations that arise from the review of individual cases identify potential areas of improvement across multiple sectors (e.g., police, health care, community services, and justice) that together respond to domestic violence. In the United States, recommendations have tended to fall under the general themes of training and education, professional development, enhanced legislation, coordination of services, and resource development (Jaffe and Dawson 2002; Town 1999; Wilson and Websdale 2006).

In 2002, Ontario established the first death review committee in Canada (Ontario DVDRC 2003). The formation of the Ontario Domestic Violence Death Review Committee (Ontario DVDRC) was in response to recommendations that arose from two separate, but major inquests into the domestic homicides of Arlene May and Gillian Hadley by their former male partners. These separate inquests generated several key recommendations that identified the need for education, training, and prevention programs; coordination of services and sharing information; risk assessment, risk management, and safety planning; modification and reconstruction of justice programs (e.g., bail hearings) and police procedures; and conducting further research into domestic violence and homicide prevention (Office of the Chief Coroner 2002; Ontario, Office of the Chief Coroner 1998; Ontario Women's Justice Network 2002). It was also recommended that a domestic violence death review committee should be created.

Until recently, Ontario has had the only death review committee in Canada. In March 2010, a British Columbia Death Review Panel (British Columbia DVDRP) conducted a one-time domestic homicide review of 11 domestic homicides from across the province, drawn from over 100 coroner case files dating back to 1995 (Coroners Service 2010: 1). In November 2008, the Manitoba Minister of Family Services and Consumer Affairs, along with the Minister of Justice and Attorney General and the Minister of Labour and Immigration (responsible for the Status of Women) announced the plan to create a domestic violence death review committee (Manitoba DVDRC) to examine and review domestic homicides in that province (Centre for Research and Education on Violence against Women and Children 2011). The Manitoba DVDRC was formally established on 16 June 2010. New Brunswick has also formed a death review team to work as an advisory body for the Office of the Chief Coroner (New Brunswick DVDRC). This committee has commissioned a study on all domestic homicides that occurred in

the province between 1999 and 2008 (New Brunswick 2010). Finally, the Alberta Council of Women's Shelters issued a position statement on the need for Alberta to create a domestic violence death review committee (Alberta Council of Women's Shelters 2010).

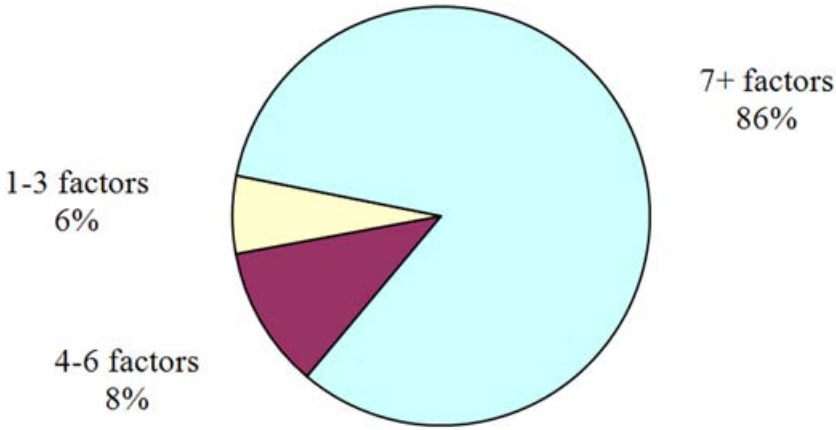
Reducing homicide risk through domestic violence death reviews

Domestic violence death review committees are a resource or mechanism that belongs to the exposure reduction framework (Dugan, Nagin, and Rosenfeld 1999, 2003; Dawson, Pottie, Bunge, and Balde 2009). The exposure reduction framework is premised on the well documented finding that chronic and persistent violence in intimate relationships often precedes intimate partner homicide and, as a result, mechanisms that help abused partners exit from violent relationships or that inhibit the development of such relationships may reduce exposure to such killings. DVDRCs seek to reduce future exposure to domestic violence through detailed interdisciplinary reviews of cases that have already occurred to identify common risk factors and potential points of or missed opportunities for intervention (Wilson and Websdale 2006). These initiatives arguably reflect and integrate both liberal and radical crime prevention models (White 2005). The former model views crime as a social problem that is, in part, the result of group disadvantage and emphasize early intervention and community development as key factors in responding to crime. The goal of the latter model is social justice, which can be achieved through political struggle that aims to address social-structural inequalities and group marginalization. Thus, while all these models focus on violence prevention, there can be several different approaches to developing a domestic violence death review committee, and not every committee is alike because committees may use different practices that best suit their communities. However, drawing from the Ontario DVDRC and British Columbia DVDRP reports, the section below discusses some of the commonalities that exist among many death review committees.

Identifying common risk factors for domestic homicide

The identification of risk factors is an important element for predicting and preventing domestic homicides. A key goal of most domestic violence death review committees is to identify common risk factors across individual cases that may be used by professionals to help predict and prevent a potentially lethal situation in the future. At its

Figure 1: Number of risk factors identified in cases reviewed for 2003–8



inception, the Ontario DVDRC conducted a literature review and compiled a list of 26 potential risk factors for domestic homicide, a list which is continually updated as research identifies potentially new and emerging risk factors (Jaffe and Dawson 2002). From 2003 to 2008, 86% of all cases reviewed by the Ontario DVDRC had seven or more known risk factors with the most common being a prior history of domestic violence and an actual or pending separation (see Figure 1; Ontario DVDRC 2008). These risk factors are consistent with findings from several research studies that have found them to be primary risk factors for domestic homicide (Campbell, Glass, Sharps, Laughon, and Bloom 2007; Campbell, Webster, Koziol-McLain, Block, Campbell, Curry, Gary, Glass, McFarlane, Sachs, Sharps, Ulrich, Wilt, Manganello, Xu, Schollenberger, Frye, and Laughon 2003; Wilson and Daly 1993).

Identifying systemic gaps or missed opportunities

The review process also identifies missed opportunities or gaps in services that may have occurred when attempting to protect victims and/or children as well as strategies for perpetrator intervention that may have been overlooked. Most death review committees examine the circumstances that lead up to and surround the incident of a domestic homicide, including whether or not the victim and/or perpetrator was involved with social services, health services, and/or justice

Table 1: Percentage of cases that had professionals involved with either the victim and/or the perpetrator

Type of Professional Involved	Percentage of cases (%)
Mental health and counselling	65%
Police	43%
Courts	27%
Medical	23%
Domestic violence treatment (e.g., shelter, batterer intervention program)	22%
Child protection services	18%
Clergy	5%

agencies. The committees review the services and interventions provided and identify any areas where these systems could have improved their responses when dealing with the at-risk couple (Websdale 2003). This is a crucial benefit of a death review process because agencies and professionals can learn from their mistakes and make the appropriate changes to policies and practices in order to improve systemic responses over time. In their 2007 annual report, the Ontario DVDRC showed the percentage of cases that involved particular professionals who had been working with either the victim and/or perpetrator in a domestic homicide case (see Table 1) (Ontario DVDRC 2007: 35). The numbers show that many agencies and services are involved with at-risk couples and thus have the opportunity to provide support and/or interventions that could prevent a homicide if such opportunities were identified and acted upon effectively.

Making recommendations

Recommendations made by DVDRCs are typically classified under common themes such as education and awareness for the public and professionals; coordination between and across services; creating resources; and enhancing system response (Websdale 1999). To date, the recommendations arising from the Ontario DVDRC fall under four major themes: (1) awareness and education, (2) assessment and intervention, (3) resources, and (4) child-related issues. The majority of the recommendations (84%) fall under *awareness and education*, in which recommendations are aimed at raising awareness and educating

the general public and professionals, training professionals, and developing systems of education (e.g., incorporating domestic homicide prevention into classroom curricula) (Ontario DVDRC 2009). After completing the one time review of 11 cases, the British Columbia DVDRP made 19 recommendations aimed at developing, changing, and evaluating policies, practices, and protocols; providing resources and training to professionals; and developing public education campaigns (Coroners Service 2010). Recommendations generated by DVDRCs are usually directed at government ministries (e.g., Ministry of Community Safety and Correctional Services of Ontario; Ministry of Health Services of British Columbia) or specific community systems that were involved with a single domestic homicide case (e.g., Police Service; Children's Aid Society) (Coroners Service 2010; Ontario DVDRC 2009). To date, there is no Canadian domestic homicide review committee that tracks responses to these recommendations. However, the Ontario DVDRC made a recommendation in the 2007 annual report for the creation of an inter-ministerial committee that will review all community, agency, and government responses to recommendations made by the DVDRC since its inception (Ontario DVDRC 2007: 4).

Sharing information

Sharing information with other systems is important, especially for communities that do not have a death review process and may depend on committees already in place to inform them of risk factors and systemic gaps in services. Sharing information also creates links to other jurisdictions, which can encourage the formation of trusting relationships across sectors. A DVDRC can provide information to the general public or help systems create public education campaigns with the aim of encouraging community members to get involved in preventing domestic homicides. For example, the Neighbours, Friends and Families public education campaign (Neighbours, Friends and Families 2010) was created in direct response to recommendations formed by the Ontario DVDRC. The campaign provides information about risks for lethality identified in case reviews. The campaign has been rolled out across multiple communities in the province and provides information brochures in 12 languages. Similarly, the British Columbia DVDRP made a recommendation around the development of public education initiatives to raise awareness of the risks of domestic homicide, referring to the Neighbours, Friends and Families campaign as a model to emulate (Coroners Service 2010).

Responding to the challenges of developing a domestic violence death review committee

Although there are many benefits to having a domestic violence death review committee, forming and implementing such committees can bring challenges. A comprehensive study of various death or fatality review committees in the United States and Canada provided a helpful framework for examining the diverse approaches to reviewing domestic homicides (Watt and Allen 2008; Watt 2010). During the 2010 think-tank that adopted a Canadian perspective, participants discussed and expanded on the challenges identified by Watt (2010), classifying them under four main headings: (1) legislation/governing body and membership, (2) resources, (3) sharing information/confidentiality, (4) accountability. Promising practices developed in response to these challenges were also discussed, specifically the practices of existing Canadian domestic violence death review committees (Ontario DVDRC, British Columbia DVDRP, Manitoba DVDRC, and New Brunswick DVDRC).

Legislation/governing body and membership

DVDRCs can range from informal community groups brought together to review an individual death to specific government-mandated groups. Many committees in the United States are formed under legislative mandates, and it has been argued that a legislative mandate creates an authority that helps to provide standard guidelines around participation of stakeholders, confidentiality and liability issues, creating avenues for funding, and sending messages to the community about the importance of these reviews (McHardy and Hofford 1999). Regardless of whether a committee is legislated or not, death review committees need to establish how they will be organized, where they will be housed, and how they will be sustained. In making these decisions, it is important to consider whether or not the home organization will fit with the death review mandate and will be able to maintain positive relationships with health and services agencies and law enforcement. Finally, the organization should be able to provide funds to the committee or have the potential to receive funding (McHardy and Hofford 1999). The Ontario and New Brunswick DVDRCs and the British Columbia DVDRP were not formed under specialized government legislation but fall under existing rules and regulations for the Office of the Chief Coroner for those provinces (Ontario DVDRC 2009; New Brunswick 2010; Coroners Service 2010). The Manitoba DVDRC was also formed without the passing of new legislation; however, this committee reports to the province's attorney general.

Membership is another important factor when forming a committee that may be linked to the existence of a legislative mandate. Committees should have representatives from across the violence against women sector and all other sectors that deal directly with victims, perpetrators, and/or children involved in cases of domestic violence (e.g., health care, education, police, social service providers). Committees are expected to be diverse and "inclusive rather than exclusive" (National Domestic Violence Fatality Review Initiative 2010). Committee members are in a position to take knowledge from the committee and make changes within their own systems. Therefore, it is important that several different systems are represented within one death review committee. The Ontario DVDRC currently has representatives from victim services, child welfare, police, health care (physicians), justice (crown attorneys), corrections, and social sciences (Ontario DVDRC 2009). The British Columbia DVDRP has members appointed to the panel under the Coroners Act and includes representatives from police, justice, corrections, and social services (Coroners Service 2010). The Manitoba DVDRC includes representatives from victim services, prosecution services, probation, police services, the Family Violence Prevention program, the Manitoba Status of Women, Manitoba Women's Advisory Council, Office of the Chief Medical Examiner, and the University of Manitoba (Manitoba 2010: 1). Finally, the New Brunswick DVDRC is composed of 10 representatives from multiple fields, including social work, family violence, policing, and violence prevention (New Brunswick 2010: 1). Committee members are usually appointed for a specific length of time and can be reappointed or replaced when their term ends. Some death review committees have an established team membership and invite other professionals, on an ad hoc basis, to share their particular expertise for a review of a specific and complex case.

Some committees may also allow family and friends of the family from particular cases to sit on the committee to help in the review process. Usually, this occurs on a voluntary basis. Family and friends who are directly involved in the case can be an important resource for the committee because they can provide information that may not be documented elsewhere. Furthermore, playing a role on the committee may be therapeutic for family and friends because the committee provides an outlet for voicing their concerns about the issues surrounding the death of someone close to them. However, others may find that discussing the case brings up conflicting and unresolved feelings as well as traumatic memories. Therefore, it is important that counsellors be available to help deal with the potential impact of their participation. With respect to confidentiality, it is important to have safeguards put

in place, as family and friends of the victim and/or perpetrator of a particular case can bring detailed and personal information to the review process that may inadvertently violate an individual's privacy (Watt and Allen 2008).

Resources

Resources, both financial and otherwise, are often a difficult challenge when forming a death review committee. The main concern usually pertains to the actual funding of a committee. If the committee is formed under a legislative body, such as the Coroner's Office, funds may be allocated to the committee by the government. Other committees, primarily in the United States, are funded through violence against women organizations and/or government grants (Websdale, Sheeran, and Johnson 2001). Smaller committees may not receive any funding, relying solely on volunteers. For instance, Ontario, New Brunswick, and British Columbia have government-funded death review committees, while Manitoba's DVDRC working group comprises government employees involved in the area of domestic violence. One concern identified was how to justify providing significant resources for death review committees in jurisdictions that have low numbers of domestic homicides. For example, New Brunswick has an average of one domestic homicide per year and Manitoba has an average of three domestic homicides per year (Statistics Canada 2008). Both of these provinces have implemented death review committees. However, participants agreed that greater numbers do not necessarily mean a more thorough review. Higher numbers can help identify patterns and trends in domestic homicides, but a thorough "biographical" review can help provide more detailed and relevant information about specific cases (Watt and Allen 2008). This kind of review can be especially beneficial for high profile and complex domestic homicide cases. Furthermore, a "biographical" approach can be used with cases concerning particular groups (e.g., Aboriginal communities) to address specific vulnerabilities and/or the needs of visible minority cultures. Approaches that are able to address the issues faced in smaller jurisdictions were discussed. These included broadening the mandate of the committee to include attempted homicides as well as suicides related to domestic violence, as for some US committees, or combining communities into one region with a death review committee representing the region (e.g., all east coast provinces). The latter approach would allow smaller provinces to combine resources and increase the number of homicide cases for review to identify patterns and trends.

Finally, concerns were expressed that some cases are not reviewed until several years after they occur. Such delays may be due to cases being caught up in court appeals or to a backlog of cases being prepared for review. Some think-tank participants viewed this as a waste of resources because new policies and protocols may have already been implemented to address the specific gaps in services involved with that particular case.

Sharing information/confidentiality

DVDRCs require multiple sectors to share personal information about both the victim and the perpetrator. It is beneficial for the committee to receive as detailed information as possible so that accurate recommendations can be formed. However, the sharing of information may result in challenges around confidentiality, respecting privacy, and gauging exactly how much information needs to be shared and with whom. The challenge for committees is maintaining a balance between an individual's right to privacy and the need for the public to acquire information regarding how to intervene and prevent domestic homicides (Thompson 2002). A thorough review may be an exhaustive process, with access to all files from medical and social service agencies and interviews with friends, family, neighbours, and coworkers. This process is expensive and time-consuming and, at some point, there may be diminishing returns to uncovering new or critical information for recommendations. Thus, the committee needs to find a balance among thoroughness, privacy, and cost-effectiveness in their investigations.

Think-tank participants discussed options for incorporating information sharing and confidentiality into reviews, such as creating a memorandum of understanding or confidentiality agreements for team members. It is standard practice for death review committees to have an oath of confidentiality, which states that none of the information obtained can be shared with anyone outside of the committee.[3] However, provincial and federal legislation can prevent certain information sharing, and it may be difficult to find best practices that take legislation and the importance of information sharing into account. Most committees also ensure that annual reports or presentations discussing statistics or cases are based on general aggregate information and omit any identifying information. However, it may be harder to comply with the spirit of confidentiality in smaller jurisdictions, where case summaries are more identifiable due to the limited number of cases that attract

publicity. Many committees obtain information in paper format from police investigations. The Ontario DVDRC is part of the Office of the Chief Coroner, which has the right to seize any information on the deceased if the Coroner has reasonable grounds to believe that the material is relevant for the purposes of the investigation (Ontario DVDRC 2009; Coroners Act s 16(2)(b)). The Coroner's office also has the right to subpoena any agency or professional for missing information that may be relevant to the case review. However, the Coroner's Office must also adhere to the Freedom of Information and Protection of Privacy Act which means that they are unable to obtain information on any victim and/or perpetrator that is still alive without their consent. This can create challenges around obtaining information that may be pertinent to the review process. Think-tank participants identified trust as another challenge related to sharing information and confidentiality. Conducting death reviews requires trust among the individuals, agencies, and systems involved, and further, trust is needed to ensure that each will hold itself accountable for a missed opportunity or a service gap that played a role in the homicide. Not only do agencies and systems need to trust each other when sharing information, but they must also believe that everyone has the same common goal. If there is a lot of turnover in committee membership, trust can be difficult to sustain. Moreover, when different agencies and systems have conflicting or different mandates, trust can be difficult to achieve. Trust within a team is not automatic and needs to be created and built.

Accountability

DVDRCs have called for acceptance of accountability from different systems and agencies that may have played a role in the outcome of the cases reviewed. By taking responsibility and accepting that errors were made, systems can start to implement changes that will ensure that similar mistakes will not re-occur. However, the challenge for a committee is to uphold the philosophy of accountability without "blaming and shaming" particular systems (National Domestic Violence Fatality Review Initiative 2010). If a committee points fingers or lays blame, systems and agencies will be reluctant to cooperate with a review and/or share information, for fear of being criticized. Furthermore, one of the main goals of a death review committee is to develop recommendations aimed at different systems that will help prevent similar tragedies from occurring. It is assumed that these recommendations will be implemented to cultivate system change. A committee needs to develop a mechanism that ensures the implementation of recommendations as well as monitors the corresponding systemic changes.

Some promising practices include creating independent task forces that monitor the implementation of recommendations or independent review committees that summarize recommendations made over the past year, noting any systemic changes that were implemented as a result (Websdale, Sheeran, and Johnson 2001). In Ontario, the 2007 report recommended that one government ministry take the lead in reviewing the implementation of all committee recommendations over the first five years of its existence:

> It is recommended that the Ministry of the Attorney General take a leadership role in creating an inter-ministerial committee that will methodically review all community, agency and government responses to recommendations that have been made by the DVDRC since its inception. It is suggested that this committee develop a work plan and timeline on the implementation of recommendations and consult with the Domestic Violence Advisory Council that currently reports to Minister for Women's Issues. It is hoped that the final report and plan could be forwarded to the Attorney General and made available to the public. (Ontario DVDRC 2007: 4)

It was noted by think-tank members that death review committees make recommendations but are not themselves accountable for outlining best practices on how these recommendations should evolve into solutions. Similarly, some think-tank participants stated that it is hard for a committee to find a balance between education and advocacy, and other participants felt that many of the recommendations are becoming redundant and do not contribute any new information for professionals or communities. As a result, some think-tank participants were of the opinion that the death review process needed to be revamped to become more proactive in identifying creative solutions and best practices. Therefore, participants recommended that death review teams include guidelines for preventative action, with examples of promising practices that have been shown to work in other jurisdictions. Critical issues that were identified included risk assessment and management strategies as well as enhanced collaboration among different systems.

Some committees in the United States have included potential best practices in their annual reports, which respond to past recommendations. For example, the Oklahoma Domestic Violence Fatality Review Board printed an article in their annual report that provided suggestions on how mental health providers could draw upon their usual practices to screen for men with depression and suicidal thoughts.

In addition, it described new and innovative questions that could provide a more detailed picture in relation to the risk for perpetration of woman abuse and lethality (Wilson 2005).

Independently of how death review committees in the United States and Canada have been structured, they share common benefits and limitations. Although reviewing domestic homicides in general may result in challenges, such initiatives are able to identify common risk factors and provide several consistent themes that have been demonstrated to be critical for addressing domestic violence and homicide prevention.

Next steps for a Canadian domestic homicide prevention initiative

Think-tank participants discussed the next steps needed to support the development of a national plan for preventing domestic homicides. First, participants felt that it was important to enhance partnerships among existing and developing domestic violence death review committees across the country. Formal partnerships among these committees could provide a source of support and consultation on emerging and promising practices, and the partnership could also help smaller jurisdictions where specialized resources are limited and there are fewer homicides. Another important next step, in the view of participants, was to create a national web site similar to the National Domestic Violence Fatality Review Initiative (www.ndvfri.org) established in the United States (National Domestic Violence Fatality Review Initiative 2010). Referred to as the *Canadian Domestic Homicide Prevention Initiative* (CDHPI), the web site would contain annual reports from committees across the country; annual reports from international death review committees; links to other web sites associated with domestic violence and homicide prevention; and newsletters that discuss upcoming conferences and initiatives around the world associated with domestic violence death review and prevention. The web site would be available to the public, but it would also contain a password-protected-members-only section, in which more sensitive information could be posted and shared with professionals in the field. The web site would also provide guidelines and templates for creating a domestic violence death review committee so that communities planning to implement a committee would not have to re-invent the wheel. For example, the web site could provide ready access to existing committee policies and coding forms. Finally, just as they advocated a

national web site, think-tank participants also discussed creating a national database that contained risk factors and descriptive data for all domestic homicide cases across the country so that it would be easier to identify trends, common risk markers, and unique factors associated with particular populations. This database would provide researchers with a wealth of data to study innovative inter-professional responses to reduce deaths and injuries due to domestic violence.

In summary, although many benefits to domestic homicide review were identified during think-tank discussions, participants agreed that forming such committees and conducting effective and careful reviews were not without challenges. Mainly, think-tank participants discussed concerns around the accountability of committees; committees not taking a proactive approach; the lack of resources; information sharing and confidentiality; and building and maintaining trust. However, think-tank participants conceptualized potential promising practices that answer these challenges and identified the next steps needed to spearhead a national plan aimed at preventing domestic homicides.

Notes

1 In 2008, London, Ontario hosted a national think-tank on the challenges and promising practices in reviewing domestic homicides. The overall objective of the think-tank was to bring together multidisciplinary perspectives from different Canadian provinces, representing various regions of the country, to share experiences in reviewing domestic homicides. The 2010 national think-tank, upon which this article is based, was a follow-up of the 2008 think-tank, with the main goal of identifying the next steps to domestic homicide review and prevention in Canada in addition to developing a framework for future directions. The 2008 think-tank was funded by the Ministry of the Attorney General of Ontario, the Ontario Women's Directorate, the University of New Brunswick, and the University of Western Ontario. Both the 2008 and 2010 think-tanks received funding from the Department of Justice, Canada.

2 This article does not reflect the individual views of individual participants or our funder. The government policy experts attended as resource persons and did not speak for their government in any official capacity. Representatives from Nunavut were unable to attend the think-tank.

3 An example confidentiality agreement is provided in the 2003 Annual Report of the Ontario DVDRC (Ontario DVDRC 2003: 99).

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