HB

398

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: January 23, 2004 **FURTHER REFERRALS:**

Date of Committee Action: January 30, 2004

The JUDICIARY Committee considered: **HB 398**

HOUSE BILL NO. 398 **DOMESTIC VIOLENCE FATALITY REVIEW TEAM**

"An Act relating to domestic violence fatality review teams."

Recommends it be replaced with [ ] HCS *or* [X] CS *for* HB 398 (JUD)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[X] Same Title [ ] New Title**

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW **FISCAL NOTES** *Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero
ADM				✓
CRT				✓
DPS				✓

PREVIOUS **FISCAL NOTES**				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP (5)	DNP	NR	AM
Gara	Garc	✓			
	SAMUELS	–			
Tom Anderson	ANDERSON	X			
Mark Gruenberg	Gruenberg	–			
Chair:	McKee	✓			
Chair:					

ALASKA STATE LEGISLATURE

Rep. Lesil McGuire, Chair
Rep. Tom Anderson, Vice-Chair
Rep. Jim Holm
Rep. Dan Ogg
Rep. Ralph Samuels
Rep. Les Gara
Rep. Max Gruenberg

State Capitol, Room 120
Juneau, AK 99801-1182
(907) 465-4990
Fax (907) 465-6592

House Judiciary Committee

Memorandum

To: Gerry Luckhaupt, Leg. Legal

From: Vanessa Tondini, Committee Aide
House Judiciary Committee

Date: January 30, 2004

Re: CS Request

Please create a final draft House Judiciary Committee Substitute for work order # 23-LS1321\I, CSHB 398 (JUD), incorporating the attached amendment. The bill was passed out of committee today.

If you have any questions, please call me at 4990. Thank you!

The information attached to this memo is **CONFIDENTIAL** an/or privileged. It is intended to be reviewed initially by only the individual named above. If the reader of this Memorandum is not the intended recipient or a representative of the intended recipient, you are hereby notified that any review, dissemination, or copying of the information contained herein is prohibited. If you have received this in error, please immediately notify the sender by telephone and return this to the sender at the above address.

CS/SB 398 (JUD)

A#1 by Rep. Samuels – PASSED

P.1, L.10
After "or", delete "earlier"
After "or", insert "at an earlier appropriate time,"

Amendment: #2 - withdrawn
by Rep. Samuels

Pg. 1, Line 7 after state Insert: for which the Department of Public Safety has primary responsibility for providing police services.

23-LS1321\I
Luckhaupt
1/29/04

CS FOR HOUSE BILL NO. 398(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - SECOND SESSION

BY THE HOUSE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES DAHLSTROM, Stoltze, Samuels, McGuire, Wilson

A BILL

FOR AN ACT ENTITLED

"An Act relating to domestic violence fatality review teams."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 18.66 is amended by adding a new section to read:

Article 4A. Domestic Violence Fatality Review Teams.

Sec. 18.66.400. Domestic violence fatality review teams. (a) The commissioner of public safety may establish domestic violence fatality review teams in areas of the state. A municipality may establish a domestic violence fatality review team in a municipality. When the investigation of fatal incidents of domestic violence and incidents of domestic violence involving serious physical injury has been completed or adjudicated by law enforcement or earlier, a domestic violence fatality review team may review those incidents for the purpose of preventing domestic violence-related fatalities, improving the response of law enforcement and other agencies to domestic violence, and providing consultation and coordination for agencies involved in the prevention and investigation of domestic violence. The review may include a review of events leading up to the domestic violence incident,

L

New Text Underlined [DELETED TEXT BRACKETED]

available community resources, current laws and policies, actions taken by agencies and persons related to the incident and persons involved in the incident, and other information the team determines to be relevant to the review. The confidential and other records of a department or agency of the state or a municipality relating to the domestic violence incident may be examined by the domestic violence fatality review team or a member of the team. The domestic violence fatality review team and each member of the team shall preserve the confidentiality of any records examined. In this subsection, "serious physical injury" has the meaning given in AS 11.81.900.

(b) The membership of a domestic violence fatality review team shall be determined by the commissioner of public safety or the municipality, as appropriate. Membership may include representatives from

(1) law enforcement agencies within the area or municipality;

(2) the district attorney for the area or municipality and municipal prosecutor if created by a municipality;

(3) the office of the chief medical examiner;

(4) the department of corrections;

(5) employees of the Department of Health and Social Services who deal with domestic violence;

(6) local agencies and organizations involved with crime victim and domestic violence protection, reporting, and counseling and assistance;

(7) other organizations, departments, and agencies determined to be appropriate.

(c) The victims' advocate under AS 24.65 is an ex officio member of each domestic violence fatality review team created under this section and may attend any meeting and review any information available to or considered by a team.

(d) Except for a public report issued by a domestic violence fatality review team that does not contain confidential information, records or other information collected by a team or any member of a team related to duties under this section are confidential and not subject to public disclosure under AS 40.25.100 and 40. 25.110. Meetings of a domestic violence fatality review team are closed to the public and are not subject to the provisions of AS 44.62.310 and 44.62.312.

(e) The determinations, conclusions, and recommendations of a domestic violence fatality review team or its members are not admissible in a civil or criminal proceeding. A member may not be compelled to disclose a determination, conclusion, recommendation, discussion, or thought process through discovery or testimony in a civil or criminal proceeding. Records and information collected by the team are not subject to discovery or subpoena in connection with a civil or criminal proceeding.

(f) Notwithstanding (e) of this section, an employee of a state or a municipal agency may testify in a civil or criminal proceeding concerning cases reviewed by a domestic violence fatality review team even though the agency's records were reviewed by a team and formed the basis of that employee's testimony and the team's report.

(g) A person who serves on a domestic violence fatality review team is not liable for damages or other relief in an action brought by the reason of the performance of a duty, function, or activity of the team.

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB398
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title: An Act relating to domestic violence fatality review teams
BRU: Legal and Advocacy Services
Component: Public Defender Agency
Sponsor: Representative, Dahlstrom, Stoltze
Requester: (H) Judiciary
Component No.: 1631

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) If funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
This bill should have minimal fiscal impact on the operations of the Public Defender Agency.

Prepared by: Linda K. Wilson, Deputy Director
Phone (907)-334-4416
Division: Public Defender Agency
Date/Time 1/26/04 11:25 A.M.
Approved by: Mike Miller, Commissioner
Date
Agency: Administration

(Revised 9/2003 OMB)

ALASKA STATE LEGISLATURE

Rep. Lesil McGuire, Chair
Rep. Tom Anderson, Vice-Chair
Rep. Jim Holm
Rep. Dan Ogg
Rep. Ralph Samuels
Rep. Les Gara
Rep. Max Gruenberg

State Capitol, Room 120
Juneau, AK 99801-1182
(907) 465-4990
Fax (907) 465-6592

House Judiciary Committee

Memorandum

To: Leg. Legal

From: Vanessa Tondini, Committee Aide
House Judiciary Committee

Date: January 29, 2004

Re: CS Request

Please create a work draft House Judiciary Committee Substitute for work order # 23-LS1321\H, HB 398, incorporating the attached four amendments (Amendments # 1, 2, 4, and 5) and addressing the questions below. The bill was heard in committee yesterday and the CS will be reheard tomorrow 1/30. Although the amendments don't state so, please treat them as conceptual for the purposes of making them grammatically correct and conforming to the rest of the section.

The following were not adopted as amendments, but were technical questions for the drafters to address. Please correct if you see fit:

1) Page 2, Line 31: Should "or" be changed to "and"?
2) Page 3, Line 11: Should "damage" be changed to "damages"?

If you have any questions, please call me at 4990. Thank you!

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Samuels, Gara

HB398

Amendment #1 - PASSED

p1 line 9

Delete "terminated"

Insert "completed or adjudicated"

Insert at after "enforcement,"

the words "or earlier"

HB398 Amendment #2 - PASSED
by Rep. Gruenberg

Add a "definitions section" to the bill and include the definition of "domestic violence" as defined in AS 18.66.990.

Amendment #3 - withdrawn
by Rep. Gruenberg

Amendment #4 - PASSED
by Rep. Gruenberg

1) P.1, Line 8-9
Delete "near-fatal incidents of domestic violence"
After "fatal", Insert, "incidents of domestic violence and domestic violence incidents involving serious physical injury"

2) In the "definitions section" add the definition of "serious physical injury" as defined in AS 11.81.900.

HB 398 Amendment #5 – PASSED
by Rep. Samuels

Page 2, Line 13
Before "Chief", Insert "office of the"
(So it reads "the office of the Chief Medical examiner;")

ALASKA STATE LEGISLATURE

Vice Chair:
Joint Armed Services Committee

Member:
Military and Veterans Affairs Committee
Labor and Commerce Committee
State Affairs Committee
Economic Development, Trade, &
Tourism Committee

Session:
Alaska State Capitol
Juneau, AK 99801-1182
Phone: (907) 465-3783
Fax: (907) 465-2293
Toll Free (877) 460-3783

Interim:
716 West 4th Avenue
Anchorage, AK 99501-2133
Phone: (907) 269-0174
Fax: (907) 269-0177

REPRESENTATIVE NANCY DAHLSTROM

ELMENDORF AFB • FORT RICHARDSON • BIRCHWOOD • FIRE LAKE • GOVERNMENT HILL • MULDOON

Representative_Nancy_Dahlstrom@legis.state.ak.us

To: Representative Lesil McGuire Chair, House Judiciary Committee
Fm: Rachel Essen
Date: January 27, 2004
Re: HB 398 **"Domestic Violence Fatality Review Teams"**

Please accept this memo and attached documents as a request for the House Judiciary Committee to schedule for hearing House Bill 398 **"Domestic Violence Fatality Review Teams."**
The bill will enable municipalities and cities throughout Alaska to create a Domestic Violence Fatality Review Team.

Thank you for your consideration of HB 398.

Attached: Sponsor Statement, HB 398, fiscal note, letters of support, and relevant articles.

Representative Nancy Dahlstrom
Representative Lesil McGuire
Representative Ralph Samuels
Representative Bill Stoltze

HB 398 Domestic Violence Fatality Review Team

Sponsor Statement

"An Act relating to domestic violence fatality review teams"

HB 398 is legislation empowering municipalities and cities throughout Alaska to create a Domestic Violence Fatality Review Team.

A growing number of homicides in Alaska are domestic violence related. In the year 2002 11 out of 18, or 61% of the homicides in Anchorage were a result of domestic violence.

This legislation authorizes the State of Alaska and its municipalities to empanel teams to systematically review facts of escalating cases of domestic violence fatalities. These teams could identify potential changes in policies, procedures, and protocols leading to the prevention of such crimes.

The legislation would provide state and local governments with additional tools to gather information on many aspects of domestic violence. This information could then be used to create legislation to combat domestic violence.

With the creation of such review teams the legislature will help stop these devastating crimes.

Amanda L. Matthews
2308 W 46th Ave.
Anchorage, AK 99517
907- 223- 6429

To Whom It May Concern:

I am writing in support of the proposed legislation to enact domestic violence fatality review teams. I think that it will give the community a better understanding of the challenges that victims face in the justice system related to domestic violence. Knowing that Alaska and Anchorage specifically, has a high rate of domestic violence and DV related homicides, it's important to put review teams in place to figure out how or why we have this rate. More importantly, to look at what needs to change in the current system to prevent domestic violence related fatalities.

Similar programs of review have proven to be useful in other communities across the United States, for example look at Florida, the first state to enact review teams. Since the teams started, they have identified possible changes in policy and/or procedures with the potential to prevent future domestic violence related deaths. I believe Anchorage has a strong core of people who are dedicated to assisting victims of domestic violence and many more who want to.

Please take this in to consideration when moving forward with this legislation.

Sincerely,

Amanda L. Matthews

Susan J. Pearson
814 W. 11th Avenue
Anchorage, AK 99501
907-272-7863

To whom it may concern,

I am writing in support of the proposed legislation to enact domestic violence fatality review teams. I feel that review of potentially fatal cases can help us better understand the benefits and challenges we face in the justice system as related to domestic violence cases.

This system of review has proven useful in other counties and states around the country and could shed light on the domestic violence issue in Alaskan municipalities.

Sincerely,

Susan J. Pearson

January 23, 2004

To Whom It May Concern:

I am writing this letter to inform you of my stand on the proposed legislation to initiate domestic violence fatality review teams. I am in support of this service being provided in the state of Alaska.

Sincerely,

Jacqueline Villalpando

Domestic Violence Fatality Reviews:

Implications for Law Enforcement

By Neil Websdale, Professor of Criminal Justice, Northern Arizona University, Flagstaff, Arizona, and Heather Moss, Research Associate, Fatality Review Initiative, and Byron Johnson, Director, Center for the Study and Prevention of Domestic Violence, University of Pennsylvania, Philadelphia, Pennsylvania

Each year in this country, male intimates kill anywhere from 1,000 to 1,600 female partners.[1] Only recently the federal government and some states began to explore the reasons for these domestic violence deaths in a systematic manner.[2] This article reviews the types of deaths linked to domestic violence, provides a few examples of domestic violence fatality reviews, and discusses the implications of these reviews for law enforcement. These fatality reviews, conducted appropriately and carefully, provide an important means of improving the response of law enforcement agencies to domestic violence. Review findings and recommendations can offer innovative suggestions for officer training, officer safety, and the coordination of policing activities with other agencies involved in dealing with family violence.

In the long term, such reviews offer the promise of a reduction in the number of domestic violence fatalities, officer injuries and deaths at these crime scenes, and dangerous hostage/barricade domestics. As a result, a reduction in the multiple liabilities associated with these (at times) complex and challenging cases is also likely. In short, fatality reviews are a powerful mechanism for enhancing police policies and procedures and developing innovations in training. The term "domestic violence fatality review" refers to a

> *[illegible] 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]

This deliberative process can be formal or informal, relatively superficial, offering basic demographic details of victims and perpetrators, or very detailed. The scope of review activity varies enormously and has involved a review of one case, all such

deaths within a particular jurisdiction, all domestic violence-related deaths within a state, or other variations. The underlying objectives of these reviews are as follows:

- Prevent future domestic violence and domestic homicide
- Provide safer provisions for battered women and their children
- Hold accountable both the perpetrators of domestic violence and the multiple agencies and organizations that come into contact with the parties

Domestic violence fatalities are normally handled by the criminal justice system, which investigates the death and identifies and charges the perpetrator, where appropriate. However, such handling does little to review the effectiveness of the systems charged with serving and protecting those vulnerable to domestic violence and death. Sometimes ad hoc reviews are conducted through the media, but these reviews are often cursory, emphasizing the sensational aspects of the case. Such media analyses rarely access the deeper history of domestic violence, the entrapment of women, the escalation of abuse before death, and the twists and turns in relationships that appear to characterize a significant number of cases.

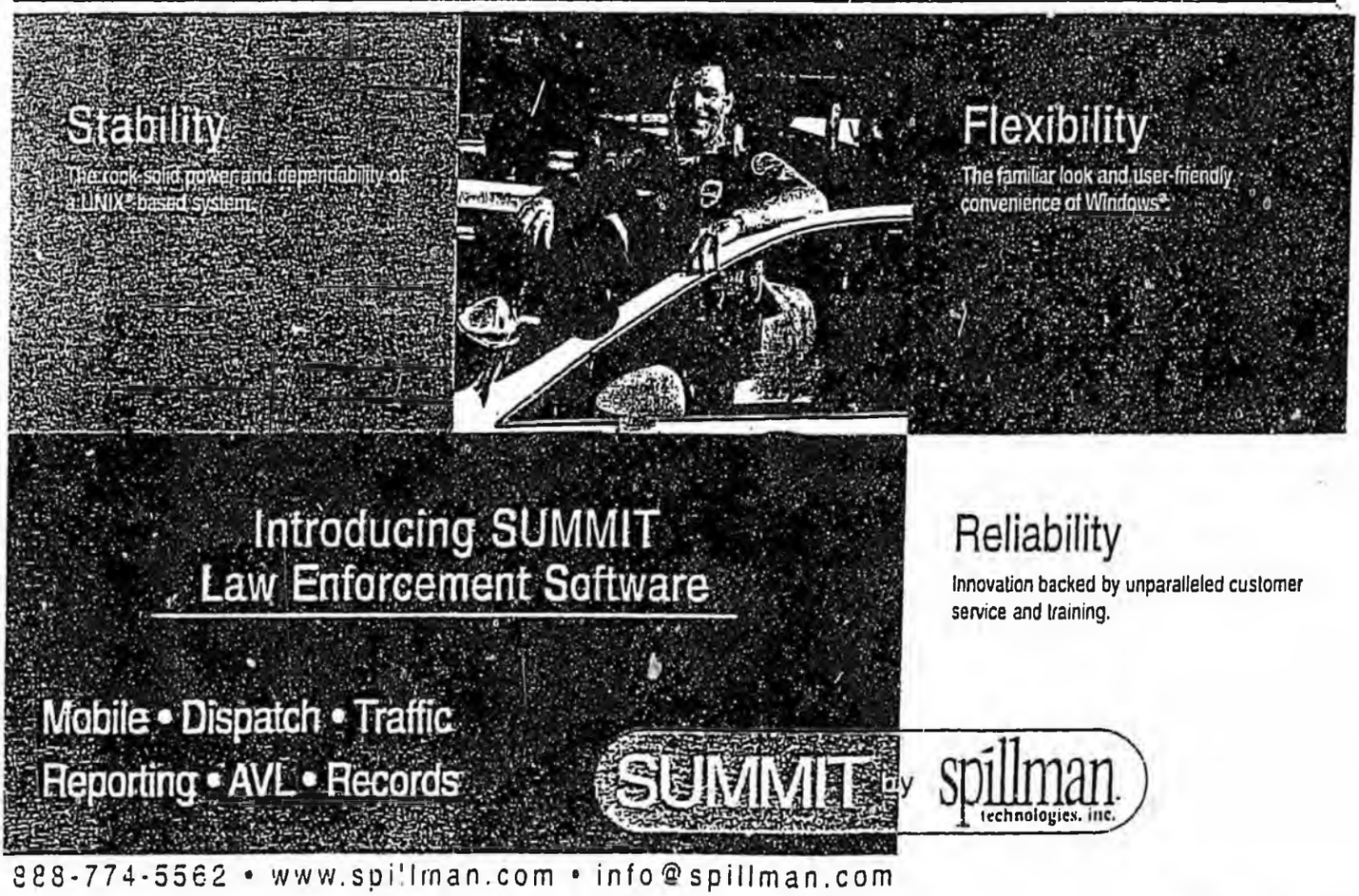
Domestic Violence-Related Fatalities

Domestic homicide takes a number of different forms, all of which might serve as the basis for a domestic violence death review. "Intimate partner homicide" usually involves a man killing his female partner, often after a long and escalating pattern of domestic violence. When women kill male partners, they typically do so in self-defense, although such defense may not qualify as such in a court of law. Non-intimate partner family members also kill each other in so-called "family homicides." Men sometimes kill other men over a woman in whom they are both interested. These "sexual competitor killings" are much smaller in number than either intimate partner or family homicides.

Many more Americans die from suicide than homicide. Research suggests that a large number of women who commit suicide do so because of their violent victimization at the hands of an intimate male partner. Authors Evan Stark and Anne Flitcraft note specifically, "in most cases we believe battered women are provoked to attempt suicide by the extent of control exercised over their lives."[4] According to these authors, the proximity between woman battering and women's suicide attempts, in general, strongly suggests that battering may be one of the principal causes of the suicide attempts. Stark and Flitcraft point out that a number of studies show abuse as a factor in as many as 44 percent of female suicide attempts.[5] For these researchers, it is very telling that more than a third of the battered women in their sample[6] "visited the hospital with an abuse-related injury or complaint on the same day as their suicide attempt."[7]

As the elderly population in the United States continues to increase, researchers have become more aware of domestic violence between older partners. Social service providers and law enforcement agencies sometimes wrongly assume that because people are elderly they are not capable of committing or being victimized by domestic violence. This attitude can translate into an assumption that homicide-suicides among the elderly usually take the form of "mercy killings" or suicide pacts. Police officers or others who investigate the homicide-suicide and find a note telling authorities that the couple could not live on with ailing health might hastily assume "mercy killing."

Upon further investigation, we find it is nearly always men who commit these



Circle no. 50 on Reader Response Card

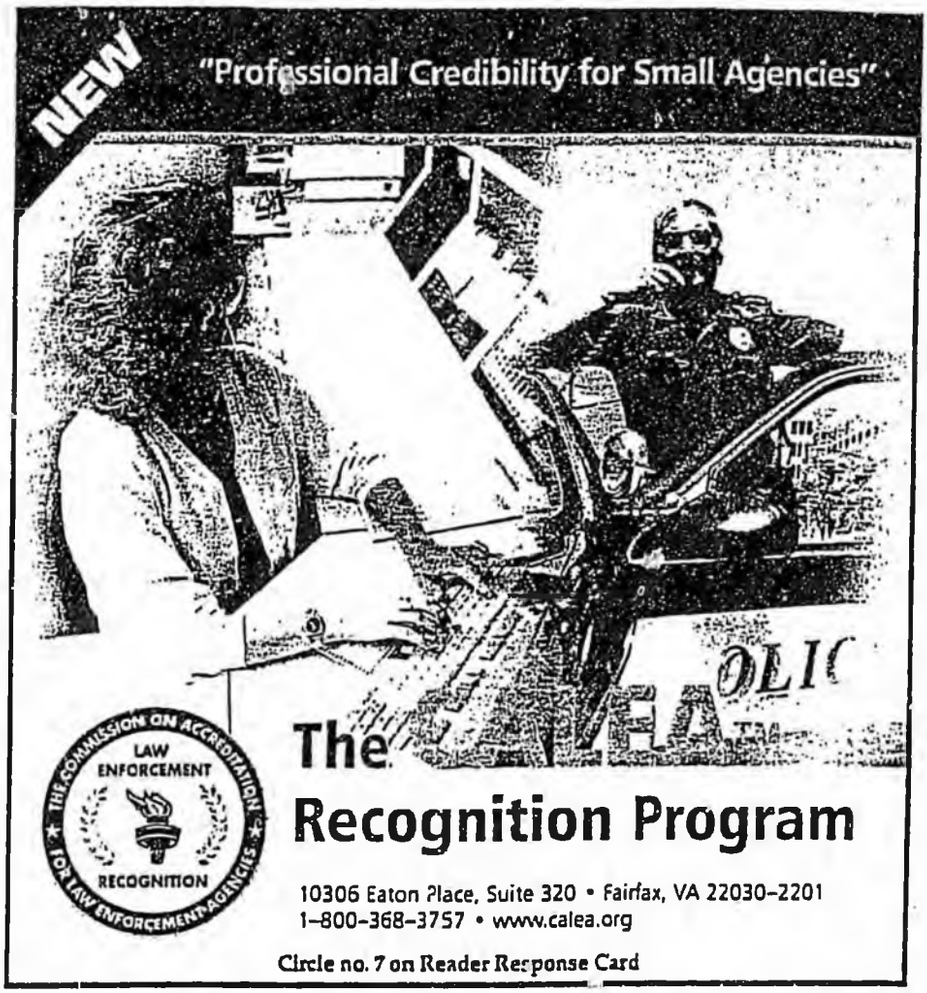
killings and that in a significant number of cases their female victims had expressed to other family members a desire to live not die.[8] Indeed, gerontologist Donna Cohen found that homicide-suicides involving elderly women in west central Florida accounted for 20 percent of the total homicides of people over the age of 55.[9] Cohen also notes that while the health had deteriorated for 50 percent of the women, two-thirds had expressed "no desire to die."[10] Evidence that women killed in so-called mercy killings or suicide pacts had previously expressed "no desire to die" suggests there may have been battering before their demise.

The scope of reviews is broadened considerably if we include deaths of women traceable to domestic violence or directly linked to domestic violence. One might argue that because battered women appear more vulnerable to HIV infections than non-battered women, some deaths of women attributed to HIV, or some complication thereof, might be traceable to the women's compromised status as battered.[11] The same could be said of homeless women dying on the streets, as roughly half of homeless women report "fleeing abuse" as the reason for their homelessness.[12]

Examples of Domestic Violence Fatality Reviews

The Commission on the Status of Women in San Francisco in 1991 conducted one of the earliest and most detailed domestic violence fatality reviews. This review, held in a public forum, highlighted the widespread breakdown of systems in the case of Veena Charan, whose husband Joseph murdered her and then committed suicide. For 15 months before her death, Veena sought the help of various government agencies and made numerous reports to the police. She separated from Joseph and secured custody of their nine-year-old son.

Immediately before Veena's 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) mandated domestic violence counseling; (2) a stay away order; and (3) 30 days in jail, of which he was given four days, the remainder to be served in the Sheriff's Work Alternative Program. Veena also obtained a restraining order that Joseph violated on several occasions. He also attempted to kidnap his son from school. Joseph killed his wife at the school, in front of teachers



The ensuing fatality review identified a range of problems in the system: gaps in communication and coordination between agencies involved, a failure to collect adequate data on domestic violence cases, a lack of sensitivity to multicultural and sexual orientation issues, a failure to train agencies in multicultural awareness, and a lack of appropriate translation services. With respect to law enforcement, the report found that an investigator at the San Francisco Police Department minimized the prior injuries to the victim. Specifically, the report notes, "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."[13] It was also noted that probation services had not adequately trained officers in the dynamics of domestic violence.

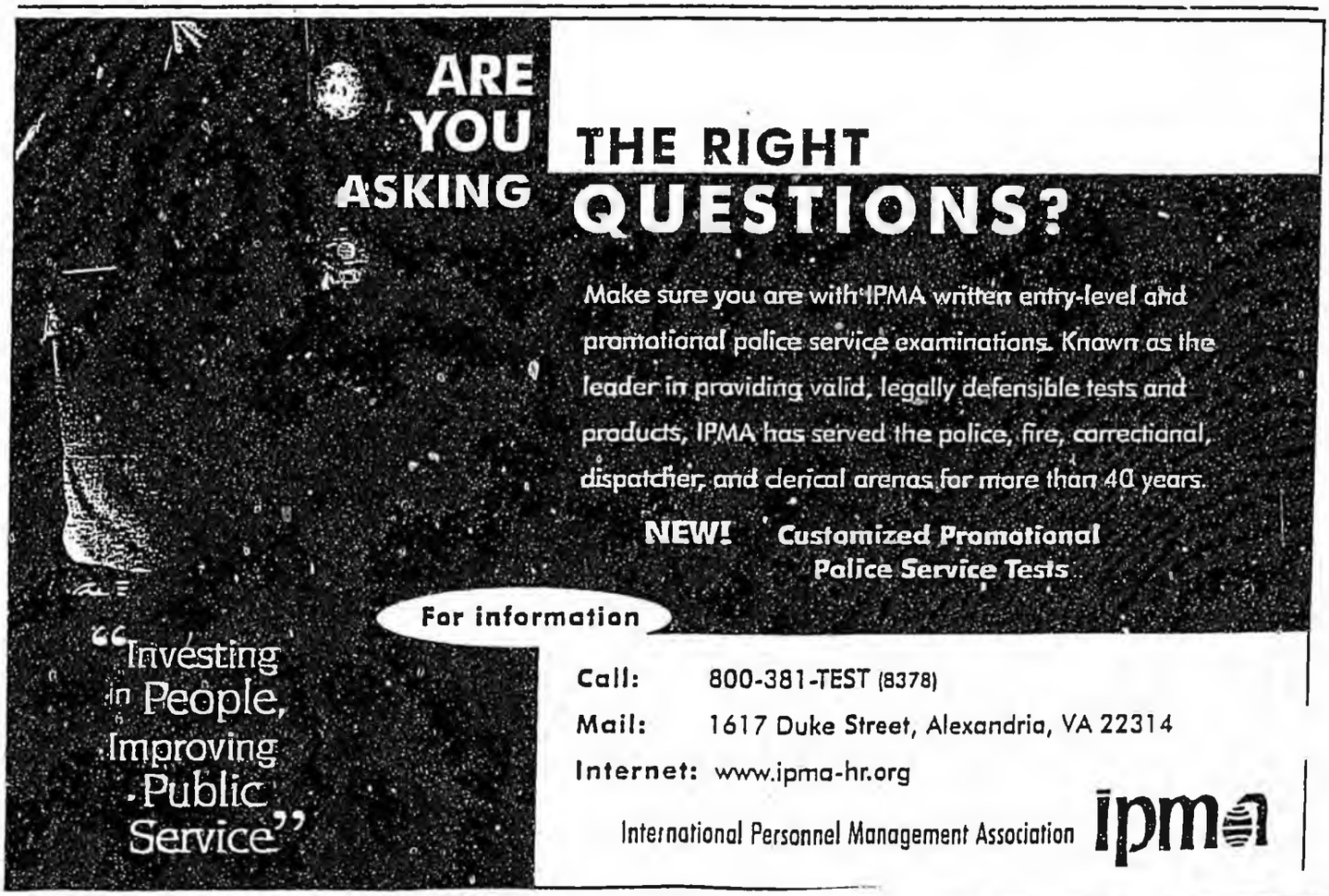
While high-profile reviews such as the Charan investigation can reveal many systemic problems, there may be a tendency for other reviews to blame one person or agency for the breakdown. Given that the batterer is the person responsible for the killing, the blame and shame that may arise from such fingerpointing can be counterproductive to long term system change. A blaming approach to the fatality review process, often referred to as "tombstone technology" in fields such as aviation and nuclear power, might encourage the covering up of information in cases of death.[14] It is also the case that men who batter women blame their victims for much that it is negative in their lives. Using reviews to blame others merely perpetuates that negative and destructive style of thinking and contributes little to healing.

Fatality reviews provide an important means of improving the response of law enforcement agencies to domestic violence.

In the years since the Charan investigation, different models have emerged to review domestic violence deaths, many of which report aggregate data rather than the details of individual cases. Without any funding or legislation, the Philadelphia Department of Public Health, with support from the district attorney's offi began the Philadelphia Women's Deat Review Team in 1997 to examine all deaths (not just domestic violence cases) of women from 15 to 60 years of age.[15] These deaths could either be directly related to domestic violence or indirectly related in cases where battered women were unable to access health care. Such an approach also means the team is open to studying suicides for any history of domestic violence.

In Florida, death reviews emerged following a recommendation from a statewide research initiative to examine the idiosyncrasies of all domestic homicides.[16] Sixteen teams now operate in Florida, and their deliberations are protected by immunity legislation. Team deliberations

> *are not subject to discovery or introduction into evidence in any civil action or disciplinary proceeding by any department or employing agency . . . and any person who was in attendance at a meeting of such an organization may not be permitted or required to testify in any civil action or disciplinary proceeding as to any evidence or other matters*



officers themselves serve on death review teams and provide feedback to departments on the use of such instruments in light of individual or aggregate deaths in their jurisdictions.

Some death review teams have argued for the use of risk assessment tools as an integral part of coordinated community responses to domestic violence cases. For example, in New Hampshire from January 1990 until October 31, 2000, 47 percent of the 224 homicides were domestic violence-related. In a recent report, the review team recommended that "domestic violence should be a topic included among continuing professional education requirements for all relevant disciplines . . . including law enforcement."[22] The report goes on to state that "all professionals working on cases involving domestic violence should conduct an ongoing risk assessment. The results of that risk assessment will be shared with other providers to the extent allowable by their profession's ethical guidelines."[23]

In Florida, the Pinellas County team believes that death reviews have sharpened existing coordinated community responses to domestic violence. From its discussions with local law enforcement, the Pinellas team identified an approach to educate men who commit domestic violence. These discussions led to the installation of a VCR at the sheriff's holding cell where perpetrators are shown videos on domestic violence. The Pinellas team is now moving toward creating a tracking system to monitor perpetrators more carefully. In the past, if perpetrators were ordered to probation and re-offended before the order was put into the computer, the perpetrator was typically not charged with a violation of probation. Through its work with probation, the courts, and the police, the team is working to close this loophole.

In Washoe County, Nevada, the death review team recommended that police reports of domestic violence contain information on prior domestic calls to the residence involving the same victim and perpetrator. In Maine, review recommendations include increased instruction on evidence collection at domestic violence crime scenes, better preparation on the use of 911 tapes, and improvement in the way officers conduct interviews. The Hamilton County, Ohio, death reviews recommended stronger enforcement of violations of protection orders and parole conditions.

Most review teams across the country have called for greater education in the dynamics of domestic violence for law enforcement and other agencies working with battered women and their families. Some recommendations call for recognizing the significance of specific warning signs. For example, in Washington State, reviewers noted the dangers posed by suicidal abusers and recommended that "officers should routinely ask victims about the abuser's history of making homicidal or suicidal threats." If such threats have been made, officers should "urge the victim to call a domestic violence program for help with safety planning."[24] The report also recommends expanding the sections of the Washington Association of Sheriffs and Police Chiefs Model Operating Procedures on "screening for suicide and responding to suicidal abusers."[25]

A number of statewide reviews recognize the urgent need for translation services in cases of domestic violence involving victims and perpetrators whose first language is not English.[26] The Washington State report recommends that "Institutions such as law enforcement, hospitals, domestic violence programs, and Temporary Aid to Needy Families (TANF) offices should create collaborative relationships with grassroots organizations based in limited English-speaking communities."[27] The report continues: "Consistent with our state law, law enforcement agencies should conduct investigations of do-

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Portage, Michigan

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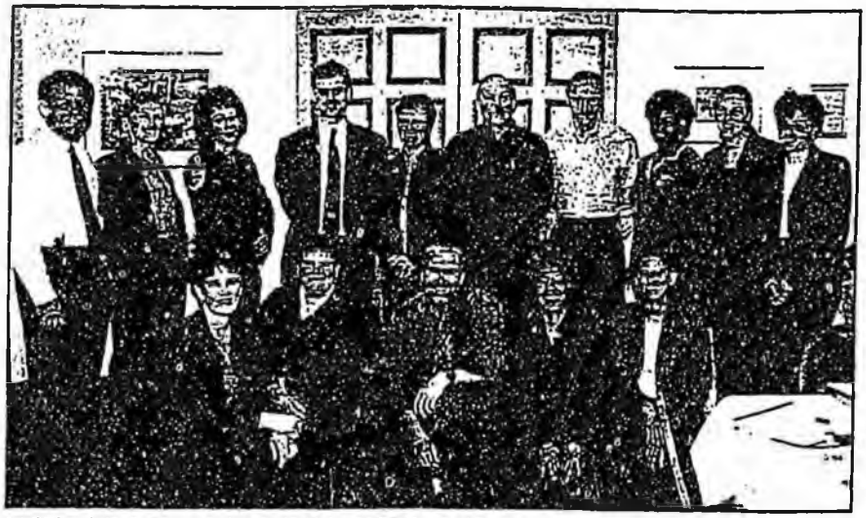

IACP's advisory team on domestic violence fatality review.

IACP Takes on Domestic Violence Fatality Review

In March the IACP's Police Response to Violence Against Women Project convened the first meeting of advisors chosen to help develop a model protocol for law enforcement on domestic violence fatality review. The meeting, held in Santa Fe, New Mexico, brought together experts in the fields of social science research, law enforcement, and victim advocacy. Under a grant from the Department of Justice's Violence Against Women Office, the advisory team will guide the development of a *Training Key* on danger assessment, gather information through visits to communities engaged in fatality reviews, and draft protocols to direct law enforcement's participation in the review process. Site visits to Florida and Delaware have been completed. Visits to Tennessee, Colorado, and Maine are planned for this summer.

IACP's Police Response to Violence Against Women Project is pleased to be working with this distinguished team of advisors: Chief James Roberts, Shreveport, Louisiana, Police Department; Lt. (Retired) Mark Wynn, Nashville; Captain Randy Lockmiller, Knoxville Police Department; Phyllis Sharps, George Washington University, Washington, D.C.; Neil Websdale, Northern Arizona University; Bryon Johnson and Heather Moss, University of Pennsylvania; Jackie Campbell, Johns Hopkins University; Judge Susan Carbon; Rhonda Martinson, Battered Women's Justice Project; David Adams, EMERGE; and advocates Margaret Hobart, Felicia Collins Correia, S. E. Chase, and Robin Hassler Thompson.

At the 108th Annual IACP Conference later this year in Toronto, two of our advisors, Dr. Websdale and Dr. Johnson, will facilitate a roundtable discussion on domestic violence fatality review. Please look for the roundtable in the conference schedule and join us for an exciting and challenging exchange.

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mestic violence crimes with qualified interpreters."[28] In one domestic homicide case in Washington State "a law enforcement officer asked a six-year-old child to translate for the family member on the scene who had discovered the bodies of the two victims."[29] In another case "a hostage situation went on for at least an hour, and because no translator was present, the young hostage had to provide translation while the murderer held a gun to her head."[30]

In addition to the potentially traumatizing effects on nonprofessional on-scene translators, the use of imprecise translators may also impede the subsequent case investigation in both domestic homicides and non-lethal domestics. The report concludes that the use of the AT&T translation service is a "compromise step" that may be "awkward" or uncomfortable for some battered women "but [is] preferable to using children or neighbors or not seeking out translation at all." Hobart goes on to note that "some departments have officers tape the entire conversation, even while using translation, so that the opportunity to transcribe and obtain professional translation services exists in the future."[31]

The problems regarding translation services in domestic violence cases echo much broader issues involving services for communities of color, especially in the inner city. Many African American battered women living in inner-city housing projects display a deep suspicion of police. So too, do their communities. The community and certain members therein might label a battered woman a "snitch" if she calls to seek protection for herself or her children. Community policing and its emphasis on greater and more varied forms of surveillance seems to make little difference on domestic violence crimes in these acutely disadvantaged areas. Given that the domestic homicide rate is many times higher among inner-city blacks than it is among whites, fatality reviews offer the potential for enhancing dialogue between inner-city minority citizens and the police. This dialogue might include discussion of the management of the war on drugs, public housing rules and regulations, welfare-to-work initiatives, and other policies that limit battered women's ability to leave dangerous intimate relationships.

Conclusion

Domestic violence and the thousands of deaths that stem from it utilize large proportions of police department budgets, result in a significant number of liability claims against departments each year, and directly result in the death and injury of responding officers. Fatality reviews, when conducted carefully and appropriately, can

- improve the response of police to these cases;
- enhance collaboration, communication, and cooperation between and among police and other involved agencies;
- reduce liability; and
- save lives and extend protections to battered women and their families.

The deliberations from domestic violence fatality reviews can augment community education about this persistent social and criminal justice problem. At the same, time law enforcement agencies can engage in deeper and more meaningful discussions about issues that affect the ability of women to escape these dangerous relationships. As the practice spreads and the sophistication of these reviews grows across the country, we urge leaders in the law enforcement community to embrace this opportunity to enhance their agency's response and improve the lives of many American families. ❖

[1] Male intimates killed 1,600 women in 1976 and 1,218 in 1999 (Bureau of Justice Statistics, 2001). See

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also James Fox and Marianne Zawitz, *Homicide Trends in the United States* (Washington, D.C.: Government Printing Office).

[2] From our work-in-progress survey of 44 states, the following have some form of domestic violence death reviews. The letter L in parentheses after a state denotes the presence of legislation that supports the review process: Alaska, Arizona, California (L), Colorado, Delaware (L), District of Columbia, Florida (L), Illinois, Iowa (L), Kansas, Kentucky, Maine (L), Michigan, Minnesota (one county with a team, local legislation), Nevada (L), New Hampshire (executive order), New Jersey (executive order), New Mexico, North Carolina, Ohio, Oklahoma Oregon, Pennsylvania, Tennessee (L), Virginia (L), Washington (L).

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

[4] Evan Stark and Anne Flitcraft, "Killing the Beast Within: Woman Battering and the Female Suicidality," *International Journal of Health Services* 25, no. 1 (1995): 55.

[5] Stark and Flitcraft, "Killing the Beast Within," 46.

[6] These authors investigated the medical records of women who came to the emergency room at Yale-New Haven Hospital as attempted suicides over a one-year period. They identified 176 such women who had attempted suicide at least once during the study year (see Stark and Flitcraft, "Killing the Beast Within," 48).

[7] Stark and Flitcraft, "Killing the Beast Within," 53.

[8] The 1999 report by the New Mexico Female Intimate Partner Violence Death Review Team, titled "Getting Away with Murder," notes that the law enforcement investigation of intimate partner homicides "may lack vigor and consistency, especially homicides in which the perpetrator then commits suicide" (19).

[9] Charles Patrick Ewing, *Fatal Families: The Dynamics of Intrafamilial Homicide* (Thousand Oaks, C Sage, 1997), 143.

[10] Cited in Ewing, *Fatal Families*, 143.

[11] N. Websdale and B. Johnson, "Battered Women's Vulnerability to HIV Infection," *Justice Professional* 10, no. 4 (1997): 183-198.

[12] Joan Zorza, "Woman Battering: A Major Cause of Homelessness," *Clearinghouse Review* 25, no. 4 (1991).

[13] *Report*, 7.

[14] See L.L. Leape, "Error in Medicine," *Journal of the American Medical Association* 272 (1994): 1851-1857.

[15] This includes deaths classified as homicides, suicides, unintentional injury, undetermined cause, those with inadequate certificates, and peculiar circumstances (asthma, AIDS). This is not to suggest that the deaths of women over 60 are not due to domestic violence. For example, "suicide pacts" where elderly men kill their female partners 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 from 1994 doubled. In all, such homicides accounted for 20 percent of the total homicides of people aged over 55. Cohen also notes that while the health of half of women had deteriorated, two-thirds had expressed "no desire to die." Evidence that women killed in so-called suicide pacts had expressed "no desire to die" may suggest they were being battered before their demise (Cited in Charles Ewing, *Fatal Families*, 143).

[16] See Neil Websdale, *Understanding Domestic Homicide* (Boston, Mass.: Northeastern University Press, 1999). For the most recent statement on the status of the Florida fatality review teams, see Neil W dale and Byron Johnson, "Implementing and Mon ing New Fatality Review Teams" (available from the Florida Department of Children and Families, Tallahassee, Florida, 2001).

[17] Florida Statutes 741.2165 s. 1(2).

[18] Florida Statutes 741.316 s. 1 (4).

[19] M. Hobart, "Honoring Their Lives, Learning from their Deaths: Findings and Recommendations from the Washington State Domestic Violence Fatality Review," Washington State Coalition Against Domestic Violence (2000).

[20] *Thurman v. City of Torrington, Connecticut*, 595 F. Supp. 1521 (Dist. Conn. 1984). See also *Bruno v. Codd*, 396 N.Y.S.2d 974 (1977).

[21] See Neil Websdale, "Lethality Assessment Tools: A Critical Analysis," VAWNET Violence Against Women Grants Office Applied Research Series (2000).

[22] New Hampshire Governor's Commission on Domestic and Sexual Violence, Nashua, New Hampshire, (November 2000): 7.

[23] New Hampshire Governor's Commission on Domestic and Sexual Violence, Nashua, New Hampshire, (November 2000): 7.

[24] Hobart, "Honoring Their Lives," 12.

[25] Hobart, "Honoring Their Lives," 11. The report recommends that law enforcement officers immediately call in mental health professionals when batterers threaten suicide (35).

[26] New Hampshire Governor's Commission on Domestic and Sexual Violence, Nashua, New Hampshire, (November 2000): 16. Santa Clara County Death Review Committee, *Final Report, October 1993-September 1997*, 13. Charan Investigation, 6. Hobart, "Honoring Their Lives," 47-51.

[27] Hobart, "Honoring Their Lives," 9.

[28] Hobart, "Honoring Their Lives," 9.

[29] Hobart, "Honoring Their Lives," 45.

[30] Hobart, "Honoring Their Lives," 49.

[31] Hobart, "Honoring Their Lives," 50.

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Domestic Violence Fatality Reviews: From a Culture of Blame to a Culture of Safety

BY NEIL WEBSDALE, PH.D., JUDGE MICHAEL TOWN AND BYRON JOHNSON, PH.D.

Introduction

As courts and communities try to confront domestic violence, the question of what to do about domestic violence fatalities continually resurfaces. Normally, these fatalities are handled by the criminal justice system, which investigates the deaths and identifies and charges the perpetrators, when appropriate. Such criminal justice handling, however, does little to review the effectiveness of the various systems charged with serving and protecting those vulnerable to domestic violence and death. This shortcoming is all the more significant given that most communities have experienced a high profile domestic violence homicide.

Traditionally, these tragedies have resulted in finger pointing, anger, fear, frustration, and distrust. Sometimes, this finger pointing has found voice in the form of editorials, lawsuits, and legislative hearings. These forms of finger pointing, sometimes referred to as "tombstone technology" in fields such as aviation and nuclear power, have not been productive.[1] They can result in accusations of stonewalling and cover-ups. Consequently, many community members, including judges, court administrators, elected officials, prosecutors, law enforcement officials, and battered women's advocates are looking for workable and fair models to review domestic violence fatalities, with a view to preventing future deaths.

This search is not for the fainthearted since it requires a paradigm shift from a culture of blame to a culture of safety in which domestic violence deaths are reviewed through the lens of preventive accountability. Fortunately, there are workable models in the fields of medicine and aviation upon which to draw. These models teach courts and communities that, with vigor, honesty, and candor, they can build reliable systems that value accountability and help prevent future death and injury from domestic violence. Because domestic violence deaths exhibit predictable patterns and etiologies, they are preventable.

We argue that the establishment of domestic violence fatality review teams is one effective way of reducing domestic violence homicides. After briefly outlining the scope and extent of domestic violence related deaths, this article discusses the history of domestic violence fatality reviews and presents several models that appear to be both effective and fair. In particular, we emphasize that these models form part of an emerging process that will take years to unfold. We especially recommend judicial leadership in promoting and establishing local review processes. This is particularly so in jurisdictions where a unified family court or closely coordinated juvenile/family court exists.

It is not our intent to present a formula for conducting such reviews. Rather, this article presents a variety of apparently effective models, since the authors believe communities will review "domestic violence deaths" in their own unique ways. By raising key questions and presenting workable

Neil S. Websdale is an Associate Professor of Criminal Justice at Northern Arizona University, presently completing a research sabbatical at Vanderbilt University.
Judge Michael A. Town is a Circuit Court Judge in Honolulu, Hawaii.
Byron R. Johnson is the Director of the Center for Crime and Justice Policy at Vanderbilt University.

models, the authors hope to contribute to the discussion about domestic violence fatality reviews within the framework of a culture of safety rather than a culture of blame.

Scope and Extent of Domestic Violence Related Deaths: An Outline

Each year deaths attributable to domestic violence constitute a significant proportion of the total number of homicides. These homicides take a number of forms. The largest sub-category of domestic violence deaths is "intimate partner homicide." This form of domestic homicide involves the killing of a person by her/his intimate or former intimate partner.[2] The other major sub-category consists of "family homicide," which involves the killing of a victim by that person's relative by blood or marriage. Examples of family homicide include cases in which parents or guardians kill children (filicide), brothers kill brothers (fratricide), sisters kill sisters (sororicide), or children kill parents (parricide).[3]

Intimate partner and family homicides are not the only deaths attributable to domestic violence. A number of researchers have argued that many women who commit suicide do so within the context of battering relationships, thus making it possible to argue that domestic violence was a prime causal factor in their self-killing.[4] Similarly, because battered women appear more vulnerable to HIV infections than non-battered women,[5] one might argue that some deaths of women attributed to HIV, or some complication thereof, might be traceable to their status as battered women.

The Emergence of Domestic Violence Fatality Reviews

MEDICAL FATALITY REVIEWS

The emergence of child and adult domestic violence fatality reviews is traceable to death reviews in the medical profession. Often, these reviews are called morbidity and mortality reviews. The medical fatality 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 review team. The team gathers the information together and reaches a conclusion about the reasons for the fatality.

One of the initial problems identified in implementing effective medical reviews was their emphasis on "catching rascals, rather than on improving hospital wide performance" (Rosen and Susman, 1983). This blaming approach was highlighted in an October 1998 editorial in the Journal of the American Medical Association (JAMA). The editorial notes that the health care system continues to rely upon "requiring individual error-free performance enforced by punishment, a strategy abandoned long ago by safer industries such as aviation and nuclear power."[6]

CHILD FATALITY REVIEWS

Unfortunately, many child fatality review teams also emerged with a similarly punitive ethos.[7] In some cases, review teams inappropriately blamed battered mothers for failing to protect children killed by abusive male partners.[8] Other child death review teams appropriately sought to identify breakdowns in the system of service delivery, focusing less on individual accountability and more on system-wide service coordination.

The most progressive child review teams currently recognize the need to blend multiple systems-wide accountability with a non-punitive ethos. This does not mean there is no accountability. Rather, there is recognition that risk and error are inevitable aspects of the coordinated delivery of complex services. Errors, therefore, should be identified and rectified within an open climate of honesty and healing.

As the Colorado Child Death Review Committee points out, if cases are handled improperly, or 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.[9] This philosophy seems to have permeated through to the review of adult domestic violence deaths in this jurisdiction. For example, the mission statement of Project Safeguard (Denver) recognizes 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."[10]

Most child death reviews involve child fatalities caused by abuse and/or neglect and as such constitute a form of domestic violence death review. However, child fatality review teams have not always been quick to recognize the key links between adult domestic violence and the killing of children. There are notable exceptions and some

teams have begun to work on identifying these links.[11] For example, Detective Linda Burton, who heads up the Child Death Review Team in Hillsborough County, Florida, reports that at least two-thirds of children killed in homicides in Hillsborough County from 1994-1998 had mothers or other female caretakers who had been beaten by their intimate male partners.[12]

THE CHARAN INVESTIGATION

One of the first domestic violence death reviews, the "Charan investigation," involved the very detailed public analysis of a domestic homicide-suicide in San Francisco. The Charan investigation pinpointed the widespread breakdown of several systems.

The Facts. On January 15, 1990, Joseph Charan killed his wife, Veena Charan, and then took his own life. For a period of 15 months prior to her death, Veena Charan sought the support of various government agencies. 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) mandated domestic violence counseling; (2) a stay away order; and (3) 30 days jail time, of which he was ordered to serve four days, with the remainder to be served in the Sheriff's Work Alternative Program. Veena Charan had obtained a restraining order, which Mr. Charan violated 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 schoolteachers and school children, before committing suicide.

Questions raised by the investigation. 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?

Gaps in service delivery identified. As a result of this investigation, 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 that had contact 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 noted, "Data on the number of domestic violence cases handled by the departments ranged from very limited to none at all."[13] 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 concerned multicultural awareness.[14] 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 mis-

TABLE 1
Additional Highlights from the Charan Investigation

- Based on the incident reports involving Joseph Charan, the San Francisco Police Department did not deem serious the injuries Veena Charan and other family members received at the hands of Joseph Charan. Specifically, the report indicated 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."[15]
- According to the felony protocol of the District Attorney's Office, prior history was one of the factors to be 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 trained adequately in the dynamics of domestic violence.
- The Commission called for greater domestic violence training of the Municipal Court, Criminal Division. In particular, it stated a "need for training judges on the interpretation of restraining orders."[16]
- Family Court Services refused to answer questions posed by the Commission, citing their need to maintain confidentiality. The Commission described this failure as "intransigence."[17] The report stated 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."[18] The Commission also criticized the mediation strategies of the Family Court.

understandings of the agreements/court orders and proceedings. Specifically, the investigation called for the development of domestic violence advisory committees in each city department working with domestic violence cases.

Contemporary Domestic Violence Death Reviews: Some Effective Emerging Models

Informal and semi-formal adult domestic violence death reviews have been conducted in a number of states for the past decade. More recently some states, such as California, Nevada, and Delaware, have introduced legislation to regulate the review process and protect review participants from liability. However, adult domestic violence fatality reviews are a relatively recent phenomenon and it is accurate to state that most domestic violence related deaths currently are not subject to systematic and multi-agency review.

The principal purpose of domestic violence fatality review is to reduce domestic violence related deaths and injuries through the identification and subsequent rectification of problems in the civil and criminal justice systems, including the delivery of multiple services to families. One way of doing this is through reviews such as the Charan investigation, which, as the authors have shown, scrutinized one case very closely yielding various concrete recommendations regarding service delivery.

Other review practices aim to do the same, although they use different approaches. These approaches are influenced by the availability of resources to fund reviews, the commitment of different agencies and jurisdictions, and their experience of domestic violence deaths. Some review teams examine large numbers of deaths with a view to identifying just how many are the result of domestic violence. This type of wide-angle approach tends to reveal the extensive role played by domestic violence in the loss of life in general. An exemplar of this wide-angled approach can be found in Philadelphia.

PHILADELPHIA: A MULTIDISCIPLINARY MODEL

The Philadelphia Women's Death Review Team is a multi-agency, multidisciplinary group convened as a public-private collaboration. It seeks 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, as well as the effects of the killing on their children.

Scope of review. Without substantial funding or any 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 deaths of women from 15 to 60 years of age, not just domestic violence cases.[19] These deaths either could be related directly to domestic violence or related indirectly due to women's inability to access health care. Roughly three thousand women die in Philadelphia every year and the team expects to look at 400 to 500 deaths. The team's central objective is to be able to identify any domestic violence directed at decedents in the 12 months prior to the fatality. The meetings are quarterly and each review takes about 30 minutes.

Observations. To date, the Philadelphia Team[20] has made the following important observations about the deaths of women:

- It is difficult to locate information on many of the female decedents, especially psychosocial data. Many women led invisible lives and their deaths often went unnoticed. Many women who died prematurely were not known to any community/legal systems.
- Often, perpetrators of domestic homicide are known within their communities, and not only in their role as offenders. Some were known to mental health providers. The team has asked whether it is possible to flag or track offenders who need but refuse psychiatric help.
- Gun merchants do not always refuse to sell firearms to individuals with Protection from Abuse Orders against them. Additionally, judges do not always order domestic violence perpetrators to relinquish previously acquired weapons. The team has raised a number of questions about the use of the judiciary to remove or manage access to weaponry.
- 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.

SANTA CLARA COUNTY, CALIFORNIA: A COUNTY BASED DOMESTIC VIOLENCE COORDINATING COUNCIL MODEL

The Santa Clara County Death Review Committee began work in 1994 and appears to have been among the first domestic violence review teams in the country. It defines "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.

The final report[21] of the committee, published in October 1997, contained information on 51 domestic violence homicides. The report included data on types of deaths (homicide, homicide-suicide, suicide, accidental death, or police shooting); police agencies involved in the case; age, race, sex, and substance abuse history of the parties; presence of children; weaponry used; status of the

TABLE 2
Highlights of the 1997 Santa Clara County Death Review Final Report

- The average adult age of perpetrators and victims was 33 years (females 32; males 35).
- Of the 51 perpetrators, 44 were male, seven female.
- Firearms were used in 29 of the 51 homicides. The report stressed that "as a community we must advocate for handgun control."[22]
- 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).
- Of the 51 victims, 17 were Asian,[23] 14 white, 12 Hispanic, five African American, two mixed-race, and one Indian (not Native American).
- The report noted a need for educating the public through agencies such as schools and the media. For example, the Santa Clara County report recommended all school districts develop a curriculum that addresses domestic violence.[24]
- The report noted a need for creating a greater awareness of the links between workplace violence and domestic violence. The Santa Clara County team noted that seven of its 51 deaths occurred in the workplace.[25]

relationship (divorced, cohabiting, separated, etc.); existence of prior restraining orders; prior police involvement; and location of residence.

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 noted, "This made members feel that we were not getting the word out about the dangers of domestic violence to the Asian community."[26] This led to calls for greater Asian representation on the death review committee. The report noted three Asian members on the team. One committee member helped form the Asian Community Against Domestic Violence Coalition, which 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 did not utilize services were 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.[27] In addressing this issue, Wang argues that battered Asian-American women have not been well understood by the domestic violence movement.[28]

Although California legislation does not address the issue of domestic violence shelters turning over their records for purposes of death review, informally the team seems to have worked around the issue of client confidentiality and it appears a mechanism has emerged so shelter team members do share information.

THE FLORIDA FATALITY REVIEW PROJECT: GOVERNOR'S RESEARCH AND POLICY MODEL

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 better to understand, intervene in, and prevent these crimes. Unlike reviews in Philadelphia and Santa Clara County, a team of researchers, hired specifically for that purpose, conducted the Florida reviews. These researchers did identify system failures, although this was not the prime focus of their research. Rather, they gathered evidence on the overall dynamics of cases prior to death.

Dynamics examined. For each domestic fatality in 1994 the researchers examined the following dynamics:

1. 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.

2. The situational antecedents to the fatality.

Researchers explored the following:

- A prior history of domestic violence in the relationship;
- The presence or absence of injunctions (restraining or protection orders) both prior to the fatality or when the fatality occurred;
- Whether a divorce was pending at the time of death (with married couples);
- Whether there was any sign of relationship breakdown (variously measured);
- Whether there was any sign of acknowledged conflict in the relationship;
- Prior police calls to the residence;
- History of drug/alcohol abuse;
- The residential origins of the perpetrator and victim;
- Whether the victim or perpetrator had any history of emotional problems or mental illness and the specific forms of these problems. (See Table 3)

3. The lethal incident.

Here researchers documented:

- The specific mode of killing;
- 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.);
- The availability of weapons;
- The involvement of drugs or alcohol during or immediately preceding the fatal episode;
- The presence of other parties at the scene (e.g., children, police, other professionals);
- The non-fatal wounding of others at the scene;

- The involvement of professionals at the scene; and
- The location of the fatal incident

Data sources. 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 her/his family. They also interviewed professionals including, but not limited to, police, court personnel, mental health workers, social service providers, and advocates for battered women.

Disparity in numbers. Although the Florida Department of Law Enforcement (FDLE) documented 230 domestic fatalities in Florida during the year of 1994, the research revealed a total of 328 domestic fatalities in that year.[29]

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 include deaths from suicide related to domestic violence. This unknown figure 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 those deaths 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 Florida homicides were related to domestic violence.[30] This ratio contrasted sharply with official police data, which identified only one-fifth of all homicides in Florida in 1994 as being caused by domestic violence.

Essential findings from the Florida Fatality Review Project.

- The analysis indicated that 294 of the 328 fatalities were consistent with the Florida Domestic Violence Statute.[31] 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.
- Men perpetrated nearly all cases with multiple victims. 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. Men killed most of the individual women. 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 abuse. When other men in domestic situations kill men, it is often because the two men are competing for a woman who has, in many cases, been victimized by one of the men. Men perpetrated three-quarters of all adult male domestic fatalities. 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 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 commission of intimate partner homicide by women varied considerably by race and ethnicity. Although African-American women constitute roughly one-eighth of Florida's female population, they comprised 16 of the 24 women who killed their male intimates. Black women who killed, like their Caucasian and Latino counterparts, were essentially backed into a corner with nowhere to go. Like white women, some had children to care for; nearly all, if not all, had been brutalized by their intimate partners; and most had, for whatever reasons, not sought out or received support from criminal justice and other state agencies. Their partners were often obsessively possessive, and a good number of these violent men had threatened to kill them. From initial field interviews in Florida it appears that black women are less likely to use shelter and criminal justice services than white or Latina women and are, therefore, more likely to be entrapped to the point of committing lethal violence.[32]

- Missing data hamper the statistical analysis of child fatalities. 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 mothers' 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 there is 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 ha prior documented contact with the police.

Children under five years of age are clearly the most vulnerable to violence. Over half of the child victims in the sample were under two years of age. Those who were older were often killed with easily obtained firearms.

As part of a grant from the Violence Against Women Grants Office, the Florida Governor's Task Force has provided technical assistance to four pilot Florida fatality review teams that are just beginning to review cases at this time of writing. Using the Florida fatality review project and its methodological approach as a touchstone, teams in Metro-Dade (Miami), Volusia-Putnam (Daytona Beach), Palm Beach, and Hillsborough (Tampa) counties have formed, created operational guidelines, and constituted various subcommittees regarding matters such as the ethics of death reviews, data collection, working with family members of the decedents, effecting policy changes, and introducing confidentiality legislation.

The issue of confidentiality and immunity from suits remains the biggest stumbling block in Florida, as team negotiate their concerns about liability. Some state statutes have already dealt with this matter, providing their teams with immunity from various legal actions stemming from the review process.[33] In Florida, initial reviews have begun with homicide-suicide cases where there is no pending criminal prosecution and cases effectively are closed and the risks of liability limited.

THE USE OF WITNESSES: AN EMERGING ISSUE FOR FATALITY REVIEW TEAMS

In Florida, as elsewhere, review teams are discussing many important issues. One matter concerns the feasibility of bringing in witnesses to improve understanding of domestic deaths. Other states have empowered teams formally 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 also can compel the production of records related to the death by filing a praecipe[34] (request) for a subpoena, through the office of the Attorney General, with the Prothonotary[35] (clerk) of any county.

TABLE 3
"Red flags" identified with the 1994 fatalities in Florida

The researchers also identified "red flags" or situational antecedents to the fatalities presented in order of their documented frequency in the 106 cases where men killed intimate female partners:

- Prior history of domestic violence (approximately 85 percent of cases). Among these cases battered women often reported an increasing entrapment.
- Obsessively possessive beliefs on the part of the perpetrator (approximately 70 percent of cases). Stalking behavior, close surveillance, inability to sleep on the part of the perpetrator, acute depression, perhaps a history of medication use, history of suicidal ideation, or, less commonly, documented suicide attempts often accompanied this.
- Attempts to break away from the perpetrator, including divorce, separation, and estrangement (approximately 70 percent of cases). In a number of cases of breaking away, researchers identified accompanying relationship difficulties regarding such matters as child custody/visitation.
- Prior police involvement in the case (approximately 50 percent of cases involving lone women killed and 30 percent of cases where women died in the course of homicide-suicides or familicides).
- 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 (67 cases), the men had prior histories of criminal behavior, nearly always involving violence. In about a fifth of the multiple killings, the male perpetrators had prior criminal histories of violence.
- Threats to kill the eventual victim (documented in approximately 30 percent of cases). These often were communicated to family friends, relatives, neighbors, and others prior to the homicide.
- Issuance of restraining orders (approximately 20 percent of cases).
- Alcohol or drug use that often escalated prior to the fatal episode (approximately 20 percent of cases).

This is a thorny issue and some advocates for battered women have argued for retaining certain informal elements to fatality review.[36] Some particularly important questions relating to subpoena power are noted below:

- Is the resort to subpoena overly inquisitorial and punitive?
- Do teams themselves want the ability to subpoena witnesses?
- Could family members of victims be subpoenaed? Given the involvement of families of victims in homicide trials and their need for information about the death, closure, and input, how should teams work with grieving families?
- What about the conflicts between confidentiality/immunity of teams from suits, and the need to be open and honest with families about the death?
- How might teams work with domestic violence shelters? For example, ought shelter staff and records also be available for review, or should they somehow be immune? One can envisage many reasons for not allowing teams to access shelter contacts with women. However, what if shelters actively discriminate against minority women, or fail to provide services for them? Would not this problem, already identified by a small number of African-American women in Florida, be something that an assessment of systems delivery would want to address? Can women entering domestic violence programs be asked to waive access to their records in the event of their subsequent deaths? Is such a waiver not insensitive? realistic? or both? Or, do a victim's rights evaporate upon death?

The authors pose these questions and issues in the spirit of inquiry to encourage discussion and debate. One specific area that needs to be explored further is the role of the judiciary in domestic violence fatality reviews.

The Role of the Judiciary in Domestic Violence

FATALITY REVIEWS

What role should the judiciary and judges play in reviewing cases or situations known to the court where there is fatal domestic violence? Should judges simply defer to others when such tragic circumstances arise or should they participate in some process to determine whether the system could be improved so future fatalities might be prevented?

At a practical level, what should judges do when legislators, the media, and others in their community raise a hue and cry regarding a highly publicized domestic violence fatality? How should judges deal with the professional and ethical constraints, which limit and guide them as part of the third branch of government? These questions inevitably surface when the issue of court involvement in domestic violence fatality reviews arises. Fortunately, other disciplines, such as medicine, have addressed the same issues carefully and it is now part of their ongoing training, protocol, discussion, and literature.[37] Perhaps it is time for the justice system to recognize it has a role to respond in a similar fashion.

It is accepted that judges may provide leadership in their courts and in their communities with respect to the fair, prompt, and effective management of domestic violence cases.[38] This role is consistent with their judicial duties as laid down in the ABA Code of Judicial Conduct, which specifically acknowledges that judges are in a unique position to improve the administration of justice.[39] Under the ABA Code, judges are required to maintain professional competence in judicial administration and cooperate with other judges and court officials in the administration of court business.[40]

As part of their leadership role and administrative responsibilities, some judges and courts have decided to play a key role in domestic violence fatality reviews.[41] While court and judicial participation in such reviews is still evolving, several models have emerged. Some courts conduct internal (or in-house) reviews, while other courts participate in an external and formal team review.[42] Some courts participate in both kinds of reviews. While some courts and judges have been active in convening such teams, other courts are more passive participants. Each model seems to depend in part on the local judicial and legal culture, as well as the judges' professional views of what role they and their courts can and should play.

One may ask, why include the judge or a member of the court in a domestic violence fatality review, however structured? There are good reasons for doing so. Judges and their staff, as well as the attorneys and others who appear before the court, (including intake officers, social workers, probation officers, and others) usually follow established procedures in processing, presenting, and deciding cases. If the case has the potential for harm to any litigant or family member, court procedures and risk assessments should be reviewed carefully from time to time for fairness and effectiveness. Such review is from a systemic standpoint and should not be focused on blame or finger pointing. Error recognition, accountability, honesty, and systemic improvement should be the focus rather than denial, blame, and personalizing the review.

For example, in a criminal case at arraignment, the court must determine bail or release conditions. If a defendant is ultimately convicted, the court must determine whether a defendant requires prison or a term of probation. If probation is ordered, it comes with a wide array of services and/or sanctions, such as a jail term, a stay away order, domestic violence intervention counseling, substance abuse treatment, mental health counseling, and more. If a judge sentences someone to probation and that person later kills a family member, the system might be reviewed to assure that the court had all the information before it by way of pre-sentence reports, related cases, criminal abstracts, and risk assessments, to fashion a fair and appropriate sentence that is cognizant of community safety, accountability, and treatment issues.

Another good example lies in family court, particularly where the court is a unified family court or a closely coordinated juvenile and family court, as the judges are often well acquainted with the families under the one judge, one family, one service team concept.[43] Those calendars require a keen sense of which cases are risk laden. They are often high volume calendars where the judge may make ten, twenty or more custody, visitation, or restraining order decisions daily. The obvious question is whether the judge is privy to all relevant information and is utilizing a valid checklist or risk assessment when rendering these key decisions.

Historically, there has been very limited participation by the judiciary in domestic violence fatality reviews.

Endnotes

1 See Leape, L.L., 1994, "Error in Medicine," JAMA, 272:1851-1857.

2 Such a definition may exclude boyfriend-girlfriend relationships where there has never been cohabitation or a child in common even where the dynamics of the relationship and eventual killing precisely parallel those between couples covered by statute. To qualify as an "intimate partner," states often require the couple to have lived together at some point or to share a child in common. For example, Florida Statute (1994 s. 741.28) 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."

According to the Bureau of Justice Statistics (BJS, 1998; Bureau of Justice Statistics, U.S. Department of Justice. 1998. "Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends," NCJ-167237 March 1998), 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.

3 For a discussion of these different categories, see Charles Patrick Ewing, 1997, Fatal Families: *The Dynamics of Intrafamilial Homicide.* Sage. Thousand Oaks, CA; Neil Websdale, 1999, *Understanding Domestic Homicide*, Northeastern University Press. Boston, MA; for a discussion of parricide see Kathleen Heide, 1995, *Why kids kill parents: child abuse and adolescent homicide.* Sage. Thousand Oaks, CA.

4 Evan Stark and Anne Flitcraft. 1995, "Killing the Beast Within: Woman Battering and the Female Suicidality." *International Journal of Health Services* 25 (1): 43-64.) addresses the links between suicide, suicidal behavior, and domestic violence. Websdale (1999) explores some of these links.

5 Websdale, N & Johnson, B. 1997. "Battered Women's Vulnerability to HIV Infection," *Justice Professional*, vol. 10, no. 4, pp. 183-198.

6 Editorial, "Promoting Patient Safety by Preventing Medical Error," *JAMA*, October 28, 1998, vol. 280, no. 16 p.1444-1447. Quoted p. 1444.

7 Maria Stone, 1995, "Domestic Violence Fatality Reviews." Boalt Law School, p. 13.

8 See for example the case of Leonard Morrow who murdered his wife Latonya and two young children before committing suicide. The Hopkins county child death review team defensively concluded that "it does not appear that the system failed Mrs. Morrow," but rather that "Mrs. Morrow failed to allow the system to protect her." (Cited in Websdale, N. 1998, *Rural Woman Battering and the Justice System: An Ethnography.* Sage. Thousand Oaks, CA, p. 149. Full discussion in Websdale, 1998, p. 147-150).

9 See Stone, 1995, pp. 15-17 and especially note 59.

10 Project Safeguard, 815 E. 22nd Avenue, Denver, Colorado, 80205, 303/863-7606.

11 This growing recognition of the links between adult parental domestic violence and child abuse, neglect, and death is reflected in recent legislation in Delaware. 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. 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.

12 See Websdale, 1999, chapter 6 Table 6.6. Websdale shows that in just over half the 57 cases of domestic child homicides where two parents/caretakers were involved in the care of the child, the female parent/caretaker was being beaten by the male parent/caretaker prior to the homicide.

13 Investigation, p. 5.

Because the judiciary is an integral part of the criminal justice system and the family court system, participation by the judiciary is increasing. As discussed above, in the Charan investigation the final report recommended systemic improvements in a variety of areas that required court involvement, ranging from translators, to training for probation officers and judges, to opening up case records in family court services. The Charan case is not exceptional. Almost every community can recite a widely publicized killing, often accompanied by widespread media and legislative concern about whether the system is responsive to and protective of battered women and children. It is far better to have a constructive review process in place rather than simply to react in *ad hoc* fashion, as has been the case historically. Indeed, with the advent of these review teams across the nation, those jurisdictions without such teams will come under even greater scrutiny and pressure to create a domestic violence fatality review team.

What can judges and the judiciary do to address the concerns raised by those in the community who ask whether the problem of domestic violence is being addressed fairly, promptly, and effectively? Judges and the judiciary can learn from the track record of current review teams and from other disciplines, such as medicine, about how they deal with fatalities. They can participate in forming their own domestic violence fatality review processes and start to discern how and where the various justice systems succeed and where they need improvement in protecting victims of domestic violence. Additionally, they can make a real effort to assure their communities that the justice system fairly and effectively addresses the litigants' legal problems and at the same time adequately protects them. Ultimately, judges must create a legal and judicial culture of safety, which prevents future harm whenever possible.

AUTHORS' ADDRESSES

Neil Websdale, Ph.D.
Center for Crime and Justice Policy
Vanderbilt University
1207 18th Avenue South
Nashville, Tennessee 37212

Judge Michael A. Town
First Circuit Court
Courtroom 13
P.O. Box 619
Honolulu, Hawaii 96809

Byron Johnson, Ph.D.
Center for Crime and Justice Policy
Vanderbilt University
1207 18th Avenue South
Nashville, Tennessee 37212

Conclusion

When a SwissAir flight went down off the coast of Newfoundland in 1998, claiming the lives of over 200 passengers and crew, a very high profile investigation ensued. Millions of dollars were spent and no stone left unturned in an effort to understand how such a crash could have occurred. These efforts were designed to identify the cause of the crash, with a view to preventing similar tragedies in the future. Given that many people use the airways, such efforts are entirely understandable.

Domestic violence claims the lives of several thousand people per year. Because intimate family relationships are a part of most people's lives, much more time should be devoted to exploring domestic violence deaths, with a view to preventing them. This article has suggested that reviewing domestic violence fatalities is a laudable development, one that will help prevent future deaths in families, reduce domestic violence in general, improve the delivery of multiple services to families experiencing such violence, and make an unequivocal statement about the undesirability of this illegal and highly injurious behavior. As is happening in the field of medicine, this article recommends creating a culture of safety in order to review domestic violence deaths effectively, honestly, and openly.

We have highlighted several approaches to death reviews. The results of these reviews have been used to implement, or at least suggest, greater system coordination in dealing with people victimized by family violence. We have acknowledged the need for communities to develop their own review processes and the authors hope that some of the highlighted information will contribute to those developments.

Of especial importance, for the purposes of this article, is the recommendation that judges adopt leadership roles in working toward establishing local domestic violence reviews. Such leadership is entirely in keeping with the role of judges in communities and government.

14 For a good recent discussion of these issues see Karin Wang, 1996, "Battered Asian American Women: Community Responses from the Battered Women's Movement and the Asian American Community." *Asian Law Journal* 3:151-185.

15 Report p. 7.

16 Report p. 11.

17 Report p. 12.

18 Report p. 13.

19 This includes deaths classified as homicides, suicides, unintentional injury, undetermined cause, those with inadequate certificates, and peculiar circumstances (asthma, AIDS), This is not to suggest that the deaths of women aged over 60 are not due to domestic violence. For example, "suicide pacts" where elderly men kill their female partners 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 percent of the total homicides of people aged over 55. Cohen also notes that while 50 percent of the women's health had deteriorated, two-thirds had expressed "no desire to die." Evidence that women killed in so-called suicide pacts had expressed "no desire to die" may suggest they were being battered prior to their demise (Cited in Charles Ewing, 1997 p. 143).

20 At 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.

21 By Rolanda Pierre-Dixon, Chair.

22 Santa Clara County Death Review Committee Final Report, October 1993-September 1997, p. 14.

23 The term "Asian" is not defined in the report.

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

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

26 Report. p. 13.

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

28 Asian 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 them 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 the 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 toward 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 homemaker are often disrupted by an American economy that requires both partners to work outside the home. This may be seen as liberating by Asian women, but it may, as Wang points out, be very threatening to the partners of Asian women. See Wang, 1996, p. 171.

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

30 Preliminary findings from 1995 reveal similar discrepancies between FDLE data and that number of domestic violence fatalities identified by the broader definition used by 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.

31 See footnote 1 for Florida Statute (1994) s 741.28

32 For further discussion of these and related matters, see Beth Richie, 1996, *Compelled to Crime*, Routledge, New York; Websdale, *supra* note 29, 1999.

33 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 (N.R.S. 217.475 ss 4). In addition, each member of the team is immune from civil or criminal liability for an activity related to the review of the death (N.R.S. 217.475 ss 8). Subsection 9 states that the "results of the review...are not admissible in any civil action or proceeding." 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 (Delaware Statute Title 13 s 2105 (h)). 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 (Delaware Statute Title 13 s 2105 (i)).

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

35 A prothonotary is an officer who officiates as principal clerk of courts in states such as Pennsylvania (Delaware Statute Title 13 s 2105 (d)).

36 For example, Barbara J. Hart made this point in her recent speech on social justice and fatality reviews in a national summit at Key West, Florida, October 26-28, 1998.

37 See for example, Editorial, "Promoting Patient Safety by Preventing Medical Error," *JAMA*, October 28, 1998, vol 280, no. 16 p.1444-1447. The authors suggest that error in medicine is real and common and must be reduced. They argue that if this error is met with blame and distrust, then suppression, stonewalling, and cover-up follow; all of which fail to reduce future harm. Alternatively, they suggest that system changes can prevent harm to patients and led to the transition from a culture of blame to a culture of safety. The editorial is well written and has generated much discussion nationally. See also, Gawande, Atul, "When Doctors Make Mistakes," The New Yorker, (Feb. 1, 1999) at p. 40. This excellent and readable article details a difficult medical procedure and sets forth how a hospital morbidity and morality conference addresses physician error and the procedures needed to overcome it. Query if courts and the justice system could adapt such conferences when preventable domestic violence takes place?

38 "Judges must provide leadership in their courts and in their communities to ensure that family violence cases are effectively managed and that adequate resources are available." Family Violence: Improving Court Practice, p. 15 (National Council of Juvenile and Family Court Judges, 1990).

39 Canon 4.B of the revised ABA Model Code of Judicial Conduct states "A judge may speak, write, lecture, teach and participate in other extrajudicial activities concerning the law, the legal system, the administration of justice and non-legal subjects, subject to the requirements of this code." The commentary discusses how the judge is in a unique position to contribute to the improvement of the administration of justice including the criminal justice system.

40 See Canon 3. C.1 of the revised ABA Model Code OD Judicial Conduct (1990). Most states have adopted some version of the American Bar Association's Model Code of Judicial Conduct, which was revised in 1990. See Shaman, Lubet and Alfini, Judicial Conduct and Ethics, pp. 3-6 (Michie, 2nd ed. 1995). The preamble to the 1990 version states that judges "must respect and honor the judicial office as a public trust and strive to enhance and maintain confidence in our legal system."

41 See Websdale, N., Sheeran, M., and Johnson, B. 1998. *Domestic Violence Fatality Reviews: Summarizing National Developments*. National Council of Juvenile and Family Court Judges. Reno, Nevada. This publication was part of the National Summit on Domestic Violence Fatality Reviews held in Key West, Florida in October 1998.

42 See for example the Philadelphia Women's Death Review Team: An Interdisciplinary Team to Reduce the Number of Violence-Related Deaths of Philadelphia Women. A paper summarizing the work of the team is available from the Family Violence Department of the National Council of Juvenile and Family Court Judges or from the Philadelphia Health Management Corporation, 260 South Broad St. Philadelphia, PA 19102-5085.

43 Typically a unified family court's jurisdiction includes all juvenile cases (delinquency, status, detention, waiver and child abuse), divorce, paternity, adoption, nonsupport, guardianship of adults and children, civil restraining orders, civil commitment in mental health cases, and in some jurisdictions crimes within the family ranging from domestic violence to intra-familial murder. Traditionally, one judge or one judicial team hears all cases affecting one family and the judge has a broad array of services to assist these families. See, e.g., materials on ABA Summit on Unified Family Courts: Exploring Solutions for Families, Women and Children in Crisis (held May 14-16, 1998, Philadelphia, PA).

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: HB398-LAW-CDCO-1-26
Bill Version: HB 398
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: LAW
Title "An Act relating to domestic violence fatality review teams."
RDU Criminal
Component CDCO
Sponsor Representatives Dahlstrom, Stoltze, Samuels, McGuire, Wilson
Requester House Judiciary
Component No.

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill allows the Commissioner of Public Safety or a municipality to establish domestic violence fatality review teams for the purpose of preventing domestic violence-related fatalities, improving law enforcement response and providing consultation and coordination for agencies involved in the prevention and investigation of domestic violence.

Passage of this legislation will have no foreseeable fiscal impact on the Department of Law.

Prepared by: Kathryn A. Daughhetee, Director
Phone 465-3673
Division Administrative Services
Date/Time 1/26/04 9:25 AM
Approved by: Kathryn Daughhetee for Gregg D. Renkes, Attorney General
Date 1/26/2004
Agency Department of Law

(Revised 12/2003 OMB)

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB398
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title: An Act relating to domestic violence fatality review teams
BRU: Legal and Advocacy Services
Component: Public Defender Agency
Sponsor: Representative, Dahlstrom, Stoltze
Requester: (H) Judiciary
Component No.: 1631

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
This bill should have minimal fiscal impact on the operations of the Public Defender Agency.

Prepared by: Linda K. Wilson, Deputy Director
Phone (907)-334-4416
Division: Public Defender Agency
Date/Time: 1/26/04 11:25 A.M.
Approved by: Mike Miller, Commissioner
Date
Agency: Administration

(Revised 9/2003 OMB)

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 398
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Administration

Title: An Act relating to domestic violence fatality review .
BRU: Legal and Advocacy Services
Component: Office of Public Advccacy

Sponsor: Representatives Dahlstrom, Stoltze, S Samuels & McGuire
Requester: (H) Judiciary
Component No.: 43

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
This bill should have no fiscal impact on the operations of the Office of Public Advocacy.

Prepared by: Josh Fink, Director — Phone 907-269-3501
Division: Office of Public Advocacy — Date/Time
Approved by: Mike Miller, Commissioner — Date
Agency: Administration

(Revised 9/2003 OMB)

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB398CS-DPS-ABI-2-6-04
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Public Safety
Title: Domestic Violence Review Teams
RDU: Alaska State Troopers
Component: Alaska Bureau of Investigations
Sponsor: Rep. Dahlstrom
Requester: (H) Judiciary
Component No.: 2744

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill authorizes that the commissioner of Public Safety or a municipality may establish domestic violence fatality review teams. The purpose of the teams is to review events leading up to a domestic violence incident in order to prevent domestic violence fatalities and to provide consultation and coordination for agencies involved in the prevention and investigation of domestic violence.

This bill would also allow those participating in the teams to receive confidential and other records of a department or an agency of the state or municipality relating to a domestic violence incident. The confidentiality of those records would be maintained.

Prepared by: Lt. Al Storey
Phone 269-4532
Division: Alaska State Troopers
Date/Time 2/8/04 8:07 PM
Approved by: Commissioner William Tandeske
Date 2/8/2004
Agency: Department of Public Safety

ANALYSIS CONTINUATION

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While the language of this bill empowers the commissioner of Public Safety to establish domestic violence fatality review teams, the teams themselves do not need to be actively over sighted by the Department of Public Safety (DPS).

The direct fiscal impact to DPS, therefore is expected to be very minimal. There would be some expected costs as the processes by which the teams will conduct business are established, as members of DPS attend the meetings, and as final reports from the teams are presented for archiving, but those costs could be absorbed by current resources.