
Reviewing Domestic Violence Fatalities

Summarizing National Developments

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Introduction

This document brings together information from across the country on domestic violence fatality reviews¹. The document:

- defines domestic violence;
- provides a state-by-state matrix of domestic violence death review initiatives;
- introduces teams' philosophies and some overarching philosophical questions;
- introduces a selection of the purposes and goals of teams;
- addresses team membership;
- explores death review team protocols;
- confronts concerns regarding confidentiality, liability, and immunity;
- offers a selection of questions, issues, concerns, and investigative methods already used by teams as they conduct death reviews;
- talks about the issue of effecting change through the process of reviewing domestic fatalities.

The full appendices listed in the print (not online) version offer an overview of existing research into domestic homicide and provide a variety of sample documents from selected states and jurisdictions who are at various stages in implementing fatality reviews. Many of these forms were not available in an electronic format and are therefore not available online at this time.

Working Definitions

Statutory definitions of domestic violence vary from state to state. For the purposes of this document, "domestic violence fatalities" refer to those homicides caused by domestic violence. The National Council of Juvenile and Family Court Judges' *Model Code on Domestic and Family Violence* defines domestic violence² as one or more of the below acts:

- i. attempting to cause or causing physical harm to another family member or household member;
- ii. placing a family or household member in fear of physical harm; or
- iii. causing a family or household member to engage involuntarily in sexual activity by force, threat of force, or duress.

¹The need for such a document was identified at the planning meeting for Domestic Violence Fatality Review: A National Summit, held in Key West, Florida, October 1998.

²Model Code 1-2,s 102(1994)

Preventable Death: "A preventable death is one in which, with retrospective analysis, it is determined that a reasonable intervention, (e.g., medical, educational, social, legal, psychological) might have prevented the death" (Colorado Child Fatality Review Commission Annual Report and Conference Proceedings, p. 15, 1991).

Reasonable: is defined by "taking into consideration the condition, circumstances or resources available" (Colorado Child Fatality Review Commission Annual Report and Conference Proceedings, p. 15, 1991).

Domestic violence death review: "means the deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence, for examination of the systemic interventions into known incidents of domestic violence occurring in the family of the deceased prior to the death, for consideration of altered systemic response to avert future domestic violence deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to eradicate, domestic violence."³

State-by-State Matrix of Domestic Violence Death Review Initiatives⁴

The following is a synopsis of known domestic violence fatality review activity on a state-by-state basis. For each state the synopsis includes a discussion of legislation introduced; the names and contact information for known fatality review teams, or committees constituted to work toward the formation of such teams; the specific foci of teams; and, examples of reviews conducted by teams or other bodies.

California

Legislation

California Penal Code s 11163.3 (a) provides for the establishment of county-level interagency domestic violence death review teams. These teams investigate both homicides and suicides related to domestic violence. The teams serve to ensure the role of domestic violence is recognized and that subsequent preventive measures are introduced.

California Penal Code s 11163.5 provides for the coordination and integration of state and local efforts to address fatal domestic violence and creates a body of information, the use of which is designed to prevent domestic violence deaths⁵. The legislation charges the California Department of Justice with the task of carrying out reviews. The California Department of Justice is to proceed with the cooperation of the state Department of Social Services, the state Department of Health Services, the California State Coroner's Association, the county Welfare Director's Association,

³Barbara Hart, Legal Committee, Domestic Violence Death Review, February 9, 1995, National Council of Juvenile and Family Court Judges.

⁴For sample legislation see Appendix B.

⁵CA Penal s 11163.5 (a).

and the state domestic violence coalition⁶. The Department of Justice produces an annual report of domestic violence deaths. Local teams report findings to the Department of Justice. Area agencies participating in the death reviews will finance the contributions of their team members. The state will not bear the costs of local teams.

Team Activity

Los Angeles County (California) Domestic Violence Fatality Review Team

Alana Bowman Special Assistant to Los Angeles City Attorney James Hahn 1600 City Hall East
200 N. Main Street Los Angeles CA 90012 213-237-0023 Fax: 213-485-8267

Santa Clara County Death Review Committee

Rolanda Pierre-Dixon Chair 70 West Hedding Street San Jose CA 95110 408-792-2533 Fax: 408-294-6746

Shasta County Domestic Fatality Review Team

McGregor Scott, Chairperson Domestic Violence Coordinating Council 1558 West Street, Suite 1
Reading CA 96001

See also:

Lt. Harry Bishop (point person for the review team) Shasta County Sheriff's Office Major Crimes
Unit 1525 Court St. Reading, CA 96001 530-245-6172

See also: Mark Williamson Family Court Services Reading CA, 96001 530-225-5707

Los Angeles County's Team Stated Goals

The Los Angeles County (California) Domestic Violence Fatality Review Team, formed in 1993 under the Chairship of Alana Bowman, identified four primary goals:

- i. establish the means to determine with accuracy the number of homicides and suicides related to domestic violence;
- ii. identify resources for appropriate on-site counseling services at the scene of a homicide or suicide (this project eventually separated off);
- iii. analyze patterns common to abusers and victims for possible identification as lethality assessment indicators;

⁶CA Penal s 11163.5 (b) (1).

- iv. develop systematic analysis of selected cases, focusing on the flow of each case through the various agencies in the system for indications of areas of improvement of strengthening of agency contacts and interagency response⁷.

Existing Reviews

The Charan Investigation

This domestic violence fatality review, conducted by the Commission on the Status of Women, City and County of San Francisco, is one of the most detailed ever conducted of a particular case. The Charan Investigation took place before the California legislation on domestic violence fatality reviews was introduced. Joseph Charan murdered his wife, Veena Charan, on January 15, 1990, and then took his own life. Veena Charan had sought the support of various government agencies for a period of 15 months prior to her demise. Veena had been separated from Joseph and was awarded custody of their nine-year-old son. During the 15 months preceding her death she made numerous reports to the police. Immediately prior to her death Joseph was arrested for felony wife beating and malicious mischief. As a result of his conviction for this offense Joseph received a 12-month suspended jail sentence. He was put on probation through the Adult Probation Department with the following three conditions: 1. domestic violence counseling; 2. stay away order; and 3. 30 days jail, of which he was given four days, the remainder to be served in the Sheriff's Work Alternative Program. Veena Charan obtained a restraining order through the civil courts. Mr. Charan violated the restraining order on several occasions. He also attempted to kidnap his son at the son's school. It was at the school that Mr. Charan killed his wife in front of school teachers and school children, before committing suicide.

The San Francisco Domestic Violence Consortium which commissioned the Charan investigation requested answers to three clusters of questions:

1. Do the departments of the City and County of San Francisco have policies and procedures relating to domestic violence? If so, what are they and how adequate are they?
2. Is there sufficient information-sharing among the departments in these particular types of cases?
3. Are there sufficient data to evaluate the effectiveness of the system? If not, what additional data need to be collected? What changes, if any, to current procedures can be adopted to avert future tragedies?

The case files and public testimony identified four essential gaps in service delivery in the Charan case:

1. Communication and Coordination

Aside from the communication between the San Francisco Police Department and the District Attorney's Office, there was little communication among the multiple agencies which had contact

⁷See also Bowman, Alana. 1997. "Establishing Domestic Violence Review Teams". *Domestic Violence Report*, August/September 1997, pp. 83, 93-94.

with Veena Charan. These multiple agencies included the municipal court, adult probation, family court services, and social services. The review committee called for centralization of information and better coordination of service delivery.

2. Data Collection

The commission recognized the need for systematic information about domestic violence cases. The investigation notes, "Data on the number of domestic violence cases handled by the departments ranged from very limited to none at all."⁸ The Commission deemed the data to be of central importance in the identification of the level of need for services and the subsequent delivery of those services.

3. Access to Services

The Commission pointed out that a lack of sensitivity to and an understanding of multicultural and gay/lesbian issues in city departments increases the numbers of those suffering from domestic violence.

4. Training

Most of the training recommendations pertained to the issues regarding multicultural awareness.⁹ Translation services were lacking. Specifically, there was a lack of translators in the Superior Court, Civil Division, and a limited number of translators in the Criminal Division. This problem created delays and misunderstandings of the agreements/court orders and proceedings. Specifically, the investigation called for the development of domestic violence advisory committees in each city department that worked with domestic violence cases.

Other excerpts from the Charan Investigation noted:

- Based on the incident reports involving Joseph Charan, the San Francisco Police Department did not deem the injuries Veena Charan and other family members received at the hands of Joseph Charan to be serious. Specifically, the report finds that "had the investigator looked at the pattern of violence established by Mr. Charan, and presented that information to the District Attorney's Office, stronger measures and responses to the situation may have prevented Joseph Charan from continuing the escalation of violence that led to the murder-suicide."¹⁰
- According to the felony protocol of the District Attorney's Office, prior history was one of the factors taken into account regarding re-booking. If the Assistant District Attorney had access to the same information the Commission did, the re-booking charges may have been different.
- Probation officers were not adequately trained in the dynamics of domestic violence.

⁸Investigation. p. 5.

⁹For a good recent discussion of these issues see Wang, 1996.

¹⁰Charan Investigation. p. 7

- The Commission called for greater domestic violence training of the Municipal Court, Criminal Division. In particular, it stated a "need for training judges on interpretation of restraining orders."¹¹
- Family Court Services refused to answer questions posed by the Commission, citing their need to maintain confidentiality. The Commission described this failure as "intransigence."¹² The report states the resistance of Family Court Services "is indicative of the lack of the department's efforts to improve the City's response to battered women and their children."¹³ The mediation strategies of the Family Court were also criticized by the Commission.

Final Report: Santa Clara County (California) Death Review Committee, October 1997.¹⁴

The Committee began work in 1994 and appears to have been among the first domestic violence review teams in the country. It defined "domestic violence related death" as one where the perpetrator and victim were "romantically linked," either at the time of death or prior to the death. At time of writing the Committee is reviewing 51 cases. Members selected three cases from 1993 to get started. The report contains information on:

- the types of deaths: homicide, homicide-suicide, suicide, accidental death, and police shootings.
- the police agencies involved in the case. Most involved the San Jose police department.
- the age, race, sex, and substance abuse history of any parties; the presence of children; weaponry used; status of the relationship (divorced, cohabiting, separated, etc.); existence of prior restraining orders; prior police involvement; and location of residence.

Highlights of the final report include:

- Age: average adult age of perpetrators and victims was 33 years (females 32; males 35).
- Sex of perpetrators: 44 male, seven female.
- 29 of the 51 homicides were committed with firearms. The report stresses that "as a community we must advocate for handgun control."¹⁵
- In 26 of the 51 cases the parties were separated or divorced at time of death.
- Police had prior domestic violence contacts with the parties in 11 cases.
- In six cases restraining orders were either active (four) or in the process of being issued (two).

¹¹Final Report: Santa Clara County pp. 11, 12, 13.

¹²Final Report: Santa Clara County pp. 11, 12, 13.

¹³Final Report: Santa Clara County pp. 11, 12, 13.

¹⁴By Rolanda Pierre-Dixon, Chair.

¹⁵Santa Clara County Death Review Committee Final Report, October 1993-September 1997.

- Race/Ethnicity: of the 51 victims, 17 were Asian, 14 white, 12 Hispanic, five African American, two mixed-race, one Indian (not Native American). Asian victims were over-represented among victims although only one of the Asian cases came to the attention of community agencies prior to the killing. The report notes, "This made members feel that we were not getting the word out about the dangers of domestic violence to the Asian community."¹⁶ This led to calls for greater Asian representation on the death review committee. The report notes three Asian members on the team. One committee member helped form the Asian Community Against Domestic Violence Coalition. This Coalition organized a domestic violence conference for the Vietnamese community in September 1997.

The suggestion that more Asian women need to be accessed through support services should not be taken to mean that those women who do not utilize services are somehow culpable for their own deaths. Karin Wang (1996) points to the way the cultural background of Asian women makes it difficult for them to utilize the support services offered by a predominantly white-run domestic violence movement.¹⁷ In addressing this issue, Wang argues that battered Asian-American women have not been well understood by the domestic violence movement.¹⁸

- The California legislation does not address the issue of domestic violence shelters turning over their records for purposes of death review. The reason offered in the report is that shelters were concerned about sharing information given by clients under guarantee of confidentiality. Informally, the team seems to have worked around this issue and it appears that a mechanism has emerged so that shelter team members do share information.
- The report also contains a list of questions that the team sought to answer regarding the delivery of services to families prior to the killing.

Colorado

Team Activity

Denver Domestic Violence Fatality Review Committee

¹⁶Report. p. 13

¹⁷Wang, 1996. She defines "Asian American" broadly to include "all persons of Asian ancestry living in the United States" (1996: 152, n3). This includes people from East Asia (including China, Japan, and Korea), Southeast Asia (including Burma, Cambodia, Laos, Thailand, Vietnam), South Asia (India) and the Philippines.

¹⁸Asian women differ from white women in at least three ways. First Wang points to the fact that the majority of Asian women are immigrants and therefore experience numerous language problems. These problems make it difficult for Asian women to obtain help from police, social services, or immigration services. For example, if police officers attending domestic disputes at Asian homes can understand the man and not the woman, it is likely that without special translator services, the Asian woman's story will be marginalized or go unheard. Second, the Asian cultural emphasis on saving face and valuing family above the individual, makes Asian women more hesitant when it comes to breaking up the family. Such a pronounced belief in the sanctity of the family in the face of violent victimization, combined with a cultural antipathy towards divorce, may make it more difficult for white shelter workers and advocates to offer support and understanding to groups like Korean women. Third, the traditional Asian gender roles of male provider and female homemakers are often disrupted by the American economy that requires both partners to work outside the home. This may be seen as liberating for Asian women, but it may, as Wang points out, be very threatening to the partners of Asian women, see Wang, 1996:171.

Project Safeguard 815 East 22nd Avenue Denver, CO 80205 303-863-7606

Project Safeguard is a pilot scheme of the City of Denver, Colorado, designed to investigate and prevent domestic violence homicides. The key goals of the project include setting up a pilot Fatality Review Committee in order to review systematically domestic deaths and educate system personnel, service providers, and perpetrator treatment programs with a view to prevention. Additionally, Project Safeguard sought to establish a red flag system through the analysis of fatalities from 1994-1996.

Delaware

Legislation

Delaware Statute Title 13 s 2105 empowers a domestic violence coordinating council to investigate and review, through a review panel, the facts and circumstances of all deaths occurring in Delaware resulting from domestic violence. This includes homicides and suicides. Reviews of deaths involving criminal investigations will be delayed at least six months from the time of death and must be authorized by the Attorney General's office. Child deaths are to be reviewed jointly by the Child Death Review Commission and the domestic violence fatal incident review panel. The death of a minor will be reviewed by the domestic violence fatal incident review panel only if the child's parents or guardians were involved in an abusive relationship and where the minor's death is directly related to that abuse.

Team Activity

Raina Fishbane, J.D. Domestic Violence Coordinating Council 900 King Street Wilmington DE 19801 302-577-2684

Formed in 1997, the fatality review team is a committee of the statewide coordinated council. The team is a multidisciplinary, multiagency group that meets monthly to research cases. The first report was expected in May 1998.

District of Columbia

Charlotte Clark U.S. District Attorney's Office Judiciary Center, Room 3433 Washington DC 20001 202-514-7375

The committee has plans to review cases from 1992 up to the present time, but only after the resolution of any pending criminal charges. They have suspended their meetings until they are able to obtain more funding.

Florida

Team Activity

The Florida Governor's Task Force on Domestic and Sexual Violence is setting up four fatality review teams. This project is funded by the Violence Against Women Grants Office, U.S. Department of Justice.

Miami/Dade Fatality Review Team

Lauren Lazarus Director, Domestic Violence Division Administrative Office of the Courts Eleventh Judicial Circuit of Florida Richard E. Gerstein Justice Building 1351 N.W. 12th Street, Room #130 Miami FL 33125 Office: 305-547-7115; Fax: 305-547-7134

Palm Beach County Fatality Review Team

Cynthia Rubenstein Chair Person, Domestic Violence Council of Palm Beach County YWCA Harmony House 901 South Olive Avenue West Palm Beach FL 33401 Office: 561-833-2439; Fax: 561-640-9155

Tampa/Hillsborough Fatality Review Team

Mabel Bexley Co-Chair of Fatality Review Team The Spring of Tampa Bay 209 N. Willow Tampa FL 33606 Office: 813-247-5433 ext. 312; Fax: 813-247-2930

Sgt. Rod Reder Co-Chair of Fatality Review Team Hillsborough County Sheriff's Department P.O. Box 3371 Tampa FL 33601 Office: 813-247-8916; Fax: 813-247-8750

Another good contact in Hillsborough County, Florida, is Detective Linda Burton, Hillsborough County Sheriff's Department, who heads up the Hillsborough County Child Fatality Review Team, 813-247-8678.

Volusia/Putnam County Fatality Review Team

Ms. M.F. Warren Co-Chair, Fatality Review Team Chief Executive Officer Domestic Abuse Council, Inc. 211 North Ridgewood Avenue, Suite 301 Daytona Beach FL 32114 Office: 904-257-2297x18; FAX: 904-248-1985

Captain Craig Broughton Co-Chair, Fatality Review Team Volusia County Sheriff's Office P.O. Box 569 Deland FL 32721 Office: 904-254-1537 ext. 1363; FAX: 904-254-1554

Existing Reviews

The first Florida Mortality Review Project Executive Summary was released in October 1998¹⁹. Highlights are shown below. For additional information contact:

Robin Hassler J.D. Executive Director Governor's Task Force on Domestic and Sexual Violence Executive Office of the Governor The Capitol Tallahassee FL 32399 850-921-2168.

¹⁹The project was carried out by Neil Websdale Ph. D. and Byron Johnson Ph. D. The project forms for the substrate for Neil Websdale's forthcoming book, *Understanding Domestic Homicide*, Northeastern University Press, 1999.

Florida Mortality Review Project: Executive Summary

Introduction

The Florida Department of Law Enforcement reported 230 domestic homicides for 1994. As a result of this disturbing statistic the Florida Governor's Task Force on Domestic and Sexual Violence funded a study of domestic fatalities in order to better understand, intervene, and prevent these crimes.

Methodology

For each domestic fatality in 1994 the researchers examined the following:

- The perpetrator-victim dyad: In particular the researchers examined the multiple dynamics of these murders, paying particular attention to the sex, race, ethnicity, sexual orientation, geo-cultural background (rural, suburban, urban), socioeconomic status, and marital status/familial relationship between perpetrators and victims.
- The situational antecedents to the fatality: Researchers explored the following:
 1. A prior history of domestic violence in the relationship.
 2. The presence or absence of injunctions both prior to the fatality or when the fatality occurred.
 3. Whether a divorce was pending at the time of death (with married couples).
 4. Whether there was any sign of relationship breakdown (variously measured).
 5. Whether there was any sign of acknowledged conflict in the relationship.
 6. Prior police calls to residence.
 7. History of drug/alcohol abuse.
 8. The residential origins of the perpetrator and victim. Was there a pattern of perpetrators abducting or transporting victims to areas beyond their regular communities before the fatality?
 9. Whether the victim or perpetrator had any history of emotional problems or mental illness and the specific forms of these problems. Had the perpetrator:
 - previously threatened to kill himself, his spouse, partner, or children?
 - fantasized, hatched a plan, or verbalized a plan to kill his spouse/partner?
 - a history of using weapons, especially firearms?
 - obsessively possessive beliefs about his spouse or partner?

- perceived his spouse/partner was betraying him by ending the relationship?
 - been hospitalized for depression and fantasized about killing his partner?
 - a history of hostage-taking?
- The lethal incident: Here researchers documented:
 1. The specific mode of killing.
 2. The types of weaponry used (handgun, rifle, shotgun, other firearm, knife or cutting instrument, blunt object, motor vehicle, poison, explosives, fire or incendiary device, personal weapons such as fists, feet, teeth, etc.).
 3. The availability of weapons.
 4. The involvement of drugs or alcohol during or immediately preceding the fatal episode.
 5. The presence of other parties at the scene (e.g. children, police, other professionals).
 6. The non-fatal wounding of others at the scene.
 7. The involvement of professionals at the scene.
 8. The location of the fatal incident.

Researchers drew information from the following data sources: police records; social service reports; court documents; newspaper accounts; autopsy reports; mental health records; hospital and public health/medical data; and, other information that may have had a bearing on the decedent and their family. They also interviewed professionals including but not limited to police, court personnel, mental health workers, social service providers, and advocates for battered women.

Key Findings²⁰

The Florida Department of Law Enforcement (FDLE) documented 230 domestic fatalities in Florida during the year of 1994. Perhaps the most important and compelling finding in this study was that the research revealed a total of **328** domestic fatalities in 1994. The disparity stemmed from four major issues:

1. Police departments often do not include child deaths due to abuse and neglect as part of their official domestic homicide count. The researchers included these deaths.
2. Police departments often do not include the suicide victims in domestic homicide-suicides in their official count. The researchers included these deaths. However, the researchers did not in-

²⁰For a very detailed case study analysis of these cases, see Neil Websdale, *Understanding Domestic Homicide*, Northeastern University Press, Boston, MA, 1999

clude those deaths from suicide that are related to domestic violence. This figure, largely unknown at this time, represents a huge number of potential deaths stemming from domestic victimization and is an area in urgent need of systematic research and policy initiatives.

3. Police sometimes did not code domestic deaths as such.
4. Police departments did not include boyfriend/girlfriend deaths as domestic homicides because they did not strictly meet the terms of the statute.

Adopting a broader definition of domestic homicide than law enforcement sources, the researchers showed that in 1994 approximately one-third of all homicides were related to domestic violence²¹. This ratio contrasts sharply with official police data which identifies only one-fifth of all homicides in Florida in 1994 as being caused by domestic violence. The essential findings from the 1994 Florida report on domestic violence deaths are shown below.

The analysis indicated that **294** of the **328** fatalities were consistent with the Florida Domestic Violence Statute²². The 34 remaining domestic fatalities either fell outside the statute criteria (e.g. victim and perpetrator were not married, lived at different addresses, and had no children together) or the researchers simply did not have enough information to determine if they met all the criteria of the statute.

Nearly all cases with multiple victims were perpetrated by men. In only six cases did a woman kill more than one victim, or murder her partner and then commit suicide. In no case did a woman murder her husband, her children, and then herself.

Many of the factors present in the multiple domestic killings also appear in the killing of individual women. Most of the individual women were killed by men. Nearly all of these cases involved women who had an extensive history of violent victimization prior to being killed. As the statistical analysis reveals, other important factors include prior threats to kill, escalating abuse, and obsessive possessiveness and jealousy on the part of perpetrators. In fewer cases there was prior documented involvement of police and other criminal justice agencies. Of all adult women victims, only three were killed by other women. Five adult female fatalities resulted from women killing themselves as part of multiple killing scenarios.

When women are killed in either multiple or single-victim domestic fatalities, it is usually the final event in an abusive relationship of long standing. When men are killed by other men or by women, it is rarely, if ever, the end-product of a battering relationship in which the men are the victims of

²¹Preliminary findings from 1995 reveal similar discrepancies between FDLE data and that number of domestic violence fatalities identified by the broader definition used Drs. Websdale and Johnson. Although FDLE identified 195 domestic homicides in 1995, as of October 1, 1998, Drs. Websdale and Johnson had confirmed at least 285 domestic violence related deaths.

²²Florida law defines "domestic violence" as "any assault, battery, sexual assault, sexual battery, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit". A "family or household member" refers to "spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a family, and persons who have a child in common regardless of whether they have been married or have resided together at any time". Florida Statute (1994) s 741.28.

abuse. When men are killed by other men in domestic situations, it is often because the two men are competing for a woman who has, in many cases, been victimized by one of the men. Three-quarters of all adult male domestic fatalities were perpetrated by men. Only one-quarter of the men who died were killed by women.

Women who killed men nearly always did so out of self-defense, or less often, the defense of their children. These women have always, or nearly always, been pushed to the brink of human endurance by the batterers who they eventually kill. While the killing of batterers by the long-standing victims of battering may not qualify as self-defense in a court of law, the act of defensive or preemptive violence by women is qualitatively different from the offensive acts of violence perpetrated by men against women.

The statistical analysis of child fatalities is hampered by missing data. Nevertheless, there are certain themes that seem to pervade these tragedies. The most common correlate is that the death of children resulting from abuse or neglect, occurs in homes where caretakers tend not to be married. About one-third of the perpetrators were mother's boyfriends, one-third were biological fathers, and approximately a quarter were biological mothers. These men sometimes had criminal records, including a history of violence. It is clear from multiple sources of data that child fatalities normally occur within a context of poverty, often abject poverty. Research findings also reveal that 50 percent of the children about whom we have reliable data have been physically abused before, often for a long period of time. However, it is not necessarily the case that this prior abuse has come to the attention of authorities. For example, very few of the families in which child fatalities occurred had prior documented contact with the police. Children who are under five years of age are clearly the most vulnerable. Over half of the child victims in our sample were under two years of age. Those who were older were often killed with easily obtained firearms.

"Red Flags" (situational antecedents) identified in order of frequency in the 106 cases where men killed in intimate female partners in Florida in 1994.

1. Prior history of domestic violence. Among these cases battered women often report an increasing entrapment.
2. Obsessively possessive beliefs on the part of the perpetrator. This is often accompanied by stalking behavior, close surveillance, inability to sleep on the part of the perpetrator, acute depression, perhaps a history of medication use, history of suicidal ideations, or, less commonly, documented suicide attempts.
3. Attempting to break away from the perpetrator, including divorce, separation, and estrangement. In a number of cases of breaking away researchers identified accompanying relationship difficulties regarding such matters as child custody/visitation.
4. Prior police involvement in the case.
5. Prior criminal history on the part of the perpetrator. In 43 percent of those cases where men killed their intimate female partners in non-multiple episodes, the men had prior histories of criminal behavior, nearly always involving violence.

6. Threats to kill the eventual victim. These were often communicated to family friends, relatives, neighbors, and others prior to the homicide.
7. Issuance of restraining orders (injunctions, protection orders).
8. Alcohol or drug use that often escalates prior to the fatal episode.

Hawaii

Team Activity

Linda A. Kiyotoki Supervisor, Domestic Violence Unit Adult Services Branch State of Hawaii Family Court First Court P.O. Box 3498 Honolulu HI 96811

An informal, in-house judicial review, that expands to include other criminal justice agency professionals and community players, has been in operation through Judge Michael Town's office in the Family Court in Hawaii for a number of years.²³

More recently, Cindy Kraemer of WATCH (Minnesota) reports that Hawaii state coalition against domestic violence was unable to gain cooperation to implement domestic fatality reviews due to fiscal constraints, confidentiality issues, and finger pointing. The coalition passed it off to the legislature. The 1997 legislative session did not introduce fatality review legislation due to financial difficulties.²⁴

Illinois

Team Activity

Neil Hochstadt, Ph.D. State Task Force Chairman LaRabida Hospital East 65th and Lake Michigan Chicago, IL 60649 Office: 773-363-6700 ext. 420

The area is trying to develop domestic violence fatality review teams using the existing child fatality review process as a linchpin.

Iowa

Probation Officer Tracy Bray and the Iowa Coalition Against Domestic Violence initiated the Iowa Domestic Violence Fatality Review Team project, which has yet to review a domestic fatality. Law enforcement had concerns about being a target or scapegoat, but once they were on board many others followed; their legislation passed in the 1998 session. The Iowa Department of Public Health

²³See review of the homicide-suicide case involving Maria Llacuna and John Lewis (1994-1996). We are grateful to Judge Town for sharing the review documentation in this case.

²⁴We are grateful to Cindy Kraemer, of WATCH (Minnesota) for this information regarding developments in Hawaii. WATCH conducted a survey of fatality review activity in the 50 states and received 47 replies. She found some activity in 19 states. We have used information from her draft document in this synopsis. E-mail communication August 14, 1998.

is the administrative agency and they are absorbing all additional expenses for the project. They anticipate reviewing approximately 12 domestic violence fatalities a year.

Kentucky

No legislation passed and no teams are in place as yet. However, the attorney general's office did conduct a synopsis of patterns of domestic violence related deaths.

Kentucky Attorney General's Task Force on Domestic Violence Crime: Domestic Violence Homicides and Suicides, October 1993.²⁵

This report emerged out of a broad initiative in Kentucky to increase awareness of domestic violence, a concern to furnish women and families with better state services, and a need to standardize data collection on domestic violence in general and domestic violence homicides and suicides in particular. The report summarizes the findings on domestic violence homicides and suicides which occurred in 1991, 1992, and the first quarter of 1993. The specific goals of the report were to collect and analyze all available data on domestic violence related homicides and suicides for the following purposes:

- To increase public and professional awareness about these particular crimes, the persons involved, and intervention measures utilized to prevent the homicide and suicide incidents.
- To improve the effectiveness of justice and community services planning for intervention in and prevention of these crimes.
- To improve the collection and reporting of domestic violence homicide and suicide incidents at the local, state, and national levels. The preliminary findings revealed:
 - 77 domestic violence related homicide and suicide incidents for 1991 (resulting in 95 deaths).²⁶
 - 63 incidents in 1992 (resulting in 74 deaths).
 - 23 incidents in the first quarter of 1993 (resulting in 30 deaths).
 - For the whole period, 96 male perpetrators killed 23 men and 82 women.
 - For the whole period, 48 female perpetrators killed 48 men and no women.
 - Domestic violence related homicides constituted 27 percent of all Kentucky homicides in 1991 and 22 percent of homicides in 1992.²⁷

²⁵By Chris Gorman, Kentucky Attorney General.

²⁶Some incidents resulted in multiple deaths. This observation is relevant to the analysis of a number of these statistics.

²⁷The report cautions that because of inconsistencies in data gathering these figures are tentative. For an analysis of homicide-suicides in Kentucky see Currens et al, 1991.

- Firearms were used to effect the majority of homicides (73 percent in 1991; 69 percent in 1992; 64 percent for the first quarter 1993).

Maine

Legislation

The Maine Commission on Domestic Abuse was constituted under Title 5, section 12004-I, subsection 74-C., and was required to establish the Domestic Abuse Homicide Review Panel, referred to in this subsection as the "panel," to review the deaths of persons who are killed by family or household members as defined by section 4002.

A. According to the legislation, the chair of the commission shall appoint members of the panel who have experience in providing services to victims of domestic abuse and shall include at least the following: the Chief Medical Examiner, a physician, a nurse, a law enforcement officer, the Commissioner of Human Services, the Commissioner of Corrections, the Commissioner of Public Safety, a judge as assigned by the Chief Justice of the Supreme Judicial Court, a representative of the Maine Prosecutor's Association, an assistant attorney general responsible for the prosecution of homicide cases designated by the Attorney General, an assistant attorney general handling child protection cases designated by the Attorney General, a victim-witness advocate, a mental health service provider, a facilitator of a certified batterers' intervention program under section 4014 and three persons designated by a statewide coalition for family crisis services.

B. The panel shall recommend to state and local agencies methods of improving the system for protecting persons from domestic abuse, including modifications of laws, rules, policies, and procedures following completion of adjudication.

C. The panel shall collect and compile data related to domestic abuse.

Team Activity

Anita St. Onge 207-780-5851 Portland ME

This state just formed a team which has held one meeting.

Minnesota

Team Activity

Jenny Harding WATCH 612-341-2747

WATCH has funding to research fatality review teams. This initial research is expected to be up and running January, 1999. WATCH has an advisory committee and is planning a site visit to observe an established team at work.

Nevada

Legislation

N.R.S. 217.475 (1997) states that a court or agency of local government can organize or sponsor one or more multidisciplinary teams to review deaths caused by domestic violence as defined in N.R.S. 33.018. The team serves at the pleasure of the court or agency. If a written request from a person related to the victim within the third degree of consanguinity is received within one-year after the fatality, then the court or agency shall review the death.

Team Activity

Washoe County Fatality Review Team

Judge Jan Berry District Court One 75 Court Street Reno NV 89501 Office: 702-328-3171

This team was established in 1994 as a subcommittee of the Washoe County Task Force on Domestic Violence. The team is multidisciplinary, multiagency, and meets regularly.²⁸

New Mexico

The University of New Mexico Department of Emergency Medicine is the administrative agency for their local domestic violence fatality review team. They initiated their effort in July, 1997 with a one-year Violence Against Women Act grant. All team members must sign a confidentiality agreement to enable them to share confidential information. With the exception of medical records, they have encountered little resistance to acquiring information when it is available. They are not pursuing legislation at this time. New Mexico had approximately 45-50 domestic violence fatalities in 1997.²⁹

New York

Bob Nicholais Staff Member on Commission New York State Office for the Prevention of Domestic Violence Capital View Office Park 52 Washington Street, Room 366 Rensselaer, New York 12144 518-486-6262

The Governor established a commission for a one-year review of domestic violence related homicides. A report of these findings entitled the "Commission on Domestic Violence Fatalities: Report to the Governor 1997" became available in October 1997. The Commission is still active with one full-time and one part-time paid position. New York City also produced a report on female homicides entitled, "Female Homicide Victims in New York City 1990-1994" available from: NYC Dept. of Health, Injury Prevention Program, 2 Lafayette Street, 20th Floor, New York, New York 10007.

Existing Reviews

²⁸Nevada Revised Statute N.R.S. 217.245

²⁹We are grateful to Cindy Kraemer, of WATCH (Minnesota) for this information regarding developments in New Mexico.

Commission on Domestic Violence Fatalities: Report to the Governor, 1997³⁰

The Commission was appointed by Executive Order of Governor George Pataki on October 1, 1996. It was charged with the responsibility to "investigate select domestic violence fatalities to determine whether the deaths were associated with any deficiencies in the social service system, law enforcement, the courts, or any other public or private entity."³¹ One of the tasks of the commission was to "assess whether a Fatality Review Board should be created to examine domestic violence fatalities."³² The commission was appointed in response to a number of high-profile domestic homicides that occurred when other forms of violent crime (e.g. murder, robbery, aggravated assault) in New York were declining.³³

Highlights of the 57 deaths,³⁴ reviewed by the Commission include:

- In most of the cases domestic violence preceded the homicide. In 70 percent of cases the perpetrator had a known history of physically abusing the decedent. Only six cases (11 percent) revealed no known history of prior abuse.
- Twenty-six of the 57 perpetrators (45.6 percent) had a prior criminal record of one or more arrests. All but four of those 26 offenders had prior arrests for domestic violence.
- In 21 of the 57 cases (36.8 percent) there was at least one active order of protection. In 17 of these 21 cases (81 percent) there had been a violation of an order prior to the homicide.
- Forty-three of the 57 victims (75 percent) had terminated, or had indicated an intention to terminate, their relationships at the time of the homicide.
- Reviewers found child custody disputes at the root of three homicides. In two of these three cases the homicide was committed in connection with the pick-up or drop-off of children.
- Most homicides took place in the home (75 percent). Nine percent occurred in the workplace and 11 percent in other public areas.
- Handguns were used in 20 (35 percent) of the cases; long guns in nine (16 percent). Of the 20 handguns used only four were possessed lawfully.
- Of the 57 offenders, 27 (47 percent) had indications of a history of alcohol abuse and 17 (30 percent) had indications of a history of drug use. These 44 offenders with a history of substance abuse included 12 with a history of both alcohol and drug use.

³⁰By Jeanine Ferris-Pirro, Westchester County District Attorney, Commission Chairperson.

³¹Report page 1. see note 1.

³²Report p. 1

³³From 1991-1995 violent crimes such as murder, robbery, and aggravated assault declined each year. There was a similar decline in property crimes such as burglary, larceny, and motor vehicle theft.

³⁴All decedents were females who had been in heterosexual relationships.

- The Commission makes the point that in 30 percent of cases there was no known history of domestic violence in the relationship. They conclude that the absence of any reported violence should not lead to the conclusion that there is a low-risk of mortality.
- Disappointingly, the Commission did not recommend the establishment of domestic fatality review teams.

Ohio

Team Activity

Hamilton County Fatality Review Team

Ann McDonald Co-Chair Women Helping Women Inc. 216 E. Ninth Street Cincinnati OH 45202-6109 513-977-5541

Terry Daly Co-Chair Hamilton County Coroner's Office 3159 Eden Avenue Cincinnati OH 45219 513-221-4524

The fatality review panel is organized under the auspices of the Hamilton County Domestic Violence Coordinating Council and is chaired by the Hamilton County Coroner. Their first meeting took place in July, 1996. Members worked on policies until January 1997, then conducted a review of an older closed case. In April, 1997 they did their first official review. They expect to review six or seven deaths a year.

Dayton³⁵

The Criminal Justice Council started their project in April, 1997. They began reviewing cases in August, 1997. Their local domestic violence coordinating council is a multidisciplinary agency, which helped in getting cooperation, especially from the police department. The Family Violence Collaborative handles all of the administrative responsibilities which are absorbed by their operating budget. They expect to review approximately 11 cases a year.

Oregon

Team Activity

Multnomah County Fatality Review Team

Chiquita Rollins Domestic Violence Coordinator Department of Community and Family Services 421 S.W. 6th, Suite 700 Portland OR 97204 503-248-3691 ext. 27806

Pennsylvania

Team Activity

³⁵At time of going to press there is little information about this team.

Philadelphia Women's Death Review Team

Dawn Berney Project Director Philadelphia Health Management Corporation 260 South Broad Street Philadelphia PA 19102-5085 215-985-2500

Another important contact in Philadelphia is Mimi Rose, J.D.

The Philadelphia Women's Death Review Team is a multiagency, multidisciplinary group convened as a public-private collaboration. Its aims are to reduce the number of domestic violence deaths by examining the role of violence in the lives of Philadelphia women killed by an intimate partner and the effects of the killing on their children. Without any funding or legislation the Philadelphia Department of Public Health with support from the District Attorney's Office is conducting reviews. This multidisciplinary team goes down to medical examiners' offices to review all homicides, suicides, unintentional injury, undetermined, inadequate certificates, peculiar circumstances (asthma, AIDS), all deaths of women from 15 to 60 years of age, not just domestic violence cases.³⁶ These deaths could either be directly related to domestic violence or indirectly related due to women's inability to access health care. Three thousand women die in Philadelphia every year and the team expects to look at 400 to 500 deaths. A central objective of the team is to be able to identify any domestic violence directed at decedents in the 12 months prior to the fatality. The meetings are quarterly.

Existing Reviews

The Deliberations of the Philadelphia Team

The Philadelphia Team³⁷ makes the following important observations about the deaths of women:

1. It is difficult to locate information on many of the female decedents, especially psycho-social data. Many of these women led invisible lives and their deaths often went unnoticed. Many of the women who die prematurely are not known to any community/legal systems.
2. Perpetrators of domestic homicide are often known within their communities and not only in their role as offenders. Some are known to mental health providers. The team asks whether it is not possible to flag or track such offenders who need but refuse psychiatric help.
3. Gun merchants do not always refuse to sell firearms to individuals with Protection from Abuse Orders against them. Additionally, judges do not always order perpetrators in domestic violence

³⁶This is not to suggest that the deaths of women aged over 60 are not due to domestic violence. In fact, the phenomenon of suicide pacts in which elderly men kill elderly women and then themselves cannot be assumed to be free of a history of domestic violence. Indeed, gerontologist Donna Cohen found that homicide-suicides involving elderly women in West Central Florida from 1988-1994 doubled. In all, such homicides accounted for 20 % of the total homicides of people aged over 55. Cohen also notes that while 50% of the women's health had deteriorated, two-thirds had expressed "no desire to die." Evidence that women killed in so-called mercy killings or suicide pacts had previously expressed "no desire to die" may suggest they were battered prior to their demise (Cited in Charles Ewing, 1997, *Fatal Families* . Sage, Thousand Oaks, CA, p. 143).

³⁷At time of writing the Philadelphia Team is in the process of producing preliminary systematic data on the deaths of women. Contact Dawn Berney for details, 215-985-2500.

situations to relinquish previously acquired weapons. The team raises a number of questions about the use of the judiciary to remove or manage access to weaponry.

4. Women who die from HIV/AIDS are often connected to lifestyles involving drug use and prostitution. It is well documented that prostitutes suffer inordinate amounts of abuse at the hands of men. Indeed there is a clear correlation between women enduring lives as prostitutes and women's poverty and interpersonal brutalization. There is also a growing literature pointing to the vulnerability of battered women to HIV infections.³⁸

Tennessee

According to Tennessee's pending legislation they will have a state panel attached to the Department of Health. Some of the duties of the state panel will include: reviewing reports from local domestic violence lethality and fatality review panels; making recommendations for any changes to laws, rules, and policies that would promote the safety and well-being of families and children of domestic violence; undertaking annual statistical studies of the incidence and cause of domestic violence fatalities; providing training and written materials to the local panels; developing protocols for the collection of data; providing technical assistance to local panels; and periodically assessing the operations of domestic violence lethality and fatality prevention efforts.

They are to establish a minimum of one local panel in each judicial district. The local panels are to: review all deaths related to domestic violence; collect and submit data to the state panel; submit recommendations and advocate for system improvements and resources where gaps and deficiencies may exist; and participate in training provided by the state panel.³⁹

Washington

Team Activity

Domestic Violence Fatality Review Project

Margaret Hobart Project Manager DSHS Children's Administration P.O. Box 45710 Olympia WA 98504-5710 Office: 360-902-7976

Under a Violence Against Women Act grant to encourage arrest, the Washington State Domestic Violence Fatality Review Project has begun to document the decision-making process regarding the form and purpose of fatality review, and has established procedures and protocols to guide it. As of October 1, 1998, the project has overseen the review of four domestic violence fatalities.⁴⁰ The team has created many materials including an overview, educational tools, surveys and forms. As of August, 1998 four fatality review teams were operating in five counties in Washington State. These teams are coordinated through Margaret Hobart's office.

³⁸See Websdale, N. & Johnson, B. 1997. "Battered Women's Vulnerability to HIV Infection," *Justice Professional* , Vol. 10, #4.

³⁹I am grateful to Cindy Kraemer, of WATCH (Minnesota) for this information regarding developments in Tennessee.

⁴⁰Conversation between the authors and Margaret Hobart (July 16, 1998). The pilot projects in Washington State have begun in Spokane County, Pierce County, and Chelan/Douglas/Okanogan Counties.

West Virginia

The Supreme Court of Appeals voted unanimously to establish fatality review teams in December, 1994. The role of the fatality review teams is to examine court cases where a death has occurred in order to identify any patterns or trends that may be present, to examine court procedures to determine whether proper steps were taken, to review applicable statutes and rules to see whether amendments are needed, and to assess whether other involved agencies followed required processes and whether there was a coordinated effort among agencies to address the issues in the case.

The West Virginia program does not focus on domestic violence deaths only, although they do acknowledge most of the cases reviewed are domestic violence related. In 1997 they reviewed four cases involving five deaths. One was a murder-suicide. The administrative director of the program reviews cases to determine if they meet their criteria. Then the case is shown to the Chief Justice of the State Supreme Court, if they concur the case is referred to one of their three Fatality Review Teams. A case is never reviewed by the team from the community in which the death occurred. The team will examine the case, produce findings, and develop recommendations. This information is given to the Chief Justice of the State Supreme Court who may make recommendations to the Supreme Court. This document is not public; however, a synopsis of all the fatality review team reports is produced each calendar year.⁴¹

Wyoming

Team Activity

Rick Robb Department of Social Services Hathaway Building #322 Cheyenne WY 82002 307-777-7150

Area social service agencies review domestic fatalities as those deaths are reported. There is no multiagency committee. Teams are just starting to review adult cases.

Fatality Review Team Philosophies

Domestic violence fatality review committees have learned much from death reviews in the field of medicine. The medical review model is based on the internal reviews of deaths that occur in hospital settings. Personnel involved with patients who die in questionable circumstances present information to the team. The team gathers the information together and reaches a conclusion about the reasons for the fatality. Teams adopting the medical review model should be aware of one of the earlier problems in this process, namely, "catching rascals, rather than on improving hospital wide performance" (Rosen and Susman, 1983). Child fatality review teams initially emerged with a punitive ethos.⁴² In particular, some teams sought to identify breakdowns in the system of service delivery. Later teams focused less on individual accountability and more on system-wide service coordination. However, as the Colorado Committee points out, if cases are handled improperly, or

⁴¹I am grateful to Cindy Kraemer, of WATCH (Minnesota) for this information regarding developments in West Virginia.

⁴²Stone, 1995:13.

if a crime is committed, agencies with the greatest involvement and clearest responsibility are asked to put things right. In especially egregious situations, matters can be submitted to a grand jury (see Stone, 1995: pp. 15-17 and especially note 59).

Domestic violence fatality reviews that have gotten off the ground in a small number of states have tried to adhere to this no-blame and shame ethos. Examples where this philosophy is explicitly written into the operational protocols include the reviews in Hawaii conducted out of Judge Michael Town's office and the Project Safeguard reviews through the City of Denver. For example, the mission statement of Project Safeguard includes, "It is recognized that perpetrators of domestic violence are ultimately responsible for the death of victims. Thus, the goal of this committee is *not to place blame* but rather to better understand the dynamics of domestic violence when death is involved and thereby diminish the possibilities of future fatalities."

Death Review Team Purposes and Goals

From reviewing existing literature, a common purpose for the existing teams is to better understand, intervene, and prevent domestic homicide.⁴³

Family Court Judge Michael Town, Hawaii, hopes review teams will:

1. improve communication among the court and agencies in a time of crisis;
2. provide accurate information to others including the media and elected officials;
3. suggest improvements in the multiple systems involved in domestic violence cases.⁴⁴

Scope of Review

It is clear from review teams across the country that there is considerable variation in terms of which deaths are reviewed. As noted, the Philadelphia Project reviews hundreds of cases, taking perhaps 30 minutes per review. The idea in Philadelphia is to identify as many cases as possible where women died as a direct or indirect result of domestic violence. Conversely, reviews like the Charan Investigation seek to identify system failures through an extremely detailed analysis of one case. In many ways the Florida fatality review project is intermediate between these two ends of the continuum. Although the Florida study has not conducted public hearings with respect to the cases reviewed, the deaths are scrutinized in great detail using materials from multiple agencies. At the same time the Florida study identified and then reviewed 328 domestic deaths, a number comparable to the Philadelphia undertaking.

As the Florida teams form and begin their review work another recurring theme has been whether to review near fatalities. This concern to review near fatalities has also cropped up elsewhere. One

⁴³This wording was used explicitly in initiating the domestic mortality review process in Florida under the Governor's Task Force on Domestic and Sexual Violence.

⁴⁴Honorable Michael A. Town, Domestic Violence Death Review Teams, National Council of Juvenile and Family Court Judges, *Family Violence: State of the Art Court Programs*, 89, (1992).

possibility is the formation of a subcommittee or offshoot review body, charged with reviewing incidents where women are severely injured but not killed. Given the fact that witnesses who survive these near-fatal episodes will be severely traumatized the approach to this kind of review raises important ethical questions.

Education and Awareness

Another commonly stated goal of teams is to educate the community in general, and women in particular, about the heightened risk of lethal domestic violence. Ideally, education may enable victims of domestic violence to make more informed choices about their survival strategies and service providers to assist them more effectively. As Stone points out, "there is a fine line between warning and frightening. The women should not be discouraged from leaving a dangerous situation; they should be assisted in developing a safety plan and protected during its implementation."⁴⁵ However, given that battered women are often extremely perceptive about men's use of violence and finely attuned to escalations in violence, none of the above should be taken to mean the reason battered women are killed is they are poorly informed of the risks they face. Clearly, as noted elsewhere, batterers are responsible for their violence and the extension of multiple services to battered women in combination with the incapacitation of batterers is the best prevention tool.

Fatality Review Team Membership

Legislation setting up child fatality review teams is varied in its mandates and recommendations regarding team membership. As Stone indicates, some states did not legislate membership,⁴⁶ others required a small number of members,⁴⁷ and still others spelled out who members should be or where they should be drawn from.⁴⁸ The discussions about membership of child fatality review teams varied by state. These discussions have informed the debate about membership of adult review teams. Usually adult fatality review teams are inclusive rather than exclusive, often being open to incorporating new members and agencies. With regard to adult review teams, Stone recommends including a member of the public to guard against members engaging in cover-ups. In Nevada, teams must include, without limitation, representatives of organizations concerned with law enforcement, physical and mental health, or the prevention of domestic violence and assistance to victims of domestic violence.⁴⁹ In Delaware, a Fatal Incident Review Team will be co-chaired by two members of the Coordinating Council. In addition to the Chairs, the Review Team shall consist of six other core members: the Attorney General or his or her designee, the Director of the Division

⁴⁵Stone, 1995:11.

⁴⁶See for example, MO. Rev. Stat. ss 210-192, 194-196 (1994). Stone, 1995: 19 and note 70.

⁴⁷See for example, GA Code Ann. ss 19-15-1, 3, 4 (1995). Stone, 1995: 19 and note 71.

⁴⁸See Oka. Stat. Tit. 10 ss 1150. 1-4, mandating the team be composed of 21 members. See Stone, 1995: 19 and note 73. Ten of these members are the: Chief Medical Examiner; Director of the Department of Human Services; Director of the Office of Child Abuse Prevention; Director of the Oklahoma Commission of Children and Youth; Chief Child Abuse Examiner; Chief of Maternal and Child Health Services of the State Department of Health; Director of the Department of Mental Health and Substance Abuse Services; Chairman of the Child Protection Committee of the Children's Hospital of Oklahoma; State Epidemiologist of the State Department of Health. The remaining eleven members are to be appointed by the Director of the Oklahoma Commission on Children and Youth. The legislation specifies the agencies from which these eleven remaining members are to be drawn.

⁴⁹N.R.S. 217.475 ss 3.

of Family Services or his or her designee, the chair of the Domestic Violence Task Force or his or her designee, the Chief Judge of the Family Court or his or her designee, the Chief Magistrate of the Justice of the Peace Courts or his or her designee and a law enforcement officer to be appointed by the Delaware Chiefs of Police Council. The Team can invite other members to serve on an ad hoc basis and participate as full members of the team for a particular review. Such persons may include, but are not limited to, individuals with particular expertise that would be helpful to the review panel, representatives from organizations or agencies that had contact with or provided services to the individual prior to his or her death, that individual's abusive partner or family member, or the alleged perpetrator of the death.

Under California Penal Code 11163.3 (d1-11) domestic violence death review teams shall be comprised of, but not limited to, the following:

1. Experts in the field of forensic pathology.
2. Medical personnel with expertise in domestic violence abuse.
3. Coroners and medical examiners.
4. Criminologists.
5. District attorneys and city attorneys.
6. Domestic violence shelter service staff and battered women's advocates.
7. Law enforcement personnel.
8. Representatives of local agencies that are involved with domestic violence abuse reporting.
9. County health department staff who deal with domestic violence victims' health issues.
10. Representatives of local child abuse agencies.
11. Local professional associations of persons described in 1-10.

The California legislation still allows for local discretion around the construction of teams. Since the originating agency is not restricted by the legislation, each county is free to decide upon the convening agency. Alana Bowman recommends that several advocates for battered women be included in the makeup of the teams to assure that the perspectives of victims are incorporated into social policy. Given the importance of appreciating the perspectives of underserved populations, it might also be useful to have advocates who have experience working with abused minority women, the elderly, women from rural communities, and disabled women.

Although membership patterns vary slightly from state to state, the core of the teams seems to be drawn from three main arenas: public health; criminal justice; and, advocacy/social services. I refer readers to the appendices for these minor variations by state.

Death Review Team Protocols⁵⁰

In the case of child fatality review teams, participants tended to organize locally and engage in face-to-face deliberations. Except for Georgia,⁵¹ all states which pioneered child teams put them under the auspices of an existing agency or state official. The early legislation establishing child death review teams did not delineate specific activities, duties, and protocols for those teams. Rather, local teams worked out these issues. Later legislation benefited from these pioneering activities and the work of subsequent teams was more closely specified.⁵²

A number of adult domestic violence fatality review teams have produced interagency agreements that facilitate the sharing of information and otherwise assist with the collation, coordination, and synthesis of data from each agency.⁵³

Under California Penal Code s 11163.3 (c) a county can develop a protocol that may be used as a guideline to assist coroners and other persons who perform autopsies on domestic violence victims to determine whether domestic violence contributed to death or whether domestic violence had occurred prior to death, but was not the actual cause of death.

The Washington State Project highlights two models for death reviews: the "Investigative Fatality Review" and the "Systems Analysis Fatality Review." The "investigative model" prioritizes the need to identify domestic violence fatalities which have not previously been identified as domestic violence related by police, prosecutors, and coroners. Its goals include understanding how or why deaths were not classified as domestic violence related and working toward clearer elucidation of causes of death. In particular, the investigative reviews make much of the need to improve protocols for coroners and others investigating deaths. If this is achieved then the outcome will be not only a more accurate count of domestic violence related deaths, but also an increase in public awareness of domestic violence as a threat to life and well-being. The "systems approach" prioritizes the need to identify how interventions were ineffective. The goal is to change the policies and procedures of involved agencies. Under this model, it is not necessary to identify every domestic violence related death.

Confidentiality, Liability and Immunity⁵⁴

This section introduces a complex set of issues that will be discussed at great length at the Domestic Violence Fatality Reviews: A National Summit, in Key West, October 1998. The information below is not designed to present definitive positions on confidentiality, liability, and immunity. Rather it

⁵⁰See Appendix A for sample interagency agreements.

⁵¹As Stone notes, "Georgia's state panel was not part of any state agency or the responsibility of any state official (1995:16; n. 26).

⁵²See for example, Cal. Penal Codes ss 11166.7, 8 (Deering 1995); Minn. Statute s 256.01 (1994); Or Rev. Stat. s 418.747 (1994); Georgia Code Ann. ss 19-15-1,3,4 (1995); all cited in Stone, 18, note 68.

⁵³See Appendix A for a sample document from Washoe County, Nevada.

⁵⁴See Appendix C for sample confidentiality documents.

is anticipated that jurisdictions will move toward resolving these issues and concerns in their own way.⁵⁵

Among child fatality review teams, Minnesota was one of the first states to address the confidentiality issue. Under the Minnesota Statute,⁵⁶ the team has access to confidential (non-public) information if maltreatment is thought to have contributed to the death. This includes private hospital records. This confidential information is not subject to subpoena or discovery. Neither can the deliberations at the Minnesota team meetings be disclosed, unless disclosure furthers the process of reviewing the death.

Regarding adult domestic violence fatality review, a small number of states have addressed issues regarding confidentiality, liability, and immunity. In Nevada, information can be shared among team members regarding the decedent or any person who was in contact with the victim and any other information deemed by the team to be pertinent to the review. This information is to remain confidential.⁵⁷ In addition, each member of the team is immune from civil or criminal liability for an activity related to the review of the death.⁵⁸ Those related to the decedent within the third degree of consanguinity may receive a report of the domestic fatality from the team.

In Delaware, the review process, and any records created by it, shall be exempt from the provisions of the Freedom of Information Act in Chapter 100 of Title 29. All records and documents contributing to the formulation of reviews are deemed confidential. Such records and documents are not subject to subpoena or discovery. Team members will not be required to make any statements regarding review deliberations.⁵⁹ Likewise members and their agents will be immune from claims and not be subject to any suits, liability, damages or any other recourse, civil or criminal, arising from any act, proceeding, decision or determination undertaken or performed or recommendation made, provided such persons acted in good faith and without malice in carrying out their responsibilities; good faith and lack of malice are presumed and the burden of proving otherwise falls upon the complainant.⁶⁰

In Maine, persons disclosing or providing information or records upon the request of the panel are not criminally or civilly liable for disclosing or providing information or records in compliance with this paragraph. The proceedings and records of the panel are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The commission shall disclose conclusions of the review panel upon request, but may not disclose information, records or data that are otherwise classified as confidential.

⁵⁵Our observations are greatly extended by information provided by Barbara Hart at the Key West Summit.

⁵⁶Minnesota Public Welfare and Related Activities, Chapter 256 Human Services; Minn. Stat. 256.01, subd. 12 (1994). Cited by Stone, 1995: 21 n. 34.

⁵⁷N.R.S. 217.475. ss 4.

⁵⁸N.R.S. 217.475 ss 8. Subsection 9 states that the "results of the review....are not admissible in any civil action or proceeding."

⁵⁹Delaware Statute Title 13 s 2105 (h).

⁶⁰Delaware Statute Title 13 s 2105 (i).

Other teams have required team members to sign statements saying they will not disclose confidential information. Under this arrangement case-identifying information with agency identifiers can only be removed from team meetings by the agency contributing the information.⁶¹

Immunity laws may be required to insulate team members from personal liability stemming from their participation in death reviews. States may want to pass laws to protect team members. However, the consensus seems to be that the risk of personal liability is minimal.⁶²

Conducting the Reveiw: Some Practical Considerations

Alana Bowman has identified a number of possible steps involved in creating review teams. I paraphrase these below:

- a. Decide upon an agency to house the project, send out notices, gather information, and generate reports.
- b. Identify key agencies and their possible representatives and alternates.
- c. Require everyone involved to sign confidentiality agreements, both individually and on behalf of their agencies.
- d. Define goals, purposes, etc. of team.
- e. Develop procedures and protocols for what the team will review.
- f. Select cases to review.
- g. Have team members conduct reviews of their own agency involvement in a case and contribute this information when team review convenes. The team can then synthesize respective contributions into an overall review.
- h. Summarize review.
- i. Decide upon dissemination of review findings.
- j. Develop aggregate data from many reviews and decide upon public dissemination and formatting.

Team members will likely review the deaths in their respective agencies and bring those findings to the death review team. Protocols need to be established regarding the timing of the review, producing reports, disseminating information, etc.. Most existing teams examine domestic violence-related deaths in which there are/were romantic links between the parties (e.g. Santa Clara County,

⁶¹To overcome the confidentiality issue across state lines may require passing federal legislation.

⁶²See Ronald F. Wright and Jack C. Smith, "State Level Expert Review Committees --- Are They Protected?" 1990. U.S. Department of Health and Human Services: Public Health Reports 105: 13-23. Cited by Stone, 1995, note 125. However, concerns about liability have assumed center-stage in our work in Florida. Team members have consistently expressed feeling vulnerable to subpoena in lawsuits if they share or a party to the sharing of sensitive information.

Washington State). It seems that teams have paid less attention to phenomena such as the killings between men stemming from competition over women. Another key issue is whether to review open or closed cases. Research in Florida reveals that reviewing cases pending prosecution is problematic because the state is unwilling or unable to share information that might compromise a conviction.⁶³ Most known teams find closed cases ideal to review. Alana Bowman suggests that for teams starting their review work it is best to review homicide-suicides in which the perpetrator is clearly identified and there is no prosecution pending.

Existing teams have varying powers regarding the acquisition of information. In Florida, teams are discussing the feasibility of bringing in witnesses to improve understanding of domestic deaths. Other states have formally empowered teams in this area. For example, the Delaware review team has the power and authority to administer oaths and to compel the attendance of witnesses whose testimony is related to the death under review. It can also compel the production of records related to the death by filing a praecipe⁶⁴ for a subpoena, through the office of the Attorney General, with the Prothonotary⁶⁵ of any county.⁶⁶

Changing Policies

Monitoring Change

Policy changes have developed as a result of team activity. The San Francisco Task Force investigating the Charan case suggested that an independent task force be established to monitor the implementation of the Charan investigation recommendations (see Stone, p.6). Under the medical model, mortality reviews are themselves reviewed. First, causes of death are scrutinized. Second, the review process is assessed by a central body under the broad umbrella of "Quality Assurance" (see Stone, 1995: 13-14 and note 52). This review of the reviews can occur on an annual basis.

Delaware review teams must issue annual reports to the Domestic Violence Coordinating Council summarizing in aggregate fashion all findings and recommendations made over the preceding year. The summaries must note any systemic changes introduced as a result of review work.⁶⁷ The commission shall disclose conclusions of the review panel upon request, but may not disclose information, records or data that are otherwise classified as confidential.

The Maine Commission shall submit a report on the panel's activities, conclusions, and recommendations to the joint standing committee of the Legislature having jurisdiction over judiciary matters by January 1, 1999, and annually thereafter.

Typical recommendations for change include:

⁶³See Websdale, 1999.

⁶⁴A praecipe is an original writ drawn up in the alternative.

⁶⁵A prothonotary is an officer who officiates as principal clerk of courts in states such as Pennsylvania.

⁶⁶Delaware Statute Title 13 s 2105 (d).

⁶⁷Delaware Statute Title 13 s 2105 (g).

- Disseminating information to victims of domestic violence so that they can make more informed choices regarding risk of lethal violence, leaving violent men, etc..
- Educating the public through agencies such as schools and the media. For example, the Santa Clara County report recommends all school districts develop a curriculum which addresses domestic violence.⁶⁸
- Producing user-friendly screening mechanisms for advocates, the courts, law enforcement, social service providers, attorneys, child protection workers, medical/public health personnel, etc..
- Creating a greater awareness of the links between workplace violence and domestic violence. The Santa Clara County team notes that seven of its 51 deaths occurred in the workplace.⁶⁹

Recommendations from the Florida Mortality Review Report

1. That systematic data on domestic fatalities be collected from multiple sources in order to better identify, statistically weigh, and as a consequence, prioritize the correlates of domestic fatalities. These correlates may then be used across agencies for awareness and sensitivity training and also as crucial frames of reference for intervening in those domestic violence episodes that present the threat of lethality. This will never be a foolproof science. However, a system of red flags based on systematic data may provide a simple and user-friendly means of assessing danger.
2. That the reporting of domestic fatalities to Florida Department of Law Enforcement should contain the names of the victims in addition to the demographic and impersonal minutiae currently available. Additionally, the report recommends that reporting agencies code their domestic fatalities more carefully, remaining cognizant of the statutory definition of domestic violence.
3. That police agencies who provide a wealth of important and useful information on domestic fatalities go several steps further and investigate whether or not red flags or warning signs existed prior to fatalities. It is crucial to be able to see clearly from a domestic violence report the history of prior violence, police involvement, injunctions, prior criminal histories, any obsessively possessive behavior, mental illness, separation pending in the relationship, etc.. At some point there must be some kind of screening mechanism or instrument that identifies high risk cases before fatalities occur. Once this identification has occurred then plans need to be made for unusual and highly proactive police/judicial/social services interventions.
4. That improved access be given to data on child fatalities.
5. That much more multiagency coordination and cooperation needs to take place to protect women better. Twenty-two women were killed in domestic fatalities in the state of Florida in 1994 while in possession of an injunction. Clearly, issuing injunctions without providing other important supports and protection for battered women is not enough. Much work remains to be done to intervene in pre-lethal situations to prevent further escalation.

⁶⁸Santa Clara County Death Review Committee Final Report, October 1993-September 1997. p. 15.

⁶⁹Santa Clara County Death Review Committee Final Report, October 1993-September 1997. p. 5.

6. That agencies within jurisdictions work together to review domestic (adult and child) fatalities. However, this review should be more than a social post-mortem. Rather the review should set in motion those strategies that interagency teams can use to prevent fatalities. The report recommends transcending the rhetoric of blame and shame, and bringing agencies to the table. This does not mean that agencies should not be held accountable for their negligence or malfeasance. Rather the report strongly recommends the carefully planned and gradual establishment of fatality review teams in selected jurisdictions in Florida.

Recommendations from the Kentucky Attorney General's Report, 1993

The recommendations promoted the establishment of county-level domestic violence councils. These interagency councils should develop, coordinate, and strengthen local criminal justice and community service responses to domestic violence. In particular with regard to the potential for lethal violence, these interagency councils should work to better protect women who decide to leave violent relationships.

Other Recommendations

A number of child fatality review teams have identified the need to provide grief counseling for the surviving family members of the decedent. This seems particularly pressing in the case of children whose parents are killed in domestic violence homicides, or who survive attempted domestic homicides themselves. As Jerry Adler notes, children should be encouraged to grieve, express their feelings of fear, loss, and anger. Particularly vulnerable according to some experts are children aged 9-13 who are moving toward independence and who may be less likely to share their emotions publicly.⁷⁰ Children who witness parental homicides are emotionally traumatized, stigmatized, and deeply scarred by such a terrifying incident. According to Sondra Burman and Paula Allen-Meares, these children exhibit debilitating symptoms comparable to post traumatic stress disorder (PTSD).⁷¹ These authors describe the behavioral and expressive therapeutic treatment strategies used to assist two child victims.⁷²

The Courts and Communities: Confronting Violence in the Family Conference Highlights Document, San Francisco (1993), noted the importance of awareness of lethality issues in the disposition of domestic cases. The *Highlights Document* raises important questions about children's safety and makes the basic point that "children are safer when moms are safer." Regarding issues of safety in the courtroom the report identifies red flags for lethal violence (prior use of deadly weapon; separation/estrangement; escalating domestic violence; public violence; threats to kill; stalking; obsessive jealousy; alcohol or drug abuse; sexual abuse; violence toward children; suicide attempts; hostage-taking). Specifically the report notes "because a domestic homicide is often preceded by numerous

⁷⁰See "How kids mourn", by Jerry Alder, *Newsweek*, September 22, 1997, p. 58, 60-61.

⁷¹See "Neglected victims of murder: Children's witness to parental homicide." *Social Work*, January 1994, 39, 1: 28-34. See also "Guidelines for intervention with survivors of fatal/severe family violence," from Michael Durfee, 4/7/97, ICAN Grief and Mourning Group. Contact Michael Durfee, DHS, 241 N. Figueroa, L.A. 90012, Tel # 213-240-8146, fax # 213-893-0919, e-mail michael55@aol.com. Another good contact person for working with decedent's children is Dr. Tasha Boychuk, Arizona State University, College of Nursing, who currently runs a group for children who have lost parents due to domestic homicide.

⁷²The Philadelphia Team has identified similar issues regarding grieving and the post-homicide process.

contacts with the justice system, developing better information systems and communications among courts, law enforcement and prosecution is an important way to reduce the risk of lethal violence."⁷³ There are also brief but useful notes on pretrial release issues, courtroom security, accelerated dockets/special dockets, and case coordination.

New York Commission

The Report of the New York Commission recommends that:

- coordinated safety plans be developed by victims in conjunction with multiple involved agencies. The plans must take into account the victim's special needs including any issues of health, language, culture, or sexual orientation.
- medical practitioners be required to report to local police any serious physical injury stemming from the assaultive behavior of another. Three members of the Commission dissented on this point arguing that victims of domestic violence are better served by a combination of domestic violence counseling, safety planning, and referral at a hospital, than by mandatory reporting by the hospital or doctor.⁷⁴
- existing requirements that hospitals and diagnostic treatment facilities document and offer referrals to victims of domestic violence to all medical practitioners be extended. Records of confirmed or suspected domestic violence currently required to be noted in a patient's chart medical staff be reported on an anonymous basis to the New York State Department of Health to provide data for research and policy development.
- the New York Criminal Procedure Law and Family Court Act be amended to expand the definition of family or household to include cohabiting couples, same-sex couples, and dating couples.
- sole or joint custody of a child not to be granted to perpetrators of domestic violence. If visitation is granted then it should be supervised (no recommendations are made as to the nature of that supervision or any indication of security arrangements or training in domestic violence issues for supervisory staff).⁷⁵
- the New York Penal Code be amended to provide that commission of domestic violence is sufficient grounds for a charge and conviction for Endangering the Welfare of a child.
- child protection and adult advocacy services be coordinated.
- New York Criminal Procedure Law be amended to provide that prosecutors can appeal bail determinations and lenient sentences; and that the criteria for bail determinations be expanded to include: the issuance of prior orders of protection against the defendant; the violation of any

⁷³Report p. 30

⁷⁴For a discussion of the role of the medical profession in domestic violence see Report p. 25-37.

⁷⁵The Philadelphia Team is also raising important policy questions about the issues surrounding child visitation and lethal domestic violence. See summary of policy notes, November 1997- April 1998, p. 3-4.

court order by the defendant; the defendant's history, if any, of prior domestic violence or threats of violence; and other circumstances that would show a propensity to harm the victim or others.

- New York Criminal Procedure Law be amended to permit the introduction of a witness's prior testimony as direct evidence, if it is inconsistent with the witness's testimony at trial and if the declarant is subject to cross-examination; and to broaden the exceptions to the hearsay rule in New York for present sense impressions and excited utterances.
- police departments be allowed to either confiscate or accept the surrender of any handguns or long guns if the owner is arrested, the subject of an order of protection, if the incident involves the use or threatened use of force, or if the officer reasonably believes that the presence of the weapon at the scene creates imminent risk of violence or serious physical injury.
- employers be responsible for developing strategies to enhance the safety of domestic violence victims in the workplace. See for example the policy adopted by Merrill Lynch to protect its employees who are victimized by domestic violence.⁷⁶
- review of availability of shelters, funding levels for shelters, and nature of service delivery be conducted.
- broad public education programs be instituted in schools, faith communities, workplaces, and other community organizations.
- a state fatality review board not be established at this time. However, local communities to review their own fatalities on an as-need-to basis, with the possibility of a state review board being established at some later date.

Appendices

Appendix A: Sample Interagency Agreements

Interagency Agreement: Washoe County, Nevada, Domestic Violence Fatality Review Committee.

Working Assumptions and Group Agreement for Domestic Violence Fatality Reviews: Washington State Domestic Violence Fatality Review Project.

Interagency Agreement to establish the multidisciplinary child fatality review committee, Denver, Colorado.

Appendix B: Sample Legislation

Nevada Revised Statutes Annotated. Title 16. Correctional Institutions; Aid to Victims of Crime. Chapter 217. Aid to Certain Victims of Crime. Assistance to Victims of Domestic Violence.

⁷⁶Report p. 69 and note 81. See also the response of the Polaroid Corporation, report p. 69-70.

Delaware Code Annotated. Title 13. Domestic Relations. Chapter 21. Domestic Violence Coordinating Council.

West's Annotated California Codes. Penal Code. Part 4. Prevention of Crimes and Apprehension of Criminals. Title 1. Investigation and Control of Crimes and Criminals. Chapter 2. Control of Crimes and Criminals. Article 2. Reports of Injuries.

Appendix C: Sample Confidentiality Documents

Denver Domestic Violence Fatality Review Committee: Member Confidentiality Agreement.

Colorado Department of Health, Division of Health Statistics and Vital Records: Agreement Regarding Access to and Use of Confidential Vital Records Information.

Barbara Hart, Legal Committee, Domestic Violence Death Review, February 9, 1995, National Council of Juvenile and Family Court Judges.

Washington State. Survey: Confidentiality and Access to Information for Washington Domestic Violence Fatality Reviews.

Domestic Violence Death Review Panel: Operating Guidelines, Hamilton County, Ohio. Includes section on confidentiality.

Appendix D: Sample Summary Instruments for Case Review

Santa Clara County: Criteria for Review.

Washington State Domestic Violence Fatality Review Project: Information forms.

Washoe County, Domestic Violence Fatality Review: Report and Recommendation.

Hamilton County, Domestic Violence Death Review Panel: Data form.

Appendix E: The Research on Domestic Violence Fatalities

Intimate Partner Homicide

"Intimate partner homicide" refers to the murder or non-negligent manslaughter of a person by her/his intimate or former intimate partner.

Trends in Intimate Partner Homicide

According to the Bureau of Justice Statistics (BJS), in the United States during the 1976-1996 period, intimate partner murder fell by 36 percent from 3,000 (1976) to 1,800 (1996). The number of U.S. women murdered by intimates fell from 1,600 in 1976 to 1,326 in 1996. During the same period the number of men murdered by intimates decreased from 1,357 (1976) to 516 (1996). This overall decline in intimate murder is most marked in the black community. The per capita rate of

intimate murders among blacks was 11 times that among whites in 1976, but only four times that among whites in 1996. The sharpest decrease occurred among black male victims. The BJS report specifically notes:

In 1976 the per capita rate of intimate murder of black men was nearly 19 times higher than that of white men. The rate among black females that year was seven times higher than the rate among white females. In 1996 the black male rate was eight times that of white males, and the black female rate was three times higher than the white female rate.

Age

In general, younger rather than older people are more likely to be both the victims and perpetrators of intimate homicide. In their analysis of FBI Supplemental Homicide Reports from 1976-1985, Mercy and Saltzman identified 16,595 spousal homicides. They found that the risk of spousal homicide increased as the age differential between the partners increased. Wilson and Daly note that "marriages with exceptionally high age disparities....have homicide rates four times as high as that prevailing in marriages with the most common gap, namely those in which the husband is about 2 years older."

Race and Ethnicity

Block and Christakos note that in 1990 in Chicago the intimate partner homicide rate was 5.7 per 100,000 for African-Americans compared with the much lower rates of 1.1 for Latinos and 0.4 for Whites. Mercy and Saltzman found similar differentials by race in their longitudinal analysis of spousal homicide. Among blacks, the rate of spousal homicide was 8.4 times higher than among whites.

Stark and Flitcraft point out that the seemingly high rates of black domestic homicide may have more to do with the lowly social class position of blacks than with race. Their argument is consistent with a number of other studies that argue that socioeconomic status rather than racial variations offer a better explanation for variations in homicide rates across states and between cities. For example, in his study of 222 intraracial domestic homicides in Atlanta, Georgia, Centerwall used the number of persons per room in residences as a proxy for socioeconomic status (SES). He reached the conclusion that once SES was controlled, blacks were no more likely than whites to commit domestic homicide. In a replication study of 349 intraracial homicides in New Orleans, Louisiana, Centerwall found similar results.

Clearly the disproportionately high number of African-American intimate partner homicides cannot be explained by innate black tendencies toward violence or homicidal behavior. If this were the case we would expect to find much higher rates of homicide in general, and domestic homicide in particular, in predominantly black cultures in Africa, and we do not. If differential rates of domestic homicide are not attributable solely to factors such as SES, then it is likely that the legacy of slavery, oppression, and discrimination plays an important part.

Sex

In the United States from 1976-1985, inter-spousal killings accounted for an estimated 18,417 fatalities. Wives comprised 10,529 victims and husbands 7,888. Using U.S. homicide data Wilson and Daly note, "for every 100 men who killed their wives, about 75 wives killed their husbands." Wilson and Daly use the term "Sex Ratio of Killing" (SROK) to refer to the "homicides perpetrated by women per 100 perpetrated by men." These sex ratios are unique to the United States. In other societies such as Australia, Canada, Denmark, England, and Wales, Scotland, and India, the proportion of women killers is much lower. However, as Moore and Tennenbaum argue, rather than asking why the U.S. SROK is so high compared with other countries, a more important and central question to ask is, "Why is the SROK so much higher for Blacks?" According to Moore and Tennenbaum the high black SROK drives up the total SROK for the U.S. They note, "Excluding blacks from our analysis reduces the total SROK for the U.S. to 48." With a SROK of 48, the (adjusted) U.S. (non-black) SROK comes much closer to that in New South Wales (1968-1986; 31), Canada (1974-1983; 31), and Scotland (1979-1987; 40).

The BJS (1998) notes that the SROK for intimate partners is declining. Reporting on the period 1976-1996, the BJS notes that 20,311 men were intimate murder victims (62 percent killed by wives, four percent by ex-wives, and 34 percent by non-marital partners such as girlfriends). In the same period, 31,260 women died at the hands of intimates (64 percent killed by husbands, five percent by ex-husbands, and 32 percent by non-marital partners such as boyfriends). This gives a SROK of 65. While the overall rate of intimate partner murder has declined, the SROK has declined, meaning that women are increasingly more likely than men to be the victims of intimate murder.

Dynamics

Marvin Wolfgang's classic study of 588 homicides in Philadelphia revealed that in the case of intimate partner homicide, the killing of men differs substantially from the killing of women. In the 47 cases in which wives killed husbands, Wolfgang concluded that 28 of the 47 husbands had precipitated their own deaths by striking a blow against the woman or showing and using a deadly weapon. This compared with only nine percent of wife killings that Wolfgang deemed "victim precipitated." In 38 of the 47 cases where husbands were killed by wives, Wolfgang found husbands had "strongly provoked" the killing. These findings on the gendered nature of intimate partner homicide have been replicated in numerous other studies.

Killing The Competition

As intimate relationships change, new partners can arrive on the scene. Sometimes women's new male partners compete with women's ex-lovers. At times these competitions end in lethal violence. As such, these so-called "love triangle" killings between competitors for the same person, can be seen as derivative of the conflict between sexual intimates, and particularly the tension surrounding women leaving one partner and developing a love interest elsewhere. In their classic and often-cited study entitled *Homicide*, Wilson and Daly remark that "Sexual jealousy and rivalry have been prominent in virtually every study of homicide motives."

Family Homicide

"Family homicide" refers to the willful killing of someone by a victim's relative by blood or marriage.

Parricide

Parricide, the killing of parents by their children, is a form of family homicide that has received scant attention in the extant literature. Kathleen Heide identifies three types of individuals who kill their parents: severely abused children, severely mentally ill children, and dangerously antisocial children. Among these three groups the "severely abused child" is most frequently encountered among the ranks of those who commit parricide. According to Mones, more than 90 percent of youths who commit parricide have been abused by their parents. Severely abused children who kill their parent(s) typically endure one or more forms of physical, sexual, and emotional abuse, or they witness some combination of these abusive episodes within their families. Much less often individuals who kill parent(s) are suffering from serious mental illness to the point that they qualify as psychotic. Heide describes these people as follows: "Psychotic individuals have lost contact with reality. Their personalities are typically severely disorganized, their perceptions are distorted, and their communications are often disjointed. Their behavior may be inappropriate to the setting and characterized by repetitive, purposeless actions....They may experience hallucinations....and bizarre delusions." Finally, Heide notes the dangerously antisocial child, nowadays referred to as someone with a conduct disorder or antisocial personality disorder who does not suffer from delusions and hallucinations. Among the ranks of these offenders we may see those who kill their parents for personal gain.

Fratricide and Sororicide

Ewing notes that sibling killings are about as common as parricides. Most are committed by males and over 80 percent of the victims and perpetrators are adults. These forms of family homicide, like intimate partner homicides, are often preceded by a long history of domestic rivalry and unresolved conflicts. As in other forms of domestic homicide, the precipitating event is prefaced by a long-standing antagonism that is often exacerbated prior to the killing by a change in one of the sibling's circumstances. Ewing puts it as follows:

In many adult sibling homicides, perpetrators are dealing not only with unresolved childhood conflicts and the stress of living with a brother or sister but often trying to cope with a variety of other problems in living. Indeed, in many cases, these other stressors - such as unemployment, divorce, substance abuse, and illness- have forced the perpetrator into a situation of being financially dependent on parents and/or the sibling who is eventually killed.

Multiple Domestic Killings

Multiple domestic homicides involve various permutations and combinations of victims including intimate partners, competitors or love-triangle antagonists, family members including children, and the perpetrator him or herself. As such, these killings combine many of the features of intimate partner, love triangle, and family killings. However, multiple domestic killings also have a number of unique characteristics that warrant mention.

Homicide-Suicide

Homicide-suicide involves the killing of one or more persons followed soon after by the suicide of the perpetrator. It is usually men who kill their wives, ex-wives, lovers, and ex-lovers, sometimes in combination with their children. In their study of homicide-suicide in North Carolina from 1972-1977, Palmer and Humphrey found few women among perpetrators of homicide-suicide. Out of 90 homicide-suicides during this period only six percent were committed by females. Wolfgang's Philadelphia study found that out of 24 cases of homicide-suicide, only eight percent were committed by women. Woman battering is a significant antecedent to homicide-suicide. For example, Marzuk, Tardiff and Hirsch note:

While some murder-suicides occur shortly after the onset of "malignant jealousy," more often there has been a chronically chaotic relationship fraught with jealous suspicions, verbal abuse, and sub-lethal violence.

Sherry Currens et al (1991) examined the phenomenon of homicide-suicide occurring in Kentucky from 1985-1990. These researchers defined a homicide-suicide cluster as one or more homicides with the subsequent suicide of the perpetrator. The 67 homicide-suicide clusters accounted for six percent of all homicides during this period. Perhaps most significantly, 65 of the 67 perpetrators were male, and 58 of the 80 homicide victims were women. In 64 homicide-suicide clusters, the homicide victim and perpetrator were known to each other. Again, very significantly, in 47 of the 67 clusters the perpetrator was either a current husband (37 clusters), boyfriend (seven clusters) or a former husband (three clusters) of the homicide victim. Currens et al found that many homicide-suicides are preceded by a history of woman abuse. They note that "the typical perpetrator is a man married or living with a woman in a relationship marked by physical abuse."

Steven Stack reports that the odds of a suicide following a homicide are significantly increased if the victim of the homicide is or was in an intimate relationship with the perpetrator. Analyzing 16,245 homicides (including 265 homicide-suicides) in Chicago and controlling for sociodemographic variables, Stack concludes that if the victim of the homicide is the ex-spouse/lover of the perpetrator, then the risk of suicide is 12.68 times higher than it is for non-intimate homicides. The risk of suicide declines as the socially prescribed intensity of the bond between the perpetrator and victim diminishes. Suicide risk is also higher if the perpetrator kills their own child (10.28), their current spouse (8.0), their current girlfriend or boyfriend (6.11), or a friend (1.88), than a stranger. Drawing upon the work of qualitative researchers, Stack identifies the relationship between perpetrators and victims as "frustrated, chaotic," and "marked by jealousy and ambivalence." Also present is a feeling on the part of the perpetrator: that one cannot live with the other person but cannot live without them either. A separation or threatened separation arouses anger and depression at the same time. The act of homicide overcomes a sense of helplessness. However, the associated depression and guilt over the loss of one's love object result in suicide.

Suicide Pacts and Mercy Killing

A number of authors allude to the role of the serious and usually chronic illness of the victim, perpetrator, or both, as a motive in suicide pacts or mercy killings. Usually the elderly male partner, who may be suffering ill-health himself, kills the ailing female with a gun and then commits suicide. The motive for the homicide allegedly is to end her suffering. His own subsequent suicide is attrib-

uted to his loss of his love object, the prospect of impending helplessness, and more rarely, guilt. However, suicide pacts and so called mercy killings are not as simple as they might first appear. In Florida Byron Johnson and I have found it necessary to explore the possibility that some of these killings in fact constitute murder and may have been preceded by abuse.

Familicide

Charles Ewing observes that it is almost always men who kill their entire families. He suggests that these men do not just kill as the culmination of increasing attempts to control their female partners, and the frustration that arises when those attempts fail. Rather, Ewing notes, "the typical family killer is more likely to have been concerned about losing control over more than just his wife and/or family. His concern is more often with losing control over all aspects of his life, or at least those that he most values. He is a man who, in his own eyes, is, or is about to become, a failure."

Inter-related Antecedents To Adult Intimate Partner Homicide/Red Flags

The research literature on domestic homicide identifies a number of inter-related antecedents to lethal violence. These antecedents include: escalating domestic violence and the increasing entrapment of battered women; the separation/estrangement/divorce of the parties; obsessive possessiveness or morbid jealousy on the part of the abusive partner; threats to commit intimate partner homicide, suicide, or both; prior agency involvement, particularly with the police; the issuance of protection or restraining orders against one of the parties, nearly always the male; depression on the part of the abuser; and, a prior criminal history of violent behavior on the part of the abusive man.

Dobash, Dobash, Wilson and Daly nicely summarize these antecedents:

Men often kill wives after lengthy periods of prolonged physical violence accompanied by other forms of abuse and coercion; the roles in such cases are seldom if ever reversed. Men perpetrate familicidal massacres, killing spouse and children together; women do not. Men commonly hunt down and kill wives who have left them; women hardly ever behave similarly. Men kill wives as part of planned murder-suicides; analogous acts by women are almost unheard of. Men kill in response to revelations of wifely infidelity; women almost never respond similarly, though their mates are more often adulterous. The evidence is overwhelming that a large proportion of the spouse-killing perpetrated by wives, but almost none of those perpetrated by husbands, are acts of self-defense.

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