Fatality Review: The State of the Art

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Historical Origins of DVFR

- Public outcry over IPH
- Rise of second wave feminism
- Women's education and paid employment
- New civil rights movement
- Increases in divorce and particularly no-fault divorce
- Women's growing control over reproductive health

Historical Origins

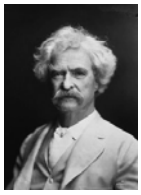
- VAWA 1994
- Rise of risk societies and concern with trans-national/global risks – e.g., aviation, nuclear power, medicine
- Victim rights revolution – 1973 US Supreme Court cases – David Garland "The return of the victim."
- Colonial and revolutionary period crimes often investigated and prosecuted by victims

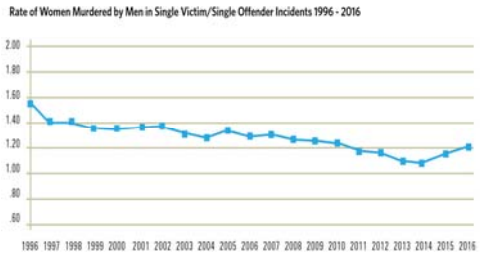
Historical Origins

- Victim Rights Act of 2004 – link to listening to voices of victims in DVFR
  - Critique of victim rights movement
- Undermines the right of the accused
- Impinges upon prosecutorial discretion
- Opens the door to vengeance/negative emotion

Mark Twain

Most people use statistics like a drunk man uses a lamppost; more for support than illumination





Stratmann & Thomas, 2016, p. 35

Dial 911 for Murder

- Stratmann & Thomas (2016)* argued that the introduction of 911 services explain much of the decrease in homicide rates
- The introduction also explains the divergence between aggravated assault and homicide rates that started in the early 1970s
- There is an economic value to shortening response times because it reduces the time cost of emergency services

Recent crime counting research

- Walby et al. (2015) lifting the cap on counting high frequency violent crime reveals increases in VAW since 2008
- Capping – UK (5), US (6), Mexico (5), Canada (3) – series of more than five crimes capped at 5, even if victim assaulted 6, 10 or 13 times Challenges pacification model, self-control, etc.
- 2008 recession had disproportionate effects on women – resources, leaving, earnings, etc

Social patterning

- IPH profoundly gendered but race, class, ethnicity, geo-social location also mediate
- About 50% of IPHs in US have prior systems contact but low collaboration, communication, coordination*
- About 50% female victims appear to die in relative isolation with no or few "system contacts"
- IPH stylized with telltale histories but much knowledge remains hidden

Trends

- Steepest decreases in the African American community
- BUT medical advances might be much more significant than CJ responses
- The IPH rate reductions coincided with improved medical interventions especially to inner city

Murder and Medicine

- Harris et al., (2002) - explored homicides and aggravated assaults from 1960-1999*
- Harris et al., estimate that without the impact of improved EMS, the 15,000-20,000 average homicides (1994-1999) would have been 45,000-70,000!
- Improved medical care reduced the lethality of violent assaults by 2.5-4.5%/year. Rise of trauma centers
- Modern wound care, antisepsis, antibiotics, anesthesia, fluid replacement, trauma surgery, and emergency services

Medical Interventions

- CDC The estimated number of people wounded seriously enough by gunshots to require a hospital stay, rather than treatment and release, rose 47% to 30,759 in 2011 from 20,844 in 2001
- Information from more than 900 trauma centers in the U.S., also found a decrease in the death rate for victims admitted for stab wounds
- Source: Centers for Disease Control and Prevention's National Electronic Injury Surveillance System-All Injury Program

DV Related Deaths

- Single and multiple homicides
- Family killings
- Sexual competitor killings

Domestic Violence Related Deaths

- Suicides of women and men
- Indirect deaths
- Near fatalities
- Bystander deaths
- Accidents, disappearances, and other suspicious deaths
- Roughly half of child maltreatment deaths occur against backdrop of battering

Telltale signs, antecedents, risk markers

- Prior history of IPV (weapons use; strangulation especially serial; escalating violence, attempts to control, & emotional harms; beating during pregnancy: previous attempts to kill; forced sex; entrapment; capable of killing)
- Separation/emotional estrangement
- Extreme jealousy linked to violence
- Depression/suicidal potential
- Alcohol & drug abuse
- Stepchildren in the home
- Compromised masculinity/humiliated fury

Definition of DVFR

- DVFRTs identify and analyze homicides, suicides, and other deaths caused by, related to, or somehow traceable to DV
- Reviews are formal or informal
- Range greatly in depth and number
- Teams devise preventive interventions

Philosophy
Radioactive Wolf from Chernobyl

Philosophy
Medical Error Deaths

Sully's Landing on the Hudson

DVFR Philosophy

- No blame and shame
- Accountability
- Lessons from other fields
  - Aviation, nuclear power, medicine
- Creating a culture of safety

DVFR Philosophy

- No-blame and shame – accountability balance
- DVFR requires a paradigm shift from a *culture of blame to a culture of safety*
- Review teams therefore work with a philosophy of kindness and concern, that respects the rights of surviving family members and decedents, but that recognizes that better agency coordination might or can save lives
- Batterer ultimately responsible?

DVFR Philosophy

- Important role of culture in DV related deaths
- Links between racial/ethnic disadvantage and DV deaths
- Are we witnessing the effects of culture or the effects of concentrated poverty?
- Important role of gender
- Note pivotal significance of race, gender, class

Geographical Spread of DVFR

- 1995-2018, roughly 200 teams in 45 states
- Statewide teams in Montana, New Mexico, Kansas, Iowa, and Oklahoma
- Florida, Maryland, and California now have at least 20 teams each, Arizona 13
- States currently not reviewing: ID, AR, MS, IL, RI

1995: 18 Domestic Violence Fatality Review Teams 13 States

2019: 200 Teams in 45 States

Forms and Organization

- Nowadays teams operate as multi-agency/multi-stakeholder bodies
- The Montana Review Commission travels to the communities where the death occurred, reviewing cases in conjunction with local partners, taking two days per case to do so. The Commission reviews two cases a year.
- The Montana Indian Country review initiative operates the same way

Forms and Organization

- Florida was the first highly populated state to develop a statewide DVFRT in addition to a network of county-based teams
- The Florida Statewide DVFRT receives information from many of the county-based teams

Scope: Reviewable Cases

- Number and type of cases
- Methodologies vary
- Review within team's capabilities
- Dangers of trying to be representative/scientific at the individual team level
- DVFRTs typically do not review all cases caused by, related to or somehow traceable to DV

Case Types

- Links with DV related deaths
- Single and multiple homicides; Family killings; Sexual competitor killings; Suicides; Indirect deaths; Near fatalities; Contract killings; Bystander deaths; Suspicious deaths, accidents and disappearances

Team Membership

Team Membership

- Inclusivity, creativity
- Lenses of decedents/perpetrators
- Various perspectives – dangers of fundamentalism! W.B. Yeats "The best lack all conviction while the worst are full of passionate intensity"
- Role of family, friends, neighbors, and co-workers
- Focus group feedback

Getting Started

- Use statute or other legal enabling mechanism as frame of reference
- Identify stakeholders to participate on the team
- Develop protocols
- Decide how the team will house documents, send out meeting notices, and generate reports
- Develop confidentiality agreements for both individuals and agencies. (See ndvfri.org "Documents" tab and "Review Teams" tab)

Getting Started

- Develop mission statements, goals, protocols, philosophies
- How many cases to review in depth versus in aggregate?
- Case selection criteria

Getting Started

- Select the first case(s) to review.
- Establish a meeting schedule that allows for maximum participation.
  - Will the team meet monthly, bimonthly, quarterly, biannually, or annually?
  - How long will the meetings generally last?
- Team members can gather and, if legally & ethically appropriate, provide documents concerning their agency's involvement

Statutory Suggestion

- Review only deaths in which the investigation is closed and there is not a pending prosecution – note exceptions
- NDVFRI team NOT permitted to lobby for legislation
- NDVFRI.org has sample statutes and our team can provide TA regarding elements of the law
- We do not write legislation
- Think carefully about team subpoena power

Organizing a DVFR

- 1. Timeline
- 2. Antecedents/red flags
- 3. Prior agency, stakeholder, and community involvement
- 4. Policy recommendations: What is to be done?
- 5. Questions

Potential Data Sources

- Police homicide logs
- Newspaper reports of homicides
- Crime scene investigation reports
- Detectives' follow up reports
- Transcripts/notes from interviews conducted by investigators with witnesses and other involved parties

Potential Data Sources

- Civil court data regarding divorce proceedings, termination of parental rights, child custody disputes, and child visitation issues (if accessible)
- Criminal histories of perpetrators and victims
- Child protective services data (if accessible)
- Summaries of psychological evaluations appearing in public record documents such as police files
- Medical examiner reports

Potential Data Sources

- Autopsy reports
- Workplace information, perhaps regarding harassment, abuse, intimidation, and stalking
- Public health data e.g. emergency room data concerning protocols/procedures/hypothetical cases
- Shelter/advocacy outreach data (not necessarily pertaining to a specific decedent that received services)

Potential Data Sources

- Statements from neighbors, family members, friends, workplace colleagues, witnesses and others
- Drug and alcohol treatment data (again, access to confidential drug/alcohol treatment data will be limited by federal statute but superficial data about these matters may be available)
- Perpetrator interview transcripts if all appellate issues closed out. Be sure to advise perpetrator that interviewees know the case well

Potential Data Sources

- Transcripts/notes from interviews by team members
- Protective orders, their affidavits and service notifications
- School data pertaining to abuse reports (detailed access might be limited)

Collateral Interviewing

- Collateral interviews are interviews with people familiar with the victim and/or perpetrator who can shed light on their lives prior to the fatality/near-death, including perpetrators and survivors in near-death reviews

Rationale for collateral interviews

- Understanding the lived experience of the deceased
- Offering family members a way to participate in the review
- Obtaining details absent from the documentary record
- Incorporating different perspectives
- Contributing to team recommendations resulting from the review

Preparation for the interview

- Know what the team wants to learn from the interview
- Review the documentary record; identify public, private and confidential information
- Determine relationship (character lists)
- Select appropriate interviewers
- Decide on method of recording
- Use existing relationships to arrange contact

The Role of Family Members

- In a significant number of deaths victims had minimal or no contact with agencies
- It was a rare case where agencies worked in concert with a battered woman prior to her demise
- Those closest to decedents often know most about their lives and the compromises they faced
- Surviving family members began to agitate for a voice at the table

The Role of Family Members

- Some family members want to contribute. Others do not
- Family members that contribute often find the experience cathartic
- Communicate the limits of family involvement -confidential workings of the team
- Persons close to the perpetrator may also wish to participate

Confidentiality

- Not legal advice!
- Nearly all states conduct fatality reviews under the protection of confidentiality statutes
- These laws shield the deliberations of teams from subpoena and guarantee the information cannot be used in lawsuits or for disciplining professionals handling cases

Confidentiality

- Confidentiality guarantees vary across state and tribal lines
- Initially, such statutory protections raised the possibility of authorities "covering up" negligence and malfeasance
- Agency representatives have openly admitted mistakes with a view to preventing them in the future

Confidentiality

- Differences between public, private, and confidential information
- Historical role of homicide-suicides
- DV victims have rights to confidentiality that survive their death. The question arises as to what information DV centers may provide a DVFRT reviewing the case of a former DV center client?
- Most women dying in IPHs have not resided in shelters or received services from DV centers

Confidentiality

- DV centers promise survivors they will not reveal any information about them without their consent, except in certain circumstances
- The power to consent to the release of confidential and privileged information belongs to the survivor not the center
- Please see: Alicia Aiken. Confidentiality and Fatality Review: 10 FAQs. NDVFRI Bulletin, 2015.

Apparent consequences of DVFR work

- Storer, Lindhorst, and Starr (2013) found two major changes effected as a result of DVFR:
- DV resources be made available for battered women with limited English proficiency (LEP)
- Police learn to routinely screen for suicidal tendencies among abusers

Montana Team

- Recommendations - creating the new strangulation law, which makes strangling a partner or family member a felony on the first offense
- Updating the school curriculum for kids learning about signs of dating violence
- Improving the state's crime victim notification program
- Making sure domestic violence advocates and shelters screen for mental health concerns

General Changes

- System changes – many examples, see ndvfri.org.
- HOPE card - Montana.
- New laws/protocols/practices - many examples, see ndvfri.org
- Florida – see the tracking of recommendations reported in the Faces of Fatality Reports (2014, 24-25; 2013, 13).

General Changes

- Links between CCR, risk assessment, safety and accountability audits, family justice centers, and fatality review
- Interagency communication (formal and informal). Many of the reports note an improvement here, although it is difficult to measure
- Changing the way people work DV cases

New questions/issues

- Why doesn't he leave?
- Emotional isolation of perpetrators
- The problematic notion of control
- Humiliated fury
- The centrality of anger
- The notion of "intent"

New questions/issues

- Challenging notions such as battered woman syndrome, the cycle of violence, learned helplessness, and stock scripts
- Through reviews battered women appear to have much more agency or resistive maneuverability
- Case reviews convey a strong sense of the complexity of human lives, contradictions

New questions/issues

- Traditional advocacy perspectives may downplay battered women's complexity
- Understanding battered women's agency helps us understand abuser behavior and better inform safety planning
- Safety planning ought always remember victims can NEVER really know what perpetrators are capable of doing

Questions

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