

10 May 2023

English only

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**Commission on Crime Prevention  
and Criminal Justice****Thirty-second session**

Vienna, 22–26 May 2023

Item 7 of the provisional agenda\*

**Use and application of United Nations standards and  
norms in crime prevention and criminal justice****Background paper on Femicide Review Committees\*\***

In his 2023 report on the use and application of United Nations standards and norms in crime prevention and criminal justice (E/CN.15/2023/9), the Secretary-General recommended that Member States should strengthen multidisciplinary and coordinated crime prevention and criminal justice responses to gender-based violence and gender related killing of women and girls, including through in-depth reviews of cases, and exploration of the possibility of establishing domestic homicide and violent death review committees.

This background paper is an advance copy of a publication developed by UNODC to support Member States in these efforts. It presents and compares the main characteristics of two initiatives focused on learning from gender-related killing (also referred to as “femicide” or “feminicide”) to improve responses: the use of death review committees in domestic violence cases and Femicide/Feminicide Observatories. In-depth reviews offer a unique opportunity to identify limitations of existing responses to gender-based violence against women and femicide/feminicide, as well as concrete opportunities for improving responses and cross-sector collaboration towards ending all forms of violence against women and girls, in line with the due diligence obligation of States under international law and the commitments enshrined in Sustainable Development Goal 5.

The background paper was prepared under UNODC’s mandate to support national efforts to eliminate violence against women and action against gender-related killing of women and girls, under General Assembly resolutions 65/228, 68/191 and 70/176.

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\* E/CN.15/2023/1.

\*\* This document has not been edited.





**UNODC**

United Nations Office on Drugs and Crime

# Background paper on Femicide Review Committees



May 2023

## Disclaimer

This background paper has not been formally edited.

The designations employed and the presentation of material throughout this background paper do not imply the expression of any opinion whatsoever on the part of UNODC concerning the legal or development status of any country, territory, city or area of its authorities, or concerning the delimitation of its frontiers or boundaries.

## Acknowledgements

This background paper has been prepared for the United Nations Office on Drugs and Crime (UNODC) by Patsilí Toledo Vasquez, International Consultant and Adjunct Professor of Gender and the Criminal Justice System, Universitat Pompeu Fabra, Barcelona, and reviewed by Sven Pfeiffer (Crime Prevention and Criminal Justice Officer, Crime Prevention and Criminal Justice Section, UNODC) under the overall supervision of Claudia Baroni (Crime Prevention and Criminal Justice Officer, Crime Prevention and Criminal Justice Section, UNODC). David Rausis and Martijn Kind (Research and Trend Analysis Branch, UNODC) provided helpful comments.

UNODC wishes to acknowledge the valuable contributions by experts from different countries: Marcela Arroyave, Lyndal Bugeja, Alicia Candia, June Castello, Khatidja Chantler, Fiona Cram, Myrna Dawson, Tamar Dekanosidze, Pauline Gulliver, Nahla Haidar, Gabrielle Hosein, Mariela Labozzeta, Leila Linhares Barsted, Moa Mannheimer, Mónica Maureira, Luz Patricia Mejía, María Cristina Mendonça, Frank Mullane, Johanna Nelles, Paola Di Nicola, Annamaria Picozzi, Ivonne Sepúlveda, Rhoda Reddock, Soledad Rojas, Laia Rosich, James Rowlands, Sophio Rusetski, Eva Villarreal and Neil Websdale. Different Members of the Gender Network of the Ibero-American Association of Public Prosecutors (Asociación Iberoamericana de Ministerios Públicos, AIAMP) were also consulted.

UNODC gratefully acknowledges the funding provided by the Government of Sweden for the development of the present background paper.

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## Table of Contents

<b>COMMISSION ON CRIME PREVENTION AND CRIMINAL JUSTICE .....</b>	<b>1</b>
<b>THIRTY-SECOND SESSION.....</b>	<b>1</b>
Vienna, 22–26 May 2023.....	1
<b>USE AND APPLICATION OF UNITED NATIONS STANDARDS AND NORMS IN CRIME</b>	
<b>PREVENTION AND CRIMINAL JUSTICE .....</b>	<b>1</b>
<b>BACKGROUND PAPER ON FEMICIDE REVIEW COMMITTEES** .....</b>	<b>1</b>
<b>DISCLAIMER.....</b>	<b>3</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>3</b>
<b>1. INTRODUCTION.....</b>	<b>6</b>
<b>2. DOMESTIC HOMICIDE / DOMESTIC VIOLENCE FATALITY REVIEW MECHANISMS.....</b>	<b>9</b>
2.1. <i>Definition of DHR/DVFR .....</i>	9
2.2. <i>Countries and territories that have implemented DHR/DVFR .....</i>	9
2.2.1 Pilot and sporadic experiences.....	11
2.2.2 Other experiences.....	13
2.3. <i>Objectives of DHR/DVFRs.....</i>	14
2.4. <i>Types of review committees .....</i>	15
2.4.1 Public agencies involved .....	16
2.4.2 Requirements for members of review committees .....	18
2.4.3 Participation of non-governmental organisations .....	20
2.4.4 Families and communities.....	21
2.5. <i>Extent of cases reviewed.....</i>	23
2.5.1 Committees that review a selection of cases.....	24
2.5.2 Committees with a wider scope review .....	24
2.5.3 Committees that review cases beyond homicides .....	25
2.5.4 Child death reviews.....	25
2.6. <i>Timing and procedures of DHR/DVFRs.....</i>	26
2.6.1 After all legal procedures are completed .....	27
<i>Example: DHR/DVFR procedure in Portugal.....</i>	27
2.6.2 Parallel to criminal investigations .....	28
<i>Example: DHR procedure in the United Kingdom.....</i>	29
2.6.3 Disciplinary procedures.....	31
2.7. <i>Data and information collected by review committees .....</i>	32
2.7.1 Information related to the victims .....	33
2.7.2 Information related to perpetrators.....	33
2.7.3 Information related to the crime.....	33
2.7.4 Information related to the previous relationship and risk factors .....	34
2.7.5 Information on interventions by agencies .....	35
2.7.6 Data analysis, reports and dissemination.....	36
2.8. <i>Recommendations issued by review committees .....</i>	37
2.9. <i>Main challenges identified.....</i>	39
2.9.1 Monitoring and reporting on the implementation of recommendations .....	39
2.9.2 Impact assessment.....	39
2.9.3 Resources involved.....	40
2.9.4 Minoritised groups and communities .....	41
2.9.5 Expertise on GBVAW .....	42
2.9.6 Other ethical aspects .....	43
<b>3. FEMICIDE OBSERVATORIES .....</b>	<b>44</b>
3.1. <i>Definition .....</i>	45
3.2. <i>Countries and normative basis .....</i>	46
3.3. <i>Objectives.....</i>	48
3.4. <i>Extent of cases included.....</i>	48
3.5. <i>Types of FObs.....</i>	50
3.5.1 Public agencies involved .....	51
3.5.2 Participation of non-governmental organisations .....	52
3.6. <i>Timing of data collection .....</i>	54

3.7.	<i>Data and information collected</i> .....	54
3.7.1	Information related to the victims .....	55
3.7.2	Information related to the perpetrators .....	55
3.7.3	Information related to the crime .....	56
3.7.4	Information related to the previous relationship and risk factors .....	56
3.7.5	Information on agencies intervention .....	57
3.8.	<i>Reports and recommendations by FObs</i> .....	58
3.9.	<i>Main challenges identified</i> .....	58
3.9.1	Monitoring and implementation of recommendations .....	58
3.9.2	Limitations in data collection .....	59
3.9.3	Resources involved.....	59
<b>4.</b>	<b>FROM DHR/DVFRS TO FEMICIDE REVIEWS: POSSIBLE INTRODUCTION OF FEMICIDE REVIEW COMMITTEES</b>	
	<b>61</b>	
4.1.	<i>Why should States consider establishing femicide review committees?</i> .....	61
4.1.1	Complementing existing legislation and policies on femicide/femicide .....	61
4.1.2	Considering the knowledge and perspectives of families and social networks, and reparatory potential of their involvement .....	62
4.1.3	Reinforcing a whole-of-state approach to GBVAW prevention .....	63
4.1.4	Focusing on State responsibility in relation to GBVAW .....	63
4.2.	<i>Normative framework for introduction of femicide reviews</i> .....	63
4.3.	<i>Political and organisational requirements</i> .....	64
4.4.	<i>Resources required</i> .....	65
4.5.	<i>Extent of femicides reviewed</i> .....	65
4.6.	<i>Steps to set up and operate a femicide review committee</i> .....	66
4.6.1	Femicide reviews within the mandate of existing multi-agency FObs .....	66
4.6.2	Involving governmental and non-governmental agencies in the review .....	67
	Characteristics of femicide review committee members .....	68
4.6.3	Selection of cases .....	68
a)	Opportunity of the review (in relation to criminal proceedings) .....	68
b)	Scope of cases .....	69
c)	Characteristics of cases .....	70
d)	Availability of services .....	70
e)	Role of non-governmental actors.....	70
4.6.4	Terms of reference of reviews .....	71
a)	Participation of families and social networks of victims and perpetrators .....	71
b)	Sectors and agencies part of the review .....	71
c)	Time frame of the review .....	71
4.6.5	Data, reports and recommendations .....	72
	Data collection and reports .....	72
	Recommendations and monitoring .....	72
	Research .....	72
4.6.6	Pilot phase.....	73
<b>5.</b>	<b>CONCLUSIONS</b> .....	<b>74</b>
<b>6.</b>	<b>EXPERTS CONSULTED</b> .....	<b>76</b>
<b>7.</b>	<b>REFERENCES</b> .....	<b>77</b>

## 1. Introduction

Gender-related killing of women, also referred to as femicide/feminicide, is an increasingly significant social and political concern worldwide. Over the last few decades, initiatives aimed at addressing these crimes have emerged, ranging from the criminalisation of femicide/feminicide in some countries, particularly in the Latin American region, to the implementation of improved risk assessments and protection measures, among others. This paper presents and compares two initiatives focused on learning from these fatalities: the use of death review committees in domestic violence cases and the initiatives of femicide observatories.

While death reviews or mortality reviews have been an established standardised practice in the healthcare sector,<sup>1</sup> to learn lessons from cases of tragic and preventable deaths (for example maternal deaths), such multidisciplinary reviews have only recently been extended to deaths related to gender-based violence against women (GBVAW). In the last decades, Domestic Homicide Reviews (DHR) or Domestic Violence Fatality Reviews (DVFR) have been implemented in several countries, to examine the specific circumstances in which a death related to domestic violence has taken place, and to learn lessons from them. So far, DHR/DVFRs have been introduced in high-income and mostly Anglophone countries, often as a reaction to high-profile cases of gender-related killing of women, which were preceded by a number of failures in the response by services providers in the criminal justice system and other sectors.

Other countries, mostly in the Latin American region, have established so-called Femicide or Feminicide Observatories (FObs). In general, these observatories are focused on collecting statistical data, in order to provide a full picture of the magnitude and characteristics of femicide/feminicide in the country or territory, including sociodemographic information of victims and perpetrators, as well as characteristics of the crimes.

While DHR/DVFRs and FObs have the common purpose of improving knowledge, understanding and prevention of domestic violence and other forms of GBVAW, with a special focus on lethal violence, they are different mechanisms. Existing DHR/DVFR mechanisms are not limited to the analysis of killings of women and also include killings of men and children occurring in the context of domestic violence. By contrast, FObs are generally solely dedicated to gender-related killing of women or femicide/feminicide, as defined in each country.

Even though some FObs review cases to a certain extent, DHR/DVFRs characteristically go a step beyond data collection to analyse all circumstances surrounding a death related to domestic or other forms of GBVAW (as defined in each jurisdiction). DHR/DVFRs do this in a specific way, by considering all previous contacts (or lack thereof) between the victim and the perpetrator on the one hand and relevant service providers and public agencies, including but not limited to the criminal justice system, on the other. One of the most remarkable characteristics of DHR/DVFRs is that they typically also aim to involve and include the

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<sup>1</sup> Liu, V. (2005). Error in medicine: the role of the morbidity and mortality conference. *The virtual mentor: VM*, 7 4.

perspectives of families, friends and social networks of victims and perpetrators. Additionally, DHR/DVFRs are the result of multi-agency work, fostering inter-sectoral coordination and allowing diverse perspectives to strengthen the analysis and the recommendations that arise from them.

In this way, the practice of DHR/DVFRs offers a unique opportunity to identify limitations of existing responses to GBVAW and gender-related killing, as well as concrete opportunities for improving responses and cross-sector collaboration towards ending all forms of violence against women and girls, as per Sustainable Development Goal 5. Considering the due diligence obligations of States in relation to GBVAW under international law, reviews of gender-related killing of women (femicide/feminicide) based on the methodology of DHR/DVFRs may constitute an important tool to review existing responses to GBVAW and promote their constant improvement, together with other wider outcomes in terms of social understanding and prevention of GBVAW.

This approach has been promoted by the OECD as part of its three-pillar approach to a whole-of-state framework for gender-based violence. Pillar III “Access to Justice and Accountability” includes documenting and studying patterns surrounding femicides/feminicides, considering the following key elements:<sup>2</sup>

- Including actions to track femicides/feminicides in order to better understand how and why women face gender-related risks of death.
- Establishing fatality review teams to build a summary of each case.
- Gathering of statistical data about both the perpetrator and the survivor/victim to better recognise warning signs and patterns of this phenomenon. Data can be gathered through official documentation (e.g., police reports, court records, other public services and publicly available medical reports), newspaper articles, and statements from or interviews with people who had relevant contact with the survivor/victim.



Figure 1. Three pillar approach to a Whole-of-State framework for GBV (From OECD (2021) *Eliminating Gender-based Violence. Governance and Survivor/Victim-centred Approaches*. page 18.)

In his 2023 report on the use and application of United Nations standards and norms in crime prevention and criminal justice, the Secretary-General recommended that Member States should strengthen multi-disciplinary and coordinated crime prevention and criminal justice

<sup>2</sup> OECD (2021), “The OECD three pillar approach to a whole-of-state framework for gender-based violence (GBV)”, in *Eliminating Gender-based Violence. Governance and Survivor/Victim-centred Approaches*. OECD Publishing, Paris, <https://doi.org/10.1787/42121347-en>, p. 57.

responses to gender-based violence and gender related killing of women and girls, including through in-depth reviews of cases, and exploration of the possibility of establishing domestic homicide and violent death review committees.<sup>3</sup>

To support these efforts and considering the growing social and political interest in the prevention and adequate responses to GBVAW and femicide/feminicide in many countries, this background paper aims to:

- Briefly present and compare the main characteristics of DHR/DVFRs and FObs in the countries in which they exist, including their similarities and diverging features (in terms of the committees/panels/teams that produce them, extent of cases included, working methods, recommendations, and their impact, etc.);
- Analyse DHR/DVFRs and FObs with a focus on the difficulties and challenges in their work and the implementation of their recommendations;
- Assess the possibility of introducing femicide reviews in countries that already have FObs as well as in other low and middle-income countries;
- Consider the expansion of femicide review committees beyond domestic or intimate partner femicide/feminicide, in order to broaden the focus to include other types of femicide/feminicide.

## **Methodology**

This background paper has been prepared based on desk research, reviewing information published in journals, books, newspapers, as well as reports by governments, international organisms, research institutions and national and international NGOs. Personal communications have also been used to gather additional information. Due to the limitations of the research, the degree of detail provided in relation to the diverse experiences presented in this document is constrained by the online availability of information.

The final version of this paper benefited from the feedback and inputs provided by experts from different countries, who joined online expert focus groups meetings that took place in March and April 2023. The experts who attended those meetings are listed in section 6 of this paper.

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<sup>3</sup> [E/CN.15/2023/9](#).



## 2. Domestic Homicide / Domestic Violence Fatality Review mechanisms

### 2.1. Definition of DHR/DVFR

In general terms, a Domestic Homicide Review (DHR) or Domestic Violence Fatality Review (DVFR) is a multi-agency review process that is conducted following the death of a person as a result of domestic violence. It entails a systematic examination of the circumstances surrounding the death, to identify what lessons can be learned from them, in order to improve responses to domestic violence and help prevent future deaths. Although domestic violence is a gendered phenomenon, DHR/DVFRs are not restricted to gender-related killing of women, and also include killings of men and, in some cases, children, in the context of domestic violence, as defined in the respective jurisdiction.

The reviews typically involve a multi-disciplinary team or committee of experts from a variety of sectors, such as law enforcement, child welfare, domestic violence services, and healthcare, who review the case and provide their perspective. The findings and recommendations from the review are intended to then be used to improve policies and practices, as well as to inform legislation, training, and education.

Despite these general shared characteristics, DHR/DVFR committees or teams that have been established in various countries differ in several aspects, such as their legislative basis, their stated objectives, their *ad-hoc* or permanent character, the extent of cases reviewed, or the agencies and procedures involved. The following sections will provide an overview of these aspects.

It should be underlined that, according to the definition used in the present background paper, DHR/DVFRs are multi-agency processes. Accordingly, other initiatives that do not involve multi-agency participation and in-depth review of individual cases (i.e., beyond statistical data), are not considered as DHR/DVFRs. Initiatives focused on data collection in cases of femicide/feminicide will be analysed in chapter 3 of this document (on Femicide/feminicide Observatories). It should also be noted that this paper focuses on DHR/DVFRs initiatives that have a permanent character and continuity in time, although some information on sporadic experiences is contained in the following section.

### 2.2. Countries and territories that have implemented DHR/DVFR

Different forms of DHR/DVFR have been implemented in the last decades, mostly in Anglophone countries. In several instances, their origin is related to the work of the coroner, a government or judicial official with the role to investigate and determine the cause of death in cases where it is sudden, unexpected, or violent. The implementation of DHR/DVFRs has been, in many cases, the result of mobilisation of women's organisations working on GBVAW.<sup>4</sup>

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<sup>4</sup> Sheehy, E. (2017). A Feminist Reflection on Domestic Violence Death Reviews. In: Dawson, M. (eds) Domestic Homicides and Death Reviews. Palgrave Macmillan, London. [https://doi.org/10.1057/978-1-137-56276-0\\_13](https://doi.org/10.1057/978-1-137-56276-0_13); Dawson, M. (2021). Domestic homicide review processes as a method of learning. In: Devaney, J., Bradbury-Jones, C., Macy, R.J., Øverlien, C., & Holt, S. (Eds.). The Routledge International Handbook of Domestic Violence and Abuse (1st ed.). Routledge. <https://doi.org/10.4324/9780429331053>.

In some countries, DHR/DVFRs are centralised review processes at the national level, as is the case in Portugal, Sweden and New Zealand. In the United Kingdom, they are regulated at the national level, but reviews take place at the local level. In the USA, Canada, and Australia, DHR/DVFRs are usually state-wide, regional or local initiatives, which is coherent with their character as federal states.

In a number of jurisdictions in the USA, these reviews have been conducted since the 1990s,<sup>5</sup> after being established at the state and local level through statutes and executive orders. The passage of the *Violence Against Women Act* (VAWA) in 1994, and its following reauthorisations also favoured the creation of DVFRs. For example, the *Violence Against Women Reauthorization Act of 2013* (VAWA 2013) includes provisions that strengthen the ability of communities to respond to domestic violence homicides and improve the collection and dissemination of data on domestic violence homicides. It also provides funding to states, tribes and localities to support fatality review teams and to improve their capacity to review domestic violence homicides.

DHR/DVFRs in Canada began in the early 2000s, initially in Ontario and later other provinces and territories established their own DHR/DVFR programs.<sup>6</sup> The normative basis for DHR/DVFRs varies among provinces and territories. In Ontario, there is no specific statute, code or executive order. Rather, the Ontario Domestic Violence Death Review Committee (DVDRC) was established under Section 15(4) of the *Ontario Coroners Act [R.S.O. 1990 Chapter c.37]*, that authorises the Chief Coroner to use experts to provide more comprehensive examinations and analyses of deaths, to identify areas for future inquiry and recommendations.<sup>7</sup> In Alberta, the Family Violence Death Review Committee was established in 2013 under the *Protection Against Family Violence Act*.<sup>8</sup>

In New Zealand, the Family Violence Death Review Committee (FVDRC) was established in 2008.<sup>9</sup> The FVDRC, together with four other mortality committees (on Child and Youth Mortality, Perinatal and Maternal Mortality, Perioperative Mortality and Suicide Mortality), were established under Sections 11 and 18 of the New Zealand *Public Health and Disability Act 2000* but became statutory committees under Section 59E of the amended New Zealand *Public Health and Disability Act* in April 2011.<sup>10</sup> All Committees report to the Health Quality & Safety Commission Board.

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<sup>5</sup> Websdale, N., Celaya, A., Mayer, S. (2017). United States. In: Dawson, M. (eds) *Domestic Homicides and Death Reviews*. Palgrave Macmillan, London.

<sup>6</sup> Dawson, M., Jaffe, P., Campbell, M., Lucas, W., Kerr, K. (2017). Canada. In: Dawson, M. (eds) *Domestic Homicides and Death Reviews*. Palgrave Macmillan, London.

<sup>7</sup> *Ibid.*

<sup>8</sup> Government of Alberta (n.d.) *Family Violence Death Review Committee*. Retrieved 15 Feb 2023 from <https://www.alberta.ca/family-violence-death-review-committee.aspx>.

<sup>9</sup> Tolmie, J., Wilson, D., Smith, R. (2017). New Zealand. In: Dawson, M. (eds) *Domestic Homicides and Death Reviews*. Palgrave Macmillan, London.

<sup>10</sup> Health Quality & Safety Commission New Zealand (n.d.) *Mortality Review Committees*. Retrieved 15 Feb 2023 from <https://www.hqsc.govt.nz/our-work/mortality-review-committees/about-us/>.

In Australia, domestic violence fatality/death reviews have typically been established through the Coroners Act of the respective territories.<sup>11</sup> Most DVFRs have been established after 2009.<sup>12</sup>

In the United Kingdom, DHRs became a mandatory legal requirement in 2011, for England and Wales and in 2020 for Northern Ireland,<sup>13</sup> under Section 9(1) of the *Domestic Violence, Crime and Victims Act 2004*, although some areas of England and Wales were conducting DHRs before that time.<sup>14</sup>

In Sweden, the National Board of Health and Welfare has conducted child death reviews since 2009<sup>15</sup> and adult domestic homicide / homicide reviews since 2012.<sup>16</sup> DHR/DVFRs are carried out in accordance with the *Act (2007:606) on investigations to prevent certain injuries and deaths*, amended in June 2018.<sup>17</sup>

In Portugal, the retrospective analysis of homicides related to domestic violence was established in Art. 4-A of the *Law 112/2009 of September 16, on the Legal regime applicable to the prevention of domestic violence, the protection and assistance of its victims*, amended by *Laws No. 19/2013 of February 21, 82-B/2014 of December 31, and 129/2015 of September 3*. The Retrospective Analysis of Domestic Violence Homicide Team (*Equipa de Análise Retrospectiva de Homicídio em Violência Doméstica*, EARHVD) was created in 2016, and the procedure for the review is regulated in *Ordinance No. 280/2016*.

### 2.2.1 Pilot and sporadic experiences

While all the above constitute examples of the introduction of DHR/DVFRs with a permanent character, there are other examples of time-limited reviews in other countries, including pilot experiences or sporadic reviews. These reviews have either been associated to some specific high-profile case or limited to a period of time,<sup>18</sup> although they often serve as precedent for proposals to introduce more permanent systems of DHR/DVFRs. The most recent examples are listed below (in chronological order):

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<sup>11</sup> For example, Coroners Act 2008 (Vic), Coroners Act 2009 (NSW), Chapter 9A; Coroners Act 2003 (Qld), Part 4A.

<sup>12</sup> Australian Domestic and Family Violence Death Review Network (2018). Data Report 2018. [https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/website%2Bversion%2B-%2Badvdrn\\_data\\_report\\_2018\\_.pdf](https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/website%2Bversion%2B-%2Badvdrn_data_report_2018_.pdf).

<sup>13</sup> Department of Justice of Northern Ireland (2020, Dec 10) *Long introduces Domestic Homicide Reviews and appoints panel chairs*. Retrieved 15 Feb 2023 from <https://www.justice-ni.gov.uk/news/long-introduces-domestic-homicide-reviews-and-appoints-panel-chairs>.

<sup>14</sup> Payton, J., Robinson, A., Brookman, F. (2017). United Kingdom. In: Dawson, M. (eds) *Domestic Homicides and Death Reviews*. Palgrave Macmillan, London.

<sup>15</sup> Moa Mannheimer, personal communication, 4-Apr-2023.

<sup>16</sup> European Institute for Gender Equality (EIGE). (2021b, Nov 22). *Measuring Femicide in Sweden*. <https://eige.europa.eu/publications/measuring-femicide-sweden>.

<sup>17</sup> Lag (2018) 1375 <https://www.lagboken.se/Lagboken/start/socialratt/lag-2007606-om-utredningar-for-att-forebygga-vissa-skador-och-dodsfall/d3290274-sfs-20181375-lag-om-andring-i-lagen-2007606-om-utredningar-avseende-vissa-dodsfall>.

<sup>18</sup> Websdale et al. (2017). cit.

- In British Columbia, Canada, the British Columbia Coroners Service (BCCS) has held an ad hoc death review panel on deaths resulting from intimate partner violence on two occasions, the last in June 8-9, 2016. It comprised a period of six years, from January 2010 to December 2015, in which 75 fatal intimate partner violence incidents occurred in BC, resulting in 100 deaths (73 IPV victims, 27 IPV perpetrators). The circumstances of the people who died were reviewed in aggregate. Current research and statistics were assessed, and key themes identified.<sup>19</sup> Before, on 9-11 March 2010, a Death Review Panel had also been convened at the Office of the Chief Coroner, to analyse 11 incidents of domestic violence that had resulted in 29 deaths.<sup>20</sup>
- In Norway, the government appointed a Partner Homicide Committee by royal resolution in October 2018. The Committee surveyed 19 cases of homicide where the perpetrator was a partner or a former partner in the period 2014–2017. It submitted its report to the Minister of Justice and Public Security in December 2020.<sup>21</sup> One of the committee’s proposals is for Norway to establish a permanent national intimate partner homicide commission.<sup>22</sup> This proposal is under consideration by the Ministry of Justice.<sup>23</sup>
- In Ireland, the Minister for Justice and Equality commissioned a Study on Familicide and Domestic Homicide Reviews in May 2019. The study team commenced consultation with a wide range of stakeholders in the third and fourth quarter of 2019, including family members of victims and some State agencies, and non-governmental organisations.<sup>24</sup> The final report was presented to the Minister for Justice for consideration in July 2022 and -as of December 2022- has not yet been made public.<sup>25</sup>
- In Costa Rica, the National Institute of Women has requested the implementation of Local Femicide Analysis Reports (*Informes Locales de análisis de Femicidio*, ILAFEM) for femicide cases that occurred in 2020. This is an ongoing project (the final report is

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<sup>19</sup> British Columbia Coroners Service (2016) Death Review Panel A Review of Intimate Partner Violence Deaths 2010-2015. Report to the Chief Coroner of British Columbia. Nov 2016

<https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/intimate-partner-violence2010-2015.pdf>.

<sup>20</sup> British Columbia Coroners Service (2010) Report to the Chief Coroner of British Columbia. Findings and Recommendations of the Domestic Violence Death Review Panel. May 2010

<https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/domestic-violence.pdf>.

<sup>21</sup> Nordic Research Council for Criminology. (2021, Jan 15). *Report by the Norwegian Partner Homicide Committee*. <https://www.nsfk.org/news/report-by-the-norwegian-partner-homicide-committee/> The report is available in Norwegian only: Norges offentlige utredninger (2020) Varslede drap? Partnerdrapsutvalgets utredning.

<https://www.regjeringen.no/contentassets/5f3dc96de14f443f869795a19088926a/no/pdfs/nou202020200017000ddpdfs.pdf>

<sup>22</sup> Norway (2021b). Submission to the SRVAW. *Gender – related killings – report from Norway 2021*.

<https://www.ohchr.org/sites/default/files/2021-12/norway.pdf>. See also: Norway (2021a). Tenth periodic report submitted by Norway under article 18 of the Convention, due in 2021 [Date received: 1 July 2021] Committee on the Elimination of Discrimination against Women. CEDAW/C/NOR/10, para. 65.

<sup>23</sup> Ragnhild Hennem, Department of Public and International Law, University of Oslo. Personal communication, 20-Feb-2023.

<sup>24</sup> Department of Justice of Ireland (2022, July 15). *Study on Familicide and Domestic Homicide Reviews*.

<http://www.fsdhr.ie/en/fsdhr/pages/wp19000001>.

<sup>25</sup> House of the Oireachtas (2022, Dec 7) *Departmental Reports Dáil Éireann Debate, Wednesday – 7 December 2022. Written answer from the Minister of Justice to Dep. Mary Lou McDonald*.

<https://www.oireachtas.ie/en/debates/question/2022-12-07/100/#pq-answers-100>.

to be presented in 2023)<sup>26</sup> developed by a team of experts that reviews the responses at the public services and community level and contributions of families of murdered women. These reviews, called also “social autopsies” are intended to identify failures and provide lessons to improve responses to GBVAW.

### 2.2.2 Other experiences

DHR/DVFRs analysed in this document are the result of the work of multi-agency committees, as set out in the definition provided above. In some cases, however, these reviews are produced by a single organisation, such as the respective coroner’s office in the case of Victoria and South Australia,<sup>27</sup> and the Ombudsman in the case of Western Australia.<sup>28</sup> In the case of Georgia, its “Femicide Watch” body is also based within a single institution, namely the Public Defensor office (Ombudsperson). It receives and analyses information from the courts,<sup>29</sup> but also requests information from other public agencies and issues recommendations according to its role as Ombudsperson.

The European Institute for Gender Equality (EIGE) has produced a series of factsheets on *Measuring Femicide* in European countries.<sup>30</sup> These factsheets include information about the existence of “Domestic homicide reviews”, and some of them state that other European countries such as Slovenia, Spain, France, Croatia, and Italy do produce these reviews. While some of these countries have conducted some type of review of domestic homicides, the information available indicates that such initiatives do not meet the definition of DHR/DVFRs that is followed in this background paper.

Some countries produce some forms of DHR/DVFRs, but not as a multi-agency review. For example, in Spain, the General Council of the Judiciary, through the Observatory against Domestic and Gender-based Violence, publishes annual reports that include a thorough analysis of femicides and their collateral victims, based on the judgments on gender-related murder and homicide cases emitted during the previous year.<sup>31</sup> Similarly, in Italy, the Ministry of Justice conducted a review of judgements for homicides of women, limited to the year 2018.<sup>32</sup>

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<sup>26</sup> Arroyave, Marcela. Gender Violence Dept. National Institute of Women, Costa Rica (Instituto Nacional de las Mujeres INAMU). Personal communication. 11 January 2023.

<sup>27</sup> Queensland Courts (n.d.). *Review of deaths from domestic and family violence*. Retrieved 15 Feb 2015 from: <https://www.courts.qld.gov.au/courts/coroners-court/review-of-deaths-from-domestic-and-family-violence>.

<sup>28</sup> Ombudsman Western Australia. (n.d.). *Review of Certain Deaths*. Retrieved 15 Feb 2015 from: [https://www.ombudsman.wa.gov.au/Reviews/review\\_of\\_certain\\_deaths.htm](https://www.ombudsman.wa.gov.au/Reviews/review_of_certain_deaths.htm).

<sup>29</sup> Public Defender of Georgia (2020). Report on Femicide Monitoring 2018-2020. <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/Femicide/2020/NHRIs/public-defender-georgia-report.pdf>.

<sup>30</sup> See EIGE (n.d.) *Providing justice to victims of femicide: country factsheets*. Retrieved 15 Feb 2023 from <https://eige.europa.eu/areas/providing-justice-victims-femicide-country-factsheets>.

<sup>31</sup> EIGE (2021a, Nov 22). *Measuring Femicide in Spain*. <https://eige.europa.eu/publications/measuring-femicide-spain>.

<sup>32</sup> Bartolomeo, F. (2018), *Inchiesta con analisi statistica sul femminicidio in Italia*, Italian National Institute of Statistics, Rome <https://www.istat.it/it/files//2018/04/Analisi-delle-sentenze-di-Femminicidio-Ministero-di-Giustizia.pdf>.

In France, the Directorate General for Justice examined the criminal files of 88 closed cases of domestic violence homicides committed and attempted between 2015 and 2016 (except homicides followed by the suicide of the perpetrator) and the report was published in October 2019.<sup>33</sup> Following one of the report's recommendations, a feedback method (RETEX) has been established in intimate partner homicide cases, based on questionnaires for all professionals who have dealt with the situation of the couple concerned (the public prosecutor's office, investigating services, social and medical services, associations, etc.) as a posteriori analysis of the case to highlight ways to improve procedures.<sup>34</sup> While this procedure involves different agencies (through the questionnaires), there is no multi-agency review of the cases, as replies to the questionnaires are sent to the Directorate of Criminal Affairs and Pardons, within the Ministry of Justice.<sup>35</sup>

In Luxembourg, considering the spike in domestic violence that resulted in death in 2018, the Cooperation Committee of Professionals in the Field of Combating Violence started to plan to carry out domestic homicide and serious attempted homicide reviews in Luxembourg.<sup>36</sup> According to recent reports, however, this recommendation has not been implemented.<sup>37</sup>

### 2.3. Objectives of DHR/DVFRs

There are three main purposes of DHR/DVFRs:

1. *To identify the lessons to be learned from the death of a person as a result of domestic violence.* These include lessons both within and between agencies, to identify any factors that may have contributed to the death, such as the presence or absence of systemic issues, problems, gaps or shortcomings in services, including local professionals and organisations working to safeguard victims. This also includes identifying trends, risk factors, and patterns from the cases reviewed.
2. *To make recommendations to improve service responses and the way that agencies from different sectors can work together.* Such recommendations are based on individual cases, as well as on the aggregate data collected from the DHR/DVFRs. Recommendations may include community services or organisations and informal

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<sup>33</sup> Inspection générale de la Justice (2019) *Mission sur les homicides conjugaux. Octobre-2019.* [https://medias.vie-publique.fr/data\\_storage\\_s3/rapport/pdf/271806.pdf](https://medias.vie-publique.fr/data_storage_s3/rapport/pdf/271806.pdf).

<sup>34</sup> France (2021a). Ninth periodic report submitted by France under article 18 of the Convention, due in 2020 [Date received: 6 April 2021] Committee on the Elimination of Discrimination against Women. CEDAW/C/FRA/9; Ministère de la Justice (2020). *Homicides conjugaux. Repérer les signaux d'alerte pour améliorer les procédures.* 1 Oct. 2020. <https://www.justice.gouv.fr/le-ministere-de-la-justice-10017/homicides-conjugaux-33527.html>

<sup>35</sup> Ministère de la Justice (2022). *Circulaire de politique pénale Générale.* Direction des affaires criminelles et des grâces. 20 septembre 2022. <http://www.justice.gouv.fr/bo/2022/20220930/JUSD2226952C.pdf>.

<sup>36</sup> Comité de coopération entre les professionnels dans le domaine de la lutte contre la violence (2019), Rapport au gouvernement pour l'année 2018. <https://mega.public.lu/dam-assets/fr/publications/publications-ministere/2018/rapport-comite-violence/Rapport-au-gouvernement-2018.pdf>.

<sup>37</sup> See Comité de coopération entre les professionnels dans le domaine de la lutte contre la violence (2021). Rapport au gouvernement pour l'année 2020; (2022) Rapport au gouvernement pour l'année 2021. Available at: <https://mega.public.lu/fr/publications.html>.

networks.<sup>38</sup> In some cases, recommendations require identifying clearly how and within what timescales they will be acted on, as well as what is expected to change as a result.<sup>39</sup>

3. *To prevent domestic violence and homicide.* This is a long-term objective and requires concerted efforts beyond the establishment of DHR/DVFRs.

Additional objectives may include:

- Referring cases to appropriate agencies for action
- Assisting in the development of protocols with a view to prevention
- Highlighting good practice
- Stimulating educational activities and disseminate educational information
- Contributing to a better understanding of the nature of domestic violence and abuse
- Helping to raise awareness in the wider community of how to help victims of DV
- Creating a comprehensive database about victims and perpetrators of DVH and their circumstances
- Conducting and promoting research
- Providing expert opinion to the relevant authority regarding the circumstances of the case
- Reporting annually to the relevant authority the trends, risk factors, and patterns identified and appropriate recommendations for preventing deaths in similar circumstances.

The findings and recommendations of the review are then used to inform policy and practice at a local and national level. It should be underlined that the rationale of DHR/DVFRs is not to apportion blame, but to identify the lessons to be learned and to improve the response to domestic violence and GBVAW.<sup>40</sup>

#### 2.4. Types of review committees

While DHR/DVFRs are carried out by multi-disciplinary committees of experts, they differ in many aspects. Beyond their denomination (whether they are called Committees, Review panels, Analysis Teams, etc.), some of their most relevant differences are related to their permanent or ad-hoc character. In New Zealand, Portugal and different provinces of Canada, for example, the review committees are integrated by permanent members who remain in their function for several years.<sup>41</sup> In other countries, such as in the United Kingdom, review

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<sup>38</sup> Jones, C., Bracewell, K., Clegg, A., Stanley, N., & Chantler, K. (2022). Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review. *Homicide Studies*.  
<https://doi.org/10.1177/10887679221081788>.

<sup>39</sup> Home Office (2016a) *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* December 2016.  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/575273/DHR-Statutory-Guidance-161206.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf).

<sup>40</sup> Notwithstanding disciplinary responsibility. See **Error! Reference source not found.** (Section 2.6.3).

<sup>41</sup> In Alberta, Canada, and in New Zealand, for example, they are appointed for a period of three years (See: Government of Alberta (n.d.) *cit.*; Health Quality and Safety Commission New Zealand (2022) *Family Violence Death Review Committee Terms of Reference* May 2021 (updated July 2022)  
<https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/FVDRC/Publications->

committees are ad-hoc, i.e. established for a concrete death review. This distinction also tends to be related to their national or local character: National committees are usually permanent (such as in New Zealand and Portugal), while local committees are often created ad-hoc for specific crimes (such as in the United Kingdom).

In most countries where DHR/DVFRs exist, review committees are composed of representatives of public or government agencies, often being state-level representatives in the case of permanent / state-wide committees and local-level representatives in the case of ad-hoc / local committees. In other countries, such as in New Zealand, or Queensland, Australia, review committees are composed of experts in diverse fields, with no relation to specific public agencies. In such cases, however, it might be difficult for the public institutions to receive and accept the recommendations arising from the reviews, when they have not been participating in them in the first place.

The review committees report to different authorities. In many jurisdictions, they report to government institutions in charge of crime prevention and criminal justice, such as the Chief Coroner (as in Ontario, Canada, and most of Australia) or the Home Office (in the United Kingdom). In other jurisdictions, review committees report to government institutions in charge of health and social services, such as the Minister of Seniors, Community and Social Services (in Alberta, Canada)<sup>42</sup>, the Health Quality and Safety Commission (in New Zealand) or the National Board of Health and Welfare (in Sweden). In the case of Portugal, the team reports annually to a broad range of Government Ministers responsible for the areas of internal administration, justice, citizenship and gender equality, social security, and health.<sup>43</sup> The DVDRT in New South Wales, Australia, reports biennially to Parliament.<sup>44</sup>

The pilot or sporadic reviews mentioned above report to the authorities that have established them, i.e. ministries of justice, equality, or the judiciary.

#### 2.4.1 Public agencies involved

In most countries, DHR/DVFRs are conducted by committees composed of representatives from public agencies, and in some cases include also non-governmental organisations, as will be seen below in section 2.4.3. Whether at the local or state-level, committees typically include representatives from public agencies, such as law enforcement / police, prosecutor's offices, medical examiners, health (including mental health) services, social services and domestic violence service providers.

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resources/FVDRC-Terms-of-Reference-FINAL-May-2021-updated-July-2022.pdf ). In Ontario, Canada, several members of the last reporting committee (2018) had been involved since the DVDRC's inception in 2003 (Ministry of the Solicitor General (n.d.)(a). *Domestic Violence Death Review Committee 2018 Annual Report. Chapter 1: Introduction and overview*. Retrieved 15 Feb 2023 from: <https://www.ontario.ca/document/domestic-violence-death-review-committee-2018-annual-report/chapter-1-introduction-and-overview>).

<sup>42</sup> Government of Alberta (n.d.) *Family Violence Death Review Committee. cit.*

<sup>43</sup> Art. 15 Ordinance 280/2016. <http://data.dre.pt/eli/port/280/2016/10/26/p/dre/pt/html>.

<sup>44</sup> Coroners Court New South Wales (n.d.). *Domestic violence death review*.

<https://www.coroners.nsw.gov.au/coroners-court/resources/domestic-violence-death-review.html#DVDRT1>



In Portugal, for example, the *Retrospective Analysis of Domestic Violence Homicide Team* (EARHVD), is a national level review committee, and it is composed of representatives of national-level agencies: the Prosecution Service (whose representative is also the Coordinator of the team), the Ministry of Justice, the Ministry of Health, the Ministry of Labour, Solidarity and Social Security, the General Secretariat of the Ministry of Internal Administration and the Public Administration body responsible for the area of citizenship and gender equality. A representative of the territorially competent security force in the area where the crime has occurred also joins the team.<sup>45</sup> Since 2022, a representative of the National Commission for the Promotion of Rights and Protection of Children and Young People joins the team whenever cases involve child victims, children of the victim or perpetrator or children who lived with any of them.<sup>46</sup>

In the United Kingdom, the review committees are established at the local level and must include representatives from the statutory agencies listed under section 9 of the 2004 Act. In the case of England and Wales, they include chief officers of police, local authorities, local probation boards, National Health Service (NHS) England, integrated care boards, providers of probation services, local health boards, and NHS trusts.<sup>47</sup> Other agencies not named in legislation, for example, the Crown Prosecution Service (CPS), representatives from housing associations and social landlords, HM Prison Service, HM Courts and Tribunals Service, medical doctors, dentists and teachers may also have a role in the review and be called upon to provide an Individual Management Review as required.<sup>48</sup> Quality assurance of all overview reports for DHRs corresponds to the Home Office Quality Assurance Panel, that includes representation from all relevant statutory agencies<sup>49</sup> as well as the voluntary sector.

In Sweden, although the review is conducted by a group of internal experts within the National Board of Health and Welfare, each review includes the contribution of experts from different authorities. In the last review, this included the employment agency, the Addiction Centre of Stockholm, the Crime Prevention Council, the Insurance Fund, the Health and Social Care Inspectorate (IVO), Correctional Service, the Östergötland County Administrative Board, the Migration Agency, the national Centre for Women's Freedom (NCK), the Police Authority, the Forensic Medicine Agency, the State Board of Institutions, the School Inspectorate and the Swedish Prosecution Authority.<sup>50</sup>

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<sup>45</sup> Art. 7 Ordinance 280/2016. <http://data.dre.pt/eli/port/280/2016/10/26/p/dre/pt/html>.

<sup>46</sup> Matos, M. and Gonçalves, M. (2022) Avaliação para a Equipa de Análise Retrospectiva de Homicídios em Violência Doméstica. Relatório Final. Centro de Investigação em Psicologia, Escola de Psicologia, Universidade do Minho.

<sup>47</sup> In the case of Northern Ireland, they are composed by the Chief Constable of the Police Service of Northern Ireland, the Probation Board for Northern Ireland, and Health and Social Care trusts. (Subsection 4 (b) of Section 9 of the 2004 Act).

<sup>48</sup> Home Office (2016a) *cit.* para 32.

<sup>49</sup> Home Office, National Offender Management Service, Department of Health, ACPO, Crown Prosecution Service, Department for Education, Refuge, Advocacy After Fatal Domestic Abuse, Southall Black Sisters, IMKAAN, Welsh Government, Department for Communities and Local Government, Independent Police Complaints Commission.

<sup>50</sup> Socialstyrelsens (2022) Socialstyrelsens utredningar av vissa skador och dödsfall 2018-2021 / The National Board of Health and Welfare's investigations into certain injuries and deaths 2018–2021 Appendix. Experts who participated in the work: <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2022-1-7738.pdf>.

Queensland, Australia, has a two-tiered domestic and family violence death review process consisting of (1) the Domestic and Family Violence Death Review Unit that assists Coroners in understanding the context and circumstances of these types of deaths, and (2) the independent multidisciplinary Domestic and Family Violence Death Review and Advisory Board. The Board is responsible for the systemic review of domestic and family violence deaths, i.e. the function of the Board is to identify systemic issues, not to investigate the circumstances of an individual death. Consequently, in practice, when the Board reviews deaths it will rely on the information that is gathered by a coroner's investigation, predominantly through case review reports and chronologies completed previously by the Unit.<sup>51</sup>

#### 2.4.2 Requirements for members of review committees

**Expertise.** The most frequent characteristic of members of the review committees is that they should be an expert or experienced in issues related to responses to domestic violence. For example, in Portugal, permanent members of the EARHVD should, preferably, be experienced professionals trained in domestic violence and risk assessment.<sup>52</sup> In New Zealand, the areas of expertise of the members include mortality review systems; legal (criminal and family), medical, indigenous, social science and/or health research and practice; intimate partner violence; child abuse and protection issues; service provision or operational policy in the social sector, including family violence services; family violence in Māori whānau in other ethnic groups, or affecting people with disabilities. Members should be able to work strategically and have credibility in relevant communities.<sup>53</sup>

In Alberta, Canada, the committee is a multi-disciplinary group of family violence experts. Members represent various sectors involved in providing programs, services and research in the field of family and domestic violence, including legal services, law enforcement, sexual assault services, victim advocacy and community organisations. The committee also engages ex-officio members for expertise on a specific subject matter when undertaking in-depth case reviews, who are subject to all governing legislation and the code of conduct as standing members.<sup>54</sup>

In Queensland, Australia, members should have appropriate experience, knowledge, or skills relevant to the Board's functions.<sup>55</sup> In some cases, the required expertise of members has been evolving over time. For example, in New South Wales, normative amendments have

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<sup>51</sup> Queensland Government, Department of Justice and Attorney-General (2016) *Domestic and Family Violence Death Review and Advisory Board Procedural Guidelines* 2016-19.

[https://www.courts.qld.gov.au/\\_\\_data/assets/pdf\\_file/0007/489175/ccq-dfv-board-procedural-guidelines.pdf](https://www.courts.qld.gov.au/__data/assets/pdf_file/0007/489175/ccq-dfv-board-procedural-guidelines.pdf).

<sup>52</sup> Art. 8.2 Ordinance 280/2016. <http://data.dre.pt/eli/port/280/2016/10/26/p/dre/pt/html>.

<sup>53</sup> Health Quality and Safety Commission New Zealand (2022). *cit.*

<sup>54</sup> Family Violence Death Review Committee of Alberta (2022) Annual Report 2020/2021. Community and Social Services, Government of Alberta <https://open.alberta.ca/dataset/9f534972-af61-44fe-8449-9d894e335bec/resource/faf77b80-45d5-416d-97f5-1365f27057e3/download/css-family-violence-death-review-committee-annual-report-2020-2021.pdf>.

<sup>55</sup> For example, in Queensland, Australia, a recruitment process was undertaken to seek nominations for non-government representatives for the Board (Queensland Government, Department of Justice and Attorney-General (2016), *cit.*).

allowed additional expertise in its membership, including representation from Corrective Services, Legal Aid NSW, the Commissioner of Victims' Rights, an alcohol and drug specialist, a mental health specialist, and a Deputy Chief Magistrate.<sup>56</sup>

In some cases, the expertise of the Chair of the committee is underlined. In the United Kingdom, skills and expertise of chairs should involve enhanced knowledge of DV issues including so-called 'honour'-based violence and understanding the role and context of the main agencies involved in the review. They should also have completed the Home Office online training on DHRs, including modules on chairing reviews and producing overview reports.<sup>57</sup> Regional agreements among Community Safety Partnerships (CSPs) are encouraged to facilitate exchange of experienced individuals as independent chairs, to share good practices and promote dissemination of information and learning.<sup>58</sup> Moreover, according to professionals involved in the DHR process in England and Wales, the role and skills of the Chair are perceived as key to ensure a safe, evidence-based, transparent, and learning-focused DHR process, to achieve the goal of accepting organisational responsibility without blaming.<sup>59</sup>

In Australia, where DHR/DVFR committees do not include specialist members (as those produced by the coroners' offices), multidisciplinary advisory teams provide support to the committee. Those teams typically comprise representatives of relevant government departments, including police, health, justice and family services and representatives from non-governmental services and organisations.

**Representation.** In the United Kingdom and in Portugal, members of the committees are representatives of diverse institutions or public agencies. In the United Kingdom, all members should be named in the report, their respective roles set out and the agencies which they represent.<sup>60</sup> In Portugal, they should have adequate knowledge to contextualize the role of the institution they represent.<sup>61</sup> The Australian committees tend to be composed of representatives of both government and non-governmental organisations.<sup>62</sup>

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<sup>56</sup> New South Wales (NSW) Domestic Violence Death Review Team (2022) Report 2019 – 2021. [https://www.coroners.nsw.gov.au/content/dam/dcj/ctsd/coronerscourt/documents/reports/2019-2021\\_DVDRT\\_Report.pdf](https://www.coroners.nsw.gov.au/content/dam/dcj/ctsd/coronerscourt/documents/reports/2019-2021_DVDRT_Report.pdf).

<sup>57</sup> Home Office (2016a) *cit.* para 39.

<sup>58</sup> *Ibid.* paras. 37 – 38.

<sup>59</sup> Haines-Delmont, Bracewell, K., & Chantler, K. (2022). Negotiating organisational blame to foster learning: Professionals' perspectives about Domestic Homicide Reviews. *Health & Social Care in the Community*, 30(5), e2818–e2826. <https://doi.org/10.1111/hsc.13725>.

<sup>60</sup> Home Office (2016a) *cit.* para. 30.

<sup>61</sup> Art. 8.2 Ordinance 280/2016. <http://data.dre.pt/eli/port/280/2016/10/26/p/dre/pt/html>.

<sup>62</sup> For example, the New South Wales Domestic Violence Death Review team consists of a full-time secretariat of two (a Manager and Research Analyst) and of a multidisciplinary group of 12 government and two non-government representatives, and two sector experts. (Australian Human Rights Commission (2016). *A National System for Domestic and Family Violence Death Review— December 2016*. [https://humanrights.gov.au/sites/default/files/document/publication/AHRC\\_2016\\_12\\_19\\_Expanding\\_DV\\_Death\\_Review.pdf](https://humanrights.gov.au/sites/default/files/document/publication/AHRC_2016_12_19_Expanding_DV_Death_Review.pdf)). The Domestic and Family Violence Death Review and Advisory Board of Queensland (Australia) consists of up to 12 experts, who are representatives of government and non-government organisations, and is chaired by the State Coroner (Queensland Courts (n.d.). *cit.*).

In New Zealand, as mentioned before, the Family Violence Death Review Committee (FVDR) is composed by experts from diverse areas but acting in their individual capacity and not as representatives of government or non-governmental organisations.<sup>63</sup>

**Seniority and independence.** In the United Kingdom, it is underlined that despite being members of governmental agencies, members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a meeting.<sup>64</sup> Similar provisions are not found in rules and regulations for review committees from other countries.

**Diversity.** Review committees in the United Kingdom are specifically directed to bear in mind equality and diversity issues at all times and to comply with the requirements of the Public Sector Equality Act duties.<sup>65</sup> In New Zealand, there is a maximum of eight members, including one member who should provide a whānau, consumer, community perspective, having relevant, lived experience, and will be well networked to whānau, consumer, community groups.<sup>66</sup> In Queensland, Australia, the Minister must ensure that the membership reflects the diversity of the Queensland community and includes at least one member who is an Aboriginal or Torres Strait Islander.<sup>67</sup> Similarly, at least two US jurisdictions have legislation that require representation from American Indian/Native American tribal organisations.<sup>68</sup>

**Specific requirements for the Chair.** In the United Kingdom, the importance of an independent chair is stressed. The chair should, where possible, be an experienced individual who is not 'directly associated' with any of the agencies involved in the review, neither a member of the Community Safety Partnership or the advocate for the family.<sup>69</sup> In other countries, as in Australia and Canada, DHR/DVFR committees are frequently chaired by the respective State Coroner or Deputy Chief Coroner.<sup>70</sup>

### 2.4.3 Participation of non-governmental organisations

Most of the DHR/DVFRs involve some degree of participation of non-governmental organisations, including academia, either as members of the review committee or as specialists or professionals who were directly involved in the case reviewed.

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<sup>63</sup> Health Quality and Safety Commission New Zealand (2022) *cit.*

<sup>64</sup> Home Office (2016a) *cit.* para. 34.

<sup>65</sup> *Ibid.* para. 35.

<sup>66</sup> Currently the Committee includes two members with legal experience, two with social work experience, two kaupapa Māori researchers, a health representative and a lived experience representative. Over half of the current Committee is Māori. In addition, while one member is specifically appointed as a lived experience representative, other members also bring a lived experience of family violence to Committee discussion. (Health Quality and Safety Commission New Zealand (2022) *cit.*).

<sup>67</sup> Queensland Government, Department of Justice and Attorney-General (2016) *cit.*

<sup>68</sup> Websdale et al. (2017), *cit.*

<sup>69</sup> Home Office (2016a) *cit.* para. 56. a).

<sup>70</sup> For example, in New Brunswick, Canada (New Brunswick, Canada. Justice and Public Service (n.d.). *Domestic Violence Death Review Committee* <https://www2.gnb.ca/content/gnb/en/departments/public-safety/law-enforcement-and-inspections/content/coroner-services/domestic-violence-death-review-committee.html>).

In Portugal, the EARHVD considers the occasional participation in the team of representatives of non-governmental organisations, only when they were involved with the specific case being examined, which means that they are not members of the EARHVD.<sup>71</sup> By contrast, non-governmental organisations are members of review committees in countries such as New Zealand and in most of Australian DHR/DVFRs. In Victoria, Australia, the VSRFVD also has a reference group comprised of non-government and government stakeholders, to provide advice and consultative support to the VSRFVD with a view to identifying system-wide issues in relation to domestic violence.<sup>72</sup> In Brunswick, Canada, the committee includes, together with public agency representatives, academics, researchers and interested citizens.<sup>73</sup>

In the case of the United Kingdom, the 2016 Home Office Statutory Guidance on DHRs states that voluntary and community sector organisations may have valuable information on the victim and/or perpetrator and, as circumstances determine, may be able to represent the perspective of the victim and/or perpetrator. It directs that specialist or local domestic violence and abuse service representation must be included.<sup>74</sup> Moreover, in some cases, experts should be consulted to help understand crucial aspects of the homicide, for example, a representative from a specialist Black and Minority Ethnic, LGBT or disability organisation.<sup>75</sup>

#### 2.4.4 Families and communities

Involvement of families and friends of victims is one of the distinctive characteristics of many DHR/DVFRs. This allows to go beyond data sharing from different service providers and enables review committees to identify factors that might be invisible for the public agencies intervening in a case. For example, the existence of prior domestic violence not reported to the police or health services usually cannot be determined from official records unless a family member and/or close friend of the victim is interviewed.<sup>76</sup>

The 2016 United Kingdom Home Office Guidance, stresses that family involvement may help to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why any interventions did not work for them.<sup>77</sup> This goes beyond the victim's family and extends to friends, neighbours, community members and professionals. It is considered that the involvement of families, friends and other support networks lead to a

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<sup>71</sup> Equipa de Análise Retrospectiva de Homicídio em Violência Doméstica (EARHVD) (2022). *Manual de Procedimentos*.

<https://earhvd.sg.mai.gov.pt/LegislacaoDocumentacao/Documents/Manual%20Equipa%202022.pdf>.

<sup>72</sup> Butler, A., Buxton-Namisnyk E., Beattie S., Bugeja L., Ehrat H., Henderson E., Lamb A. (2017). Australia. In: Dawson, M. (eds) *Domestic Homicides and Death Reviews*. Palgrave Macmillan, London.

<sup>73</sup> New Brunswick, Canada. Justice and Public Service (n.d.). *cit.*

<sup>74</sup> Home Office (2016a) *cit.* para. 29.

<sup>75</sup> *Ibid.* Para. 40 d).

<sup>76</sup> Dawson, M., Mathews, S., Abrahams, N., Campbell, J. (2017). *Death Reviews in the Context of Domestic Homicide in Low- to Middle-Income Countries: South Africa as a Case Study*. In: Dawson, M. (eds) *Domestic Homicides and Death Reviews*. Palgrave Macmillan, London.

<sup>77</sup> Home Office (2016a) *cit.* para. 9.

number of benefits, ranging from obtaining information not recorded in official records to contributing to their own healing and recovery process.<sup>78</sup>

According to professionals involved in the DHR process in England and Wales, promoting the role of families/survivor networks and professionals on an equal footing also supports a more democratic process.<sup>79</sup>

In the United Kingdom, the involvement of families, friends and others is always voluntary. Still, the chair/review panel should try to include the family and ensure adequate approach and interaction with them.<sup>80</sup> Specialist advocates and support for families and specially children should be considered. However, some research has found that DHRs provide limited information on children's needs, or their future care and children are only rarely involved in the review process itself, despite often being witnesses of the violence.<sup>81</sup>

The United Kingdom charity Advocacy After Fatal Domestic Abuse (AAFDA) has identified a 7-step model for working with families in DHRs,<sup>82</sup> to ensure they are integral to the process:

1. Have the help of a specialist & expert advocate,
2. Assist with the scope of the DHR,
3. To contribute using the medium they prefer,
4. Meet the DHR panel,
5. Be updated regularly,
6. Review the draft report in private (in their own home) and have plenty of time, and
7. Help create change after the review.

The potential involvement of families and social networks of perpetrators is also considered in the USA and the United Kingdom. This can provide a broader understanding of the circumstances surrounding the crime,<sup>83</sup> or other elements, including abuse of previous partners. The 2016 United Kingdom Home Office Guidance foresees the possibility of approaching the family of the perpetrator, as well as other networks which victims and perpetrators may have disclosed relevant information to (e.g. friends, employers and colleagues, health professionals, local professionals in domestic violence prevention work). However, it also notes that even among a victim's family there may be potential witnesses or even defendants, especially in cases of suspected so-called 'honour'-based violence, which means that timescales for interviews should be discussed with and take guidance from the Senior Investigative Officer.<sup>84</sup>

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<sup>78</sup> *Ibid.* Para. 53. See also: Rowlands, & Cook, E. A. (2022). Navigating Family Involvement in Domestic Violence Fatality Review: Conceptualising Prospects for Systems and Relational Repair. *Journal of Family Violence*, 37(4), 559–572. <https://doi.org/10.1007/s10896-021-00309-x>.

<sup>79</sup> Haines-Delmont, et al. (2022). *cit.*

<sup>80</sup> Home Office (2016a) *cit.* para. 51.

<sup>81</sup> Stanley, N., Chantler, K., & Robbins, R. (2019). Children and Domestic Homicide. *The British Journal of Social Work*, 49(1), 59–76. <https://doi.org/10.1093/bjsw/bcy024>.

<sup>82</sup> <https://aafda.org.uk/public/help-for-families>.

<sup>83</sup> Neil Websdale, personal communication, 23 March 2023.

<sup>84</sup> Home Office (2016a) *cit.* para. 55.

In Portugal, the Terms of Reference of the EARHVD also provide details on how the participation of victim/perpetrator families should take place.<sup>85</sup>

## 2.5. Extent of cases reviewed

DHR/DVFRs vary greatly among jurisdictions in relation to the extent of cases reviewed. In most cases, the committees review not all but some cases of those falling within the definition of domestic violence homicides. In other cases, such as in the United Kingdom and New South Wales, Australia, DHR/DVFRs are intended to cover all cases of domestic violence homicide occurring in the country.

The extent of cases is also limited by the specific definition on domestic violence homicide used in each context.<sup>86</sup> In Ontario, Alberta and New Brunswick, Canada, for example, the scope is limited to intimate partner homicide.<sup>87</sup> In the United Kingdom, on the contrary, according to Section 9 (1) of the Domestic Violence, Crime and Victims Act 2004, a domestic homicide review (DHR) has to be carried out in all cases in which “the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves”. The 2016 United Kingdom Statutory Guidance on DHRs explicitly underlines that the cross-governmental definition of domestic violence and abuse<sup>88</sup> includes so-called ‘honour-based’ violence, even when victims may not perceive what has happened as such.<sup>89</sup>

Some review committees in the USA have also reviewed homelessness, drug addiction, HIV, and sex worker deaths, possibly linked to female decedents’ histories of IPV. Others have examined the deaths of bystanders, witnesses and ‘sexual competitor’ killings, often involving a male batterer who kills his estranged female partner’s new boyfriend.<sup>90</sup>

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<sup>85</sup> EARHVD (2022), *cit.*

<sup>86</sup> In Australia, for example, DHRs in diverse jurisdictions operate within their own legislative frameworks: Coroners Act 2009 (NSW); Domestic and Family Violence Protection Act 2012 (Qld); Family Violence Protection Act 2008 (Vic); Intervention Orders (Prevention of Abuse) Act 2009 (SA); Restraining Orders Act 1997 (WA) and Parliamentary Commissioner Act 1971 (WA); and Domestic and Family Violence Act 2007 (NT).

<sup>87</sup> The Ontario DVDRRC defines domestic violence deaths as “all homicides that involve the death of a person, and/or his or her child(ren), committed by the person’s partner or ex-partner from an intimate relationship” (Ministry of the Solicitor General (n.d.)(a). *cit.*). In Alberta, Government of Alberta (n.d.) *Family Violence Death Review Committee. cit.*; New Brunswick, Canada. Justice and Public Service. (n.d.). *cit.*

<sup>88</sup> In 2013 the Government introduced a definition of domestic violence and abuse as: “any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; emotional.

*Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

*Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”* (Home Office (2016a) *cit.*).

<sup>89</sup> Home Office (2016a) *cit.* para. 17.

<sup>90</sup> Websdale, et al. (2017). *cit.*

### 2.5.1 Committees that review a selection of cases

In the USA, DHR/DVFRs committees differ greatly in terms of the number and type of cases they review. Committees usually choose which domestic violence-related deaths to review, based on factors, such as the case's impact on the community, legal challenges, available resources, and the possibility of identifying new prevention strategies.<sup>91</sup>

In Alberta, Canada, the Family Violence Death Review Committee reviews all incidents of family violence deaths related to intimate partner violence, but it selects some cases for further in-depth review to represent different ages, cultures and ethnicities, relationship statuses and geographical locations in the province. The Committee has the autonomy to select which cases they will review in-depth; there is no referral process for case reviews and the Committee cannot be compelled to review a specific case.<sup>92</sup> So far, 11 cases have been reviewed in depth, while between 2011 and 2020 there were 165 deaths in Alberta due to family violence, according to the Committee's criteria.<sup>93</sup> In New Brunswick, the Committee reviewed and submitted reports on 21 cases for the period 2010 – 2020.<sup>94</sup>

In Portugal, the EARHVD is responsible for the retrospective analysis of selected cases of domestic violence homicides. This committee analyses between six and ten cases annually, considering factors such as social impact, previous involvement of agencies, and specially, if the victim is under 18 years old or otherwise considered particularly vulnerable, or if there was a previous report related to the violence.<sup>95</sup>

### 2.5.2 Committees with a wider scope review

Other DHR/DVFRs cover all domestic violence homicides. This is the case in the United Kingdom and New South Wales, although the cases included vary according to the normative definitions involved.

In Sweden, in addition to the crime, there must have been a need for protection, in order for the National Board of Health and Welfare to carry out an investigation. In cases involving children, the crime must have been connected to some relationship entailing a need for protection of the child, for example when the crime has been committed in the child's home or the child or the perpetrator has been in contact with agencies regarding need of support as health problems, problems in school, substance abuse, financial problems or unemployment.<sup>96</sup> In cases of adults, it is required that the adult had been in need of protection or support and help to change their situation. For example, it could be that the

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<sup>91</sup> *Ibid.*

<sup>92</sup> Government of Alberta (n.d.) *cit.*

<sup>93</sup> Family Violence Death Review Committee of Alberta (2022), *cit.*

<sup>94</sup> Office of the Chief Coroner (2021, June) *Recommendations from the Domestic Violence Death Review Committee 2020* <https://www2.gnb.ca/content/dam/gnb/Departments/ps-sp/pdf/Publications/domestic-violence-2020.pdf>.

<sup>95</sup> EARHVD (2022), *cit.*

<sup>96</sup> Moa Mannheimer, personal communication, 4-Apr-2023.



adult, either a crime victim or perpetrator, has sought support and help for mental illness or previous exposure to violence.<sup>97</sup>

### 2.5.3 Committees that review cases beyond homicides

In USA and the United Kingdom, cases to be reviewed are not limited to homicide, as cases of suicide as a consequence of domestic violence are included. In the case of the United Kingdom, it is stressed that a review should be undertaken, even if a suspect is not charged with an offence related to domestic violence, or they are tried and acquitted.<sup>98</sup> Suicides, on the contrary, are expressly excluded in New Zealand<sup>99</sup> and Portugal.<sup>100</sup>

In some cases, these reviews go beyond cases of homicide and cover also attempted homicide or near deaths cases, as in the case of Portugal,<sup>101</sup> Sweden,<sup>102</sup> and at least a dozen states in the USA.<sup>103</sup> In Ontario, Canada, at the discretion of the Chair, the DVDRC may review other deaths if they occurred within the context of an incident where the intended victim was the perpetrator's partner or ex-partner, and the intended victim did not die.<sup>104</sup> It is considered that such reviews, with the participation of a near-decedent and, possibly, a cooperating perpetrator, can reveal rich data about how involved systems operate or fail to do so.<sup>105</sup>

### 2.5.4 Child death reviews

Child Death Reviews (CDR) have been introduced in different countries in the last decades.<sup>106</sup> In cases of child deaths connected with domestic violence, they may overlap with DHR/DVFRs. In the United Kingdom, in the case of children, a *Local child safeguarding practice review* (LCSPR) or -before 2019- a *Serious Case Review (SCR)*, takes place.<sup>107</sup> In cases involving victims

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<sup>97</sup> Socialstyrelsen (n.d). *Socialstyrelsens skade- och dödsfallsutredningar* (The National Board of Health and Welfare's injury and death investigations). Retrieved 15 Feb 2023 from:

<https://www.socialstyrelsen.se/kunskapsstod-och-regler/omraden/vald-och-brott/skade-och-dodsfallsutredningar/>.

<sup>98</sup> Home Office (2016a) *cit.* para. 18.

<sup>99</sup> Health Quality and Safety Commission New Zealand (2022) *cit.*

<sup>100</sup> EARHVD (2022), *cit.*

<sup>101</sup> *Ibid.*

<sup>102</sup> Socialstyrelsen (n.d). *cit.*

<sup>103</sup> Websdale, et al. (2017), *cit.*

<sup>104</sup> Ministry of the Solicitor General (n.d.)(a). *cit.*

<sup>105</sup> Neil Websdale, personal communication, 23 March 2023.

<sup>106</sup> Fraser, J., Sidebotham, P., Frederick, J., Covington, T., & Mitchell, E. A. 2014. Learning from child death reviews in the USA, England, Australia, and New Zealand. *The Lancet*, 384(9946): 894–903.

<sup>107</sup> LCSPRs (called Child Practice Reviews in Wales) apply to cases involving death or serious harm to a child. They are produced by three statutory partners: the local authority, local health services (via the clinical commissioning group/s for any areas, any part of which falls within the local authority area) and the police (the chief officer for a police area any part of which falls within the local authority area) (s.16E of the Children Act 2004, as amended by the Children and Social Work Act 2017). The three partners are equally responsible for safeguarding children in their area. The statutory partners are then joined by other 'relevant agencies', which may include (amongst others) schools, other providers of education and training, NHS trusts and foundation trusts, district councils, charities, prisons, youth offending teams and Cafcass (Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018). (Dickens et al. (2022) Learning for the future: final analysis of serious case reviews, 2017 to 2019. December 2022. Department of Education [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1123286](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1123286)

between 16 and 18 years old, a LCSPR and DHR will be required. In Western Australia, Child Death Reviews and Family and Domestic Violence Fatality Reviews are conducted by the Ombudsman.<sup>108</sup> In Sweden, Child death reviews are conducted since 2009, including all homicides of children, not only those related to domestic or family violence. From 2019, the reviews include attempted homicide and certain cases of severe abuse.<sup>109</sup>

In South Africa, the *South African Child Death Review Project*, piloted in 2014, has been adopted by the Department of Health in the Western Cape as a 'best practice model' and has been integrated into the routine practice of Forensic Pathology Services. The Child Death Reviews (CDR) also involve the South African Police Service, the Department of Social Development, the National Prosecuting Authority of South Africa, and various role players from the Department of Health (including district paediatricians, neonatologists, and epidemiologists). The CDR process drew on the provisions of the Children's Act of 2005 that provides a framework for the child protection system in South Africa.<sup>110</sup>

## 2.6. Timing and procedures of DHR/DVFRs

Not all DHR/DVFRs follow an established procedure, and often, such procedures are specific to a committee and evolving in time.<sup>111</sup> For instance, in the USA, review committees differ greatly in terms of the way they review the cases,<sup>112</sup> indicating great diversity, as there are approximately 200 domestic violence fatality review teams currently in operation in the country.<sup>113</sup>

Bearing in mind the wide variety of existing procedures, this section will focus on those committees that are formally established, for example, through normative guidance or internal regulations. Considering that a relevant aspect in all cases is the relationship between DHR/DVFRs and criminal procedures, it is useful to separately consider those DHR/DVFR that take place only after all legal procedures are completed, and those that may be initiated in parallel to criminal procedures.

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[/Learning\\_for\\_the\\_future\\_-\\_final\\_analysis\\_of\\_serious\\_case\\_reviews\\_\\_2017\\_to\\_2019.pdf](#)). The procedure is also different from DHRs, in terms that within 15 days of notification of a "serious child safeguarding case" the local Panel must hold a Rapid Review, and then decide if a further Local or National Review is needed (Local reviews are required where safeguarding partners consider that a case raise issues of importance in relation to their area, and National reviews, where the panel considers that a case raises issues which are complex or of national importance). Any Local or National Review must normally take place within six months (similar to DHRs). (Crown Prosecution Service (CPS) (2019, Nov 26) *Child and Vulnerable Adult Case Reviews* <https://www.cps.gov.uk/legal-guidance/child-and-vulnerable-adult-case-reviews>).

<sup>108</sup> Ombudsman Western Australia. (n.d.). *cit.*

<sup>109</sup> Moa Mannheimer, personal communication, 4-Apr-2023.

<sup>110</sup> Dawson, M., Mathews, S., Abrahams, N., Campbell, J. (2017). *cit.*

<sup>111</sup> Health Quality and Safety Commission New Zealand (2022) *cit.*

<sup>112</sup> Websdale, N., et al. (2017). *cit.*

<sup>113</sup> National Domestic Violence Fatality Review Initiative (NDVFRI) (n.d.) *A Wealth of Knowledge*. Retrieved on 15 Feb 2023 from: <https://ndvfri.org//resources/getting-started/>.

### 2.6.1 After all legal procedures are completed

In many cases, DHR/DVFRs are initiated only after all legal procedures are completed. This is the case, for example, in Portugal,<sup>114</sup> Sweden,<sup>115</sup> the Canadian provinces of Ontario<sup>116</sup> and Alberta,<sup>117</sup> and in the New South Wales, Australia.<sup>118</sup> In Sweden, Prosecutors and the Police Authority are obliged to notify the National Board of Health and Welfare if they suspect a crime covered by the law. The National Board of Health and Welfare may not initiate an investigation unless such notification has been received.<sup>119</sup>

Therefore, in these cases reviews may take place several years after the homicide, particularly if the case proceeded to trial, but many cases are up for trial and closed legally after 6-12 months.<sup>120</sup> Homicide cases in which the perpetrator subsequently committed suicide tend to be reviewed more quickly because criminal proceedings are not required.

In New Zealand, originally the committee was expected to review each family violence death within six months of the death event. However, as judicial processes can take over two years to complete and the information collected through it has value, in-depth reviews are now only conducted after this process has been completed.<sup>121</sup>

#### *Example: DHR/DVFR procedure in Portugal*

In Portugal, the analysis process unfolds in six phases.<sup>122</sup> In the first place, the Coordinator decides the case to be analysed and names a Case Manager, as well as non-permanent and occasional members that will join the team. The decision could be opposed by other Team members within five days.

In the next phase, the Case Manager prepares the analysis meeting, organizing the dossier, and elaborate the preliminary report. During this phase all the members of the Team collect information about the possible course of the case in their sector. In this phase, also, the surviving victim, the aggressor and "relatives, friends or third parties" of the victim or the aggressor are heard by the Team. The hearings of the victim, the aggressor and family members may result from the initiative of the EARHVD or from their own request.

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<sup>114</sup> EARHVD (2022), *cit.*

<sup>115</sup> Socialstyrelsen (n.d). *cit.*

<sup>116</sup> Ministry of the Solicitor General (n.d.)(b). *Domestic Violence Death Review Committee 2018 Annual Report. Chapter 3: DVDRC reviews – frequently asked questions.* Retrieved 15 Feb 2023 from: <https://www.ontario.ca/document/domestic-violence-death-review-committee-2018-annual-report/chapter-3-dvdrc-reviews-frequently-asked-questions#section-1>

<sup>117</sup> Family Violence Death Review Committee of Alberta (2022), *cit.*

<sup>118</sup> Australian Human Rights Commission (2016). *cit.*

<sup>119</sup> Socialstyrelsen (n.d). *cit.*

<sup>120</sup> Moa Mannheimer, personal communication, 4-Apr-2023.

<sup>121</sup> Health Quality & Safety Commission New Zealand (2022b). *Family Violence Death Review Committee. Seventh Report. A duty to care.* June 2022 <https://www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/FVDRC/Publications-resources/Seventh-report-transcripts/FVDRC-seventh-report-web.pdf>

<sup>122</sup> EARHVD (2022), *cit.*

The Case Manager may, at any time, request the Coordinator to include new non-permanent or occasional members for the analysis of the specific case.

After the preliminary report is presented by the Case Manager; the analysis meeting is convoked by the Coordinator. During this meeting, the preliminary report is reviewed, and its conclusions and recommendations are debated to reach consensus.

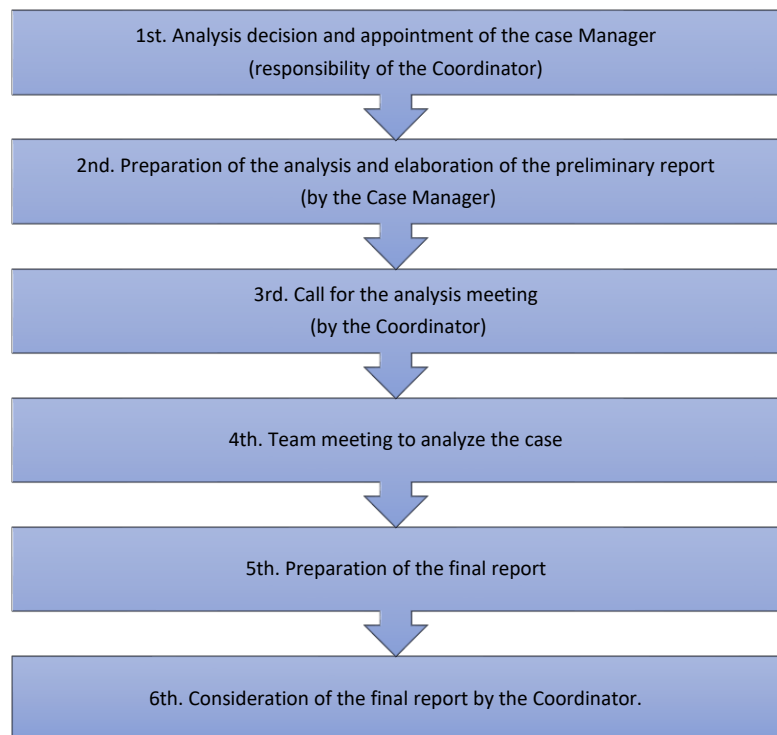
The final report is prepared by the Case Manager, reflecting the results of the analysis meeting. Its structure is made up of the following parts: a) Team Composition; b) Summary of the case in analysis; c) Summary of the information collection procedures carried out; d) Description of accurate facts; e) Analysis/discussion of the case; f) Conclusions resulting from the analysis of the case; g) Recommendations to entities responsible of prevention, protection, support, and repression of domestic violence.

The final report is signed by the members of the EARHVD who participated in the analysis of the case, after it was submitted to the approval of the Coordinator. The publicity of the reports of the EARHVD is ensured through their publication on the EARHVD website, respecting the privacy of the people involved in the cases analysed.

### 2.6.2 *Parallel to criminal investigations*

Within Australia, the Victoria, Queensland, South Australia and Western Australia committees review both open and closed cases.<sup>123</sup> In the United Kingdom, DHRs also take place independently of the stage or the existence of criminal investigations or an inquest.

It is the responsibility of the review committee chair, in the United Kingdom, to ensure contact is made with the chair of any parallel process.<sup>124</sup> The review should take account of a coroner's inquiry, and/or any criminal investigation related to the homicide, including disclosure issues, ensuring that relevant information can be shared without incurring significant delay in the review process. The chair of the review committee needs to consider if they are becoming aware of information that may be of interest to judicial processes.<sup>125</sup>



<sup>123</sup> Australian Human Rights Commission (2016). *cit.*

<sup>124</sup> Home Office (2016a) *cit.* para 40 c).

<sup>125</sup> *Ibid.* para. 47.

Where there is an on-going criminal investigation, it is the responsibility of the review committee chair to ensure that early contact is made with the Senior Investigating Officer (SIO) to ensure no conflict exists between the two processes.<sup>126</sup> The SIO should be informed of the Terms of Reference of the review – this is to ensure that the SIO has an opportunity to express any views on the content before the terms of reference are finalised.<sup>127</sup> All material generated or obtained in the DHR whilst the criminal case is ongoing must be made available to the SIO and disclosure officer to assess whether it is relevant to the criminal case.<sup>128</sup>

If, following representation from the SIO, it is agreed by the committee to delay progressing the DHR at any stage, then following the criminal proceedings, the review should be concluded without delay.<sup>129</sup>

The official guidance provides that it is important that a review is opened promptly so that early lessons can be identified, and rapid action taken to address them. It is essential that necessary learning is not delayed, to prevent the same mistakes being replicated in other cases.<sup>130</sup> Even if the review is delayed, preliminary work, such as commissioning and analysing Individual Management Reviews and drafting a first iteration of a chronology, whilst avoiding speaking to potential witnesses can be undertaken before a criminal trial has taken place.<sup>131</sup>

#### *Example: DHR procedure in the United Kingdom*

In general terms, in the United Kingdom, the process is initiated by the police, who are required to report any domestic homicide to the Community Safety Partnership (CSP), multiagency forums responsible at a local level for producing crime reduction strategies. Also, professionals or other agencies may refer cases to the CSP if they consider there are important lessons for inter-agency work to be learned from them.<sup>132</sup>

The local CSP makes the decision whether to conduct a DHR and informs the Home Office of their determination, as well as the victim's family. This decision, taken in consultation with local partners with an understanding of domestic violence, must be made within one month from the date of the homicide coming to their attention.<sup>133</sup> Where the CSP considers that DHR should be undertaken, they will utilise local contacts and request the establishment of a DHR Review Panel.

The Review Panel can either have a fixed, standing membership or be tailor-made for the purposes of undertaking a particular DHR. The CSP or the Review Panel should appoint an independent chair of the panel who is responsible for managing and coordinating the review process and for producing the final overview report based on evidence the Review Panel decides is relevant.<sup>134</sup>

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<sup>126</sup> *Ibid.* para. 41.

<sup>127</sup> *Ibid.* para. 48.

<sup>128</sup> *Ibid.* para. 94.

<sup>129</sup> *Ibid.* para. 50.

<sup>130</sup> *Ibid.* para. 92.

<sup>131</sup> *Ibid.* para. 49.

<sup>132</sup> The CSP comprises police, local government, fire and rescue authorities, probation and health services.

<sup>133</sup> Home Office (2016a) *cit.* para. 44.

<sup>134</sup> *Ibid.* Para. 36.

The Review Panel should define the terms of reference of the review according to the nature of the homicide, including the contact with other parallel processes, the need of specialist in relation to some aspects of the homicide, specific considerations related to equality and diversity, immigration status impact, risk assessment, protection orders, issues of so-called 'honour'-based violence, housing issues, management of issues concerning family and friends, the public and the media, among others.<sup>135</sup>

The Review Panel should commission Individual Management Reviews (IMRs) from the agencies involved, as well as reports or information from any other relevant interests, including from their contact with families and other networks. The Panel should meet an appropriate number of times to ensure there is robust oversight and rigorous challenge.<sup>136</sup>

The overview report should be completed within six months of the date of the decision to proceed unless the Review Panel formally agrees an alternative timescale with the CSP.<sup>137</sup> Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder. The Home Office provides detailed guidance in relation to the contact with families, friends, and other networks.<sup>138</sup>

The overview report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports or information commissioned from any other relevant interests.<sup>139</sup> It should also make recommendations for future action which the review panel should translate into a specific, measurable, achievable, realistic and timely (SMART) action plan.

Once agreed, the Review Panel should provide a copy of the overview report, executive summary and the action plan based on the recommendations to the CSP.<sup>140</sup> The CSP should arrange feedback and debriefing to staff, family members and the media as appropriate,<sup>141</sup> and send all documents together with a data collection form to the Home Office.

The overview report and executive summary are published, anonymised, after approval from the Home Office Quality Assurance Panel,<sup>142</sup> responsible for quality assurance regarding all overview reports for DHRs. The Quality Assurance Panel includes representation from all relevant statutory agencies,<sup>143</sup> as well as the voluntary sector. If the panel finds that a final report is inadequate, the Chair will feed back directly to the CSP responsible for the review to explain the reasons why the report requires amendment. This panel will ensure that final

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<sup>135</sup> *Ibid.* Para. 40.

<sup>136</sup> *Ibid.* Para. 31.

<sup>137</sup> *Ibid.* Para. 46.

<sup>138</sup> *Ibid.* Paras. 51 – 59.

<sup>139</sup> *Ibid.* Paras. 69 – 73.

<sup>140</sup> *Ibid.* Para. 77.

<sup>141</sup> *Ibid.* Para. 78 b).

<sup>142</sup> *Ibid.* para. 78 f).

<sup>143</sup> Home Office, National Offender Management Service, Department of Health, ACPO, Crown Prosecution Service, Department for Education, Refuge, Advocacy After Fatal Domestic Abuse, Southall Black Sisters, IMKAAN, Welsh Government, Department for Communities and Local Government, Independent Police Complaints Commission.

reports recognise the experience of families, friends and colleagues and are approached in an open, true, and honest manner.<sup>144</sup>

All overview reports and executive summaries should be published, anonymised, and translated if appropriate, to restore public confidence and improve transparency of the processes in place across all agencies. Reviews will not be published if there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen.<sup>145</sup>

DHRs are often publicly available only for limited periods, and there is no central repository for completed DHRs.

The following table, reproduced from Rowlands (2023) illustrates the DHR process in England and Wales.

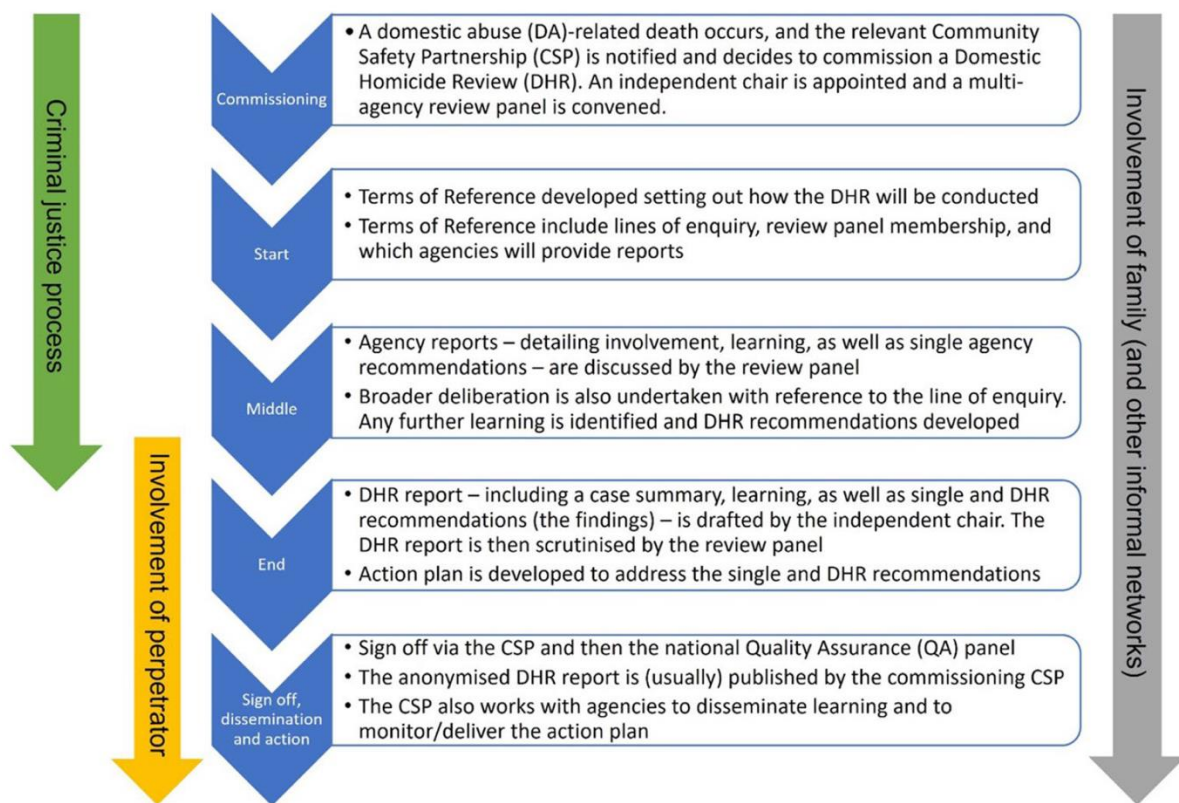


Fig. 1. The DHR process in England and Wales. Reproduced from Rowlands (2023)

### 2.6.3 Disciplinary procedures

DHR/DVFRs are not part of any disciplinary inquiries, but information may emerge during a review indicating that disciplinary action should be taken. In the United Kingdom, the

<sup>144</sup> Home Office (2013). Terms of Reference (June 2013) Domestic Homicide Review Quality Assurance Panel. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/208143/terms-of-reference-june-2013.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/208143/terms-of-reference-june-2013.pdf).

<sup>145</sup> Home Office (2016a) *cit.* paras. 80 – 86.

Statutory Guidance foresees that, in this case, the established agency disciplinary procedures should be undertaken separately to the DHR process.

Alternatively, reviews may be conducted concurrently with disciplinary action. This is a matter for agencies to decide in accordance with their disciplinary procedures. The same consideration should be taken in relation to complaint procedures underway against any single agency.<sup>146</sup>

## 2.7. Data and information collected by review committees

In general terms, DHR/DVFR are based on a detailed examination of the circumstances leading up to the death, including the actions and decisions of the agencies -public and private entities intervening in the field- and individuals involved. DHR/DVFRs also collect administrative data related to the cases, including age, sex of the victim and the perpetrator, relationship type, previous contact of the victim or the perpetrator with services (e.g. police, mental health), children present in the household and method of killing. The data collected varies among countries and is not necessarily collected in line with international standards, i.e. the International Classification of Crime for Statistical Purposes (ICCS)<sup>147</sup> and the *Statistical framework for measuring the gender-related killing of women and girls (also referred to as "femicide/feminicide")*.<sup>148</sup>

In the United Kingdom, the Community Safety Partnership should send, together with the overview report, executive summary and action plan, a data collection form to the Home Office. The content of the data collection form includes information in relation to the victim/s, the perpetrator and general information related to the homicide.<sup>149</sup> In Portugal, the EARHDV Procedure Manual contains a model form where data should be recorded.<sup>150</sup> In Australia, the *National Minimum Dataset on Intimate Partner Homicides* (NMDS), created by the Australian Domestic and Family Violence Death Review Network,<sup>151</sup> identifies specific data variables for collation, which include homicide details; demographic details, and other characteristics for the deceased and offender; case characteristics; histories of violence; and relationship characteristics between the deceased and the offender.<sup>152</sup>

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<sup>146</sup> *Ibid.* Para. 62.

<sup>147</sup> UNODC (2015), International Classification of Crime for Statistical Purposes (ICCS) Version 1.0 March 2015. Available at: [https://www.unodc.org/documents/data-and-analysis/statistics/crime/ICCS/ICCS\\_English\\_2016\\_web.pdf](https://www.unodc.org/documents/data-and-analysis/statistics/crime/ICCS/ICCS_English_2016_web.pdf).

<sup>148</sup> UNODC and UN Women (2021). *cit.* In addition to standard measures such as age, sex, intoxication status, the relationship between the victim and the perpetrator, date and time, location, etc., the Statistical framework also recommends collecting data on the marital status, economic activity status, gender identity, sexual orientation, pregnancy status, disability status and ethnicity status of the victim while also recording if there is a previous record of physical, sexual, or psychological violence/harassment against the victim. For the perpetrator it is also recommended to record whether they are the subject of a restraining order. This standard list of disaggregated data allows for greater international comparability of data.

<sup>149</sup> Included in the Appendix Four - Executive Summary Template of the 2016 Statutory Guidance.

<sup>150</sup> Annex VII - Retrospective Analysis Form. EARHVD (2022), *cit.*

<sup>151</sup> Established in 2011 to identify, collect, analyse, and report data on domestic and family violence-related deaths across Australia.

<sup>152</sup> Australian Domestic and Family Violence Death Review Network, & Australia's National Research Organisation for Women's Safety (ANROWS). (2022). Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010–2018 (2nd ed.; Research report 03/2022).



### 2.7.1 *Information related to the victims*

In the United Kingdom, the data collection forms include, in relation to the victims: gender, age at time of incident, relationship to perpetrator, ethnicity, nationality, religion, sexual orientation, disability. In the case of Portugal, the information includes sex, gender identity, date of birth, marital status, nationality, qualifications, profession, county and district of residence), including also the characterization of their work situation (worker, beneficiary of the social action subsystem (cash benefits of an occasional nature and benefits in kind) and/or the solidarity subsystem (RSI benefits, social pensions, social unemployment subsidy, solidarity supplement for the elderly and other social supplements), student, other). Information on the relationship between the victim and the perpetrator is also collected, including in relation to cohabitation (previous or at the time of the homicide), marriage or de facto union and its duration, current or past courtship. Furthermore, information related to specific vulnerability of the victim is recorded (including age, disability, disease, pregnancy - and relation to the perpetrator-, economic dependency, other). In Australia, the NMDS includes also information on the country of birth, visa status, employment, disability, convictions, and alcohol or other drug use.<sup>153</sup>

Information in relation to children is also recorded in some countries. For example, in Portugal, it includes number, age and gender of children in common and children from other relationships of the victim and of the perpetrator; number, age and gender if children present at the time of the murder; their relationship with the victim/aggressor; children living with the victim / aggressor.

### 2.7.2 *Information related to perpetrators.*

In the United Kingdom, the data collection forms include, in relation to the perpetrator: gender, age at time of incident, relationship to victim, ethnicity, nationality, religion, sexual orientation, disability, details of verdict. In the case of Portugal, the information also includes whether there is information on excessive consumption of alcohol or illicit substances, or information about the existence of mental health problems and procedures under the Mental Health Act. As in the case of victims, in Australia, the NMDS also includes information on the country of birth, visa status, employment, disability, convictions, and alcohol or other drug use.<sup>154</sup>

### 2.7.3 *Information related to the crime.*

In the United Kingdom, the data collection forms include, in relation to the homicide: date, place of murder, method of killing, number of children in household. In Portugal, the information recorded includes a wide variety of variables: place of occurrence of the facts; cause of death or injuries suffered by the victim; means of aggression used; people who were

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<https://anrowsdev.wpenginepowered.com/wp-content/uploads/2022/02/ADFVDRN-ANROWS-Data-Report-Update.pdf>.

<sup>153</sup> *Ibid.*

<sup>154</sup> *Ibid.*

present at the time of the aggression or who are aware of the context of violence; criminal record of the aggressor; previous denouncements filed or whose investigation/instruction was temporarily suspended in the context of crimes against people [whether the victim is the same or other(s)]; the basis of any decision to close the case; any injunctions and rules of conduct applied and the final result of the process in case of temporary suspension of the process; previous contacts made for reasons of domestic violence, suspicion of domestic violence or dangerous situations for children and young people, involving the suspect/defendant and the victim, with police entities, social security, health services, Commissions of Protection of Children and Young People or other services, entities and organizations that support victims of domestic violence; the summary characterization of the situation and the intervention carried out; judicial proceedings involving the aggressor and the victim, within the scope of children and family rights; any communications between them and the criminal process; knowledge of occurrences of the same type between the aggressor and another person. The record also includes information in relation to the criminal procedure and current situation of the perpetrator, as well as information from the forensic report on the cause of death and injuries suffered by the victim and perpetrator (if any).

In Ontario, Canada, the review committee collects basic information on death factors (e.g., trauma – cuts-stabs, shooting – shotgun, asphyxia-hanging) and involvement factors (e.g., abuse – domestic violence, alcohol involvement, Children’s Aid involvement), as well as the ‘manner of death’ or ‘by what means’ the death occurred (natural, accident, suicide, homicide, or undetermined). This information is collected on all homicides for which domestic violence is identified as a contributing factor, whether the committee has reviewed it yet or not.

#### *2.7.4 Information related to the previous relationship and risk factors*

DHR/DVFRs collect information about the previous relationship between victim and perpetrator, although this is not simple raw data collected as in the case of socio-demographic characteristics. For example, the NMDS in Australia collects information relating to the history of domestic and family violence between homicide offenders and victims and the types of abusive behaviours adopted by the domestic violence abusers, the relationship characteristics, separation or intention to separate, as well as domestic violence order histories.<sup>155</sup>

Much of the information gathered by DHR/DVFR committees is related to risk factors, in some cases more explicitly than others. In Ontario, Canada, the Committee collects detailed information about risk factors, based on 40 defined risk factors. This information is collected only after the cases have been reviewed by the committee.<sup>156</sup> In other contexts, risk factors are identified after DHR/DVFRs are analysed, for example, through academic research based on DHRs in England and Wales.<sup>157</sup>

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<sup>155</sup> *Ibid.*

<sup>156</sup> Dawson, M., Jaffe, P., Campbell, M., Lucas, W., Kerr, K. (2017). *cit.*

<sup>157</sup> Chopra, Sambrook, L., McLoughlin, S., Randles, R., Palace, M., & Blinkhorn, V. (2022). Risk factors for intimate partner homicide in England and Wales. *Health & Social Care in the Community*, 30(5), e3086–e3095. <https://doi.org/10.1111/hsc.13753>.

### 2.7.5 Information on interventions by agencies

One of the most relevant characteristics of DHR/DVFRs is the collection of data in relation to agencies' interventions in every case, and its analysis. DHR/DVFRs focus on the family and community allows an understanding the context and environment in which professionals and agencies involved in a case made decisions and took (or did not take) actions. This would include not only data in relation to number of visits or contacts, but also, for example, the culture of the organisation, the training the professionals had, the supervision of these professionals, the leadership of agencies and so forth.<sup>158</sup>

Information on the interventions by agencies is often provided through Individual Management Reviews (IMRs) from each of the agencies, bodies or organisations identified as part of the scope of the review, in relation to their involvement with the victim or perpetrator, as in the case of the United Kingdom.<sup>159</sup> However, such information could also be provided by other actors such as families or friends. In Portugal, for example, non-governmental organisations that provided services to the victims may also participate in the review and provide valuable information on the agencies' intervention.

In Ontario, information on the cases under review comes from the police, Children's Aid Society (CAS), healthcare professionals, counselling professionals, courts, probation, and parole, etc. The focus is on the history of the relationship, circumstances of the killing, actions of the perpetrator, the victim, and their families leading up to the death,<sup>160</sup> and could also include agencies' intervention (or lack thereof) in the case.

It should be underlined that data protection issues in relation to DHR/DVFRs tend to emerge in relation to access to records, for example medical records. Data protection obligations would not normally apply to deceased individuals, meaning that obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR/DVFR should not normally pose difficulty.<sup>161</sup>

In the United Kingdom, the Department of Health encourages clinicians and health professionals to cooperate with DHRs and disclose all relevant information about the victim and, where appropriate, the individual who caused their death unless exceptional circumstances apply.<sup>162</sup> However, some research indicates that guidance for health-care professionals in England and Wales on sharing information about domestic is numerous, inconsistent, ambiguous and lacking in detail, and there is a need for coherent recommendations for cross-speciality clinical practice.<sup>163</sup>

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<sup>158</sup> Home Office (2016a) *cit.* para. 9.

<sup>159</sup> *Ibid.* para. 60.

<sup>160</sup> Dawson, M., Jaffe, P., Campbell, M., Lucas, W., Kerr, K. (2017). *cit.*

<sup>161</sup> Home Office (2016a) *cit.* para. 98.

<sup>162</sup> *Ibid.* para. 99.

<sup>163</sup> Dheensa, & Feder, G. (2022). Sharing information about domestic violence and abuse in healthcare: an analysis of English guidance and recommendations for good practice. *BMJ Open*, 12(6), e057022–e057022. <https://doi.org/10.1136/bmjopen-2021-057022>.

### 2.7.6 Data analysis, reports and dissemination

Data and information collected is often available in annual public reports. In Canada, such reports contain information about the number of deaths that occurred each year as well as a statistical overview of previous years, the number of deaths reviewed, findings with respect to demographic and other victim, perpetrator, and incident characteristics, as well as the presence of risk factors.<sup>164</sup> In New Zealand, the annual reports set out the work of the Family Violence Death Review Committee, while various specialised reports provide further details on specific topics.<sup>165</sup>

In Australia, the *Australian Domestic and Family Violence Death Review Network Data Report (2018)* was published in May 2018 and provided national data with respect to all intimate partner homicides that occurred in a domestic violence context between 2010 and 2014.<sup>166</sup> Later, the Network and Australia's National Research Organisation for Women's Safety (ANROWS) worked in collaboration to update the 2018 Data Report to include intimate partner homicide data from July 2010 to June 2018, published in 2022.<sup>167</sup>

In the United Kingdom, a 2022 report by the Home Office identified key findings from analysis of DHRs for the 12 months from October 2019 (124 DHRs), including statistics and key themes from the analysis of a sample of 50 of the DHRs.<sup>168</sup> In 2016, a similar report was produced, based on DHRs from the four previous years.<sup>169</sup>

Concerning the dissemination of DHR/DVFRs of individual cases, different countries adopt varying approaches. In the United Kingdom, the final overview report and executive summary that are sent to the CSP must keep personal details and other identifying features anonymous,<sup>170</sup> in order to protect the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the Data Protection Act 1998.<sup>171</sup> It is for the families to decide if they want to choose a pseudonym for the victim to be used in the report.<sup>172</sup>

In principle, all overview reports and executive summaries in the United Kingdom should be published. This allows for analysis and research to be conducted by other actors, as the

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<sup>164</sup> Dawson, M., Jaffe, P., Campbell, M., Lucas, W., Kerr, K. (2017). *cit.*

<sup>165</sup> The reports are available at: <https://www.hqsc.govt.nz/resources/resource-library/?query=&programme=33>.

<sup>166</sup> Australia (2021) *Submission to the SRVAW by the Government of Australia*, 3 November 2021, <https://www.ohchr.org/sites/default/files/2021-12/australia.pdf>.

<sup>167</sup> Australian Domestic and Family Violence Death Review Network & ANROWS. *cit.*

<sup>168</sup> Home Office (2022, March 30) *Key Findings from Analysis of Domestic Homicide Reviews*. December 2021. <https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews>.

<sup>169</sup> Home Office (2016b) *Domestic Homicide Reviews, Key Findings from Analysis of Domestic Homicide Reviews*.

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf).

<sup>170</sup> Home Office (2016a) *cit.* para. 70.

<sup>171</sup> *Ibid.* para. 81.

<sup>172</sup> *Ibid.* para. 53 g).

academia.<sup>173</sup> This should not happen if there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review.<sup>174</sup> In Portugal, all final reports (19 cases reviewed to date) are anonymised and published on the website of the EARHVD.<sup>175</sup>

On the contrary, in Ontario, as laid out in Section 15 of the Coroners Act, the information reviewed, and the final report is for the sole purpose of a coroner's investigation. As such, there may be limitations on records accessed for reviews, particularly for those involved in the case who are still alive (e.g., perpetrators), due to various privacy legislations. Accordingly, individual reports, minutes of review meetings, and other documents or reports produced by the committee must remain private and protected. All committee members are bound by confidentiality agreements that recognize these limitations. Redacted final reports that contain a synopsis of each case may be made available upon request.<sup>176</sup>

In Sweden, New Zealand and Australian jurisdictions, DHR/DVFRs of individual cases are usually not available.<sup>177</sup>

## 2.8. Recommendations issued by review committees

The purpose of DHR/DVFRs is to formulate recommendations for the improvement of services and interventions by different stakeholders in cases of domestic violence or other forms of GBVAW. They are not limited to public agencies and may include also non-governmental organisations with a role in preventing or protecting against such violence.<sup>178</sup>

Some jurisdictions have issued specific guidance on recommendations. For example, in Alberta, Canada, the review committee underlines that all recommendations are made using the SMART Criteria (Specific, Measurable, Achievable, Realistic/Reliable, Timely).<sup>179</sup> The same criteria should be used in DHRs in the United Kingdom, where all DHRs should include a targeted and achievable action plan to help achieve the purposes of DHRs.<sup>180</sup>

A 2022 comparison of available studies on recommendations by diverse DHR/DVFRs identified four central themes:<sup>181</sup>

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<sup>173</sup> For example, the Homicide Abuse Learning Together (HALT) study analysed the findings and processes of 302 Domestic Homicide Reviews (DHRs) as part of a research project - funded by the Economic and Social Science Research Council (ESRC) and led by Professor Khatidja Chantler at Manchester Metropolitan University with researchers at the University of Central Lancashire (UCLan). <https://domestichomicide-halt.co.uk>.

<sup>174</sup> Home Office (2016a) *cit.* para. 81.

<sup>175</sup> EARHVD (n.d.) *Relatórios / Recomendações*. Retrieved 15 Feb 2023 from <https://earhvd.sg.mai.gov.pt/RelatoriosRecomendacoes/Pages/default.aspx>.

<sup>176</sup> Dawson, M., Jaffe, P., Campbell, M., Lucas, W., Kerr, K. (2017). *cit.*

<sup>177</sup> Some individual cases reports (systemic reports) are published in Queensland (Queensland Courts (n.d.). *Review of deaths from domestic and family violence*, *cit.*); and in South Australia, there have been nine Coronial Inquests with a domestic violence context and they are available at <https://officeforwomen.sa.gov.au/womens-policy/womens-safety/coroners-research-position>.

<sup>178</sup> Australian Human Rights Commission (2016). *cit.*

<sup>179</sup> Family Violence Death Review Committee of Alberta (2022), *cit.*

<sup>180</sup> Home Office (2016a) *cit.* para. 75.

<sup>181</sup> Jones, C., et al. (2022). *cit.*

- Prevention measures, involving training and awareness raising,
- Provision and coordination of services, including services to victims, perpetrators, and children,
- Recommendations for children impacted by DVA and domestic homicide, and
- Recommendations in relation to the processes and teams involved in DVFR/DHRs.

In practice, those recommendations tend to focus on the following issues:<sup>182</sup>

- Better intra and inter agency working relating to better information gathering, record keeping and sharing information with other agencies,
- Training for various professional groups to better understand different types of domestic homicides (e.g., intimate partner, adult family; those involving minoritised victims or perpetrators; homicide-suicide),
- Adhering to current policy/procedures or developing local policy regarding GBV,
- The importance of reflective practice and supervision,
- Encouraging professional curiosity in agencies that have had contact with either the victim or perpetrator, to ask probing questions, think holistically and not work in siloed' ways, e.g., substance use services not to just focus on harm reduction regarding misusing substances.

In the United Kingdom, the summary of information from DHRs for the 12 months from October 2019,<sup>183</sup> identified the following issues in relation to recommendations:

- From the recommendations in the DHRs, 25 per cent were for partnerships (typically community safety partnerships), 24 per cent for health organisations (including clinical commissioning groups, medical doctors, hospitals, and mental health trusts) and 13 per cent for the police.
- 28 per cent of the recommendations were to review existing practice.
- 26 per cent of the recommendations were to raise awareness, of which 72 per cent were recommending raising awareness about domestic abuse to staff.
- 16 per cent of the recommendations concerned information: including the quality of information and sharing information between agencies.

While these recommendations tend to point to certain common failures, the local nature of them allows to illuminate the local context with specific recommendations for each agency e.g., health, policing, social services, etc., facilitating their implementation at the local level.<sup>184</sup>

In the case of New Zealand, recommendations from the review committee have evolved over time. Early reports focused on how individual agencies (for example, police) or components of the system (judiciary) responded to individuals, before moving on to understanding the full journey of a family or whānau affected by a family violence death. Increasingly, reports have reflected on the wider systemic processes or structures that work as a whole to reinforce violence experience or work against safety. For example, the Sixth report include issues such as decolonise services, address racism and structural inequities, and calls to develop holistic ways of working with whānau and families. The Seventh report, moreover, states: “(...) we have not provided recommendations in this report. We are not saying in this report how

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<sup>182</sup> Khatidja Chantler, personal communication, 4 April 2023.

<sup>183</sup> Home Office (2022, March 30) *cit.*

<sup>184</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

government agencies need to change, as we have done in previous reports. Rather, we are insisting that the people in these agencies, and the agencies themselves, simply do their job and uphold the spirit of service to the community.”<sup>185</sup>

## 2.9. Main challenges identified

### 2.9.1 *Monitoring and reporting on the implementation of recommendations*

In the case of the United Kingdom, the Community Safety Partnership (CSP) should monitor the implementation of the actions set out in the action plan.<sup>186</sup> However, often DHRs make recommendations to national government, but CSPs lack the powers or capacity to follow up with Departments to ensure their learning is understood and implemented.<sup>187</sup>

In other jurisdictions, however, there is a lack of tracking of the implementation of DHR/DVFR recommendations. In North America, for example, agencies are not usually mandated to respond to or implement the recommendations of these reviews.<sup>188</sup> In Ontario, Canada, relevant recommendations are identified, distributed to relevant agencies and organisations that may be in a position to affect implementation, and listed in annual reports. However, there is no obligation for agencies and organizations to implement or respond to these recommendations. Still, it is typically requested that such organisations and agencies update the DVDRC about the status of implementation of recommendations within 1 year.<sup>189</sup>

In some cases, where DHR/DVFRs are implemented within the jurisdictional powers of a Coroner, agencies have an obligation to respond to the Coroner’s recommendations.

The implementation of recommendations appears to be closely related to the position of committees’ members within the respective institution, as those members with more senior roles may be in a better position to facilitate the follow-up and implementation of recommendations.

### 2.9.2 *Impact assessment*

The evidence about the impact of DHR/DVFRs remains anecdotal. This key gap is closely related to the fact that few teams have systematically tracked their recommendations.<sup>190</sup> Some studies indicate that media and dissemination of annual reports have educated the public and that reviews have improved cooperation between courts and agencies, changed law enforcement practices regarding weapons removal and increased funding for services to abused women.<sup>191</sup> Other examples of the impact of reviews include the institution of a data-

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<sup>185</sup> Cram, F. Chair’s introduction. Health Quality & Safety Commission New Zealand (2022b). *cit.*

<sup>186</sup> Home Office (2016a). *cit.* para. 79 f).

<sup>187</sup> Domestic Abuse Commissioner (n.d.) *Analysis of Domestic Homicide Reviews shows the need for more oversight*. Retrieved 15 Feb 2023 from: <https://domesticabusecommissioner.uk/blogs/analysis-of-domestic-homicide-reviews-shows-the-need-for-more-oversight/>.

<sup>188</sup> Jones, C., et al. (2022). *cit.*

<sup>189</sup> Dawson, M., Jaffe, P., Campbell, M., Lucas, W., Kerr, K. (2017). *cit.*

<sup>190</sup> Dawson, M., Mathews, S., Abrahams, N., Campbell, J. (2017). *cit.*

<sup>191</sup> In Washington State, New Hampshire, Maine and Ontario, respectively. Sheehy (2017). *cit.*

collection system for domestic violence; a change in policies regarding batterer intervention programs; adoption of a specific danger assessment tool; and new domestic violence screening procedures for men presenting with mental health and suicide risks.<sup>192</sup> DHR/DVFRs have contributed to the development of risk assessments in many US states (e.g. Minnesota, Arizona, Nevada) and cities (e.g. Baltimore, Phoenix).<sup>193</sup>

In Portugal, the 2022 EARHVD Assessment concluded that the reviews have impact at different levels, such as improving prevention and awareness, qualified training, and promoting self-reflection on practices, specifically through recommendations issued by the Team. Most consulted professionals working on DV value the work of the EARHVD and refer to its positive influence on their professional practice.<sup>194</sup>

Different studies have also underlined that it is difficult, in any case, to establish a causal chain between the DHR/DVFRs, their recommendations and the incidence of deaths. Furthermore, DHR/DVFRs' focus on identifying gaps in local service provisions and interagency working may lead to different "successful outcomes" that are not necessarily captured in traditional studies such as randomised control trials. This means it may not be feasible to link outcomes from recommendations with a reduction in domestic homicides.<sup>195</sup> In fact, outcomes such as improved responses from police, prosecutors, schools, hospitals, social welfare, and housing agencies are harder to be measured, as is the case for the increase of social awareness on the dynamics of such violence, along with increased funding for various services.<sup>196</sup>

### 2.9.3 Resources involved

The resource requirements vary for DHR/DVFRs vary and different solutions are in place to secure required funding. Death review in Australian states is funded by state governments.<sup>197</sup> In the United Kingdom, it is understood that the cost of DHR/DVFRs is covered at the local level, and there is no specific funding provided by the Home Office in this respect.

In other jurisdictions, limited funding has been associated with lack of consistency in DHR/DVFR processes and affects the numbers of cases selected for review. Some teams in the US and Canada have operated on a voluntary basis without funding, particularly for smaller committees with lower numbers of homicides.<sup>198</sup>

In New Zealand, the Member's fees are set with reference to the Cabinet Fees Framework<sup>199</sup> and specified in each member's letter of appointment. Actual and reasonable expenses for activities required by the review committee of its members (e.g. travel, accommodation) will

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<sup>192</sup> In California, Georgia, Montana, and Minnesota, respectively. Wilson J.S., Websdale N. (2006) Domestic violence fatality review teams: an interprofessional model to reduce deaths. *J Interprof Care*. 2006 Oct;20(5):535-44. doi: 10.1080/13561820600959253. PMID: 17000479.

<sup>193</sup> Websdale et al. (2017). *cit*.

<sup>194</sup> Matos, M. and Gonçalves, M. (2022). *cit*.

<sup>195</sup> Jones, C., et al. (2022). *cit*.

<sup>196</sup> Sheehy, E. (2017). *cit*.

<sup>197</sup> Australian Human Rights Commission (2016). *cit*.

<sup>198</sup> Jones, C., et al. (2022). *cit*.

<sup>199</sup> Public Service Commission (2022, Oct 6) *Guidance: Cabinet Fees Framework*.

<https://www.publicservice.govt.nz/guidance/interpreting-and-implementing-the-cabinet-fees-framework/>.



be met from the committee's budget. The attendance of representatives of stakeholder organisations invited to speak at the committee's meetings is at the cost of the respective organisation. However, the expense associated with additional co-opted people to the committee where additional expertise is required, will be met within the committee's budget.<sup>200</sup>

In different countries, many DHR/DVFRs recommendations emphasize the necessity for increased resources and service provision to enhance services for victims.<sup>201</sup>

#### 2.9.4 Minoritised groups and communities

In the United Kingdom, the Home Office Guidance on DHRs acknowledges that age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, ethnicity, sex and sexual orientation may all have a bearing on how the review is explained and conducted, and how the outcomes are disseminated to local communities.<sup>202</sup> The guidance also refers to the need to consider whether the victim's or perpetrator's immigration status had an impact on how agencies responded to their needs.<sup>203</sup>

Despite this detailed guidance, studies have underlined deficiencies in addressing minoritisation in DHRs in the United Kingdom. It has been suggested that statutory sector services should strengthen their responses to black and minoritised victims by ensuring proper recording of cultural background is used to inform practice; engage professionally trained interpreters with an awareness of domestic violence; resist framing domestic violence as endemic to minoritised cultures; and enhance trust and confidence in public services within minoritised communities. The best examples of DHRs challenged service narratives and usually sought expertise from a specialist black/minoritised domestic violence service or community organisation (frequently minoritised women's rights organisations).<sup>204</sup>

In other countries, the experiences of indigenous women who end up being killed are characterised by lack of access and responsiveness from services due to racism, but state institutions tend to react defensively when racism is revealed by review committees.<sup>205</sup>

The limited scope of DHR/DVFRs, in particular, when restricted to intimate-partner killings, may exclude the experiences of GBV of some women. In Canada, the Sisters in Spirit initiative documented that by 2010, over 580 Aboriginal women and girls across Canada were murdered or went missing. Among the findings was that Aboriginal women were killed more often by male acquaintances or strangers than by partners. According to national data

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<sup>200</sup> Health Quality & Safety Commission New Zealand (2022). *cit.*

<sup>201</sup> Jones, C., et al. (2022). *cit.*

<sup>202</sup> Home Office (2016a) *cit.* para. 35.

<sup>203</sup> *Ibid.* para. 40 f) and g).

<sup>204</sup> Chantler, Bracewell, K., Baker, V., Heyes, K., Traynor, P., & Ward, M. (2022). An analysis of minoritisation in domestic homicide reviews in England and Wales. *Critical Social Policy*, 26101832211330–. <https://doi.org/10.1177/02610183221133052>.

<sup>205</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

between 1980 and 2014, where Aboriginal identity was known, Aboriginal females represented 16 per cent of female homicides but only about 4 per cent of the population.<sup>206</sup>

In this sense, it has been stressed that review teams need to consider, not only the current violence being experienced by victims and their families but also the legacy of historical trauma and harm as a result of the larger historical, social, and structural context.<sup>207</sup> Often, the emphasis on individual level and relational level factors preclude the necessary focus also on community and societal level factors. A lack of attention to the latter by review committees is bound to provide only a partial picture, particularly for groups who suffer various types of discrimination and racism.<sup>208</sup>

In the case of Australia, the following limitations have been identified for the intimate partner violence homicide dataset analysed in the 2022 report,<sup>209</sup> as related to minoritised groups:

- A potential under-reporting of Aboriginal and Torres Strait Islander peoples, due to a reliance on service data, which may not consistently collect accurate administrative data of this nature. This could also be related to the fact that definitions of family and kinship may be very different in multi-cultural settings.
- A potential under-reporting of people with disability as a result of inconsistencies in the identification and definition of disability in service data.
- A potential under-reporting of LGBTQ couples, due to the relationship not being disclosed or recognised by services, families or friends prior to the homicide.

#### 2.9.5 Expertise on GBVAW

Domestic violence, as a form of GBVAW, should be analysed considering the gendered factors that underpin the cases, even when the direct victims might be other than women (for example, children themselves, or men in the case of a woman killing an abusive partner). However, in some cases, the reviewed cases are framed as gender-neutral, due to the review committees, teams or panels not having the required expertise on the gendered individual and broader social power-dynamics that characterise this violence, or due to a lack of expert advice from, for example, women's frontline groups or researchers. These deficiencies may lead to a distorted or poor understanding of the crimes, and the dynamics of GBVAW,<sup>210</sup> and, therefore, recommendations may result inadequate to improve responses to GBVAW.

In some cases, panel chairs are former members of criminal justice agencies (for example, former prosecutors or former police officers), and this may also frame the reviews with a perspective that is close to those agencies. In addition, members might not have the adequate expertise on GBVAW or adequate interviewing skills to avoid risk of secondary victimisation of families and friends.

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<sup>206</sup> Dawson, M., Jaffe, P., Campbell, M., Lucas, W., Kerr, K. (2017). *cit.*

<sup>207</sup> Dawson, M., Mathews, S., Abrahams, N., Campbell, J. (2017). *cit.*

<sup>208</sup> Myrna Dawson, personal communication, 20 April 2023.

<sup>209</sup> Australian Domestic and Family Violence Death Review Network, & ANROWS. (2022). *cit.*

<sup>210</sup> Sheehy, E. (2017). *cit.*

### 2.9.6 Other ethical aspects

Some research has pointed at other ethical issues involved in DHR/DVFRs.<sup>211</sup> In general, there are no standardised ethical frameworks for the review processes, and some of the ethical concerns identified are related to:

1. **Confidentiality** is a key issue to consider in relation to the access to private information and the protection of sensitive information in reports. It involves the members of the review committees, as well as families and professionals that could provide information to the committee during the review. Issues of confidentiality are relevant also to dissemination of information and final reports, as it has been underlined that even when final reports are anonymised, very often the cases and individual victims are identifiable because of some characteristics of the case.<sup>212</sup>
2. **Case selection** also presents ethical implications, in terms of what type of cases result reviewed and what others are excluded from review. There is a risk of excluding low profile cases or those from marginalised territories or communities, or even the excessive focus on certain types of cases could contribute to marginalisation of certain groups.
3. **Family members participation** involves ethical questions, especially in relation to their safety and wellbeing. Despite the involvement of families always being voluntary, there is often a risk that they could be identified even if they decide not to participate in the review, raising concerns specifically in relation to children. Together with physical safety, their emotional safety should be considered, as family members could face secondary trauma because of the review itself, their involvement in the review, or being interviewed by untrained individuals.<sup>213</sup>  
Emotional wellbeing of families could also be affected when there is no clarity of the purpose of the review, and expectations of families might be different to the outcomes of the review. For example, some committees tend to focus on identifying risk factors, while other focus on wider issues related to service provision and due diligence.<sup>214</sup>

These ethical implications can also be replicated when the reviews (public reports) are used in subsequent research. Some additional concerns include the use of reviews when families have not endorsed the report or their findings, or when there is a lack of clarity in the reports on the criteria that led to some information being included or excluded.<sup>215</sup>

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<sup>211</sup> See, for example: Cook, E.A., Rowlands, J., Bracewell, K. *et al.* (2023) Parallels in Practice: Applying Principles of Research Integrity and Ethics in Domestic Violence Fatality Review (DVFR). *J Fam Viol.* <https://doi.org/10.1007/s10896-023-00505-x>.

<sup>212</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

<sup>213</sup> Cook, E.A., *et al.* (2023). *cit.*

<sup>214</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

<sup>215</sup> *Ibid.*

### 3. Femicide observatories

In the last decades, many States have implemented different initiatives dedicated to collect statistical data on femicide/feminicide, i.e., gender-related killings of women. These initiatives in several cases coexist with others promoted by civil society, academia, or other non-governmental organisations, including at an international level.<sup>216</sup> Though the concrete denominations of the initiatives or programs differ among countries, in this document they will be referred to as “femicide observatories” (FObs).

While FObs seem to have grown in a variety of low, middle, and high-income countries, compared to mostly high-income countries where initiatives of DHR/DVFRs have proliferated, this difference is not only related to economic income. In different Latin American countries, for example, the magnitude of femicide/feminicide has been a controverted issue between authorities and civil society organisations, and so, establishing the number of cases has been a critical and sensitive political problem, leading to a greater focus on data collection initiatives.

Globally, FObs initiatives tend to be quite diverse,<sup>217</sup> and the purpose of this chapter is not to provide an exhaustive review of them but to identify some of their common features, which will be presented in the next sections. The aim of this chapter is to, concisely, provide elements to compare FObs to DHR/DVFRs (highlighted at the end of each section), in order to identify and assess their shared characteristics and their potential complementarity.

The rising development of DHR/DVFRs and FObs reflects the increasing social and political importance of policies to prevent and address GBVAW in the last decades. More concretely, their expansion and significance are related to the growth of concern about gender-related killing of women, including from international organisations.

From this perspective, both DHR/DVFRs and FObs are framed by the same broad social concern. In a context of urgent calls for adequate responses to GBVAW, DHR/DVFRs and FObs are, at different levels, producing reliable information on gender-related killing of women, critical to develop evidence-based policies.

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<sup>216</sup> For example, the Observatory of Gender Equality for Latin America and the Caribbean (OIG), from the Economic Commission for Latin America and the Caribbean (ECLAC) <https://oig.cepal.org/es/indicadores/feminicidio> and the European Observatory on Femicide (EOF) <http://eof.cut.ac.cy> in Europe. In the Latin American region, since 2009, the OIG has compiled the information produced by the countries on the incidence of deaths of women caused by an intimate partner or ex-intimate partner (intimate femicide/feminicide) as well as other femicide/feminicide cases according to the respective legal definitions (Programa Regional de la Iniciativa Spotlight para América Latina (2022). Estudio sobre la calidad de la medición del femicidio/feminicidio y las muertes violentas de mujeres por razones de género).

<sup>217</sup> In fact, due to their diversity, several initiatives have been implemented at the international level, aimed at improving and harmonizing data collection instruments, for example, the UNODC and UN Women (2021). *Statistical framework for measuring the gender-related killing of women and girls (also referred to as “femicide/feminicide”)*. [https://www.unodc.org/documents/data-and-analysis/statistics/Statistical\\_framework\\_femicide\\_2022.pdf](https://www.unodc.org/documents/data-and-analysis/statistics/Statistical_framework_femicide_2022.pdf), and Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

### 3.1. Definition

In general, femicide observatories are initiatives that collect and analyse data, information, and statistics focused on gender-related killing of women committed in a specific country, notwithstanding the name of the offence or its legal qualification. The observatory's work typically includes research, data analysis, advocacy, and raising awareness on the issue of femicide and GBVAW.

Though FObs vary widely among countries in terms of their names, mandates and methodologies, with different geographic and thematic scopes, they tend to rely mainly on information from the criminal justice systems (in particular, the police and courts), although they often include information from other sources, such as the health system. In some cases, regular data collection based on the information from a single institution (for example, the police) allows for the identification and quantification of some forms of gender-related killing of women.<sup>218</sup> While some FObs are multi-agency initiatives as, for example, in Latin American countries, in other cases they are single-agency data-collection projects, as in the case of single governmental or non-governmental (civil society or academic) observatories, as will be discussed in section 3.5.

FObs have often been the consequence of civil society mobilisation and advocacy to address these crimes. In some cases, FObs have initially been implemented by non-governmental organisations, given a lack of official data.<sup>219</sup> In fact, in a number of countries, official data is still insufficient or inexistent, and non-governmental or academic FObs produce some information, often based on media reports.<sup>220</sup>

In recent years, FObs have been promoted by international human rights mechanisms, such as the CEDAW Committee<sup>221</sup> and the UN Special Rapporteur on Violence Against Women (SRVAW).<sup>222</sup>

Similar to what has been underlined in relation to DHR/DVFRs, references to FObs in this background paper focus on permanent initiatives or mechanisms. Therefore, time-limited, or

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<sup>218</sup> For example, in the Philippines, data collected by the Philippine National Police – Women and Children Protection Center (PNP-WCPC) allows identification of intimate-partner and family-related femicides. (Philippines (2020). *Submission to the SRVAW by the Government of the Philippines*, 23 December 2020 <https://www.ohchr.org/sites/default/files/2021-12/submission-philippines.pdf>).

<sup>219</sup> As in the Latin American region, since the early 2000s. (Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*).

<sup>220</sup> For example, in Greece, by the Greek Observatory of Femicide, is a 2021 academic initiative based on media reports: <https://femicide.gr/posotika-dedomena-2021/> Though the Government of Greece had informed in 2020 to the SRVAW of the creation of new units responsible for domestic violence, including data collection, within the Hellenic Police, there is no subsequent information on official femicide data after their creation. (Greece (2020). *Submission of the Government of Greece*, 2020. <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/Femicide/2020/States/submission-greece.pdf>).

<sup>221</sup> Committee on the Elimination of Discrimination Against Women (CEDAW) (2017), *General Recommendation No. 35 (2017) on Gender-based violence against women*. CEDAW/C/GC/35.

<sup>222</sup> OHCHR (2015, Nov 23), *UN rights expert calls all States to establish a 'Femicide Watch'*. <https://www.ohchr.org/en/press-releases/2015/11/un-rights-expert-calls-all-states-establish-femicide-watch>.

sporadic data collection initiatives or studies in some countries, although relevant, are not considered as FObs.<sup>223</sup>

FObs are data collection initiatives on gender-related killings of women, with varying levels of analysis. While DHR/DVFRs also collect data, their focus goes beyond description to in-depth reviewing of the cases, in order to identify lessons that can be learned from them to improve existing responses to violence and prevent deaths.

### 3.2. Countries and normative basis

Currently, no comprehensive list of countries with FObs exists. The SRVAW has requested such information in successive calls to States, and 61 countries replied to this call between 2018 and 2021.<sup>224</sup> Not all States that replied have implemented a FObs.<sup>225</sup> On the contrary, in several cases the submissions to the SRVAW only refer to general crime statistics indicating the total number of women killed in the respective country in the last years,<sup>226</sup> or refer to diverse initiatives taken by the States in order to prevent GBVAW and femicide.<sup>227</sup>

In some countries, the creation of FObs or data collection initiatives has been expressly determined by legal mandate. This is the case of many Latin American countries,<sup>228</sup> where the production of official information is closely related to the fact that many of them have specifically criminalised femicide/feminicide in the last decades, and the laws also indicate minimum variables to be considered for the registration of cases. In some cases, the

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<sup>223</sup> For example, the 2022 research brief of the South African Medical Research Council *Decrease in Femicide in South Africa: Three National Studies Across 18 Years*. <https://www.samrc.ac.za/sites/default/files/files/2022-10-21/DecreaseFemicideSouthAfricaResearchBrief.pdf> based on data collected from medico-legal mortuaries and from the South African Police Service.

<sup>224</sup> The countries that have provided information to the SRVAW on femicide data are: Albania, Algeria, Andorra, Argentina, Australia, Austria, Azerbaijan, Bolivia, Bosnia and Herzegovina, Colombia, Brazil, Canada, Cambodia, Colombia, Costa Rica, Croatia, Cuba, Cyprus, Ecuador, El Salvador, Finland, France, Germany, Georgia, Guatemala, Greece, Honduras, Hungary, Iraq, Ireland, Israel, Japan, Italy, Jordan, Lebanon, Liechtenstein, Luxembourg, Malaysia, Mauritius, Mexico, Monaco, Netherlands, Nicaragua, North Macedonia, Norway, Panama, Paraguay, Qatar, Peru, Portugal, Philippines, Qatar, Serbia, Slovakia, Slovenia, South Africa, Spain, Sudan, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland, Turkey and Ukraine.

<sup>225</sup> The Government of South Africa, for example, launched its femicide watch in 2018, but it does not include any statistical data on femicide, consisting instead of a repository of information for victims and stakeholders. (Department of Justice and Constitutional Development (n.d.) *Femicide watch*. Retrieved 15 Feb 2023 from <https://www.justice.gov.za/vg/femicide/index.html>).

<sup>226</sup> Still, information on the total number of women killed every year is not a reality in many countries. As of 2021, only 133 UN Member States have reported data that distinguish between male and female homicide victims, meaning that of all homicide victims estimated globally in 2021, 36% had no information on the sex of the victim. (UNODC (2022). *Gender-related killings of women and girls (femicide/feminicide)*. Global estimates of gender-related killings of women and girls in the private sphere in 2021. Improving data to improve responses).

<sup>227</sup> For example, Austria (2020). *Submission from the Government of Austria to the SRVAW* in Nov. 2020 <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/Femicide/2020/States/submission-austria.pdf>.

<sup>228</sup> Argentina, Bolivia, Colombia, Ecuador, El Salvador, Mexico, Nicaragua, Panama, Paraguay, Peru and Uruguay (Programa Regional de la Iniciativa Spotlight para América Latina, 2022).

legislation specifically dictates the creation of institutional observatories on GBVAW, as in Argentina, Ecuador, Paraguay, Peru and Uruguay.<sup>229</sup>

The creation of FObs may also be motivated by specific obligations foreseen in international human rights treaties. According to the Istanbul Convention,<sup>230</sup> for example, States should collect disaggregated relevant statistical data at regular intervals on cases of all forms of violence covered by the scope of the Convention.<sup>231</sup> The Explanatory Report to the Convention states that, despite leaving to the States Parties the choice of data categories used, as a minimum requirement, recorded data on victim and perpetrator should be disaggregated by sex, age, type of violence as well as the relationship of the perpetrator to the victim, geographical location, as well as other factors deemed relevant by Parties such as disability.<sup>232</sup>

CEDAW General Recommendation No. 35 (2017) on GBVAW, as well as the updated Model Strategies and Practical Measures on the Elimination of Violence against Women in the Field of Crime Prevention and Criminal Justice, also stressed the importance of data collection in relation to all forms of GBVAW.<sup>233</sup> Despite the fact that the Belem do Para Convention<sup>234</sup> does not contain specific provisions on data collection, it has been considered that it is part of the State's due diligence obligation to prevent all forms of GBVAW.<sup>235</sup>

While legal provisions in domestic law and international instruments are addressed to States or public agencies, it should be reminded that, as will be seen in section 3.5, some FObs are implemented by non-governmental actors such as civil society organisations or academia. In these cases, they lack any specific normative framework.

In normative terms, both FObs and DHR/DVFRs have been implemented following either legal or regulatory mandates, except those FObs implemented by non-governmental actors, that lack of a specific normative framework.

In general, both FObs and DHR/DVFRs constitute concrete applications of the broader human rights obligations of the States in relation to GBVAW, in particular, as a crucial element for the adequate prevention of lethal violence.

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<sup>229</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022) *cit.*

<sup>230</sup> Council of Europe (2011a) *Convention on preventing and combating violence against women and domestic violence*. Adopted in Istanbul, 11.05.2011.

<sup>231</sup> Art. 11.1 of the Istanbul Convention.

<sup>232</sup> Council of Europe (2011b) *Explanatory Report to the Council of Europe Convention on preventing and combating violence against women and domestic violence* Istanbul, 11.V.2011 <https://rm.coe.int/ic-and-explanatory-report/16808d24c6>.

<sup>233</sup> CEDAW (2017), *cit.* para 34 (b); [A/Res/65/228](#), annex, para. 21.

<sup>234</sup> Organization of American States (OAS) (1994) *Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women*. Adopted in Belem do Para, 9.06.1994.

<sup>235</sup> CEDAW (2017) *cit.*

### 3.3. Objectives

FObs have been created to produce statistical information on the magnitude, prevalence, and characteristics of femicide/feminicide in a country, with the aim of monitoring, preventing, and combating the phenomenon. These statistics are an indispensable basis for the elaboration and implementation of adequate measures to prevent and address GBVAW.

FObs and DHR/DVFRs share a common goal of producing information and knowledge that allows to respond more accurately to GBVAW. However, DHR/DVFRs more specifically aim to improve existing responses in prevention, including comprehensive essential service provision, protection and provision of remedies, through lessons learned and recommendations from review of cases, beyond just producing a baseline of statistical information and analysis.

### 3.4. Extent of cases included

The extent of gender-related killing of women included in data collected by FObs varies widely among countries. This is related to the crimes and the factors considered as gender-related, affecting the extent of cases considered as such in diverse jurisdictions.<sup>236</sup>

In most countries where official data collection on homicides allows for the inclusion of gender-related factors, they are often limited to the identification of intimate partner (or former intimate partner) killings and family-related killings.<sup>237</sup> In these circumstances, the role of non-governmental and academic initiatives may provide for an expansion of data available on gender-related killing of women, through for example, the identification and analysis of cases where other gender-related factors were present, for example, in media reports.<sup>238</sup>

The restriction of gender-related killing of women to those cases in which an intimate partner or former intimate partner commits the crime is often related to legal definitions. In Spain, until 2021, only killings committed by intimate partners or ex-partners were considered as gender-related in official data, according to the definition of domestic legislation. From 2022 onward, to adapt data collection to the wider concept of GBVAW contained in the Istanbul Convention, the Spanish government additionally has been collecting data on non-intimate partner femicide, including family-related femicide (where so-called 'honour crimes' are included), sexual femicide, social femicide and vicarious femicide.<sup>239</sup>

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<sup>236</sup> Despite the fact that the UNODC / UN Women Statistical framework for measuring the gender-related killing of women and girls provides a statistical definition and typology (in line with ICCS) of gender related killing of women and girls, and a list of variables that can be used to identify and count the various types of such killings, this tool is not yet widely used (see also footnote 148).

<sup>237</sup> As in the Philippines (2020, *cit.*); Georgia (Public Defender of Georgia (2021). Submission to the SRVAW. December 2021. <https://www.ohchr.org/sites/default/files/2021-12/public-defender-georgia.pdf>).

<sup>238</sup> For example, the Greek Observatory on femicide (<https://femicide.gr/>) in Greece, and in Spain, the initiative [femicidio.net](http://femicidio.net).

<sup>239</sup> Delegación del Gobierno contra la Violencia de Género (n.d.) *Notas metodológicas*. Retrieved 15 Feb 2023 <https://violenciagenero.igualdad.gob.es/violenciaEnCifras/victimasmortales/notasm Metodologicas/notasm Metodologicas.htm>.



Complementing the recommendation of the SRVAW concerning femicide/feminicide data collection in broad terms,<sup>240</sup> UNODC and UN Women supported the development of more concrete guidance through the *Statistical framework for measuring the gender-related killing of women and girls (also referred to as “femicide/feminicide”)*, which was adopted by the UN Statistical Commission in 2022.<sup>241</sup> It specifies that data collected should include cases in which the perpetrator is (1) an intimate partner; (2) other family member; or (3) other perpetrator known or unknown to the victim when there is any of the following: a) Previous history of violence, b) Illegal exploitation, c) Abduction or illegal deprivation of liberty, d) Involvement of victim in the sex industry, e) Sexual violence on the body of the victim, f) Excessive mistreatment of the body of the victim, g) The body of the victim was disposed of in a public space, or h) Hate or bias against women victim.

In countries where femicide/feminicide is criminalised as a separate offence, often including some of the above-mentioned circumstances,<sup>242</sup> the cases registered are those fitting the respective legal definition. In some Latin American countries, such as Argentina, Chile, Costa Rica, and the Dominican Republic, the operational definitions for data collection purposes are even broader than the legal definitions of femicide/feminicide, based on a wider definition of GBVAW according to the Belem do Para Convention.<sup>243</sup> This means that they include gender-related killing of women committed by intimate-partners, family members or perpetrators unknown to the victim.

In few cases, as the FO of the Argentinian Ombudsman, the data also includes cases of femicide-suicide, i.e. suicide of women as a consequence of GBVAW they suffer.<sup>244</sup> Some FOs also collect data on the children killed in the context of GBV against their mother, such as Spain<sup>245</sup> and Argentina.<sup>246</sup> These cases are referred to as “related femicide” (*femicidio vinculado*) in Argentina, which is an aggravated offence according to its criminal legislation against femicide.

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<sup>240</sup> Under three broad categories: (1) intimate-partner femicide; (2) family-related femicide, based on the relationship between the victim and the perpetrator, and (3) other femicides, according to the local context.

<sup>241</sup> UNODC and UN Women (2021) *cit.*

<sup>242</sup> For example: killings of women committed in the context of partner/ex-partner relationship or family relationship; in the context of sexual violence; existence of previous complaint and/or repeated violence; existence of a relationship of trust, authority, or hierarchical descent; crime committed in the presence of children or ascendants; crime committed against pregnant and/or postpartum woman; in the context of trafficking; crime committed with cruelty; committed by more than one person or in group rites; committed against a minor or older adult; or against a person with disability or a condition that involves discrimination, against a person who has practiced prostitution or other sex-related occupation. (Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*).

<sup>243</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>244</sup> Defensoría del Pueblo de la Nación Argentina (2021) *Submission to the SRVAW from the Defensoría del Pueblo de la Nación Argentina*. <https://www.ohchr.org/sites/default/files/2021-12/defensoria-argentina.pdf>.

<sup>245</sup> Consejo General del Poder Judicial (2022), Informe sobre víctimas mortales de la Violencia de Género y Doméstica en el ámbito de la pareja o ex pareja. Año 2021.

<sup>246</sup> Corte Suprema de la Justicia de la Nación, República Argentina (2022) Registro Nacional de Femicidios de la Justicia Argentina, Edición 2021.

In some countries, the crimes included are not limited to consummated gender-related killing of women. For example, in Chile, data includes frustrated femicide,<sup>247</sup> and France's annual reports of intimate-partner killings include attempted homicides.<sup>248</sup>

Similar to DHR/DVFRs, the scope of cases included in the analysis of FObs in most cases ranges from intimate partner-killings to family-related killings. Remarkably, some countries where FObs exist go beyond those cases to include other gender-related killings of women not committed by intimate partners or family members, according to their own legislation or following international guidance. Some countries also include cases of femicide-suicide (suicide of a woman as a consequence of GBV), and killings of children in the context of GBV against their mothers. Moreover, non-governmental and academic FObs often use wider femicide/feminicide definitions.

### 3.5. Types of FObs

FObs can be single or multi-agency initiatives, whether from the governmental or non-governmental sector or both. Their character and their establishment respond to the varying social and political dynamics in relation to GBVAW in different countries and regions, as will be discussed in this section.

In some cases, FObs involve partnerships between various organizations, government agencies, civil society groups, and academic institutions. In other cases, a single institution collects data, whether produced by that same institution (e.g. the police or the judiciary) or by various agencies. In other countries, FObs are non-governmental or academic initiatives, with no participation of any public institution.<sup>249</sup> In some countries, there are more than one FOb. In Argentina, for example, the national FOb has been implemented by the Supreme Court,<sup>250</sup> although there is also a FOb within the Ombudsman institution,<sup>251</sup> together with similar initiatives by non-governmental organisations.

In most countries, however, data collection initiatives on GBVAW fall within the scope of responsibility of certain institutions, whether ministries of equality, interior or justice, or national statistics bodies, as will be seen in the following sub-section. In these cases, the concrete implementation of the FObs is usually framed by administrative regulations.

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<sup>247</sup> Circuito Intersectorial de Femicidios (2022) *Informe Anual 2021*. <https://www.sernameg.gob.cl/wp-content/uploads/2019/07/Informe-Anual-CIF-2021.pdf>.

<sup>248</sup> Ministère de l'Intérieur et des Outre-Mer (2022, Aug 26). *Étude nationale sur les morts violentes au sein du couple 2021*. <https://www.interieur.gouv.fr/actualites/actu-du-ministere/etude-nationale-sur-morts-violentes-au-sein-du-couple-2021>.

<sup>249</sup> See in section 3.5.2: Participation of .

<sup>250</sup> SRVAW (2021). Report of the Special Rapporteur on violence against women, its causes and consequences, Dubravka Šimonović. Taking stock of the femicide watch initiative. 12 July 2021. A/76/132.

<sup>251</sup> Defensoria del Pueblo de la Nación Argentina (2021) *cit*.

### 3.5.1 Public agencies involved

It is considered that three sectors are key in data collection related to femicides/feminicides: gender equality entities (either called women's ministries or other mechanisms for the advancement of women), official statistics bodies, and the criminal justice sector.<sup>252</sup> In those Latin American countries in which there is a legal mandate on GBVAW and femicide/feminicide data collection, such responsibilities are more frequently established in the sectors of justice,<sup>253</sup> criminal prosecution,<sup>254</sup> and police,<sup>255</sup> as well as the health sector.<sup>256</sup> Still, femicide/feminicide data is based mainly on police, forensic, prosecutorial and judicial data.<sup>257</sup>

Interestingly, regular spaces of inter-institutional coordination for statistical purposes have been created in some Latin America countries (Argentina, Chile, Costa Rica, Peru and Uruguay).<sup>258</sup> These coordinating spaces or bodies allow for the exchange of experiences and better management and dissemination of information. Moreover, methodologies for validating the data on femicide/feminicide are also inter-institutional in some countries. For example, in Argentina, Chile, Ecuador, El Salvador, Honduras, Peru and Uruguay, there are regulated inter-institutional procedures for validating information on femicides/feminicides. These procedures rely on the existing inter-institutional architecture (commissions, working tables or coordination groups) that has been set up in the countries with the aim of monitoring cases of femicide/feminicide.<sup>259</sup>

In Croatia, a Femicide Watch was created, based on a decision of the Ombudsperson for Gender Equality. The members of the Femicide Watch are representatives of the Ministry of the Interior, the Ministry of Labour, Pension System, Family and Social Policy, the High Misdemeanour Court, the Ministry of Justice, the Faculty of Law and organizations of civil society.<sup>260</sup> This monitoring body collects detailed (gender) statistics on femicide cases, monitors and analyses individual cases and situations which resulted in femicide for the purpose of identifying the key omissions by the relevant authorities, as well as for the purpose of enhancing the legislative framework and practice, prevention of violence and protection of victims. It also aims to improve the education of police and judicial officers dealing with femicide and gender-based violence issues.

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<sup>252</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>253</sup> Argentina, Bolivia, Ecuador, Guatemala, Panama, Paraguay and Peru.

<sup>254</sup> Bolivia, Ecuador, Guatemala, Mexico, Panama and Paraguay.

<sup>255</sup> Guatemala, Mexico, Panama, Paraguay, Peru and Uruguay.

<sup>256</sup> Argentina, Bolivia, Ecuador, El Salvador, Mexico, Panama, Paraguay, Uruguay. The responsibility of instances of subnational powers, such as municipalities and federal entities, in the record of GBVAW is explicit in legislation from Bolivia, Ecuador, El Salvador, Mexico and Paraguay.

<sup>257</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>258</sup> In Chile, composed by Superior Courts, Courts of Justice, Public Prosecutors, Council of the National Magistracy; in Costa Rica, the Inter-institutional Subcommittee for the Registration of Femicide; in Ecuador, the Technical Subcommittee for the Validation of Femicide; in El Salvador, the Inter-institutional Roundtable for the Conciliation of Homicides and Feminicides; in Honduras, the Inter-institutional Commission for Monitoring Violent Deaths of Women and Femicide, and in Peru, the Inter-institutional Statistical Committee on Crime. (Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*).

<sup>259</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>260</sup> Croatia (2021). *Submission to the SRVAW by the Government of Croatia.*

<https://www.ohchr.org/sites/default/files/2021-12/croatia.pdf>.

In France, while there is inter-agency coordination on GBVAW, the reports on gender-related killings of women remain within the sphere of the Ministry of Interior. The Inter-ministerial mission for the protection of women against violence and the fight against human trafficking (MIPROF) acts as a national observatory on violence against women (ONVF). MIPROF is responsible for "collecting, analysing and disseminating information and data relating to violence against women". It works in close partnership with representatives of ministries of interior, justice, women's rights and health, as well as statistics bodies and research institutes (ONDRP, Insee, Ined). The collected information is based on the activity of the police, the gendarmerie and the justice system.<sup>261</sup> Information on intimate partner killings of women, however, is produced by the Ministry of Interior since 2014, in its annual reports on intimate partner killings.<sup>262</sup>

In several countries, statistical information on femicide/feminicide (and other crimes) is produced and collected by institutions separately, such as the police or the ministries of Interior, with no further coordination with another sector.<sup>263</sup> For example, in Algeria, the General Directorate of National Security has set up a system to collect information, relating offenses related to violence against women and girls, including intentional homicide and intentional assault and battery resulting in death.<sup>264</sup> In Sweden, the Swedish National Council for Crime Prevention, responsible for Sweden's official criminal statistics, publishes annual information on the number of confirmed cases of lethal violence, including the total number of cases where the victim was a woman, and if the victim and the perpetrator were or had been in an intimate relationship.<sup>265</sup>

### 3.5.2 Participation of non-governmental organisations

In several countries, especially the Latin American region, there have been various initiatives by civil society to create observatories on GBVAW and femicide/feminicide. In this region, femicide/feminicide activism has been prominent since the 2000s, and the focus on data collection has been a critical part of feminist CSO work. CSO data collection initiatives have been implemented in a number of countries long before the establishment of official mechanisms of data collection,<sup>266</sup> and before the specific criminalisation of femicide/feminicide in those countries, in the last two decades. These CSO initiatives remain

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<sup>261</sup> France (2021b) *Submission to the SRVAW by the Government of France*, 19 Nov 2020, <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/Femicide/2020/States/submission-france.pdf>.

<sup>262</sup> See, for example: Ministère de l'Intérieur et des Outre-Mer (2022) *cit.*

<sup>263</sup> For example, in Serbia and Austria. (Serbia (2020) *Submission to the SRVAW by the Ministry of Human and Minority Rights and Social Dialogue of Serbia*, 23 November 2020. <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/Femicide/2020/States/submission-serbia.pdf>; Austria (2020). *cit.*).

<sup>264</sup> Algeria (2020). *Submission from the Government of Algeria to the SRVAW*. 30 Nov 2020 <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/Femicide/2020/States/submission-algeria.pdf>.

<sup>265</sup> Sweden (2020). *Submission by the Government of Sweden to the SRVAW*. <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/Femicide/2020/States/submission-sweden.pdf>.

<sup>266</sup> For example, in Mexico, since 2007 and in Argentina, since 2008 (See: <https://www.observatoriodefemicidiomexico.org/copia-de-publicaciones>; <http://www.lacasadencuentro.org/femicidios02.html>).

in place in many countries and, in some others, they are the only source of data on gender-related killings of women. CSO initiatives, however, tend to be separated from official data collection, and have diverse methodologies including, for example, the cases reported by the media.<sup>267</sup> In some cases, also academic groups or institutions have set femicide observatories.<sup>268</sup>

In some countries, crime data is primarily collected by non-governmental entities. In Brazil, the Fórum Brasileiro de Segurança Pública (FBSP) collects and publishes reports on crime statistics, including on femicide/feminicide.<sup>269</sup> Nevertheless, the Brazilian Federal Senate created in March 2016 the Observatory of Women against Violence (OMV)<sup>270</sup> being some of its functions gathering and systematising official statistics on violence against women - including femicide/feminicide-, and analysing and producing reports from official and public data.<sup>271</sup>

Other countries and territories have set up organisms that combine governmental and non-governmental organisations,<sup>272</sup> including academia in some cases.<sup>273</sup> For example, the Government of Morocco created its national observatory on violence against women with a tripartite composition (the Government, NGOs and academics).<sup>274</sup>

In the Latin American region, only Costa Rica and Honduras include civil society participation in the process of producing information on femicides/feminicides. Their participation has been found to enrich the analysis, contribute to a better explanation of the problem and to reduce underreporting gaps.<sup>275</sup>

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<sup>267</sup> For example, in Argentina (La Casa del Encuentro <http://www.lacasadelencuentro.org/femicidios02.html>), or Austria (Verein Autonome Österreichische Frauenhäuser <https://www.aofef.at/>).

<sup>268</sup> This is the case of the Canadian Femicide Observatory for Justice and Accountability, established at University of Guelph in 2017 <https://www.femicideincanada.ca>; the Israel Observatory on Femicide set up in 2020 at the Hebrew University of Jerusalem; the Greek Observatory on femicide <https://femicide.gr/> and the European Observatory on Femicide <http://eof.cut.ac.cy>. In Romania, the Institute of Sociology of the Romanian Academy maintains the Romanian observatory for the analysis and prevention of murder, which analyses data on intentional killings in the country, including the characteristics of victims and perpetrators. Similarly, the National Observatory of Violence in Honduras was established by the University Institute on Democracy, Peace and Security at the National Autonomous University of Honduras (SRVAW, 2021).

<sup>269</sup> See, for example, Samira Bueno, Amanda Lagreca, Isabela Sobral (2022). *Violência contra meninas e mulheres no 1º semestre de 2022* <https://forumseguranca.org.br/wp-content/uploads/2022/12/violencia-contra-meninas-mulheres-2022-1sem.pdf>.

<sup>270</sup> Senado Federal (n.d.)(a) *Observatório da Mulher contra a Violência*. Retrieved 15 Feb 2023 <https://www12.senado.leg.br/institucional/omv>.

<sup>271</sup> For example, information available on feminicide (updated to 2019) includes total number of cases, ethnicity, age, marital status, and education level of the victims; place where the crime was committed and death cause: Senado Federal (n.d.)(b) *Painel de Violência contra Mulheres*. Retrieved 15 Feb 2023 from [https://www9.senado.gov.br/QvAJAXZfc/opendoc.htm?document=senado%2FPainel OMV - Violência contra Mulheres.qvw&host=QVS%40www9&anonymous=true](https://www9.senado.gov.br/QvAJAXZfc/opendoc.htm?document=senado%2FPainel%20OMV%20-%20Viol%C3%ancia%20contra%20Mulheres.qvw&host=QVS%40www9&anonymous=true).

<sup>272</sup> For example, the Palestinian National Observatory of Violence Against Women (Palestinian National Observatory of Violence Against Women (2020). *Submission to the SRVAW*. <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/Femicide/2020/NHRIs/violence-against-women-observatory-palestine.pdf>).

<sup>273</sup> The Government of Morocco created its national observatory on violence against women with a tripartite composition (the Government, NGOs and academics).

<sup>274</sup> SRVAW (2021) *cit*.

<sup>275</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit*.

In Argentina and Uruguay, consultative processes have been developed. For example, in Argentina, once the number of cases/victims of femicide for each jurisdiction has been presented, the Women's Office of the Supreme Court of Justice of the Nation (CSJN) compares it with two registries based on secondary sources (press) and with specialists, if necessary.<sup>276</sup>

The SRVAW has recommended that all the institutions cooperate and harmonize the collection of data and analysis of cases.<sup>277</sup>

There is much more diversity among FObs than DHR/DVFRs in terms of the actors involved. Although FObs in some cases are multi-agency initiatives, this is not a general rule, although it tends to be a characteristic of those FObs that were created by specific legal mandate, as in many Latin American countries.

Differently from DHR/DVFRs, some FObs are solely civil society initiatives that have no relation with public agencies.

FObs with a multi-agency character share a very important characteristic with DHR/DVFRs, as they promote collaborative inter-agency work and the exchange of experiences.

### 3.6. Timing of data collection

Most FObs collect data regularly, receiving information from the diverse agencies involved. In most cases, those agencies are part of the criminal justice system and often include the police.

In the case of Latin American countries, a report by the Spotlight Initiative found that the majority of countries reviewed (9) considered that administrative data is received in a timely manner, but others (6) reported obstacles to the timely receipt of data. According to the report, there should be a periodicity of no more than six months for the exchange of information between the different institutions responsible of producing administrative data that allows for the construction of statistical information on femicide/feminicide.<sup>278</sup>

### 3.7. Data and information collected

FObs collect data and some information on gender-related killings of women, in a similar way to DHR/DVFRs, in particular, information in relation to the victims, perpetrators, and the crime.

While the specific data collected varies from diverse countries, some have more developed data collection frameworks. Latin America is unique in that it is the only region in the world where most countries have enacted laws that specifically criminalise gender-related killings of women, known as femicides/feminicides. This has led to significant progress in terms of

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<sup>276</sup> *Ibid.*

<sup>277</sup> SRVAW (2021) *cit.*

<sup>278</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

collecting official data and information on these crimes in the region. In fact, in most Latin American countries, their specific legislation on GBVAW includes a minimum set of data for mandatory collection. It should be noted, however, that standardized data collection can be achieved irrespectively of existing legal definitions, as outlined in the *Statistical framework for measuring the gender-related killing of women and girls (also referred to as “femicide/feminicide”)*.

### 3.7.1 Information related to the victims

According to a comparative analysis of data collection among 16 Latin American countries by the Spotlight Initiative,<sup>279</sup> in general, the mandatory collection of data in relation to the victim includes age, marital status, profession/occupation, and educational level. Some countries also include categories such as race/ethnicity, sexual orientation, gender identity, disability, immigration status, among others, as mandatory.<sup>280</sup>

The Spotlight Initiative also reports that the Argentinian FOB collects the highest number of variables related to the victims: sex, date of birth (age), nationality, gender identity, ethnic-racial identity, disability, marital status, schooling, occupation, number of children or dependent people, pregnancy, human trafficking, previous complaints for GBVAW, and the relationship with the perpetrator.

### 3.7.2 Information related to the perpetrators

In all countries reviewed by the Spotlight Initiative, a reduced number of variables are collected in relation to perpetrators, being the most common sex, age, and relationship with the victim. The existence of criminal records in the perpetrator is registered by nine countries, contrasting with the information on whether the aggressor had a registered weapon, which is included only in Argentina and Paraguay.<sup>281</sup>

Diverse countries, such as France, also include the motivation for the crime, as well as their socio-professional category. In addition, information is collected in relation to previous psychological or psychiatric monitoring of victims and perpetrators, including the existence of previous psychiatric internment.<sup>282</sup>

Occupation, education, nationality, and ethnic-racial identity of perpetrators are included in less than half of the Latin American countries reviewed by the Spotlight Initiative. Honduras systematically collects information on the affiliation of perpetrators to criminal groups, such as gangs or *maras*.<sup>283</sup>

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<sup>279</sup> The countries included in the review are: Argentina, Brasil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Bolivia, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic and Uruguay. Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>280</sup> *Ibid.*

<sup>281</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>282</sup> Ministère de l'Intérieur et des Outre-Mer. (2022) *cit.*

<sup>283</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

### 3.7.3 Information related to the crime

Most countries collect some information in relation to the crime. For example, the statistics in Algeria include time and place of the crime, its legal consequences, as well as the geographical distribution of the crimes.<sup>284</sup>

All Latin American countries reviewed by the Spotlight Initiative also collect information related to the place where the crime took place, according to their administrative territorial division, the time when it occurred and the modalities of the crime (modus operandi, means to cause the death).<sup>285</sup>

### 3.7.4 Information related to the previous relationship and risk factors

Information related to the previous relationship between the victim and perpetrators is crucial for the identification of gender-related cases by FObs, in particular, those related to intimate-partner violence or family violence.

In Georgia, the Public Defender -where the FOB is based- analyses data collected and published by the General Prosecutor's Office. It divides all killings of women into domestic crimes and killings of women on other grounds; and it disaggregates domestic crimes (family killings, by type of relationship between the victim and the perpetrator) and crimes committed by a husband or former husband.<sup>286</sup>

In other countries, police statistics allow for data collection related to the relationship between victims and perpetrators. For example, in Slovenia, the police collect information with a focus on the categories of "gender" and "relationship between victim and perpetrator", covering the following relationships: ex-spouse or intimate partner, intimate partner, child, parent and spouse.<sup>287</sup> In Slovenia, data include cases of homicide and other types of violence against women and the number of femicides is obtained from the number of murders and manslaughters of women when committed by perpetrators with those types of relationship to the victims.<sup>288</sup> The statistics in Algeria, together with allowing for data collection on characteristics of perpetrators and victims, including age, profession or level of education, include aspects such as the family relationship between them, family situation, social and economic situation, crime motives, among others.<sup>289</sup>

In France, the type of intimate partner relationships include: marriage, civil partnership, cohabiting couples, non-official couples, ex-spouses, ex-partners and ex-civil partners. There is also information on the existence of previous violence, and the type of violence (physical, psychological, sexual, and cyberviolence).<sup>290</sup>

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<sup>284</sup> Algeria (2020). *cit.*

<sup>285</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>286</sup> Public Defender of Georgia (2021). *cit.*; SRVAW (2021), *cit.*

<sup>287</sup> SRVAW (2021), *cit.*

<sup>288</sup> *Ibid.*

<sup>289</sup> Algeria (2020). *cit.*

<sup>290</sup> Ministère de l'Intérieur et des Outre-Mer (2022) *cit.*



Likewise, in various Latin American countries there is an express legal mandate to record the relationship between the parties.<sup>291</sup> In some cases, when there were previous reports of violence against the perpetrator, the information collected include the result of the risk assessment done at the time of the previous report.<sup>292</sup>

### 3.7.5 Information on agencies intervention

Countries where FObs are more consolidated often include information in relation to a previous intervention by criminal justice institutions in the case, for example, the existence of previous police reports or protection orders granted to the victim. In France, data is collected on the number of people killed in the context of violence within the couple and the victims of violence between partners and sexual violence. This information includes data on prosecutions and convictions for violence within the couple and sexual violence, as well as protection orders pronounced.<sup>293</sup> The annual reports on intimate partner killings include information on previous reports to police, complaints filed and protection orders, detailing the type of intervention by security forces (for example, home intervention, computerised daybook, judicial intelligence report).<sup>294</sup>

In eight of the 16 countries analysed in Latin America, data collected includes previous complaints or reports of violence, and the type of violence.<sup>295</sup> In Argentina, in addition, a yearly report is published on the justice system's response to femicide cases, to identify the need for improvements.<sup>296</sup>

Interestingly, in Chile, the Intersectoral Femicide Circuit (CIF) was created in 2009 with a focus on responding adequately to the needs of children who were indirect victims of femicide. The CIF registers a set of variables that go beyond characterising the victims, perpetrators, and the crimes, to include also indirect victims, such as children and other family members, to guarantee adequate assistance services and to promote studies on the phenomenon.<sup>297</sup>

Data collection is a common trait between FObs and most DHR/DVFR initiatives. While the concrete data and information collected by the diverse mechanisms may differ, they tend to focus on characteristics of victims and perpetrators, as well as the previous relationship between them, mostly in the context of intimate partner relationships. In some cases, there is also detailed information on children as indirect victims of femicide, and the provision of follow-up services and assistance.<sup>298</sup>

A key distinction between FObs and DHR/DVFRs in this matter lies in the comprehensiveness of the information gathered and the sources from which it is obtained. FObs typically rely on

<sup>291</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>292</sup> Circuito Intersectorial de Femicidios (2022) *cit.*

<sup>293</sup> France (2021b) *cit.*

<sup>294</sup> Ministère de l'Intérieur et des Outre-Mer (2022) *cit.*

<sup>295</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>296</sup> SRVAW (2021) *cit.*

<sup>297</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*; Circuito Intersectorial de Femicidios (2022) *cit.*

<sup>298</sup> Circuito Intersectorial de Femicidios (2022) *cit.*

administrative data from various public agencies, primarily those within the criminal justice system. On the other hand, DHR/DVFRs use not only such administrative data but also incorporate information provided by non-governmental organisations, as well as friends and family members of those affected by the crime in question, allowing for a more nuanced and deeper understanding of the circumstances surrounding victims and perpetrators.

Another key difference is related to information on the involvement of governmental or non-governmental agencies. FObs tend to limit the data gathered to variables related to victims, perpetrators and the crime, with little information about the involvement of agencies, except for the criminal justice system in some cases (previous reports, prosecution, convictions, protection orders). DHR/DVFRs, on the contrary, provide a much wider perspective on the previous involvement of governmental or non-governmental agencies, including social and healthcare services, specialised services on GBVAW, child protection, etc.

### 3.8. Reports and recommendations by FObs

In Latin American countries, such as Argentina, El Salvador, Mexico, Nicaragua, Paraguay, Peru, Uruguay and Venezuela, States are obliged by law to periodically develop reports, studies and investigations on GBVAW.<sup>299</sup> Comparing 16 Latin American countries, most of them publish the information more than once a year (Bolivia, bi-weekly; Ecuador, El Salvador, Mexico, Panama and Peru, monthly; Costa Rica, bi-monthly; and Dominican Republic, quarterly), and four do so annually (Argentina, Chile, Colombia and Paraguay).<sup>300</sup> Annual reports by the FObs are the norm in different other countries.<sup>301</sup>

Most reports include not only data analysis, but also recommendations for improvement of responses, based on the trends identified.

### 3.9. Main challenges identified

FObs face some of the same challenges that DHR/DVFRs, although to a different extent considering their specific focus.

#### 3.9.1 *Monitoring and implementation of recommendations*

Although certain FObs may offer suggestions for enhancing responses to GBVAW based on the data they gather, it remains unclear whether these recommendations are put into practice. While the reports are typically accessible to the public, it is ultimately up to the

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<sup>299</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>300</sup> *Ibid.*

<sup>301</sup> In France, since 2013, on the occasion of 25 November, the International Day for the Elimination of Violence against Women, the Inter-ministerial mission for the protection of women against violence and the fight against human trafficking (MIPROF) has published annual data in a dedicated issue of "The Letter from the National Observatory of Violence Against Women" (France (2021b) *cit.*), as in Georgia (Public Defender of Georgia (2021) *cit.*). The Moroccan observatory on violence against women has published two reports since its creation, in 2016 and 2017 (SRVAW (2021) *cit.*).

specific institutions or sectors to decide whether or not to utilise them to improve their own services or responses.

### 3.9.2 Limitations in data collection

In many countries, the information collected is quite limited, covering only intimate-partner and family-related femicides/feminicides. In many cases there is limited information on the characteristics of victims and perpetrators. Even though the *Statistical framework for measuring the gender-related killing of women and girls (also referred to as “femicide/feminicide”)* provides a list of variables that can be used to identify and count the various types of such killings, it is not yet part of the standardised data collection practice in most countries.<sup>302</sup>

In some cases, there are inconsistencies in the information produced by different institutions or organisms. For example, the National Observatory on Violence Against Women and Members of the Family Group of Peru publishes data on the number of femicides. However, and despite its role of intersectoral articulation, the Spotlight Initiative found that the numbers provided by different national institutions presented on the Observatory's website do not coincide with each other.<sup>303</sup>

The comparability of data on femicides/feminicides, even among countries with FObs in place, continues to be a challenge, mainly due to methodological differences in the collection of information and the heterogeneity of the data sources. These challenges are being addressed by regional initiatives, intended to improve data collection initiatives in the continent, as well as to increase the comparability of the data.<sup>304</sup>

### 3.9.3 Resources involved

In most countries, data collection depends on the budget of the institutions responsible for it. Resources are also necessary for training on GBVAW and capacity building for improving administrative records. In some countries, FObs implementation has been supported by UN agencies such as UN Women<sup>305</sup> and UNDP.<sup>306</sup>

A specific budget dedicated to the processes of producing information on femicides/feminicides exists in most Latin American countries. These funds are often used for broader data collection processes on GBVAW, or for statistics bodies. According to information provided by 16 Latin American countries to the Spotlight Initiative, 11 considered that they had sufficient resources to develop the registry of statistical information on

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<sup>302</sup> See footnote 143.

<sup>303</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

<sup>304</sup> *Ibid.*

<sup>305</sup> For example, in Georgia. Public Defender of Georgia (n.d.) *Femicide watch*. Retrieved 15 Feb 2023 from <https://ombudsman.ge/eng/femitsidze-zedamkhedvelobis-meqanizmis-sakonsultatsio-sabchos-shesakheb>.

<sup>306</sup> Since 2014, UNDP has been developing the InfoSegura Regional Project in Central America and the Dominican Republic. In recent years, InfoSegura has supported countries in the production of official data and in the analysis of information related to various forms of VAWG, including violent deaths of women and femicides/feminicides, as well as the relationship between both phenomena. (Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*)

femicides/feminicides, namely: Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico, Nicaragua, Peru, El Salvador, and Uruguay. Bolivia considered that resources were available but insufficient. Honduras, Panama, Paraguay, and the Dominican Republic indicated a lack of institutional resources, be they human, material, technological or budgetary, for the construction of information on femicide/femicide.<sup>307</sup>

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<sup>307</sup> Programa Regional de la Iniciativa Spotlight para América Latina (2022). *cit.*

## 4. From DHR/DVFRs to Femicide Reviews: Possible introduction of Femicide Review Committees

FObs and DHR/DVFRs are two of the most relevant measures that have been implemented in diverse countries in the last decades, in order to prevent and address gender-related killing of women. As has been discussed in the previous chapter, there are several points of connection between DHR/DVFRs and FObs, which constitute a common ground that allows for assessing the possibility of introducing multi-stakeholder, in-depth reviews of femicide/feminicide cases, especially in countries that have already implemented FObs.

While DHR/DVFRs until now have focused on the context of domestic violence, there is an opportunity to broaden the scope or use the same methodology to review gender-related killing of women or femicide/feminicide. The methodology could be applied in other countries, including low and middle-income countries. In countries where FObs have been established, specific laws and policies focused on femicide/feminicide are typically already in place and, therefore, the introduction of femicide reviews may be consistent with that political and normative framework. However, the existence of FObs should not be considered as a requirement to implement femicide reviews, as such reviews could also be implemented in countries with no FObs in place, as will be outlined below.

The following sections will examine the potential of introducing multi-stakeholder, in-depth femicide reviews, whether by establishing femicide review committees or by broadening the scope of FObs or even of existing DHR/DVFRs. This will be discussed in light of the aspects highlighted in the preceding chapters in relation to DHR/DVFRs and FObs, as well as other aspects that may be applicable to particular regions or circumstances.

### 4.1. Why should States consider establishing femicide review committees?

The use of death review procedures in femicide/feminicide cases can have a range of different advantages, particularly in countries where DHR/DVFRs have not yet been used. Establishing femicide review committees can complement and enrich existing legislation and policies on femicide/feminicide through in-depth analysis of cases, and the inclusion of new sources of knowledge and information, such as families and friends. Femicide review committees can reinforce a whole-of-state approach to GBVAW prevention, enhancing multi-sectoral and coordinated responses among all governmental and non-governmental agencies, and promote an understanding of GBVAW as a social problem that requires multi-sectoral interventions. All this can catalyse efforts by states to comply with their due diligence obligation to adequately prevent and address GBVAW, detect failures, and improve their responses to such violence.

#### 4.1.1 *Complementing existing legislation and policies on femicide/feminicide*

In-depth reviews of gender-related killing of women may have a strong impact in moving towards coordinated, multi-sectoral approaches. In those countries where

femicide/feminicide has been specifically criminalised, femicide reviews may allow to expand the scope of prevention measures to be adopted. In countries where femicides/feminicides are not specifically criminalised, but already socially and politically acknowledged as gender-based (i.e., not as gender-neutral violence), the introduction of femicide reviews may reinforce existing preventive policies and contribute to broader reforms.

Femicide reviews could complement existing FObs, where they exist, and constitute a step further in the work of providing knowledge to informing policies and measures to prevent GBVAW. In fact, many FObs have a wider scope than currently existing DHR/DVFR mechanisms, as they are not limited to gender-related killing committed by intimate partners or the domestic sphere, and this can contribute to death reviews that are equally wide, including gender-related killing of women committed also by perpetrators unknown to the victims. Broadening the scope of existing DHR/DVFRs could result in similar benefits in relation to GBVAW beyond domestic violence.

#### *4.1.2 Considering the knowledge and perspectives of families and social networks, and reparatory potential of their involvement*

Femicide reviews allow for the inclusion of the perspectives of families and social networks of victims (and possibly, perpetrators) who can provide valuable information that often remains invisible to institutions; they are, in fact, experts on the case.<sup>308</sup> This may facilitate a better understanding of the dynamics of GBVAW cases, as well as provide a view of existing services from a perspective very close to that of victims and perpetrators. The inclusion of families, friends and social networks expands the sources of information on gender-related killing of women, limited in most countries to criminal investigations and some public agencies.

In several countries, organised families of femicide/feminicide victims have played a critical role in pointing out failures and promoting better responses to gender-related killing of women.<sup>309</sup> Through femicide reviews, their expertise and perspective on concrete cases can also benefit the processes of identifying failures and lessons to be learned for improving multi-sectoral responses to GBVAW.

Moreover, the participation of families of the victims and the due consideration of their concerns and perspectives, can contribute to their own healing process and, in this sense, also constitutes an element of reparation for them. This will only be achievable if the purposes of the review are clearly set, so families know what to expect as an outcome of the review,<sup>310</sup> if the risk of secondary victimisation is minimised, and if a victim/survivor centred approach is ensured, respecting their agency, wishes, decisions, safety, dignity, and integrity.<sup>311</sup>

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<sup>308</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

<sup>309</sup> For example, organisations founded by families (mostly mothers) of women victims of feminicide in Mexico, such as “Nuestras Hijas de Regreso a Casa” (Our Daughters Back Home) <https://nuestrashijasderegresoacasa.blogspot.com>; “Justicia para nuestras hijas” (Justice for our daughters) [https://www.forofeministacyl.org/public/files/justicia\\_para\\_nuestras\\_hijaspdf.pdf](https://www.forofeministacyl.org/public/files/justicia_para_nuestras_hijaspdf.pdf); or in Colombia, as Fundación Femicidios Colombia, <https://www.femicidioscolombia.org>.

<sup>310</sup> See section 2.9.6 of this document.

<sup>311</sup> CEDAW General Recommendation No. 35, para. 33 b).

#### 4.1.3 Reinforcing a whole-of-state approach to GBVAW prevention

Instead of emphasising mainly criminal law responses to femicide/feminicide, in-depth reviews underline the importance of whole-of-state responses to GBVAW including gender-related killing of women. Femicide reviews have the potential to enhance multi-sectoral and coordinated responses among all governmental and non-governmental agencies, including sectors often not considered in the aftermath of femicide/feminicide, as the health sector, social services, education, housing, etc. In fact, DHR/DVFR practitioners and researchers indicate that review committees act as communities of practice and foster culture of inter-institutional cooperation. Femicide reviews would thus promote an understanding of GBVAW as a social problem that requires multi-sectoral interventions.

#### 4.1.4 Focusing on State responsibility in relation to GBVAW

Femicide reviews have the potential to catalyse efforts by States to comply with their due diligence obligation to prevent and address GBVAW.<sup>312</sup> Particularly in countries where State responsibility has been at the centre of women's mobilisations around femicide/feminicide, these reviews may help detect failures and improve the State's responses to GBVAW.

It should be underlined that femicide reviews do not preclude any disciplinary responsibility that might arise during the review of any case. Likewise, the practice of femicide reviews should not be framed as an alternative to legal remedies, including those available to families who allege a State's human rights violations in relation to any gender-based killing of a woman.

### 4.2. Normative framework for introduction of femicide reviews

As has been seen in the previous chapters, the introduction of FObs and DHR/DVFRs is consistent with the international human rights framework on GBVAW. The State's obligations to prevent, protect and, in general terms, adequately respond to GBVAW are well established in international human rights instruments at the UN and regional levels.

More specifically, to prevent and address GBVAW committed by private actors (non-State actors), States are under an obligation of due diligence to act, i.e. adopting and implementing diverse measures, including laws, institutions and a system in place to address such violence and "ensuring that they function effectively in practice and are supported by all State agents and bodies who diligently enforce the laws".<sup>313</sup> Femicide reviews have the potential to play a critical role in relation to these aspects.

Femicide reviews offer States the opportunity to identify weaknesses in their responses to GBVAW beyond limited statistical information by analysing gender-related killings of women in depth. Through this process, femicide reviews become a powerful tool to assess the effectiveness of existing GBVAW systems and to suggest ways for improvement.

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<sup>312</sup> See, e.g., UN Declaration on the Elimination of Violence against Women, [A/Res/48/104](#).

<sup>313</sup> CEDAW (2017) *cit*, para. 24 b).

Moreover, in-depth reviews that focus on all the circumstances surrounding femicides, including the role played by public services and other stakeholders, even when there was no previous report of violence by the victim, should contribute to an understanding of GBVAW as a social rather than a solely individual problem. This understanding of GBVAW highlights the broader social responsibilities to prevent and address such violence, in line with the recommendations of international human rights bodies.<sup>314</sup>

At the same time, existing legislation on GBVAW in different countries will often allow for the implementation of femicide reviews. These reviews fall easily within the scope of broader GBVAW prevention programs and mechanisms, which often have a multi-agency character.

It is, however, important to consider the explicit inclusion of femicide reviews in the respective domestic normative framework, as this may contribute to raise social awareness, as well as to reinforce the understanding of GBVAW and femicide prevention as a social concern. A legislative mandate would also ensure that femicide reviews are part of State policies on GBVAW, ideally transcending individual governments and legislatures, and facilitate the involvement of all relevant institutions. Specific normative provisions could outline the objectives of femicide reviews and clarify that public agencies have an obligation to implement the recommendations arising from femicide reviews.<sup>315</sup>

#### 4.3. Political and organisational requirements

Femicide reviews could be implemented, to a limited or wider extent, in any country. However, some countries are in a better position to put these reviews into practice. Countries where FObs exist are often countries where femicides/feminicides have reached the consideration of a serious public concern. Therefore, measures addressed at responding adequately to GBVAW and improving the prevention of these crimes may be considered highly needed. In such countries, femicide reviews may be considered as a step further to simply measuring or counting femicides/feminicides.

The introduction of femicide reviews may be especially adequate in countries where FObs are multi-agency initiatives. Partnerships among diverse government agencies, civil society groups, and academic institutions allow to pool resources, expertise, and knowledge, and help to ensure a comprehensive and multi-disciplinary perspective. Multi-agency FObs, then, are well placed to implement femicide reviews, building up on their previous working experience. In some countries, multi-agency coordinating bodies working on GBVAW including civil society organisations have been created, which could also implement femicide reviews.<sup>316</sup>

The inclusion of civil society organisations is important to ensure that a multi-disciplinary, inclusive, and representative approach is adopted in the selection and review of femicide/feminicide cases. These organisations often have specialised knowledge and expertise in GBVAW, human rights, and gender equality, together with specific knowledge

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<sup>314</sup> CEDAW (2017) *cit.*

<sup>315</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

<sup>316</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.



and understanding of minoritised groups of women. Their inclusion also helps to promote transparency and accountability, an issue particularly relevant in countries in which there is a lower level of trust in the authorities involved.

It is also necessary that essential services for cases of GBVAW are available and accessible in the territory (social services, housing / shelters, healthcare including mental health, police, justice sector).<sup>317</sup> As femicide reviews are intended to identify lessons to be learned and to improve the responses to GBVAW, it is indispensable that a minimum package of essential services are in place and that recommendations can be addressed to specific service providers from different sectors. In this sense, the utility of femicide reviews would be lower in cases where no services are available or accessible for victims/survivors of GBVAW, such as in remote or isolated rural areas.

#### 4.4. Resources required

In low-income countries or countries where female homicide numbers are high, the resources required to initiate and sustain a broad femicide review system may seem excessive. However, there may be a possibility to use available resources to set up a femicide review committee at the national, regional, or local level. For example, in countries where there are less resources at local and provincial level, it would be better to have committee at the central (or federal) level.<sup>318</sup>

In any event, to make femicide reviews feasible considering limited resources, a phased approach has been recommended,<sup>319</sup> starting with the review of a limited number of selected femicide cases, and later increasing the number of cases analysed. Some criteria for this gradual implementation are presented in the following sections.

#### 4.5. Extent of femicides reviewed

While DHR/DVFRs have focused on intimate-partner and family-related femicide, the methodology could be applied to other forms of gender-related killing, for example linked to sexual femicide. A restriction to killings related to domestic violence only would not be justified in countries where a wider concept of femicide/feminicide is used in legislation, public policies or in statistical frameworks.

Although non-intimate partner femicides/feminicides are related to complex social dynamics, the multi-agency selection of cases to be reviewed may be a valuable tool to focus on those that can provide the greater potential for improvement in agencies responses, according to the specific violence dynamics in specific countries and regions.

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<sup>317</sup> See UN Women, UNFPA, UNODC and UNDP (2015), *Essential Services Package for Women and Girls subject to Violence*, <https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence>.

<sup>318</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

<sup>319</sup> Dawson, M., Mathews, S., Abrahams, N., Campbell, J. (2017). *cit.*

However, if a phased approach is considered, it may make sense to initially prioritise intimate-partner femicides, especially considering that it tends to be the most prevalent form of gender-related killing of women, globally.

#### 4.6. Steps to set up and operate a femicide review committee

The present section outlines a number of steps that could be followed, in order to establish femicide reviews in a broad range of countries, particularly low and middle-income countries.

##### 4.6.1 *Femicide reviews within the mandate of existing multi-agency FOb*

In those countries in which there exist a multi-agency FOb, femicide reviews could be introduced in their mandate, as often their regulations already include, together with data analysis, research, advocacy, and raising awareness on femicide/feminicide and GBVAW. This means that, although in some cases DHR/DVFRs have been introduced by specific legislation, such as in the United Kingdom and Portugal, precise legal provisions are not a requirement to the implementation of femicide reviews where inter-agency collaboration is ongoing within FObs.

In countries where no multi-agency FObs are established, but some type of inter-agency coordination body exists in the area of GBVAW, femicide reviews could be introduced as part of the mandate of such bodies. In many countries, multi-sectoral initiatives are often in place to provide adequate responses to GBVAW, whether at the State or local levels.

For example, in Serbia, Coordination and Cooperation Groups are formed for the area of every public prosecutor's office. The Deputy Public Prosecutor chairs the Group, and representatives of the police and the Centre for Social Work participate in the group. The meetings are attended, if necessary, by representatives of the National Employment Service, health, educational and other relevant institutions, as well as the victims themselves. Subgroups for coordination and cooperation have been formed for individual municipalities. Moreover, a Council for Combating Domestic Violence was established in 2017, focused on coordination and prevention of domestic violence, and includes representatives of state bodies and institutions as well as representatives of scientific and other professional institutions and associations.<sup>320</sup> In countries that have similar mechanisms in place, femicide reviews could be introduced in the work of either cooperation and coordination groups, at the local level, or at central level within the scope of the functions of the Council for Combating Domestic Violence or similar body. In a first pilot phase, it could be adequate to place femicide reviews at the national or sub-national (e.g. regional or federated state) level, to allow for an adequate process of selection of cases to be reviewed.

In any case, the decision to set up a permanent femicide review committee at national or sub-national level, or several committees at the local level, will depend on available resources. In a first stage, it may be easier to set up a femicide review committee at national or sub-national level, with a permanent or stable character. This would allow the committee to consolidate its working processes and have a consistent inter-agency work.

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<sup>320</sup> Serbia (2020) *cit.*

#### 4.6.2 *Involving governmental and non-governmental agencies in the review*

While multi-agency FObs are a good starting point in terms of having a comprehensive and multi-disciplinary perspective around GBVAW and femicide, the specific work and political meaning of femicide reviews would require the inclusion of governmental and non-governmental actors. Academic and non-governmental organisations, including specialised GBVAW advocates and researchers in the field, should also be part of these committees. Their inclusion may be particularly beneficial to ensure that the process is not seen as an “internal procedure” within the State, especially in countries where the level of trust in public institutions is low.

The involvement of public agencies beyond the criminal justice system is also essential. As discussed, social and health services tend not to be the part of the regular work of FObs. It is important to ensure that all institutions that may receive recommendations deriving from a femicide review are part of the committee, as the review provides an opportunity of self-reflection in relation to the weaknesses and opportunities for learning and improvement in the responses of the different agencies.

Accordingly, femicide reviews committees should ensure the participation of:

- Gender equality / women’s affairs ministry (or equivalent);
- Ministry of Justice and related services;
- Public prosecutor’s office;
- Police and security agencies;
- Probation services;
- Social Affairs ministry and services, including child and family services;
- Ministry of Health and health services, including mental health;
- Specific governmental or non-governmental services addressing GBVAW, including shelters;
- Frontline victim’s advocates, including specialised in minoritised groups of women;
- Ministry of Education and educational institutions, in particular in cases where children have been either direct or indirect victims;
- Indigenous peoples’ ministry (or equivalent), where they exist;
- Other sectors/institutions, as relevant: services or entities specialised in minoritised communities, housing services;
- Any other governmental or non-governmental institution that, in the concrete context of the country, has a relevant role on GBVAW and femicide responses.

Those members who are representatives of public agencies should have a senior position within their own institution, a position that may ensure that the review and its conclusions and recommendations can be accepted and adopted by the respective agencies.

## Characteristics of femicide review committee members

All members of the review committee or team should have expertise in GBVAW. The appointment of an independent chair, who does not belong to any of the public agencies involved in the review, should also be encouraged. Independent and competent chairing can have an important impact on effective reviews and reduce the risk of secondary victimisation of indirect victims, as families and friends.<sup>321</sup>

Independence of the chair is particularly relevant in countries where State responsibility for impunity in feminicides has been a serious public concern or even been established as a human rights violation.<sup>322</sup> Independence of the committee as a whole could also be strengthened through the inclusion of academia and civil society organisations.

It is also important to ensure that the chair has adequate skills to conduct the review emphasising organisational responsibility while not attributing blame, and to ensure a safe and transparent review process.<sup>323</sup> However, it should be clearly stated that in case of arising issues that could be related to disciplinary responsibility, the corresponding disciplinary procedures should be taken.

### 4.6.3 Selection of cases

In low and middle-income countries, as well as in countries with high levels of gender-related killing, the review of all femicides is almost impossible. While this would allow to provide richer evidence, and a greater potential to stimulate system-wide improvements,<sup>324</sup> in many countries it is beyond feasibility.

The review of some femicide cases, as in some countries with DHR/DVFRs in place, may still offer a wide range of benefits in terms of lessons to be learned, for the agencies involved in GBVAW responses, as well as for societies and communities. Some criteria for the selection of cases are presented below.

#### a) Opportunity of the review (in relation to criminal proceedings)

As part of a first stage in a phased approach, it would appear appropriate to restrict reviews to femicide cases in which all legal procedures are closed or, at least, when criminal investigations are concluded. As discussed, this is the case in various countries where DHR/DVFRs are in place. Experts from different countries have underlined that reviews are facilitated by the information provided by the criminal justice system,<sup>325</sup> as this information can provide a starting point for the in-depth analysis.

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<sup>321</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

<sup>322</sup> For example, in Mexico. See: Inter-American Court of Human Rights (2009), *Case of Gonzalez et al. ("Cotton Field") vs. Mexico*. Judgement of November 16, 2009 (Preliminary Objection, Merits, Reparations and Costs).

<sup>323</sup> Haines-Delmont, et al. (2022). *cit.*

<sup>324</sup> Payton, J., et al. (2017). *cit.*

<sup>325</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

A clear time separation between criminal proceedings and a femicide review would help to avoid confusions related to the character and purposes of both processes. It would facilitate the understanding that femicide reviews are focused on learning lessons for agencies and communities and facilitating reforms, which is separate from and goes beyond establishing the individual responsibility of the perpetrator/s.

Nevertheless, if the conclusion of all legal procedures results in excessively delayed femicide reviews, it would be reasonable to initiate them at an intermediate stage, for example after the investigation phase is finished.

#### b) Scope of cases

In principle, the review of femicide/feminicide cases should not be restricted to those committed within the scope of intimate-partner violence or family violence. Although these crimes may constitute the most prevalent form of gender-related killing of women, other relevant contexts should not be excluded, as they might point at other type of deficiencies in responses to GBVAW. For example, the analysis of cases of sexual femicide or femicide committed in the context of gang-related violence or even organised crime, could be of the utmost importance in countries where this type of violence is increasing, as in some Latin American countries. Often, existing standard prevention procedures (SOPs) or protocols are not adequate for these cases, as they have been designed within a framework limited to intimate partner violence, and femicide reviews could provide important inputs for their improvement.<sup>326</sup>

It would also be beneficial to consider including other deaths related to GBVAW, such as the killings of children in the context of violence against their mothers. These crimes, as mentioned in section 3.4, in some cases are included in the data collected on femicide/feminicide, as in the case of Argentina (related to femicide) and Spain. In countries like Sweden, where child death reviews have been in practice for more than a decade, it is considered that these cases provide a possibility to learn about both women and children in very vulnerable situations and about women and children in marginalised groups.

Additionally, the reviews could include cases related to the suicide of women because of GBVAW they suffered, and other cases of lethal violence in the context of GBVAW, such as cases in which a woman kill her abuser.

The review of cases of attempted gender-related killing may be particularly useful, as these cases may benefit from the perspectives of the survivor and, maybe, a cooperating perpetrator, in relation to the access and functioning of available services.<sup>327</sup>

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<sup>326</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

<sup>327</sup> Neil Websdale, personal communication, 23 March 2023.

### c) Characteristics of cases

The criteria for the selection of cases could be based on the characteristics of crimes. Examples include the following:

- Those affecting minoritised communities or particularly marginalised groups of women, including for example, indigenous, immigrant, transgender women or women with disabilities;<sup>328</sup>
- Cases comprising deaths of women and their children or other family members;
- A selection of cases representative of different types of gender-related killing of women in a country or territory;
- Cases of non-intimate partner or non-family-related femicide/feminicides that are considered particularly relevant in the territory.

Adequate safeguards should be established to ensure confidentiality of the process, as well as the safety of reviewers. Risks should be assessed, in particular in cases related to some forms of organised criminality. Cases in which there is an ongoing risk of violence against families or the review team, femicide reviews should not be encouraged.

It is important to avoid an excessive focus on exceptional cases in the selection process, as such cases may not be representative of femicides generally. The selection should ideally include cases that represent common forms of gender-related killing occurring in the country or territory, rather than selecting only high-profile cases that indicate major agency failings, or campaigning on the part of advocates for the victim. Unless there is a specific justification, such as that those cases might still provide important lessons to be learned by agencies involved in GBVAW, a focus on exceptional cases may stand in the way of achieving the full potential of femicide reviews.

### d) Availability of services

Availability and accessibility of essential services on GBVAW in the place where the femicide/feminicide took place could also be considered. This could mean prioritise the crimes committed in territories where such services are more readily available and accessible, as for example, in cities and urban areas. In these cases, identified learning lessons could be concretely applied to improve the work of existing service providers and agencies in different sectors. However, reviews of femicides committed in rural or remote areas could be an important way to shed light on the necessity of implementing adequate mechanisms of response to GBVAW in those areas.

### e) Role of non-governmental actors

To strengthen the independence in the process of cases selection, the role of expert and non-governmental actors should be stressed. However, it is important to manage the selection process in a way to avoid potential competition among victims' advocates.

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<sup>328</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.

#### 4.6.4 Terms of reference of reviews

After the cases to be reviewed are selected, terms of reference should be established for every femicide review. The following elements should be considered, as a minimum.

##### a) Participation of families and social networks of victims and perpetrators

In all cases, the participation of families, friends and social networks of the victims should be considered as an essential part of the review process. Adequate safeguards should be put in place, including advocacy and support, to guarantee a central role for families in the review process, to ensure their concerns are addressed and that there is no further revictimisation or secondary victimisation in the process. Special measures should be taken when children are invited to take part of the review.

There should be clarity in relation to the purpose of reviews, to ensure that expectations of families and friends are not beyond what femicide reviews can achieve. This clarity is essential also in terms of understanding femicide reviews as a tool to drive change in society, and not only an initiative to collect information or identifying risk factors.

The participation of families and social networks of perpetrators should also be encouraged, as they could bring valuable insight into their often-unseen perspectives. This also correctly puts the focus on the perpetrators, the behaviours, relations and circumstances surrounding those who have committed a crime, instead of focusing the review on victims, their behaviours, and relations.<sup>329</sup>

##### b) Sectors and agencies part of the review

The terms of reference should identify all sectors and agencies that will be part of the review. These agencies should include agencies in contact with children where they have been direct or indirect victims of the femicide/femicide (schools, nurseries, juvenile agencies, or groups).

##### c) Time frame of the review

The terms of reference should define a timeline for the review to take place, as well as the period of time that it will cover. To enhance the review's value, it would be worthwhile to select the time frame so as include the effects of the crime, particularly on children of both victims and perpetrators, as well as the agencies involved in the crime's aftermath. The time frame that is covered in the review should be narrow enough to focus on events that are connected to the killing.<sup>330</sup> This is important to ensure that the recommendations arising from the review are consistent with the aim of preventing GBVAW.

The terms of reference should be agreed by the Committee or review team and be amended, as necessary.

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<sup>329</sup> Gabrielle Hosein, Expert focus group meeting, 4 April 2023.

<sup>330</sup> Moa Mannheimer, personal communication, 4-Apr-2023.

#### 4.6.5 Data, reports and recommendations

##### Data collection and reports

Data collection, through existing FObs or data collection initiatives, should continue separately or may be integrated into femicide reviews. In any case, the case selection of femicide reviews (in case not all gender-related killing of women is to be reviewed) should take into account the main trends identified through data collection.

It would be beneficial to ensure that all data is collected in line with the ICCS and the *Statistical framework for measuring the gender-related killing of women and girls (also referred to as “femicide/feminicide”)*, a statistical framework that allows for standardised data collection, and facilitates their comparability. All statistical data should also be published adequately to allow studies and research.

In principle, all femicide review reports should also be publicly available. However, the opinion of the victim’s families should be considered in relation to the use of pseudonyms for the victim and the adequate protection of personal and family details. Reports should be presented in the first place to families and be published later. Considering that individual reports should contribute to mourning and healing of families and communities affected by the crimes, specific and adequate mechanisms for their dissemination should be considered. Thematic reports should also be published, based on aggregate findings of individual reviews.

##### Recommendations and monitoring

Recommendations should be specific, measurable, achievable, realistic/reliable and timely. A mechanism for the follow up of recommendations should also be clearly established. Annual reports should identify general trends in relation to the crimes and the recommendations issued. Annual reports should also provide information on implementation of recommendations.

It is important that members of the Committees also support the implementation of recommendations within the institutions, including governmental and non-governmental agencies and services. For example, in Portugal, members of the EARHVD regularly have meetings with ministers in order to drive the implementation of recommendations in their sectors.<sup>331</sup>

##### Research

Studies and research based on publicly available femicide review’ reports and recommendations should also be encouraged, including the creation -where FObs do not exist- of a system to aggregate findings of individual published reviews.

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<sup>331</sup> Expert focus group meetings, 4-5 April 2023. See Section 6 of this document.



#### 4.6.6 *Pilot phase*

Initially, femicide reviews could be implemented as a pilot, in order to detect any difficulties in the processes related to country-specific factors, and also to benefit from insights gathered by agencies and professionals involved. The pilot could be limited to a specific region and/or territory, or to femicides committed during a specific period of time. Once the pilot is concluded, it should be reviewed, and the conclusions of the pilot should be the basis for the consolidation of femicide reviews.

## 5. Conclusions

This background paper has provided an overview of the main characteristics and work of DHR/DVFR committees and FObs in different countries. These mechanisms have a common focus on gender-related killings of women, understanding that these extreme crimes of GBVAW provide valuable information for broader GBVAW prevention policies.

While FObs focus mostly on data collection, DHR/DVFRs go a step further to in-depth analysis of domestic homicide cases, including the voices and perspectives of multiple agencies and social actors, including family members, friends, and social networks of the victim (and perpetrators). This allows DHR/DVFRs to identify specific weaknesses and, later, concrete recommendations for improvement in the services responses to GBVAW, even in the absence of previous reports of violence by the victims. The broader information gathered also enables a better identification of risk factors.

The introduction of femicide reviews have the potential to improve States' responses to GBVAW thanks to a deeper analysis and better recommendations. In addition, femicide reviews may have a wide array of broader impacts. Through the analysis of previous interventions (or lack thereof) of different agencies and services beyond the criminal justice system, based on existing data, records and the inputs and perspectives provided by friends and families, femicides reviews shift the focus of social and institutional attention beyond individual criminal responsibility and criminal justice responses. This contributes to a social understanding of GBVAW and femicide as complex social problems, beyond individual victims and perpetrators.

At the same time, femicide reviews place emphasis on the role of all agencies and communities dealing with GBVAW and the people affected by it, including children, friends, and family members. While public and private actors do not have the same obligations in relation to GBVAW, they all have a role in GBVAW and femicide prevention. The State and public agencies have a due diligence obligation to prevent and adequately respond to GBVAW, and for doing so, they must consider the role of private actors (from families to communities). Femicide reviews can help state agencies to take social and community factors into consideration in their interventions to end GBVAW.

Femicide reviews also have the potential to foster multi-sectoral coordination and whole-of-state responses to GBVAW. They promote the role of specialised agencies and personnel working on GBVAW, as well as other agencies and services dealing with GBVAW cases, like schools, nurseries, healthcare services including mental health, etc. The voices and perspectives from these agencies are often left out in processes focused on criminal procedures, and their expertise and understanding of complex cases of GBVAW is typically not shared with other agencies. Femicide reviews provide a unique opportunity for increased coordination, mutual knowledge and understanding among diverse agencies directly or indirectly involved in GBVAW, clarifying the roles and services each one is providing.

Femicide reviews cover a wider time frame, including the analysis of elements not only related to the crime, but also before and, possibly, after the crime. Accordingly, the sources of data are also wider, including agencies and services beyond the criminal justice system and other actors such as families, friends and social networks of victims and perpetrators.

Femicide reviews may also contribute to other positive outcomes at the level of families, communities affected by these crimes. For example, for the families and friends of the victims, femicide reviews may contribute to their own mourning and healing processes. Reviews may allow for the death of their family member or friend to become not just a tragedy but a learning experience for all agencies and for society in a broad sense, a contribution to improved responses to other GBVAW cases.

For the services previously involved with victims or perpetrators and their families, femicide reviews may allow professionals to cope with the emotional distress caused by the killings (for example, frustration or hopelessness). At the same time, these reviews may acknowledge their need for support in the aftermath of these crimes, and to transform a dramatic experience into a learning opportunity.

The existing diversity of DHR/DVFR models is a positive feature that can facilitate the adoption of femicide reviews in other countries. Each country or territory has unique characteristics that may make certain types of femicide review more appropriate than others, such as State or local level initiatives, a broader or more focused selection of cases, etc. Therefore, the diversity of existing DHR/DVFR models can be seen as an advantage, allowing for greater flexibility and adaptability in implementing femicide reviews.

In fact, femicide reviews could be implemented in any country, regardless of the existence of FObs or other specific initiatives focused on gender-related killings of women. However, as this background paper has stressed, the similarities between DHR/DVFRs and FObs constitute a strong starting point for the implementation of femicide reviews in countries where FObs exist. In particular, in countries where FObs have a multi-agency character, or where there are other inter-agency bodies working on GBVAW, femicide reviews could be introduced within the scope of their activities.

A phased approach to the introduction of femicide reviews seems appropriate. Different countries may develop femicide reviews at their own pace, according to the availability of human and material resources, and to the varying political and social concerns and sensitivities in relation to GBVAW and femicide.

Most importantly, for societies and communities, femicides reviews reinforce the understanding of GBVAW as a social problem, beyond inter-personal violence between two individuals. They emphasise the role of public and private agencies and entities, as well as communities, in adequately responding to GBVAW.

## 6. Experts consulted

- Marcela Arroyave (Costa Rica) Instituto Nacional de la Mujer de Costa Rica, INAMU
- Lyndal Bugeja (Australia) Operations Manager of the Coroners Court of Victoria, which includes the management of the Victorian Systemic Review of Family Violence Deaths
- Alicia Candia (Chile) Ministry of Gender Equality / Coordinator of Inter-sectoral Circuit of Femicide
- June Castello (Jamaica) Consultant on Gender and Development. Professor at the University of West Indies
- Khatidja Chantler (United Kingdom) Professor and researcher specialised on GBV and domestic abuse/homicide. Principal investigator of project HALT, focused on learning from DHRs, based in Manchester Metropolitan University
- Fiona Cram (New Zealand) Chair of the NZ Family Violence Death Review Committee
- Myrna Dawson (Canada) Professor of Sociology, University of Guelph and Director of the Canadian Femicide Observatory for Justice and Accountability.
- Tamar Dekanosidze (Georgia) Eurasia Regional Representative Equality Now and author of the last report of the Femicide Watch by the Public Defensor of Georgia
- Pauline Gulliver (New Zealand)
- Nahla Haidar (Lebanon) Member of the CEDAW Committee
- Gabrielle Hosein (Trinidad and Tobago)
- Mariela Labozzeta (Argentina) Coordinator of the Gender Network of the Ibero-American Association of Public Prosecutors (Asociación Iberoamericana de Ministerios Públicos, AIAMP)
- Leila Linhares Barsted (Brazil) Expert from the Committee of Experts of the Follow-up Mechanism to the Belém do Pará Convention (MESECVI)
- Moa Mannheimer (Sweden) Serious case reviews to prevent certain injuries and fatalities / National Board of Health and Welfare
- Mónica Maureira (Chile) Expert from the Committee of Experts of the Follow-up Mechanism to the Belém do Pará Convention (MESECVI)
- Luz Patricia Mejía (Venezuela) Technical Secretary of the Follow-up Mechanism to the Belém do Pará Convention (MESECVI)
- María Cristina Mendonça (Portugal) Permanent member of the EARHVD
- Frank Mullane (United Kingdom) CEO at Advocacy After Fatal Domestic Abuse (AAFDA) Ltd and DHR Network
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- Annamaria Picozzi (Italia) Deputy Prosecutor of Palermo and Legal adviser to the Senate Commission on femicide
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- Rhoda Reddock (Trinidad and Tobago), Member of the CEDAW Committee
- Soledad Rojas (Chile) Red Chilena contra la Violencia hacia las Mujeres
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- Eva Villarreal (Spain) Member of the Executive Secretariat of MESECVI
- Neil Websdale (USA), Professor of Criminology and Criminal Justice at Northern Arizona University and Director of the National Domestic Violence Fatality Review Initiative (NDVFRI).

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