

08/27/02 **Karen Cleaver**, 39, and her friend **Mike Bailey**, 55, killed in a fire set by her ex-boyfriend.

09/10/02 **Lori Ann White**, 24, shot by her boyfriend, who also shot and wounded a neighbor who tried to intervene.

09/22/02 **Ingrid Jernigan**, 18, stabbed and strangled by her housemate's ex-boyfriend after he broke into their house. His ex-girlfriend's five-year-old son was also in the house.

09/23/02 **Rachel Burkheimer**, 18, kidnapped and shot by her ex-boyfriend and a group of his friends.

09/27/02 **Jennifer L. Moses**, 34, shot by her husband.

10/06/02 **Katherine Kushell**, 47, shot by her fiancé, who then killed himself.

10/15/02 **Tallen Chartier**, 7, stabbed by his father.

10/18/02 **Cresenciano Gatlula**, 71, stabbed by his wife.

11/14/02 **Teresa Cahill**, 51, bludgeoned by her husband.

11/27/02 **Ricky Sinclair**, 34, shot by friends of his female friend's ex-boyfriend, after her ex-boyfriend was arrested for violating her protective order. She was also shot and wounded.

11/27/02 **John McDonald**, 55, bludgeoned and stabbed by his ex-girlfriend.

01/05/03 **Karin Osterhaug**, 31, shot by her husband, who then killed himself. She was six months pregnant.

01/18/03 **Hyung "Max" Lee**, 52, slashed with a machete by a business client who believed Lee was having an affair with his wife.

01/18/03 **Teresa Jackson**, 27, strangled by her boyfriend.

01/21/03 **Jamare Johnson**, 12, and **David Rodriguez**, 9, beaten and stabbed by their mother's ex-boyfriend. He also tried to kill their mother.

02/14/03 **Diana Kovis**, 48, shot by her husband, who then killed himself.

03/01/03 **Carlin Louise Lane**, 68, stabbed by her boyfriend.

03/01/03 **Candace Fugate**, 41, slashed with a sword by her boyfriend.

03/07/03 **Tawni Baldwin**, 30, shot by her husband, who then killed himself.

03/31/03 **Brittany Louise Stroh**, 17, and her son, **Dylan James McGlenn**, 1, strangled with a belt by her husband, who then killed himself.

04/08/03 **Gum Soon Park**, 76, stabbed by her former son-in-law, who blamed her for his divorce.

04/26/03 **Crystal Brame**, 35, shot by her estranged husband, who then killed himself in front of their two children.

04/29/03 **Frank "Skip" M. Smith Jr.**, 53, shot by his son-in-law.

05/22/03 **Sheila Sinclair**, 35, stabbed by her boyfriend in front of their three-year-old son.

05/26/03 **Trevor Crilly**, 22, shot by his girlfriend's estranged husband, who also shot and wounded Crilly's brother.

06/01/03 **Esther Keene**, 85, shot by her husband, who then killed himself.

06/14/03 **John LaViolette**, 41, stabbed by his ex-girlfriend.

06/20/03 **Martha Elizabeth Vaughn**, 54, stabbed and strangled by her son as she intervened in a fight between him and his wife. The couple's three children witnessed the killing.

07/01/03 **Theodore Kim**, 57, shot by his girlfriend, who then killed herself.

07/03/03 **Fauzia Sarwary**, 42, stabbed by her husband in front of her mother and children. Her husband injured her mother when she tried to intervene.

07/05/03 **Angela Marie Alden**, 32, strangled by her estranged husband.

07/12/03 **Joseph Hatley**, 18, shot by his wife's ex-husband, who then killed himself. His wife and her son escaped.

07/16/03 **Jessica Lynn Meyers**, 21, strangled by her husband and his friend.

08/01/03 **Helen Hampton Lycklama**, 54, shot by her estranged husband, who then killed himself.

08/01/03 **Unnamed woman**, 27, shot by her boyfriend.

08/03/03 **Jason R. Radach**, 31, stabbed by his female friend's boyfriend in front of her and her children.

08/05/03 **Donald Aaron Hayden**, 33, shot by his girlfriend's male friend who perceived him as a rival, who then killed himself.

08/06/03 **Marisela Sital Ross-Serna**, 45, and her nephew, **Nathan Sital**, 21, shot by her ex-boyfriend.

08/22/03 **Sarah Montgomery**, 25, shot by her husband, who then killed himself. Their two children were asleep nearby.

08/25/03 **Donna Lynn Wojahn**, 37, shot by her boyfriend, who then killed himself in front of her four-year-old son. She was five months pregnant.

08/28/03 **Ashley M. Parks**, 16, killed by a man who admitted having a sexual relationship with her.

09/11/03 **Shamsa H. Osman**, 44, stabbed by her husband in front of their children. He also injured one of their sons.

09/13/03 **Edward Boyer**, 65, shot by his girlfriend in front of her four-year-old son.

10/15/03 **Raymond Ubis**, 54, shot by his girlfriend.

11/14/03 **Loan Thoy Tran**, 38, shot by her husband, who then killed himself.

11/14/03 **Marilyn Derosia**, 51, strangled by her husband.

11/20/03 **Lashonda Shantell Flynn**, 17, stabbed by her ex-boyfriend's new girlfriend as he watched.

11/30/03 **Leta Kay Kiesz**, 44, shot by her estranged husband.

12/26/03 **Victoria Monique Ramon**, 2, beaten by her mother's boyfriend after he threatened to kill her and her mother.

01/06/04 **Gail M. Hope**, 80, shot by her nephew who was her caregiver, who then killed himself.

02/28/04 **Jong Ja Taylor**, 61, and her friend **Joy Meei Shang Sun**, 54, shot by Taylor's husband, who then killed himself.

03/17/04 **Dori M. Cordova**, 31, shot by her boyfriend, who was then killed by police when he pointed a shotgun at them.

03/18/04 **Emily May Jacobson**, 20, strangled by her boyfriend.

03/18/04 **Kimberly Faye Denni**, 37, shot by her husband.

03/21/04 **Kenneth Allen Hoshowski**, 40, beaten and stabbed by his girlfriend's estranged husband, who also tried to kill her.

03/24/04 **Heather Ann Young**, 26, shot by her ex-boyfriend outside her grandmother's apartment while their six-year-old son was inside.

03/31/04 **Noelle K. Staneart**, 46, shot by her estranged husband, who also shot and wounded her boyfriend and then killed himself.

04/12/04 **Andrea Atkinson**, 29, hit by a van driven by her estranged husband as he chased her and three of their children. His nine-year-old daughter was in the van with him.

04/21/04 **Tara Pitts**, 28, drowned by her husband.

04/23/04 **Mychael Dean Alexander**, 20, shot by his sister's ex-boyfriend in a park where his former high school football team was practicing.

05/03/04 **Blair Arnold Buse**, 49, shot by his estranged wife while her sixteen-year-old son was nearby.

05/06/04 **Judiann E. Hughes**, 31, shot by her husband in their home while their children were outside. He then killed himself.

05/18/04 **Dean K. Lai-how**, 34, shot by his ex-wife.

05/24/04 **Dayna Marie Fure**, 18, shot by her ex-boyfriend, who then killed himself.

05/30/04 **Johnny Luevano**, 32, shot by his girlfriend's ex-boyfriend, who then killed himself.

06/14/04 **William Laws**, 48, shot by his fiancée's ex-husband, who then killed himself.

06/16/04 **Maria Estella Vasquez Chavez**, 50, stabbed by her husband in front of their five-year-old son.

every

life

lost

is  
a

call

for

## Findings and Recommendations from the Washington State Domestic Violence Fatality Review

DECEMBER 2004

By Kelly Starr, Margaret Hobart and Jake Fawcett for the  
Washington State Coalition Against Domestic Violence

change

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December 2004

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The Washington State Coalition Against Domestic Violence gratefully acknowledges that this project was supported by funding from the Washington State Department of Social and Health Services, Children's Administration, Division of Program and Policy.

Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the Washington State Department of Social and Health Services.

In issuing this report, we remember the work of **Susan Schechter**, who lost her life to endometrial cancer in early 2004. Author of the book *Women and Male Violence: The Visions and Struggles of the Battered Women's Movement*, Susan was a champion for all victims, and she pioneered our efforts to bring advocates, activists and professionals from every discipline to one table for one purpose: protecting women and children from abuse. Susan was a remarkable educator and advocate. She understood the role that each individual and institution occupies in a comprehensive and well-coordinated response to domestic violence. She articulated the intersections of race, class and gender, and encouraged us to attend to those who are most marginalized and oppressed. In so many ways, her leadership paved the way for the efforts of the Fatality Review panels that are documented here in *Every Life Lost Is a Call for Change*. Most important, perhaps, was Susan's commitment to keeping the voices of domestic violence victims and survivors central in every discussion. That is what we have attempted to do in this report. For the people included here, and for Susan Schechter, we do not dwell on their dying. It is their living that mattered.

# In This Report

## Executive Summary

A brief overview of the Domestic Violence Fatality Review's goals, eight key recommendations, strategies for how to use this report as a tool for implementing change and a complete list of all the recommendations contained in this report.

## Overview of Fatalities

A quantitative summary of the domestic violence fatality cases we have tracked, and those we have reviewed in depth. This chapter contains descriptive information about the fatalities, such as who was killed, how frequently homicidal domestic violence abusers were also suicidal and what weapons were used.

## Implementation of Fatality Review Recommendations

An exploration of how communities have (or have not) implemented recommendations issued in previous Domestic Violence Fatality Review reports, and a discussion of barriers and supports to implementing change.

## Findings and Recommendations

Findings and recommendations are based on the thirteen domestic violence fatalities reviewed in depth by Fatality Review panels between September 2002 and June 2004. Each chapter includes narrative explaining our findings, and detailed recommendations which respond directly to those findings.

## Appendices

Appendix A explains the history of the Domestic Violence Fatality Review and how we identify and review domestic violence fatalities. Appendix B provides a glossary of terms used in this report. Appendix C contains a summary of key recommendations and data from this report in an easy-to-use photocopy format.

## A Note About Language Used in This Report

With one exception, all the individuals who committed homicides in the cases reviewed by Fatality Review panels in the past two years were male. This is consistent with national trends and our prior findings that most domestic violence homicides are committed by male abusers against their female intimate partners, and that men commit the majority of murders overall.<sup>1</sup> Thus, we will generally refer to victims with female pronouns and abusers with male pronouns.

## What Is a Domestic Violence Fatality?

The Domestic Violence Fatality Review (DVFR) defines a domestic violence fatality as those fatalities which arise from an abuser's efforts to seek power and control over his intimate partner. Using this definition, domestic violence fatalities include:

1. All homicides in which the victim was a current or former intimate partner of the perpetrator.
2. Homicides of people other than the intimate partner which occur in the context of domestic violence or in the context of attempting to kill the intimate partner. For example, situations in which an abuser kills his current/former intimate partner's friend, family or new intimate partner, or those in which a law enforcement officer is killed while intervening in domestic violence.
3. Homicides occurring as an extension of or in response to ongoing abuse between intimate partners. For example, when an individual kills children in order to exact revenge on his partner.
4. Suicides which may be a response to abuse.<sup>2</sup>

## Relationship of This Report to Our Previous Reports

The DVFR has issued two previous reports: *Honoring Their Lives, Learning from Their Deaths* (December 2000) and *"Tell the World What Happened to Me"* (December 2002). These reports cover the Fatality Review's findings from its inception in 1997 through August 2002. The reports contain a series of recommendations aimed at almost every part of the coordinated response to domestic violence.<sup>3</sup>

This report builds upon those previous DVFR reports and should be considered a companion publication as opposed to a replacement. None of our findings in the last two years suggest that the problems identified in previous reports no longer exist; the recommendations made in those reports are still valid. In the cases we examined between September 2002 and June 2004 (discussed in the following chapters), many of the same issues emerged as were identified in the 2000 and 2002 reports. Rather than repeat the same topic areas and discussions, this report brings forward some new areas of concern, elaborates on previous findings and focuses on the implementation of DVFR recommendations.

<sup>1</sup> The Bureau of Justice Statistics reports that at least 75% of murders attributable to intimate partners are women killed by male partners. Looking at overall murder rates, men commit 91% of murders of women and 89% of murders of men. Bureau of Justice Statistics, *Special Report: Intimate Partner Violence*, by Callie Rennison, Ph.D. and Sarah Welchans, NCJ 178247 (Washington, DC: U.S. Department of Justice, May 2000).

<sup>2</sup> While suicides which may be a response to abuse fit within our criteria, current limitations on our staff and access to confidential information make it impractical to track these cases with any accuracy at present.

<sup>3</sup> Washington State Coalition Against Domestic Violence, *Honoring Their Lives, Learning from Their Deaths: Findings and Recommendations from the Washington State Domestic Violence Fatality Review*, by Margaret Hobart (Seattle: WSCADV, 2000) and Washington State Coalition Against Domestic Violence, *"Tell the World What Happened to Me": Findings and Recommendations from the Washington State Domestic Violence Fatality Review*, by Margaret Hobart (Seattle: WSCADV, 2002).

# Acknowledgements

We would like to offer our sincere gratitude to the domestic violence survivors and the families and friends of domestic violence homicide victims who took the time to share with us their experiences and the struggles they or their loved ones faced.

The Domestic Violence Fatality Review is indebted to the hundreds of people around the state who have generously shared with us their time, expertise, insights and support. This report would not have been possible without them.

We would like to thank the following people who served on Fatality Review panels from September 2002 through June 2004.

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We are very appreciative of the following people who participated on Fatality Review advisory committees in 2004. These individuals generously shared their insights and expertise through discussions of the findings and recommendations for this year's report.

**Alisa Bierria**  
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**Merril Cousin**  
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**Maria de Lourdes Lopez**  
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**Norma Timbang**  
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**Reverend Harriet Walden**  
Family Empowerment Institute, Seattle

**Christine Wall**  
Alternatives to Violence of the Palouse, Pullman

**Dr. Carolyn West**  
University of Washington, Tacoma

The Fatality Review conducted several research projects in preparing for this report. These projects simply would not have been possible without the vision and commitment of the following individuals, and we thank them for their contributions.

**Gayle Erickson**  
Washington State Coalition Against Domestic Violence, Volunteer

**Joanne Gallagher**  
Washington State Coalition Against Domestic Violence

**Jim LaMunyon**  
Washington Association of Sheriffs and Police Chiefs

**Dr. Taryn Lindhorst**  
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**Chief Colleen Wilson**  
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A special thank you to **Heather Storer**, who contributed significantly to this report as the primary researcher of the Fatality Review panel participant research project discussed in the "Implementation of Fatality Review Recommendations" chapter, and to **Dr. Taryn Lindhorst** for her contributions to this research.

We would also like to thank **Jennifer Creighton** at the Administrative Office of the Courts for her assistance.

Thank you to **Juliet Shen** of Shen Design for the cover art, design and layout of this report.

The Fatality Review is extremely grateful to **Gayle Erickson** and **Susan Merriman** for generously giving their time to the project. We thank them for the commitment and dedication they have shown through their volunteer work.

All staff of the Washington State Coalition Against Domestic Violence contributed to this report. Thank you to:

**Leigh Hofheimer, Grace Huang, Tyra Lindquist, and Nan Stoops** for their careful reading of drafts of this report and for their thoughtful feedback.

**Teresa Atkinson, Judy Chen, Mette Earlywine, Reed Forrester, Sarah Nason, Lupita Patterson, Ilene Stohl, Jeri Sweet and Sandi Winters** for providing us with ideas, inspiration and support.

**Joanne Gallagher** for her significant contributions as staff to the Fatality Review project, preparing for and facilitating reviews discussed in this report.

And a special thank you to **Christine Olah**, the meticulous, patient and always gracious copyeditor of this report.

# Executive Summary

<sup>4</sup> Washington Association of Sheriffs and Police Chiefs, Uniform Crime Reporting Project, *Crime in Washington State 2003* (Olympia, WA: WASPC, 2004).

## Introduction

In 2003, 44% (n=23) of women who were murdered in Washington state were killed by their current or former husband or boyfriend.<sup>4</sup> Between January 1, 1997 and June 30, 2004, 281 people were killed by domestic violence abusers in Washington. The domestic violence victims whose murders are discussed in this report walked through our communities' courtrooms, schools, parks, hospitals, doctors' offices, prosecutors' offices and workplaces. They talked to teachers, welfare workers, neighbors, police officers, doctors, friends, co-workers, attorneys, family members and religious leaders in the weeks, months and years before they were killed. Their abusers murdered them in our neighborhoods, community centers and parking lots, and on our streets, sidewalks and doorsteps.

The Domestic Violence Fatality Review (DVFR) examines domestic violence-related fatalities in order to advance thinking about how to improve our communities' responses to domestic violence. We draw attention to the loss of life at the hands of abusers for two reasons. First, to recognize and honor the lives lost to domestic violence and insist that the battered women, children and their friends and family members killed by abusers are not forgotten. Second, to direct attention to the struggles and challenges faced by the thousands of domestic violence victims in our state living in the shadow of life-threatening abuse, who can still be helped by our efforts to respond more effectively to domestic violence.

Building communities that respond to domestic violence and support victims and their families is a task for all of us, and a goal that is within our reach. With this, our third biennial DVFR report, we challenge every person in our state to consider that *Every Life Lost Is a Call for Change*—a call to each of us to change the systems that failed those who were murdered, to recognize and make meaning of their loss, and not wait to act until the next life has been lost.

What we have learned from in-depth reviews of domestic violence fatalities over the last seven years is that domestic violence and domestic violence homicides are not an inevitable fact of life. Most homicides are preceded by multiple efforts to get help by the victim and multiple opportunities for the legal system and community to hold the abuser accountable for their violence.

The actions and choices of both victims and abusers are substantially influenced by the institutional, social and cultural reality which surrounds them. In this and our previous reports, we identify the shortcomings in policy, practice, knowledge, training, collaboration, resources, communication and referrals that worked to amplify abusers' ability to control and terrorize their partners, or conspired to create insurmountable obstacles to safety and autonomy for domestic violence victims and their children. The homicide perpetrator in each case is responsible for their actions and ultimately responsible for the murder(s) they have committed. However, the response to the abuser's violence prior to that murder and providing options for the victim to obtain some measure of safety, self-determination and economic autonomy separate from the abuser are all of our responsibility.

We know from closely examining the events leading up to domestic violence homicides that domestic violence victims were often trying to get away from their abuser. The way their community addressed issues related to domestic violence significantly impacted their ability to achieve safety and self-sufficiency for themselves and their children. A number of other factors also affected the ability of victims to escape their abuser's violence: the availability of safe and affordable housing; judicial decisions regarding custody and protective orders; access to civil legal representation; the quality of law enforcement investigations into the crimes committed against them; the degree to which criminal sentences were appropriate to the crime and strongly enforced; the availability of help and information in their first language; access to advocacy and safety planning; and the capacity of friends and family to respond supportively to the challenges they were facing.

Throughout this report, you will find specific recommendations for various institutions and disciplines. The recommendations are also summarized by discipline in the "Summary of Recommendations" section below. Each of these recommendations is related directly to findings from thirteen in-depth reviews of domestic violence fatalities conducted by the DVFR since September 2002.

While the findings in this report come directly from the observations of Fatality Review panel members, the recommendations do not. Review panels are not recommendation-making bodies. Rather, they focus on identifying issues and gaps in the response to domestic violence. The Washington State Coalition Against Domestic Violence (WSCADV) developed the recommendations in this report in conversation with advisory committees convened over the last year. WSCADV takes full responsibility for the recommendations contained herein, and the reader should note that some DVFR panel or advisory committee members may have differing opinions about what should be done to rectify the problems identified during the course of reviewing individual cases.

#### **KEY RECOMMENDATIONS**

We have identified eight key recommendations out of the many that appear in this report. These recommendations merit priority because they speak to issues or problems that Fatality Review panels identified repeatedly in domestic violence fatality cases. However, please keep in mind that each recommendation in this report is relevant to the ability of our communities to support domestic violence victims and hold abusers accountable and is directly rooted in the close examination of a domestic violence fatality.



### **All Disciplines**

People who work with teens in any capacity should receive training regarding teen dating violence and domestic violence, and teen advocacy resources in the community.

### **Domestic Violence Programs**

Domestic violence programs should develop policies and procedures that maintain safety for all program participants while providing services to substance-abusing domestic violence victims.

### **Law Enforcement Agencies**

Consistent with our state law, law enforcement agencies should conduct investigations of domestic violence crimes with qualified interpreters (either in person or via telephonic services) for all Limited English Proficient individuals, with the goal of obtaining complete victim, perpetrator and witness statements at the initial crime scene, as well as high-quality investigative and follow-up work.

### **Civil Courts**

All courts issuing civil Protection Orders should have domestic violence advocacy services available on-site and ensure that advocates have extensive training on how to assist women with safety planning. If resources are limited, courts should minimally require, as mandated by RCW 26.50.035, that clerks routinely provide all petitioners with referral information to the local domestic violence program for assistance with safety planning.

### **Prosecutors and Probation**

Prosecutors and probation offices should employ well-trained domestic violence victim advocates who can contact partners of abusers, and provide resources and safety planning. If resources are limited, prosecutors and probation offices should work closely with community-based domestic violence programs in order to provide advocacy to victims.

### **Judges**

Judges in both civil and criminal courts should receive mandated training on domestic violence and on assessing danger and lethality in domestic violence cases. Judges should routinely examine histories and patterns of behavior in domestic violence cases when considering how to proceed (e.g., they should ask the prosecutor, victim and advocate about the batterer's abuse history and consistently make use of computerized databases that track criminal histories).

### **Department of Social and Health Services (DSHS)**

DSHS should ensure implementation of its policy of screening all WorkFirst program participants for domestic violence and providing an appropriate response (in the form of resources and workplans) for domestic violence victims.

### **Legislature and State Agencies**

Funding should be made available for community organizing projects aimed at building safety and accountability strategies outside of the criminal legal system, particularly within marginalized communities and communities of color. Funding for such projects should go to organizations with established credibility and trust within the communities that will be the focus of organizing efforts.

## Summary of Recommendations

This summary of Domestic Violence Fatality Review recommendations is prioritized by discipline. Each chapter of the report provides context and explains in detail how our findings led us to make these recommendations. The page number following each recommendation indicates where it is found in the text of the report.

### ALL DISCIPLINES

- Use the Fatality Review reports as a tool for implementing change (p.53–54):
  1. Read the reports and remember the stories of those who have lost their lives to domestic violence.
  2. Share the reports with others. Copies of the 2000 and 2002 Fatality Review reports can be ordered at [www.wscadv.org](http://www.wscadv.org); the full text of the reports is also available on the website to read and print for free. Email the link to co-workers, advocates, judges, police officers, mental health professionals, chemical dependency counselors, prosecutors, healthcare workers, religious institutions, schools, friends, family and victims of domestic violence. Print a specific section that you think would be particularly relevant to another individual's work, and share it with them.
  3. Make a discussion of the report the focus of a staff meeting at your workplace. As an agency, identify five to ten recommendations particularly relevant to your community and work toward their implementation. View the recommendations as an ideal to strive for and identify steps to move toward that goal. Utilize the recommendations for strategic planning.
  4. For non-profit agencies: Share the report with your board and offer it as a tool for education and strategic planning.
  5. Create discussion groups in your community to talk about the report. These groups can be inter-disciplinary groups of professionals, or a group of community members interested in making their communities safer and healthier (e.g., religious groups, neighborhood watch). As a group, identify a few recommendations to prioritize and plan action steps toward achieving them.
  6. If your community has a domestic violence task force or commission, share the report with the group's facilitator and make it a topic for a future meeting. As a community task force, identify areas where the community is doing well and which areas need improvement. Identify a few key recommendations for your local task force to address. Start a fatality review work group to report back to the task force as a whole on its progress.
  7. Use the Fatality Review findings, recommendations and statistics in community education, with the media and in grant proposals.
- Organizations, institutions and individuals that work with domestic violence victims or abusers need to collaborate on establishing protocols for identifying and minimizing the danger that suicidal domestic violence abusers pose to intimate partners and others. (p.49)
- People who work with teens in any capacity should receive training regarding teen dating violence and domestic violence, and teen advocacy resources in the community. (p.49)
- All agencies, programs and institutions that respond to domestic violence (including domestic violence programs, law enforcement, courts, social service agencies and community organizations) should identify ways to improve support for friends and family of domestic violence victims. (p.83)

### **DOMESTIC VIOLENCE PROGRAMS**

- Domestic violence programs should prioritize resources and work to make their services relevant and accessible for domestic violence victims with limited English proficiency. (p.49)
- Domestic violence programs that do not provide outreach and services to friends and family of domestic violence victims should consult with programs that do provide such services for assistance implementing similar practices. (p.49)
- Domestic violence programs should become familiar with the court process for resolving outstanding warrants and offer victims assistance with this process. (p.49)
- Domestic violence programs should develop policies and procedures that maintain safety for all program participants while providing services to substance-abusing domestic violence victims. (p.49)
- Domestic violence advocates should always ask victims about abusers' suicidal threats or behaviors. If victims reveal a history of suicidal ideation, advocates should inform and educate them about the risk of homicide and intensify safety planning. (p.49)
- Funding should be allocated for domestic violence advocacy programs to hire or contract with attorneys trained on domestic violence to represent victims. (p.61)
- Domestic violence advocates should develop safety planning tools to assist friends and family members of victims who call domestic violence crisis lines. (p.83)
- Domestic violence programs should evaluate how their own program policies reinforce isolation for victims, and make changes in order to promote victims' connection with their friends, family and community. (p.83)
- Domestic violence advocates should strategize with shelter residents to help them maintain or rebuild connections with friends and family while living in confidential shelter. (p.83)
- Funders and domestic violence programs should recognize community education and prevention efforts as a part of core services. (p.83)

### **LAW ENFORCEMENT**

- Law enforcement agencies should work with their community to develop and implement a plan for providing equal protection and access to Limited English Proficient individuals in their community. (p.49)
- Law enforcement agencies should conduct investigations of domestic violence crimes with qualified interpreters. (p.49)
- The Washington Association of Sheriffs and Police Chiefs (WASPC) should develop an accreditation standard requiring law enforcement agencies to develop and implement a policy regarding the initial response to domestic violence-related crimes when the victim or perpetrator has limited English proficiency. (p.49)
- Every law enforcement agency should establish policies and procedures for gun removal and storage for convicted domestic violence offenders and domestic violence offenders subject to protective orders. (p.50)
- Police and sheriffs' departments without a mechanism or policy in place to monitor the accuracy and completeness of domestic violence incident reports should consult with departments that have an existing mechanism or policy for assistance developing and implementing similar standards. (p.50)

- Law enforcement agencies should require the completion of a Domestic Violence Supplemental Form at all domestic violence calls that prompts officers to document the history of abuse, including both criminal and non-criminal tactics, and to identify signs of escalating violence. (p.68)
- Law enforcement officers should always document threats of homicide and suicide in their reports. When domestic violence and suicide threats co-exist, officers should recognize the increased danger to the victim and should provide the victim with information about the increased risk of homicide and refer to a community-based domestic violence program for safety planning and other services. (p.68)
- Officers should attempt to remove guns from the home when the abuser has a history of homicidal or suicidal threats. Domestic Violence Supplemental Forms should include questions that prompt officers to ask suspects about access to, location of and use of weapons. (p.70)
- Local law enforcement officers should not inquire about citizenship status when responding to a crime scene. (p.76)
- Local law enforcement agencies should not coordinate efforts with the Bureau of Immigration and Customs Enforcement (ICE) in patrol, investigation and follow-up work on non-federal, non-terrorism-related crimes. (p.76)
- Local law enforcement agencies should not be involved in enforcing immigration law. (p.76)
- Local law enforcement should work with immigrant communities to publicize and clarify their policies regarding when and if they cooperate with ICE and what non-citizens can expect to happen when they call 911. (p.76)
- Local law enforcement agencies who have actively decided not to enforce immigration law should be in dialogue with other law enforcement agencies (particularly those in the same region) with differing policies, educating them about the safety concerns and increased danger to battered women and children that collaborative enforcement relationships raise in immigrant communities. (p.76)
- Law enforcement agencies should budget for telephonic interpretation services for all Limited English Proficient (LEP) calls and prioritize hiring employees who are qualified to provide services and intervention in relevant languages. (p.77)
- Consistent with Washington state law, law enforcement agencies should conduct investigations of domestic violence crimes with qualified interpreters (either in person or via telephonic services) for all LEP individuals, with the goal of obtaining complete victim, perpetrator and witness statements at the initial crime scene, as well as high-quality investigative and follow-up work. (p.77)
- Law enforcement agencies should hold officers accountable for conducting inadequate investigations when they fail to follow policies regarding interpretation and translation. (p.77)
- Police officers should hand out domestic violence information to friends, family and neighbors at the scene of domestic violence crimes. (p.83)
- Police, prosecutors and judges should make every effort to identify and remove abusers' guns at each step of the criminal and civil legal process. (p.83)

### **CIVIL ATTORNEYS, JUDGES AND CIVIL COURTS**

- All courts issuing civil Protection Orders should have domestic violence advocacy services available on-site and ensure that advocates have extensive training on how to assist women with safety planning. If resources are limited, courts should minimally require, as mandated by RCW 26.50.035, that clerks routinely provide all petitioners with referral information to the local domestic violence program for assistance with safety planning. (p.50)
- Courts should employ well-trained evaluators, or work with their guardian ad litem (GAL) or court-appointed special advocate (CASA) registries to identify and train individuals to specialize in domestic violence cases. These specialists should provide assistance to judges in civil proceedings by conducting thorough assessments for domestic violence cases and providing recommendations regarding residential time and visitation which protect the safety of domestic violence victims and minimize the effects of domestic violence on their children. These evaluators, CASAs and GALs should receive extensive training, similar to that required of state-certified batterer's intervention providers as outlined in WAC 388-60 and RCW 26.50.150, on the manipulative and coercive tactics abusers use. (p.50)
- Funding should be increased for legal aid programs to assist with representation of domestic violence victims in domestic violence and family law matters, and legal aid programs should collaborate with domestic violence advocacy programs to provide comprehensive advocacy services. (p.61)
- The Washington State Bar Association and local bar associations should partner with local domestic violence programs to create pro bono panels to represent domestic violence victims in domestic violence and family law cases. Individuals who participate should be recognized for their efforts, and receive free continuing legal education (CLE) credits for taking these cases. (p.61)
- Law schools should prioritize the creation and support of legal clinics for representation of domestic violence victims in domestic violence and family law cases, and incorporate domestic violence education in core courses. (p.61)
- Low-cost and free legal representation services should work to ensure their intake processes are accessible to domestic violence victims (e.g., provide flexible times for intake appointments). Also, they should prioritize assisting domestic violence victims so that they are not "conflicted out" by their abuser (if the abuser contacts the available local resources and secures legal representation or legal advice first, then his victim can be denied services because of rules governing attorneys that prohibit conflicts of interest). (p.61)
- Judges should specifically inquire about the existence of firearms and order that abusers surrender their firearms when granting Protection Orders. (p.62)
- Judges, attorneys, advocates and court staff should ensure that Protection Order petitioners who mention an abuser's homicide or suicide threats are connected to advocacy services, made aware of their increased danger given these threats and supported to engage in immediate and detailed safety planning. (p.62)
- All players in the civil legal system should receive education regarding: identifying domestic violence; resources for support; lethality indicators and what to do if lethality seems high. Training should include examples of appropriate action for varied roles (e.g., attorney, judge, commissioner, advocate). (p.62)

- To determine parenting plan arrangements, courts should utilize neutral, well-trained evaluators who can: assess for the existence of domestic violence; obtain all available prior civil and criminal legal records which may pertain to the existence of domestic violence, including Protection Orders, arrest records and information regarding the offender's history of compliance with court orders; speak to corroborating sources; assess for the domestic violence victim's and children's safety; and provide the judge with well-informed recommendations. (p.62)

#### PROSECUTING ATTORNEYS, JUDGES, CRIMINAL COURTS AND CORRECTIONS

- Additional funding available for improving the domestic violence response in the criminal legal system should be directed to probation and post-sentence supervision for misdemeanor domestic violence cases.<sup>5</sup> (p.50)
- Judges should have access to in-depth pre-sentencing reports to inform decision making about sentencing conditions and options. (p.66)
- Jurisdictions should implement specialized domestic violence probation units, with caseloads which allow officers adequate time for monitoring and responding to lack of compliance by abusers. (p.66)
- Probation officers and/or judges should be empowered to require attendance at a specific batterer's intervention program, or minimally, specify programs to avoid. (p.66)
- Probation offices should have domestic violence victim advocates on staff who can contact partners of abusers, and provide resources and safety planning. (p.66)
- Judges should inquire specifically about abusers' access to weapons, should order abusers to surrender weapons as part of temporary and permanent Protection Orders, and should make surrender of weapons a condition of pre-trial release for domestic violence charges. (p.70)
- Judges should receive mandated training on domestic violence and on assessing danger and lethality in domestic violence cases. Judges should routinely examine histories and patterns of behavior in domestic violence cases when considering how to proceed (e.g., they should ask the prosecutor, victim and advocate about the batterer's abuse history and consistently make use of computerized databases that track criminal histories).<sup>6</sup> (p.71)
- Prosecutors should employ well-trained domestic violence advocates in their offices, or should work closely with community-based domestic violence programs in order to provide advocacy to victims. (p.72)
- Jails and prisons should designate resources to develop programs for inmates aimed at prevention or reduction of domestic violence incidents, such as certified batterer's intervention, chemical dependency treatment and mental health treatment. (p.72)
- Police, prosecutors and judges should make every effort to identify and remove abusers' guns at each step of the criminal and civil legal process. (p.83)

<sup>5</sup> WSCADV has published model guidelines for all jurisdictions to follow in post-arrest supervision of domestic violence offenders. Washington State Coalition Against Domestic Violence, *Post-Arrest Model Response for the Supervision of Domestic Violence Offenders*, by Roy Carson (Olympia, WA: WSCADV, 1999). To request a copy, call WSCADV at 206-389-2515.

<sup>6</sup> See *Domestic Violence Cases in Municipal Court: Judicial Decision-Making* for further guidance. This bench card was produced by the Washington State Supreme Court's Gender and Justice Commission in 2004 and posted on the Washington Courts' Intranet under "Judges' Resources."

<sup>7</sup> WSCADV has published model guidelines for all jurisdictions to follow in post-arrest supervision of domestic violence offenders. Washington State Coalition Against Domestic Violence, *Post-Arrest Model Response for the Supervision of Domestic Violence Offenders*, by Roy Carson (Olympia, WA: WSCADV, 1999). To request a copy, call WSCADV at 206-389-2515.

## LEGISLATURE AND STATE AGENCIES

- Additional funding available for improving the domestic violence response in the criminal legal system should be directed to probation and post-sentence supervision for misdemeanor domestic violence cases.<sup>7</sup> (p.50)
- The Washington State Legislature should increase resources for domestic violence programs to provide material support for victims, such as childcare assistance, transportation, deposits for housing and attorney fees. In addition, the Legislature and state agencies should increase access to financial resources in the Temporary Aid to Needy Families (TANF) program and Crime Victims Compensation Program. (p.56)
- The Governor's Office should ensure collaboration among state agencies to develop and implement consistent policies to support and protect domestic violence victims. (p.57)
- DSHS should ensure implementation of its policy of screening all WorkFirst program participants for domestic violence and providing an appropriate response (in the form of resources and workplans) for domestic violence victims. (p.57)
- DSHS training and practices should support effective, individualized and compassionate implementation of their policies consistently across all programs. (p.57)
- Employment Security offices should create programs and institutionalize practice to customize services for domestic violence victims to ensure their safety and success in seeking employment. (p.57)
- The Division of Child Support should implement policies for identifying and serving domestic violence victims which include screening for domestic violence and ensuring domestic violence victims' safety when enforcing support.
  - In establishing policy, DSHS should look to programs in other states (for example, Massachusetts) which create a specialized caseload with workers knowledgeable about domestic violence and empowered to respond quickly and effectively to abusive tactics and safety concerns in the context of child support enforcement. (p.57)
- Employment Security should institute programs designed to ensure wage progression (meaning participants make more money from one year to the next), so that domestic violence victims are not trapped in abusive relationships by economic instability. (p.57)
- DSHS should devise a system to measure Community Service Office accountability to providing domestic violence screens for WorkFirst program participants. This measurement system should:
  - Place the emphasis on the worker doing the screening, not the victim disclosing.
  - Communicate to Community Service Offices (through policy directives) the agency's expectation that a certain number of participants will be identified as domestic violence victims and need exemptions from some of the WorkFirst program requirements in response to their safety or trauma issues related to the abuse, and provide offices with a benchmark against which they can measure their performance in terms of quality screening for, and response to, domestic violence.
  - Be created in consultation with state-level groups possessing domestic violence and welfare advocacy expertise to design a system which ensures (as much as possible) that recipients are not penalized or characterized negatively for disclosing (or choosing not to disclose) abuse. (p.57–58)
- The DSHS Children's Administration (which encompasses the Division of Children and Family Services) should engage in community partnerships to develop

philosophy, policy and protocols for identifying and responding to domestic violence between adult intimate partners.

Policies should include:

- Universal and effective screening for domestic violence with both parents, including screening for suicidal and homicidal threats.
  - Checking for the existence of current or defunct Protection Orders and domestic violence convictions and obtaining copies of Protection Orders.
  - Establishing collaborative, information-sharing relationships with Family Court Services and other workers who provide civil courts with parenting and domestic violence evaluations.
  - Routine referral to local resources for battered women when domestic violence is identified. (p.59)
- The Division of Children and Family Services' (DCFS) policies should emphasize an approach in which the worker's interactions and interventions with family members attempt to meet the following three goals:
    - to protect the child;
    - to help the abused parent protect herself and her children, using non-coercive, supportive and empowering interventions whenever possible; and
    - to hold the domestic violence abuser, not the adult victim, responsible for stopping the abusive behavior.<sup>8</sup> (p.59)
  - New DCFS policies on domestic violence should be backed up with intensive training for staff to ensure their appropriate implementation. (p.59)
  - Training of DCFS staff should involve locally based domestic violence advocates and emphasize the importance of forging links with local resources. (p.59)
  - DSHS should collaborate with the Washington State Coalition Against Domestic Violence (WSCADV) and other researchers to analyze how many domestic violence victims in domestic violence fatality cases had come into contact with DSHS services prior to the fatality, whether they were screened for domestic violence, what intervention they received, how such interventions affected their safety and how this group compares to the larger DSHS caseload. (p.60)
  - Funding should be increased for legal aid programs to assist with representation of domestic violence victims in domestic violence and family law matters, and legal aid programs should collaborate with domestic violence advocacy programs to provide comprehensive advocacy services. (p.61)
  - Funding should be allocated for domestic violence advocacy programs to hire or contract with attorneys trained on domestic violence to represent victims. (p.61)
  - The Washington State Legislature should prioritize funding for supervised visitation and exchange resources for domestic violence cases. Supervisors should receive specialized training on the dynamics of domestic violence, the potential for abusers to use visitation to stalk and control their partners, and the risk to children when one parent has a history of perpetrating domestic violence. (p.62)
  - The Washington Administrative Code should require batterer's intervention programs to have a victim liaison who contacts women by phone or in person. This person should be separate from the abuser group leader. (p.66)
  - Batterer's intervention programs should be required by the Washington Administrative Code to give victims accurate information in plain language about the limitations of batterer's intervention and the conditions under which it is more likely to be effective, including complete citations to research literature on the topic. (p.66)

<sup>8</sup> Family Violence Prevention Fund, *Child Abuse and Domestic Violence: Creating Community Partnerships For Safe Families: Suggested Components of an Effective Child Welfare Response to Domestic Violence*, by Janet Carter & Susan Schechter (San Francisco: FVPP, 1997).



- The Washington State Legislature should direct the Washington Association of Prosecuting Attorneys, in collaboration with domestic violence advocates, to develop model guidelines on the prosecution of domestic violence cases. (p.71)
- The Washington State Legislature should fund innovative, community-based child abuse prevention and juvenile delinquency prevention programs based in agencies which already have trust and credibility within their target communities. (p.78)
- Funders should prioritize strategies that engage friends and family of domestic violence victims and that support victims to build and maintain connection with their communities. Funders should offer grants to fund innovative projects to develop such strategies, including those that address the needs of particular neighborhoods and marginalized communities. (p.83)
- Funding should be made available for community organizing projects aimed at building safety and accountability strategies outside of the criminal legal system, particularly within marginalized communities and communities of color. Funding for such projects should go to organizations with established credibility and trust within the communities that will be the focus of organizing efforts. (p.83)
- Funders and domestic violence programs should recognize community education and prevention efforts as a part of core services. (p.83)

#### **EMPLOYERS**

- Employers should proactively implement workplace safety policies to specifically address abuse and stalking of their employees, as well as supporting victims of domestic violence in retaining their employment while receiving support for coping with the abuse. (p.56)
- Employers should support (and not penalize) victims who need to take time off work to attend civil and criminal proceedings, or go to medical or counseling appointments related to domestic violence. (p.56)

#### **COMMUNITY ORGANIZATIONS**

- Community groups (such as neighborhood associations, block watch groups, fraternal and volunteer organizations) should create opportunities for members to learn about domestic violence. (p.83)
- Funding should be made available for community organizing projects aimed at building safety and accountability strategies outside of the criminal legal system, particularly within marginalized communities and communities of color. Funding for such projects should go to organizations with established credibility and trust within the communities that will be the focus of organizing efforts. (p.83)

# Overview of Fatalities

## Domestic violence fatalities discussed in this report

Please note that this report makes reference to four different sets of domestic violence fatalities:

1. All fatalities which have occurred since January 1, 1997.
2. Fatalities which occurred since the 2002 Domestic Violence Fatality Review report (between September 1, 2002 and June 30, 2004).
3. All reviewed cases: The fifty-four cases the Domestic Violence Fatality Review (DVFR) has reviewed in depth with locally based, multi-disciplinary review panels (as described in Appendix A) since 1998.
4. Recently reviewed cases: The thirteen cases examined in depth by review panels in the two years since our 2002 report.

A glossary of terms used in this report to describe cases and fatalities can be found in Appendix B.

While the DVFR tracks all domestic violence fatalities occurring in Washington state (as described in Appendix A), staffing constraints dictate that we can review only a small portion of these fatalities in depth. We gather a great deal of information on reviewed cases from both public records and Fatality Review panels. The Office of the Administrator of the Courts' Justice Information System allows us to track civil and criminal histories. The anecdotes, detailed information about cases, and findings discussed in this report reflect that information. For unreviewed cases, news accounts serve as our primary source of information. We gather a limited amount of information for these cases, including the date and circumstances of the fatality, and the names, ages, genders and relationships of those involved.

DOMESTIC VIOLENCE FATALITIES DISCUSSED IN THIS REPORT	Number of cases	Total number of fatalities*	Cases drawn from which counties
<b>All cases</b> (reviewed and unreviewed)			
All fatalities which occurred from January 1997 through June 2004	313	416	Entire state
Fatalities which occurred from September 2002 through June 2004	81	107	Entire state
<b>Reviewed cases</b>			
All cases reviewed in depth	54	86	Benton, Chelan, Clark, Douglas, Franklin, King, Kittitas, Okanogan, Pierce, Snohomish, Spokane, Walla Walla and Yakima
Cases reviewed in depth from September 2002 through June 2004	13	19	Benton, Clark, Franklin, King, Pierce, Snohomish and Walla Walla

\*includes abuser suicides

## Reviewed cases

Since our last report in December 2002, the DVFR has reviewed thirteen cases in depth, involving nineteen fatalities (this figure includes five abuser suicides). Close to half of the reviewed cases occurred in the last four years.

YEARS IN WHICH RECENTLY REVIEWED DOMESTIC VIOLENCE FATALITIES OCCURRED	1997	1998	1999	2000	2001	2002	Total
Year fatality occurred							
Number of reviewed cases	3	1	3	2	1	3	13
Percent of reviewed cases	23%	8%	23%	15%	8%	23%	100%

### Overview of all domestic violence cases since 1997 and cases between September 1, 2002 and June 30, 2004

In previous reports, DVFR data has covered a 24-month period, usually August to August. For this report, we are covering a 22-month period, September 2002 through June 2004. Cases counted as new include one case from late August 2002. We did not receive information about that case prior to data analysis for the 2002 report, so it is included here.

A total of 107 people died in domestic violence-related fatalities between September 1, 2002 and June 30, 2004—an average of almost five per month. This number includes twenty-four suicides by domestic violence abusers (row 18), and two cases in which abusers were killed by law enforcement while threatening lethal force against the officers or a victim (row 17). Domestic violence abusers killed almost all of the homicide victims (89%). These are enumerated in rows 1 through 12 in the table below. They included domestic violence victims, their children, friends and family members. Two homicides (2%) were committed by suicidal battered women who killed their children in failed murder/suicide attempts (row 19). Domestic violence abusers killed by domestic violence victims or their friends or family comprise the remaining 9% of homicide victims (rows 13-16).

ALL DOMESTIC VIOLENCE FATALITIES	9/1/02–6/30/04	1/1/97–6/30/04
1. Female domestic violence victim killed by current/former husband/boyfriend	40	176
2. Female domestic violence victim killed by other male intimate (e.g., caregiver)	1	4
3. Female domestic violence victim killed by female intimate partner	0	1
4. Female domestic violence victim killed by abuser's associate	1	2
5. Male domestic violence victim killed by current/former wife/girlfriend	8	20
6. Male domestic violence victim killed by male intimate partner	0	1
7. Children killed by male domestic violence abuser	5	21
8. Friends/family killed by male domestic violence abuser	9	32
9. Friends/family killed by female domestic violence abuser	0	1
10. New boyfriend of female domestic violence victim killed by male domestic violence abuser	8	19
11. Co-worker of female domestic violence victim killed by male domestic violence abuser	0	1
12. Law enforcement killed by male domestic violence abuser	0	3
13. Male domestic violence abuser killed by female domestic violence victim in self-defense, no prosecution	1	7
14. Male domestic violence abuser killed by female domestic violence victim, case prosecuted, but history of abuse claimed	2	8
15. Male domestic violence abuser killed by female domestic violence victim, not in self-defense	3	6
16. Male domestic violence abuser killed by friend or family of female domestic violence victim	1	10
17. Male domestic violence abuser killed by law enforcement <sup>9</sup>	2	9
18. Male domestic violence abuser suicide	24	93
19. Children killed by female domestic violence victim	2	2
<b>Totals</b>		
20. All domestic violence fatalities (rows 1-19)	107	416
21. All homicide victims (rows 1-16 and 19, excludes suicides and abusers killed by law enforcement)	81	314
22. All homicides committed by domestic violence abusers or their associates (rows 1-12)	72	281

## Undercounts

The DVFR tracks domestic violence cases primarily by collecting news accounts of murders around the state and referring to the domestic violence homicide section of the *Crime in Washington* report issued yearly by the Washington Association of Sheriffs and Police Chiefs (WASPC). However, these methods are imperfect, and result in undercounts in five key areas:

### 1. Children killed by domestic violence abusers

The DVFR's count of children killed by domestic violence abusers as part of an ongoing pattern of abuse directed at both the domestic violence victim and her children is undoubtedly low. Sometimes media coverage of children's deaths makes clear that the perpetrator was also abusive to the mother and/or killed the child as an act of punishment or revenge directed at their partner. Often, though, this information is not available or not reported. It is likely that a larger number of child deaths are directly related to patterns of abuse by one intimate partner toward another, but our current methods of tracking these cases do not allow us to consistently identify this circumstance.

### 2. Same-sex relationships

It is also likely that we undercount domestic violence homicides committed by same-sex partners, particularly gay men (two females were murdered by other females in 2003, while 112 males were killed by other males<sup>10</sup>). According to WASPC's *Crime in Washington* report, 6.8% of homicide perpetrators in 2003 were "friends" of the victim. It is possible that these cases include gay or lesbian relationships which were not fully or accurately identified at the time of reporting. Same-sex relationships may also be classified as "other known to victim" (7.7% of homicide perpetrators) or even "unknown relationship" (21% of homicide perpetrators).<sup>11</sup>

### 3. Suicides of battered women

Far more women commit suicide each year in Washington than are murdered. For example, according to the Washington State Department of Health's Center for Health Statistics, 169 women killed themselves in 2002, approximately three times the number of women murdered each year.<sup>12</sup> Without more thorough examination of these cases, we cannot be sure how many of these women's despair was directly tied to feeling trapped and abused at the hands of their partners.

### 4. Homicides mistakenly classified as suicides or accidents

Our count relies on cases identified as homicides by law enforcement, therefore any homicide mistakenly classified as a suicide or accident is also missed.

### 5. Missing women cases in which the woman has been murdered

Many women are reported missing each year in Washington. It is likely that some of these cases are murders in which no body has yet been found, and that some of those murders are domestic violence-related.

<sup>9</sup> Abusers' actions in these cases essentially forced law enforcement officers to shoot them. For example, one abuser had killed his former girlfriend by the time police responded and was running through a public place with the loaded firearm, refusing officers' requests to drop the weapon when they killed him. In another case, police were talking to the victim about an assault when the abuser returned to her home with three loaded firearms. After he pointed a shotgun at the victim and police, officers shot him.

<sup>10</sup> This information was extracted from 2003 crime data by Kellie Lapczynski, Statistical Compiler for the Washington State Uniform Crime Reporting Project at WASPC, by special request from the DVFR.

<sup>11</sup> Washington Association of Sheriffs and Police Chiefs, Uniform Crime Reporting Project, *Crime in Washington State 2003* (Olympia, WA: WASPC, 2004).

<sup>12</sup> "Mortality Table C5: Age-Adjusted Rates for Selected Causes by Sex for Residents, 2002," <http://www.doh.wa.gov/ehsph/chs/chs-data/death/2002/2002c5.htm>.

<sup>13</sup> Christine E. Rasche, "'Given' Reasons for Violence in Intimate Relationships," *Homicide: The Victim/Offender Connection*, ed. Anna Wilson (Cincinnati, OH: Anderson, 1993), p. 88 and Nancy Jurik and Russ Winn, "Gender and Homicide: A Comparison of Men and Women Who Kill," *Violence and Victims* 5, no. 4 (1990), p. 236.

## Men killed by female intimate partners

Consistent with national trends, a significant number of women in Washington state kill their male intimate partners each year. Research into this phenomenon has consistently indicated that most women who kill their male partners have been victims of that partner's abuse prior to the homicide.<sup>13</sup> However, the circumstances of these homicides are not always consistent with legal definitions of self-defense; thus, a large portion of battered women who kill their partners are prosecuted, most for second-degree murder or manslaughter.

Because the DVFR cannot conduct an in-depth review of every fatality, we do not have full details on every case we track. Therefore, we must classify cases and try to determine who is the victim and abuser in each case based on limited information. In prior reports, we have used the following criteria for classifying cases in which women killed their male partners:

1. Battered women defending themselves:

Homicides that were so clearly self-defense that no charges were ever filed against the woman, or the woman was acquitted based on a self-defense argument.

2. Battered women using probable self-defense:

Homicides in which prosecutors did file charges, but the woman claimed there was a history of abuse and those claims were credible enough to prevent conviction on first- or second-degree murder charges.

3. Women killing male domestic violence victims:

Homicides in which the woman was convicted of first- or second-degree murder, or in which the woman did not make any abuse or self-defense claims.

Using these criteria, the DVFR may have overcounted the number of women classified as domestic violence abusers. In re-examining the criteria to use for this report, we felt that these categories were unsatisfactory in that they relied heavily on the workings of the criminal legal system to sort out victims from abusers, which is problematic for multiple reasons:

- Battered women frequently receive poor representation when they are prosecuted for killing their abusers.
- Defense attorneys may decide to avoid a battered women's syndrome defense for strategic reasons. (For example, they may feel that the jury would be less sympathetic to their client if they thought she stayed in the relationship despite being abused.)
- Courts and juries frequently do not understand the complex issues at stake for battered women. (People often underestimate the multiple coercive tactics abusers employ to keep victims trapped in relationships and to instill fear in them.)
- We know from past fatality reviews that a lack of prior documented abuse does not mean that no abuse took place.

Looking carefully at all the cases, we identified a group of battered women who killed abusive male partners, but in ways which did not conform to legal definitions of self-defense. Some of these women claimed a history of abuse, yet were still sentenced to second-degree murder. Others did not cite abuse in their defense, but some indication of it existed (such as a friend telling the press that the woman was abused), and they were convicted of manslaughter. To more accurately reflect these nuances, we have added a fourth category of cases: battered women who killed abusers, not in self-defense.

For example, in one case, the woman testified that her partner had assaulted her many times, and his assaults had caused her to miscarry multiple pregnancies. About the homicide, she claimed that she was holding a knife and her partner lunged toward her and impaled himself. She was prosecuted and convicted of second-degree murder. In sentencing her, the judge acknowledged her partner’s history of abuse toward her. Using the previous DVFR criteria, this woman would have been classified as the abuser because she was convicted of second-degree murder. Under our new criteria, she is classified as a domestic violence victim who committed a homicide that did not meet the definition of self-defense. This category recognizes that the woman in this case was the victim of a history of abuse by her male partner and that she killed him in a homicide that was not justified by self-defense.

The following four categories summarize the new DVFR criteria for classifying cases in which women killed their male partners:

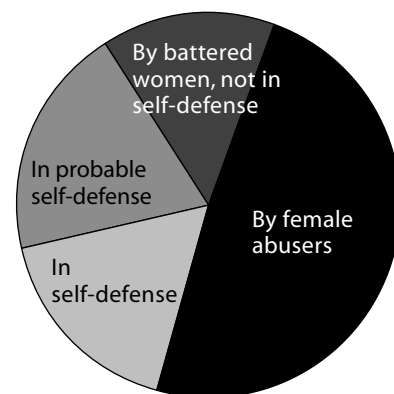
1. Battered women who killed their abusers in self-defense:  
Homicides that were so clearly self-defense that no charges were ever filed against the woman, or the woman was acquitted based on a self-defense argument.
2. Battered women who killed their abusers, probably in self-defense:  
Homicides in which prosecutors did file charges, but the woman claimed there was a history of abuse and those claims were credible enough to prevent conviction on first- or second-degree murder charges.
3. Battered women who killed their abusers, not in self-defense:  
Homicides in which there was evidence that the woman was the victim of a history of abuse by her male partner, but which were not justified by self-defense, and the woman was convicted of manslaughter or second-degree murder.
4. Female domestic violence abusers who killed male domestic violence victims:  
Homicides in which the woman was convicted of first- or second-degree murder, *and* in which there was no evidence of a history of abuse by the male victim toward his female partner.

Examining cases in which female domestic violence abusers killed male victims, some important differences emerged from the majority of cases in which male abusers killed female victims. In particular, mental health issues seemed to figure more largely in the histories leading up to these homicides. In at least 40% of the 20 cases since 1997 in which female domestic violence abusers killed their current or former male intimate partner, the women had documented histories of mental illness or instability. In one case, the female abuser had multiple admissions to state hospitals for mental illness. In another case, the judge had enough reservations about the woman’s mental health to order a competency evaluation; other women had been diagnosed with multiple personality disorder or bipolar disorder at some point. Another woman’s co-workers described her as distraught, and unable to stop crying and talking about her funeral arrangements in the month prior to the murder.

In the one reviewed case in which a female abuser killed a male victim, the review panel noted that the case differed from others reviewed in that it did not appear that the woman had engaged in an escalating pattern of abuse toward her partner prior to his murder. On the other hand, she did have a history of mental health issues, suicidal and self-harming behavior, substance abuse and nonviolent criminal behavior. Fatality Review panels have not conducted enough in-depth reviews of homicides involving female abusers and male victims to draw strong conclusions about how they differ

MEN KILLED BY FEMALE INTIMATE PARTNERS BETWEEN 1/1/97 AND 6/30/04

Total cases: 41



- Male victims killed by female abusers: 49%
- Abusers killed in self-defense by battered women: 17%
- Abusers killed in probable self-defense by battered women: 19%
- Abusers killed by battered women, not in self-defense: 15%

from cases with male abusers and female victims. However, the question merits further examination: Do precursors and warning signs differ when female abusers kill their male partners?

**Homicide-suicides**

Almost a third (32%) of the 260 abusers who committed homicides since January 1, 1997 committed homicide-suicides. An additional six abusers killed themselves after attempting homicide. This substantial percentage underlines our ongoing concern about the ability of community response systems to identify and respond to the risk suicidal abusers pose to themselves and others.<sup>14</sup>

Considering all fatality cases, we know that abusers were suicidal in 32% (n=101) of the 313 cases from the fact that they killed or attempted to kill themselves. The portion of suicidal abusers may be higher, as some abusers may have intended to commit suicide when they committed homicide, but then were apprehended before they had the opportunity or lost some of their suicidal drive after killing someone else.

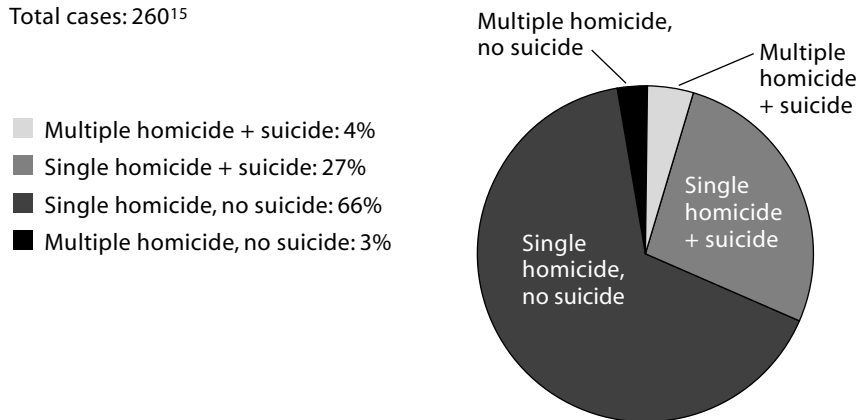
Of the 101 abusers we have been able to identify as suicidal, only 5 did not commit a lethal or potentially lethal assault prior to killing or attempting to kill themselves. In other words, almost all of the suicidal abusers the DVFR identified were homicidal as well. However, our data cannot give us an accurate count of how many domestic violence abusers become suicidal but never become homicidal, or commit suicide without attempting to commit homicide, and so we cannot know with certainty how often abusers who are suicidal are homicidal as well. Even so, the large percentage of suicidal abusers involved in domestic violence homicides or attempted homicides underscores the urgency of developing screening tools and protocols aimed at identifying the nexus of abuse and suicidal thoughts in abusers, and providing appropriate intervention to decrease the risk of homicides.

<sup>14</sup> We have included the deaths of abusers killed by law enforcement in counts of suicidal abusers. In all of these cases, abusers acted consciously with life-threatening force that compelled law enforcement officers to respond with deadly force. This behavior has been defined by researchers as "suicide by cop" or "law enforcement officer-assisted suicide." See Daniel Kennedy, Robert Homant and R. Thomas Hupp, "Suicide by Cop," *FBI Law Enforcement Bulletin* 67 (1998), p. 30-48, and Robert Homant and Daniel Kennedy, "Suicide by Police: A Proposed Typology of Law Enforcement Officer-Assisted Suicide," *Policing* 23 no. 3 (2000), p. 339-355.

<sup>15</sup> This number excludes 2 cases in which domestic violence victims killed their children, 31 cases in which abusers were killed by their partners or a friend or family member of their partner, 8 cases in which law enforcement were compelled to kill abusers (and no other homicide took place), 11 cases which were suicides in which no homicide took place and 1 suicide in which the abuser killed his partner's mother in another state.

HOMICIDES COMMITTED BY DOMESTIC VIOLENCE ABUSERS BETWEEN 1/1/97 AND 6/30/04

Total cases: 260<sup>15</sup>



## Women's suicides and attempted suicides

Over 150 women commit suicide each year in Washington, and battered women are at higher risk of suicide.<sup>16</sup> It is unusual for suicidal women to commit homicides prior to their suicide. Since September 2002, two suicidal battered women killed their children and attempted to kill themselves.<sup>17</sup> Women rarely kill their children in the carefully planned manner that is often associated with male domestic violence abusers who kill their entire families or their children in the midst of custody disputes. (Since 1997, sixteen male abusers have killed twenty-one children; five (31%) of those abusers killed children along with their mothers.) In both cases with suicidal women, there were indications that the abuse they experienced contributed to their decision to kill themselves and their children. These unusual cases highlight the need to attend to the intersection of domestic violence victimization, mental health issues and suicidal ideation for women.

The best known and most widely practiced psychological treatment models for suicidal thoughts or attempts and depression in women (for example, Dialectical Behavior Therapy<sup>18</sup>) do not clearly direct therapists to screen for domestic violence, consider how domestic violence may affect the patient's ability to participate in treatment, or attend to the potentially life-threatening safety issues domestic violence victims may be facing. In the fields of psychology and psychiatry, attention to domestic violence has not been institutionalized, and an analysis of how it may play into the problems people present with in therapy has not been integrated into treatment models, professional training or licensing requirements. Assessing and responding appropriately to domestic violence in the context of depression or suicidal thoughts depends largely on the individual psychologist's or psychiatrist's experiences and interests.

## Weapons

Consistent with prior DVFR reports and national crime trends, the majority of domestic violence homicides have been committed with firearms. Since 1997, abusers used firearms to kill 57% (n=159) of domestic violence homicide victims. Since September 2002, abusers used firearms to kill 54% (n=39) of domestic violence homicide victims.

The DVFR's findings, as well as national research, implicate firearms in increasing the risk of homicide for battered women. Several national studies have found that the presence of a gun in the home significantly increases women's risk of being killed by their intimate partner.<sup>19</sup> One study in which over 400 battered women were interviewed found that two-thirds of the women who had a gun in the home had been threatened by their partner with that firearm. About 5% of women's partners had actually shot at them.<sup>20</sup> Other studies have shown that homicide rates are higher for women when there are firearms in their homes.<sup>21</sup>

<sup>16</sup> See, for example, Evan Stark and Anne Flitcraft, "Killing the Beast Within: Woman Battering and Female Suicidality," *International Journal of Health Services* 25, no. 1 (1995), p. 43-64.

<sup>17</sup> Although DVFR data collection methods are imperfect, cases in which women kill children are unusual enough to be consistently covered in newspapers. We have noted only one other case in which a woman killed her young child and then herself, but did not include it in our DVFR data because we were unable to ascertain whether domestic violence was a factor.

<sup>18</sup> See Marsha Linehan, *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (New York, NY: The Guilford Press, 1993).

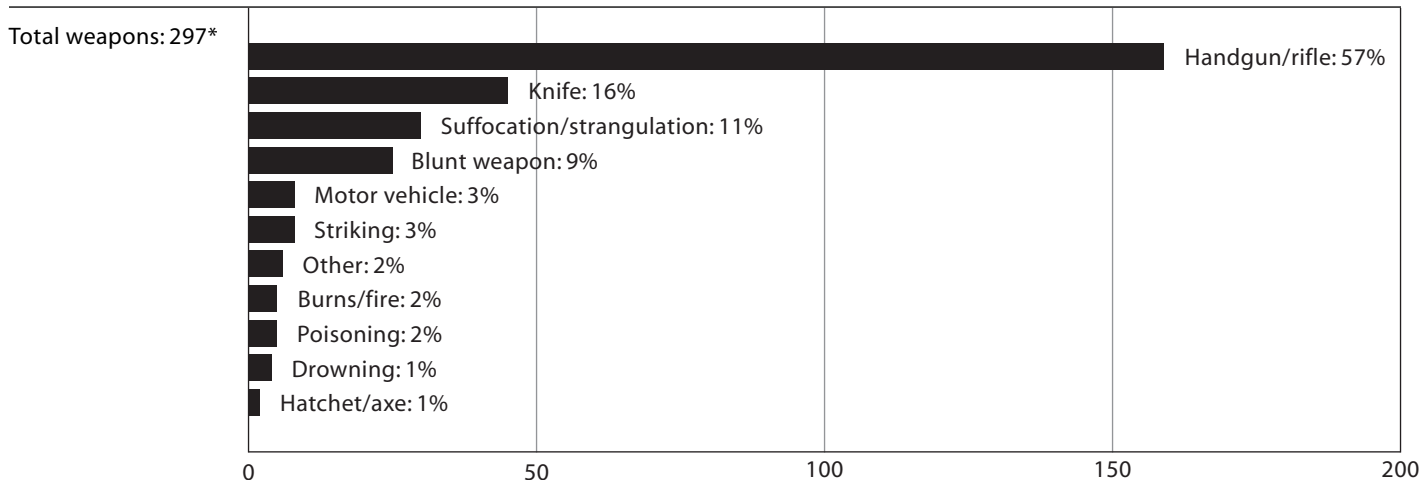
<sup>19</sup> See, for example, Jacquelyn C. Campbell et al., "Risk Factors for Femicide in Abusive Relationships: Results from a Multisite Case Control Study," *American Journal of Public Health* 93, no. 7 (July 2003), p. 1089-1097.

<sup>20</sup> Susan B. Sorenson, Ph.D. and Douglas J. Wiebe, Ph.D., "Weapons in the Lives of Battered Women," *American Journal of Public Health* 94, no. 8 (August 2004), p. 1412-1417.

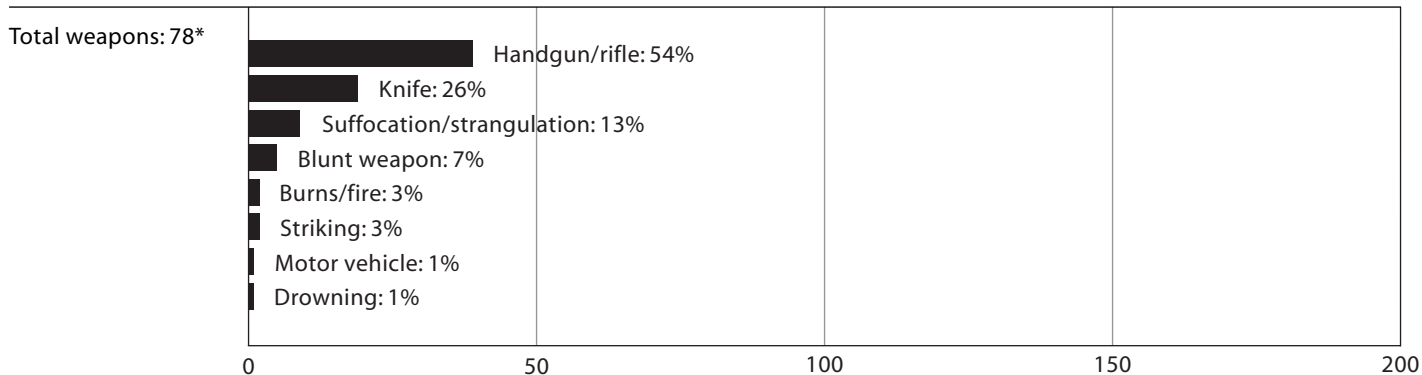
<sup>21</sup> J. E. Bailey et al., "Risk Factors for Violent Death of Women in the Home," *Archives of Internal Medicine* 157, no. 7 (1997), p. 777-782.



WEAPONS USED BY DOMESTIC VIOLENCE ABUSERS TO KILL 281 VICTIMS IN DOMESTIC VIOLENCE HOMICIDES COMMITTED BETWEEN 1/1/97 AND 6/30/04



WEAPONS USED BY DOMESTIC VIOLENCE ABUSERS TO KILL 72 VICTIMS IN DOMESTIC VIOLENCE HOMICIDES COMMITTED BETWEEN 9/1/02 AND 6/30/04



\*Some homicides involved multiple weapons; therefore, percentages total greater than 100%.

**Age at onset of relationship with abuser**

The DVFR’s findings indicate that a significant number of domestic violence homicide victims became involved with their abusers as teenagers.

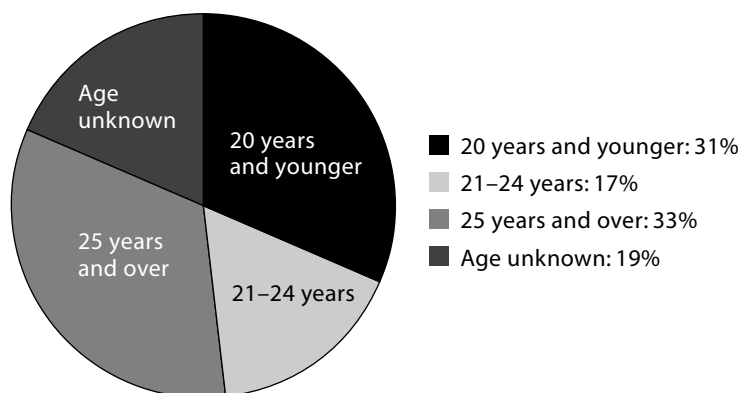
This is clear in some cases, because the victims were still teenagers at the time of their death. Twelve percent of the female intimate partners killed by their male abusers since 1997 were under 21, and of those, 40% were not yet 18.

Another indicator of age at onset of the relationship is the victim’s age at the birth of her first child in common with the abuser. Fifty-four women killed by their intimate partners had children in common with those partners living in the home. Of those women, 31% (n=17) were 20 or younger when they had their oldest child with the abuser. An additional 17% (n=9) had children before the age of 25. Other research has indicated that domestic violence abusers frequently make efforts to sabotage their teen girlfriends’ efforts to use birth control, as well as their efforts to succeed at school or work. One study involving over 400 teenagers found that the severity of abuse was positively correlated with the frequency and severity of birth control sabotage and job or education sabotage. In that study, two-thirds of the teens who had experienced domestic violence reported that their partner made verbal or physical efforts to prevent their use of birth control.<sup>22</sup>

<sup>22</sup> *Domestic Violence and Birth Control Sabotage: A Report from the Teen Parent Project*, Center for Impact Research, February 2000, [www.impactresearch.org/documents/dvandbirthcontrol.pdf](http://www.impactresearch.org/documents/dvandbirthcontrol.pdf).

## VICTIM'S AGE AT TIME OF BIRTH OF FIRST CHILD WITH ABUSER: 1/1/97 TO 6/30/04

Total women: 54



Teen girls are vulnerable to abusers because they rarely receive any education about dating violence or abuse in their schooling; resources and supports for teens in abusive or unhealthy relationships are scarce; their emotional support systems may not be well developed; forming intimate relationships is still new and some teens may be unsure of the difference between what is healthy and what is unhealthy; and parents often do not know how to intervene productively, may not recognize abuse or may not have the skills to provide support. When a teenager becomes pregnant by the abuser (either voluntarily or through his interference with her birth control), then that young woman faces many more barriers to safety and self-sufficiency.

Teen *mothers* in abusive relationships face all the challenges of parenting—social pressure to marry the father of her child and rely on him for help with parenting, isolation from support systems brought about by the abuse and the demands of parenting, a lack of substantive social or economic support for childraising, and a job or WorkFirst program which may require long work hours even when children are very young—in addition to the ongoing emotional and physical abuse they suffer at the hands of their intimate partner. Under these circumstances, forging an emotionally and economically independent life is a daunting task. The lack of resources in our communities to support young mothers' educational attainment and economic autonomy, while also helping them succeed at creating loving, functional relationships with their children, leaves teen mothers very vulnerable to abusers.

Fatality Review panels examining deaths of teens and deaths of women who became involved with their abusers as teens have repeatedly identified a dearth of resources in their schools and communities for teens. When programs do exist, they are often small, unfunded, called in at the discretion of individual teachers, and do not have the capacity to reach all of the diverse teen populations in their area. While examining the death of a young woman who became involved with her abuser in high school, one review panel made clear that given the multiple demands and tight budgets school systems face, the issue of dating violence will probably remain neglected (even though it affects so many students<sup>23</sup>) until there is more community pressure and resources to address it.

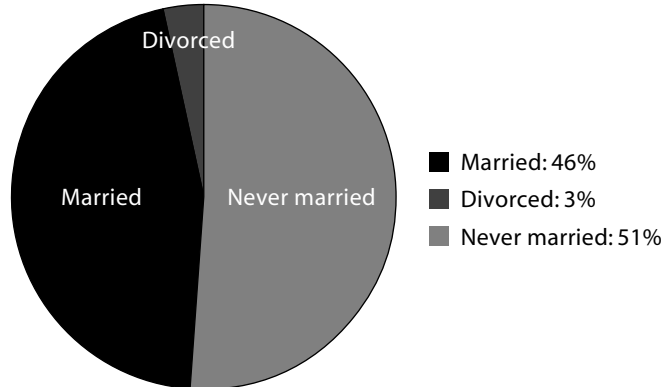
<sup>23</sup> The Bureau of Justice Statistics reports that women age 16-20 had higher rates of intimate partner violence than any other age group in 1999. *Intimate Partner Violence and Age of Victim, 1993-99*, by Callie Rennison, Ph.D., NCJ 187635 (Washington, D.C.: U.S. Department of Justice, October 2001), <http://www.ojp.usdoj.gov/bjs/abstract/ipva99.htm>.

### Relationship status at the time of the homicide

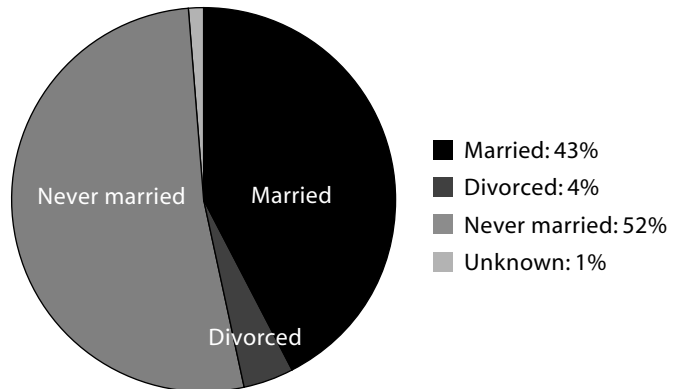
Almost half (49%) of the female domestic violence victims killed by male abusers since 1997 had been married to their abuser at some point; of those, almost all (93%) were still married at the time of the homicide.

Almost half (47%) of the male abusers who killed either their intimate partner or her children, friends or family were married to their partner at some point. Of these, 91% were currently married at the time of the homicide.

MARITAL STATUS OF 176 FEMALE DOMESTIC VIOLENCE VICTIMS KILLED BY CURRENT OR FORMER MALE INTIMATE PARTNER FROM 1/1/97 TO 6/30/04



MARITAL STATUS OF 236 MALE ABUSERS WHO COMMITTED 257 HOMICIDES FROM 1/1/97 TO 6/30/04<sup>24</sup>



<sup>24</sup> This number excludes 20 homicides of male domestic violence victims committed by female abusers, 1 homicide of a family member killed by a female abuser, 1 homicide of a female domestic violence victim by a female abuser, and 2 homicides committed by associates of male abusers.

## Separation violence

News reports or in-depth fatality reviews made clear that in at least 44% of the cases in which the domestic violence abuser killed someone (most often their intimate partner, but also including children, family members, friends and new love interests of the victim), the domestic violence victim had left, divorced or separated from the abuser, or was attempting to leave or break up with the abuser.<sup>25</sup> The DVFR's finding of a high rate of separation violence is consistent with national findings: in 2001, the Bureau of Justice Statistics reported that married but separated women reported the highest rate of intimate partner violence, and divorced women reported the next highest rate. Currently married and never married women reported the lowest rates.<sup>26</sup>

Consideration of the large number of homicides that take place after separation highlights the following points:

- Victims of domestic violence frequently take active steps to end the relationship. However, this may not make them safer, unless community resources are available to assist in holding the abuser accountable and providing the victim with the support and resources she needs to avoid the abuser's violence.
- Most helping professionals in the criminal justice, social service, mental health and medical fields assume that victims of domestic violence will be safer if they leave their abuser, but our findings indicate that no simple correlation exists between leaving and safety, and that women's danger (and the danger to their children, friends and family) may increase upon separation.
- Battered women particularly need safety planning before breaking up, filing for divorce or moving out, and this planning should take into consideration that control tactics and violence may escalate.

## Children: left motherless, witnesses and victims

Of the 176 women killed by male current or former intimate partners since 1997, at least 88 (50%) had children living in the home with them at the time they were murdered. Of the children for whom we have age information, 37% (n=43) were age five or younger. At least twenty additional women had an unknown number of adult children living outside their home at the time of their death.

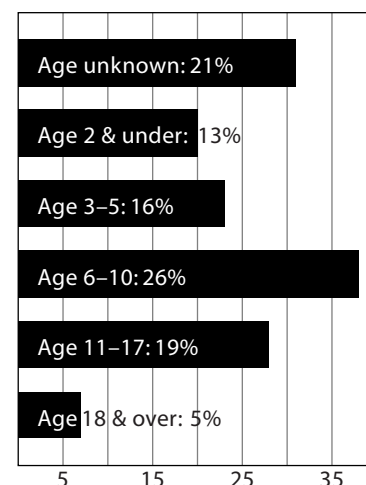
More than half (63%) of the children living in the home of women killed by their male intimate partners were present when their mother was killed. News reports indicate that of the children present, 43% (n=40) witnessed the actual killing; this number may be higher. In any case, it is likely that most of the children who were in the home at the time of the murder saw the murder scene and will grow up with the image of their slain mother in their minds. Abusers killed eight children alongside their mothers, and attempted to kill more. One abuser apparently intended to kill the one-year-old child of his girlfriend and another abuser critically injured the child of his victim, but both of these children survived.

<sup>25</sup> It is possible that a higher percentage were in the process of breaking up or leaving. For cases not reviewed in depth, information on the status of the relationship and whether or not the victim was attempting to break up or leave is often incomplete.

<sup>26</sup> Bureau of Justice Statistics, *Intimate Partner Violence and Age of Victim*, 1993-1999.

### AGES OF CHILDREN LIVING WITH THEIR MOTHER AT THE TIME OF HER MURDER: 1/1/97 TO 6/30/04

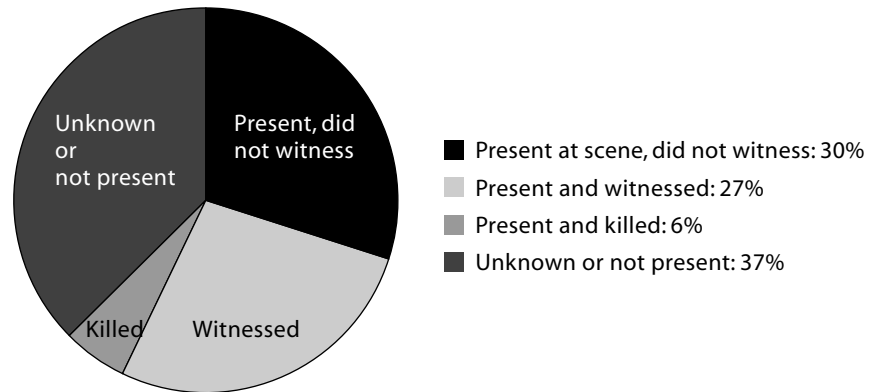
Total: 147 children of 88 women



Five male domestic violence victims had children living with them at the time of their murder; in four of those cases, the children were the female abuser's and not theirs. In the fifth case, the children were both the victim's and abuser's. In these five cases involving seven children, all seven children were present at the time of the homicide and five witnessed the homicide.

LOCATION OF CHILDREN AT THE TIME OF THEIR MOTHER'S HOMICIDE: 1/1/97 TO 6/30/04

Total: 147 children of 88 women murdered by their male intimate partners



**Prenatal care: a critical point of intervention**

At least 28% (n=25) of the women killed by their male intimate partner since 1997 who had children in the home (whose ages are known) had given birth to a child in the previous five years. Of these twenty-five, over half had children age two years and younger. The DVFR is aware of at least four women killed by their current or former intimate partner who were pregnant at the time of their murder; however, it is quite possible that more homicide victims were pregnant and this fact was not covered in news accounts. For each of these women, prenatal care was an important opportunity for intervention. Washington State's Pregnancy Risk Assessment Monitoring System data showed that 6% of childbearing women reported physical violence by a husband or partner in the year prior to their pregnancy, during pregnancy or the three months following birth.<sup>27</sup>

DVFR findings reinforce the fact that healthcare providers are a critical source of intervention for domestic violence victims. For victims isolated by their abusers, medical appointments may be their only opportunity to obtain information and resources. The Washington State Department of Health's Perinatal Partnership Against Domestic Violence urges doctors to screen all pregnant women every trimester and postpartum, assure the patient's safety if violence is disclosed, and refer patients who disclose violence or abuse to local domestic violence resources.<sup>28</sup>

<sup>27</sup> Washington State Department of Health, "Washington State Domestic Violence and Pregnancy Facts," 2004, <http://www.doh.wa.gov/cfh/PRAMS/DVandPregnancyFactSheet2004.pdf>.

<sup>28</sup> The American College of Obstetricians and Gynecologists supports universal screening, as does the American Medical Association, the American Academy of Family Physicians, the American Nurses Association and the National Association of Social Workers. All of these organizations have position papers on universal domestic violence screening posted on their websites.

Healthcare providers can find more information about interventions and resources related to pregnancy and domestic violence from the Washington State Department of Health at [http://www.doh.wa.gov/cfh/mch/perinatal\\_partners\\_against\\_dv.htm](http://www.doh.wa.gov/cfh/mch/perinatal_partners_against_dv.htm).

## Protective orders

At least 45 of the 313 abusers (14%) tracked in cases since January 1, 1997 were subject to some sort of protective order (temporary or permanent Restraining Order, Anti-Harassment Order, Protection Order or No Contact Order) prior to the domestic violence fatality.

Focusing on cases which occurred September 1, 2002 to June 30, 2004, 14 of the 81 abusers (17%) were subject to a type of protective order at some point before the murder. Some had been respondents in multiple orders. In one case, the victim's mother, sister and brother-in-law all filed Anti-Harassment Orders against the abuser because of his threatening and intimidating behavior. In another, the abuser had victimized multiple women and had several assault charges pending at the time he killed his girlfriend; several No Contact Orders were in place. Ten of the fourteen abusers (71%) were restrained by domestic violence temporary or permanent Protection Orders at some point. At the time that the domestic violence homicides occurred, ten protective orders were in place affecting seven abusers: six No Contact Orders, three Protection Orders and one Anti-Harassment Order.

These findings cannot tell us what role protective orders play in preventing lethal violence. However, they do suggest that a substantial segment of dangerous domestic violence abusers have come to the attention of the civil or criminal legal system prior to committing domestic violence homicides. These were opportunities for professionals to assess the danger these individuals posed to their partners and communities and communicate a clear lack of tolerance for abuse. The presence of protective orders also suggests that a significant number of women at risk for domestic violence homicide seek help from courts. DVFR findings continue to point to courts as a critical point of contact for victims and abusers. For some domestic violence victims, filing for a Protection Order is their only documented contact with community institutions regarding the abuse. Panels have repeatedly noted the need for advocacy in courts issuing Protection Orders, a subject explored in greater detail in the "Implementation of Fatality Review Recommendations" chapter of this report.

## Domestic violence homicides by county

The following table represents the number of domestic violence-related fatalities (as defined by the Domestic Violence Fatality Review, see Appendix B for glossary of terms) in each Washington county by year.<sup>29</sup> Please note that the data for 2004 reflects only the first six months of the year, January 1 through June 30. This includes homicides of domestic violence victims, their children, friends and family, law enforcement, homicides in which victims killed their abuser and abuser suicides. Cases in which law enforcement officers were compelled to shoot abusers (see definition of "suicide by police" in Appendix B) are included in the number of abuser suicides. As discussed in the "Homicide-Suicides" section, most suicides were committed after one or more homicides. It is likely that the numbers in this table represent an undercount of domestic violence fatalities. Some domestic violence homicides may be unsolved, mistakenly classified as accidents or unreported.

<sup>29</sup> Discrepancies from counts in the 2002 DVFR report reflect corrected and updated information (for example, one woman accused of hiring someone to kill her husband in 1997 has since been cleared of that accusation). Discrepancies also reflect a change in our policy regarding counting fetuses; previously, we had counted fetuses of pregnant women, or miscarriages brought about by abuse in which the mother survived, as separate homicides. Fetuses are no longer included in our count of domestic violence fatalities. We continue to track when women killed are pregnant, but acknowledge that this information is too frequently unavailable to make an accurate count.

Additionally, although miscarriages caused by abuse in which the mother survives are occasionally noted in news accounts, it is likely that abusers cause far more miscarriages than those that receive news coverage. Since the DVFR's methods of identifying domestic violence fatalities do not allow us to accurately count these cases, we have decided to exclude the few we are aware of. To accurately assess the toll of domestic violence on both its victims and our communities, efforts should be made by public health researchers to identify the number of abuse-precipitated miscarriages and stillbirths.

## DOMESTIC VIOLENCE HOMICIDES BY COUNTY

	1997		1998		1999		2000		2001	
	Homicides	Abuser suicides	Homicides	Abuser suicides	Homicides	Abuser suicides	Homicides	Abuser suicides	Homicides	Abuser suicides
Adams	—	—	—	—	—	—	—	—	—	—
Asotin	—	—	—	—	—	—	1	1	—	—
Benton	—	—	—	—	1	1	—	—	1	1
Chelan	—	—	1	—	—	—	—	—	—	—
Clallam	2	—	1	—	—	—	1	—	1	—
Clark	3	2	2	2	1	—	—	—	5	2
Columbia	—	—	—	—	—	—	—	—	—	—
Cowlitz	—	—	—	—	1	—	—	—	—	—
Douglas	—	—	—	—	—	—	—	—	—	—
Ferry	—	—	—	—	—	—	—	—	—	—
Franklin	—	—	2	—	—	—	2	—	3	1
Garfield	—	—	—	—	—	—	—	—	—	—
Grant	—	—	2	—	—	—	—	—	—	—
Grays Harbor	—	—	—	—	—	—	2	2	—	—
Island	1	—	—	—	2	—	1	—	1	—
Jefferson	—	—	—	—	—	—	—	—	—	—
King	13	2	16	5	15	1	6	1	10	3
Kitsap	5	2	2	—	1	1	1	—	2	—
Kittitas	—	—	—	—	1	—	—	—	—	—
Klickitat	—	—	—	—	—	—	—	—	1	1
Lewis	—	—	—	—	—	—	1	—	—	—
Lincoln	—	—	—	—	—	—	—	—	1	—
Mason	—	—	1	—	1	—	—	—	—	—
Okanogan	1	—	1	—	1	1	—	—	—	—
Pacific	—	—	—	—	—	—	—	—	—	—
Pend Oreille	—	1	—	—	—	—	—	—	1	—
Pierce	5	3	9	2	4	2	4	1	7	4
San Juan	—	—	1	1	—	—	—	—	—	—
Skagit	—	1	—	—	—	—	1	—	1	—
Skamania	—	—	—	—	1	1	—	—	—	—
Snohomish	4	—	2	—	3	1	3	—	4	3
Spokane	2	2	3	1	3	2	3	1	1	1
Stevens	—	—	—	—	—	—	—	—	—	—
Thurston	1	—	3	1	3	1	—	—	2	1
Wahkiakum	—	—	—	—	—	—	—	—	—	—
Walla Walla	2	1	—	—	—	—	—	—	—	—
Whatcom	1	—	—	—	—	—	1	1	—	1
Whitman	—	—	—	—	—	—	—	—	—	—
Yakima	1	1	2	—	—	—	2	2	4	2
<b>Total DV fatalities</b>	41	15	48	12	38	11	29	9	45	20

2002		2003		Data through June 30, 2004		Total homicides	Total abuser suicides	
Homicides	Abuser suicides	Homicides	Abuser suicides	Homicides	Abuser suicides			
—	—	—	—	—	—	0	0	Adams
—	—	—	—	—	—	1	1	Asotin
—	—	4	1	—	—	6	3	Benton
—	—	—	—	1	—	2	0	Chelan
1	—	—	1	1	1	7	2	Clallam
2	—	2	2	4	1	19	9	Clark
1	—	—	—	—	—	1	0	Columbia
2	1	—	—	1	1	4	2	Cowlitz
—	—	—	—	1	—	1	0	Douglas
—	—	—	—	—	—	0	0	Ferry
1	—	1	1	—	—	9	2	Franklin
—	—	—	—	—	—	0	0	Garfield
1	—	—	—	—	—	3	0	Grant
2	—	—	—	—	—	4	2	Grays Harbor
2	2	—	—	—	—	7	2	Island
1	—	1	—	—	—	2	0	Jefferson
12	4	18	4	4	1	94	21	King
—	—	1	—	—	—	12	3	Kitsap
1	—	—	—	—	—	2	0	Kittitas
—	—	—	—	—	—	1	1	Klickitat
—	—	—	—	—	—	1	0	Lewis
—	—	—	—	—	—	1	0	Lincoln
—	—	1	3	—	—	3	3	Mason
—	1	—	—	1	1	4	3	Okanogan
—	—	—	—	—	—	0	0	Pacific
—	—	1	—	—	—	2	1	Pend Oreille
7	—	10	2	2	1	48	15	Pierce
—	—	—	—	—	—	1	1	San Juan
2	—	—	—	—	—	4	1	Skagit
—	—	—	—	—	—	1	1	Skamania
6	—	4	2	2	2	28	8	Snohomish
3	—	1	—	1	—	17	7	Spokane
—	—	—	—	—	—	0	0	Stevens
—	—	1	—	—	—	10	3	Thurston
—	—	—	—	—	—	0	0	Wahkiakum
—	—	—	—	—	—	2	1	Walla Walla
2	—	1	1	1	—	6	3	Whatcom
—	—	—	—	—	—	0	0	Whitman
2	2	—	—	—	—	11	7	Yakima
48	10	46	17	19	8	314	102	<b>Total DV fatalities</b>



## The Complexity of Victims' Lives and Multiple Barriers

In the thirteen cases reviewed over the past two years, Domestic Violence Fatality Review (DVFR) panels saw that victims faced not just one or two system failures, but many barriers to accessing services and obtaining safety and self-sufficiency. Throughout this report, we address specific topic areas and disciplines; however, the lived experience of domestic violence does not divide up so neatly, and the complexity of the cumulative barriers and system shortcomings can be lost by examining one area at a time. This chapter tells several victims' stories to illustrate the multiple challenges victims faced prior to their murder.<sup>30</sup> Among these stories, one common thread is a lack of connection to advocacy resources.

<sup>30</sup> All of the names used in this chapter are pseudonyms.

### **Abusers threatening to kill others and sabotaging victims' attempts to leave**

The community response to domestic violence often focuses on the victim and the steps she can take to be safe, such as: relocating; accessing a shelter; or changing her routine, name or entire identity. In five of the cases reviewed, however, the abuser made explicit threats to kill the victim's friends and/or family members. For these women, plans that focused on their safety alone or fleeing from the abuser were inadequate because they did not address the abuser's continued violence and the danger their friends and family faced. These cases highlight a need for safety planning to include friends and family, and for communities to address abuser accountability in addition to victim safety.

In nine of the thirteen reviewed cases, the domestic violence victim had, at some point, either ended the relationship with the abuser, attempted to leave or clearly stated a desire to end the relationship prior to the homicide. The abusers in these cases used a variety of coercive tactics to maintain control over the victim, including: moving across state to follow the victim; stalking the victim at her workplace; threatening escalated violence; and using contact with the children or other family members to manipulate her. Carrie's story illustrates how an abuser's tactics, when coupled with the limitations of the system, can combine to have a devastating impact on the victim and her family.

**CARRIE** was twenty years old when she met Daniel through a friend. They began dating, and moved in together shortly thereafter. Carrie and Daniel had a child together a few years later. Throughout their relationship, Daniel controlled Carrie with verbal abuse, physical abuse, threats and manipulation. He listened in on her phone conversations to monitor what she talked about to family and friends, isolating her from her support system.

Carrie tried to leave Daniel many times. She talked about the abuse with her family and Daniel's family. Daniel's family minimized the abuse, and discouraged Carrie from reporting it to law enforcement. Carrie's family took many steps to help her plan for her safety, and she stayed with family members on multiple occasions; however, it did not appear that they recognized the lethality of the situation. When Carrie tried to end the relationship with Daniel, he threatened both her and her family, pointing out that he could easily enter her family members' homes in order to hurt them.

On one occasion, after Daniel assaulted Carrie, she sought medical treatment at a local hospital for her injuries. Daniel told her to lie to the physicians about how she had sustained the injuries. Following this incident, Carrie again tried to end the relationship and moved in with a family member. Daniel repeatedly demanded to have their infant child for overnight visits and then refused to return her. He continued to threaten Carrie and her family in an effort to manipulate her. Daniel ultimately carried out his threats and killed a member of Carrie's family who came to Carrie's aid as Daniel attempted to force her to reconcile with him.

### **Access to support and resources**

Victims faced significant barriers to contacting the criminal legal system and community domestic violence programs, as well as accessing the support of friends and family. Six of the thirteen victims in reviewed cases never contacted the police about their abusers, and it did not appear that any of the individuals in reviewed cases accessed a community domestic violence program.<sup>31</sup> Four of the thirteen victims seemingly never spoke to any friends, family members or co-workers about the abuse.

**LIZA** and her husband Rick lived in a small community. They were married for over twenty-five years, and had one child together. Both had college degrees, attended church regularly and were very active in their church congregation. Throughout much of their marriage, Rick was employed by the local school district. Liza never called the police or sought a protective order against Rick, and it did not appear that she ever contacted the domestic violence program in their county.

Had Liza called the police or petitioned for a Protection Order at any point during their relationship, these contacts would have been a part of public records and would likely have negatively impacted Rick's career with the school district. Out of concern for Rick's career and the financial stability of the family, Liza may have felt she could not seek protection from the police or the courts. The fact that Liza and Rick lived in a small community, geographically isolated from the urban-based domestic violence program in their county, created an additional barrier to her accessing services and support. Rick shot and killed Liza in their home and subsequently committed suicide.

<sup>31</sup> Because confidentiality prohibits community domestic violence programs from disclosing the provision of services unless the individual signed a release, we cannot be absolutely certain that none of these individuals accessed such a program. However, there was no indication throughout the investigation of the homicides or interviews with family members or friends that they did.

**AMY** was twenty-two years old when she met Sean and they began dating. Sean had a substantial criminal history that illustrated his propensity for violence. Amy had a history of arrests as well (although significantly fewer than Sean and for less serious crimes). Both Amy and Sean had outstanding warrants at various times during their relationship.

Amy's friends reported distancing themselves from her when she started dating Sean because he was violent and they were afraid of him. Family members described multiple ways in which Sean controlled Amy, including not allowing her to leave her apartment. Throughout the relationship, Sean assaulted Amy, threatened to kill her, and threatened to kill her friends. Sean's controlling tactics and use of violence isolated Amy from her friends and family as a source of support. Neither Amy nor her friends or family ever reported Sean's assaults or threats to the police.

Utilizing the criminal legal system did not appear to be a viable option for Amy for several reasons:

- Amy's prior arrests and outstanding warrants limited her ability to call the police for her own protection.
- Sean's extensive criminal history indicated that involvement with the criminal legal system was not a meaningful consequence for him.
- Amy may have feared retaliation from Sean if she reported him to the police, since he often followed through on his threats of violence toward her and others.

Approximately two weeks before her murder, Amy paid her apartment manager to change the locks on her apartment, but the manager had not yet done so. After leaving a series of threatening phone messages, Sean came to Amy's apartment, let himself in with his key, and shot and killed both her and a member of her family.

**MARIA** was born in Mexico. She moved to the United States with her husband, Javier, and their four children approximately ten years prior to her death. She and Javier had a fifth child after they moved to the U.S. It appeared that both Maria and Javier had limited English proficiency. Maria and Javier worked at the same place for a time, and their employer noted that he was a "jealous husband." After Javier left that job, Maria continued to work there, and co-workers saw Javier stalking her at the workplace on several occasions. Maria told friends that she wanted to leave Javier, and that she had asked him for a divorce, but he would not grant her one.

On one occasion, Javier assaulted Maria while family members were in the other room. No one called the police to report the assault. In fact, it did not appear that Maria ever contacted the criminal legal system or any community agencies for safety or support. Two days after that assault, Javier shot and killed Maria. All of their children were in the home at the time of the shooting.

Maria faced multiple barriers to accessing resources to address Javier's abuse:

- Based on her immigration status, Maria may have feared reporting Javier's abuse to the police. Many domestic violence victims are afraid to call the police because they fear the police will inquire about their status. Additionally, Javier may have threatened to report Maria to Immigration and Customs Enforcement (ICE)<sup>32</sup> or take her immigration documents as a means of exerting power and control over her.

<sup>32</sup> ICE is the new division charged with enforcement of immigration laws within the Department of Homeland Security. ICE is one of the agencies that replaced the Immigration and Naturalization Service (INS).

- Maria and her family members may not have reported the abuse to the police out of concern that some local law enforcement agencies work with ICE and Javier may have been subjected to deportation if arrested. In addition, if the court convicted Javier of domestic violence, he may have risked deportation.
- Many immigrants do not have information about which organizations or institutions will inquire about their immigration status and report them to ICE. This lack of information may have prevented Maria from contacting any community or government resource for assistance.
- Language barriers could have discouraged Maria from accessing a community domestic violence program, shelter, legal assistance program for low-income individuals or other social service agency to address the abuse she experienced. She may also have been unaware of the services available from these local agencies, in part because they may not do extensive outreach in the Limited English Proficient communities in which they are located and in part because such services may not exist in immigrants' home communities (and therefore Maria may not have been familiar with the process of seeking this type of aid). In addition, if her culture was not represented among the staff or customs practiced at an agency, she may not have perceived their services as a resource available to her.

### Substance abuse and housing

Fatality Review panels identified substance use as an issue for nine of the abusers and four of the victims in the thirteen reviewed cases. Although substance abuse does not cause domestic violence, their co-occurrence increases the severity of injuries and lethality rates.<sup>33</sup> For the four victims who were drinking or using other drugs at some point, this appeared to pose a significant barrier to their safety, as well as their ability to access the criminal legal system and social services to address the domestic violence they experienced.

Many victims also dealt with a lack of housing as a barrier to safety and self-sufficiency. Issues related to housing came up in three of the thirteen reviewed cases, including: women having to stay with relatives in order to flee the residence they shared with an abuser; staying with an abuser in order to avoid breaking a lease; and eviction. Lisa's story illustrates challenges with both substance abuse and housing and how these issues undermined her ability to escape her abuser.

**LISA** struggled with chemical dependency, and her friends and family described her as having a difficult and troubled life. Some family members reported not understanding Lisa's addiction, and lacked information about how they might have intervened.

Lisa worked as a bartender when she met Brian, who frequented the bar where she worked. Shortly after they started dating, Brian began using physical violence against her. Lisa's employer noticed that she often came to work with visible injuries. Friends described an incident when Brian assaulted Lisa at his apartment, kicking her and pushing her down the stairs. Both Lisa and Brian talked to co-workers about the abuse. Lisa told some of her co-workers about Brian's violence, but they did not believe her because they had seen Brian at the bar and he did not fit their image of a batterer. Brian told his employer that he assaulted Lisa, and the employer advised him to stay away from her. No one reported the abuse to the police.

<sup>33</sup> Donald G. Dutton, "Theoretical and Empirical Perspectives on the Etiology and Prevention of Wife Assault," in *Aggression and Violence Throughout the Life Span*, ed. R. DeV. Peters, R. J. McMahon & V.L. Quinsey (Newbury Park, CA: Sage, 1992), p. 192-221.

Lisa moved into an apartment across the street from Brian. One month she paid rent with a bad check and her landlord began eviction proceedings. Lisa did not appear to understand the legal papers; she showed the court paperwork to a friend and asked what it meant. She did not respond to the eviction summons, and the court entered a default judgment, resulting in her eviction. Lisa temporarily moved in with an ex-boyfriend, a man who was her main supplier of drugs and very abusive to her. She left his home, becoming homeless, and slept in a park. During this time, Lisa actively used drugs and she lost her job.

A friend talked to Lisa's family about permitting her to stay with them, but the family did not feel they could allow this given Lisa's drug use. For a while, Lisa stayed with another friend, who tried to make emergency shelter arrangements for her. Lisa stated she would not go to a shelter and left her friend's home. Even if she had been willing to go to an emergency shelter, she would not have been allowed to stay at the local domestic violence shelter while she was actively using drugs, and the program did not have services for women detoxing or specifically dealing with both addiction and abuse.

At this point, Lisa's financial struggles, her drug use and Brian's abuse all posed serious risks to her safety. She had very limited options. Her drug addiction had progressed to a point that most agencies would not have provided services to her. In addition, most services tend to address either domestic violence or substance abuse, but fail to take into account how an abusive relationship can interfere with one's recovery or how substance use can interfere with one's ability to safety plan. As a result of her drug use and financial struggles, Lisa also became very isolated from friends and family who might have supported her.

A few days after Lisa left her friend's house, Brian strangled her to death at his apartment. The next day, he borrowed a gun from a friend and shot and killed himself.

As you read this report, please keep these women's stories and the complexity of their lives in mind. Each gap and failure in the community response to domestic violence tends to have a cascading effect on victims dealing with multiple barriers as they attempt to keep themselves and their children safe. We thank you for joining us in remembering the lives lost to domestic violence, and hope that you will share this report with others in your community and work together to implement some of the issued recommendations.

# Implementation of Fatality Review Recommendations

## Why discuss implementation?

The Washington State Coalition Against Domestic Violence (WSCADV) issued a series of findings and recommendations in its 2000 Domestic Violence Fatality Review (DVFR) report, *Honoring Their Lives, Learning from Their Deaths*, and 2002 DVFR report, *Tell the World What Happened to Me*.<sup>34</sup> These reports contain approximately 300 recommendations for improving the response to domestic violence. In addition to discussing new findings and recommendations in this year's report, we wanted to explore how communities have (or have not) implemented the previous recommendations.

Also, the enabling legislation (passed in the year 2000) guiding the work of the DVFR mandates: "The annual report in December 2010 shall contain a recommendation as to whether or not the domestic violence review process provided for in this chapter should continue or be terminated by the legislature."<sup>34</sup> We would like this recommendation to be informed by feedback from communities about the DVFR, the process of conducting reviews and the usefulness of reports. Since we are approaching the mid-point in the timeline set forth by this legislation, we asked communities about implementation of the recommendations, both to learn if they were useful at a local level and to explore barriers to implementing change.

<sup>34</sup> RCW 43.235.800.

In an effort to learn about implementation, we conducted several research projects:

- 1) WSCADV collaborated with the University of Washington to conduct a survey of all current and former DVFR panel participants.<sup>35</sup> Panel members were asked to evaluate how recommendations from the first two reports have been addressed in their communities. In addition to this survey, key informant interviews were conducted with local domestic violence community leaders in the counties where Fatality Review panels exist(ed) to further explore barriers and supports regarding the implementation of DVFR recommendations.
- 2) WSCADV conducted a telephone survey of all Superior, District and Tribal Courts in Washington that issue civil Protection Orders to learn about the implementation of one specific DVFR recommendation regarding courts.
- 3) WSCADV collaborated with the Washington Association of Sheriffs and Police Chiefs (WASPC) to distribute a survey to all law enforcement agencies in the state to learn about the implementation of DVFR recommendations regarding law enforcement.
- 4) WSCADV distributed a survey to all domestic violence programs in the state to learn about the implementation of DVFR recommendations related to their work.

<sup>35</sup> The Institutional Review Board (IRB) at the University of Washington authorized all research procedures for this component of the research project (approval number 03-9734-G).

## Research findings

The vast majority of respondents to these research projects identified the DVFR recommendations as priorities in their county, and saw the DVFR reports and recommendations as a valuable source of information. Approximately half of the respondents from all of the projects reported that some steps had been taken in their community toward the implementation of recommendations; however, responses varied regarding the degree of implementation achieved. It appeared that some

communities took many steps toward implementing DVFR recommendations, while others took few, if any. Overall, a wide discrepancy was apparent between what respondents identified as important and actual change being implemented.

### **Survey of Fatality Review panel participants**

This study explored the capacity of the DVFR to impact the community response to domestic violence by surveying individuals who have participated on a Fatality Review panel. In addition to the survey, nine key informant interviews were conducted with community leaders in the domestic violence field from counties that held fatality reviews. The survey asked participants about:

- the prioritization of nine DVFR recommendations;
- the implementation of the same nine recommendations;
- barriers to implementing the recommendations; and
- factors that supported or facilitated the implementation of the recommendations.

The nine recommendations issued in previous reports that this survey discussed were:<sup>36</sup>

- 1. Domestic violence programs and Limited English Proficient individuals:** All domestic violence programs should work to make their programs and services relevant and accessible for battered women with limited English proficiency.
- 2. Law enforcement and Limited English Proficient individuals:** Law enforcement agencies should work with their community to come up with a plan for providing equal protection and access to Limited English Proficient (LEP) individuals in their community.
- 3. Gun removal:** Every jurisdiction should establish a protocol for gun removal for convicted domestic violence offenders and domestic violence offenders subject to protective orders.
- 4. Protection Order advocacy:** All courts issuing civil Protection Orders should establish advocacy in their Protection Order offices.
- 5. Outreach to friends and family:** Community-based domestic violence programs should increase their outreach services to friends and families of domestic violence victims in order to increase the capacity of people in the community to support domestic violence victims.
- 6. Suicidal abusers:** Organizations, institutions and individuals that work with domestic violence victims or perpetrators need to collaborate on establishing protocols for identifying and minimizing the danger the combination of suicide and domestic violence poses to intimate partners and others.
- 7. Teen dating violence:** People who work with teens in any capacity should receive training regarding teen dating violence and domestic violence, and teen advocacy resources in the community.
- 8. Court evaluators trained in domestic violence:** Courts should employ well-trained evaluators [other than guardians ad litem (GALs) or court-appointed special advocates (CASA)] who can provide assistance to judges in civil proceedings by conducting thorough assessments for domestic violence and providing recommendations regarding custody and visitation which protect the safety of domestic violence victims and their children.
- 9. Probation and post-sentence supervision:** Additional funding available for improving the domestic violence response in the criminal legal system should be directed to probation and post-sentence supervision for misdemeanor domestic violence cases.

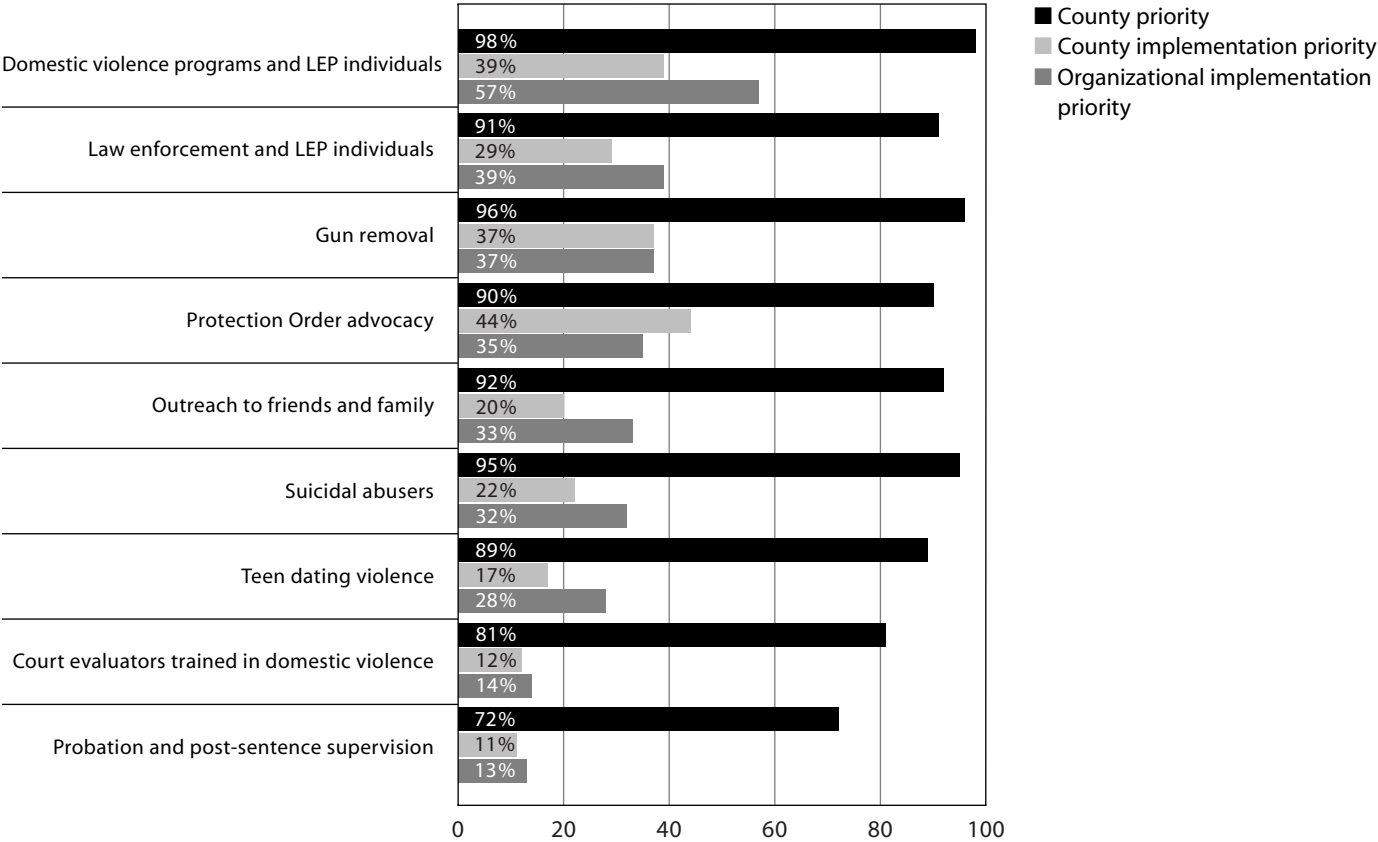
<sup>36</sup> Based on findings from this research project and cases reviewed in the past two years, we have clarified the language of some of these recommendations for this year's report. The modified recommendations can be found on pages 49–50.

The survey, distributed to current and former Fatality Review panel participants in 2003, had a 60% (n=133) response rate, with respondents from every county that had a Fatality Review panel. Respondents came from a range of professional affiliations, including: domestic violence advocates, public health workers, law enforcement officers, prosecutors, judges, medical providers, batterer’s intervention providers, probation officers, mental health providers, chemical dependency providers, child protective services workers, university academics and school administrators.

The majority of respondents (72%–98%)<sup>37</sup> reported that each of the nine recommendations either are or should be county-wide priorities. In other words, they felt the issues and needs addressed were relevant and urgent in their county. In contrast, a much lower number of respondents reported that their county had prioritized implementing the same recommendations (11%–44%) or that their individual organization/ institution had prioritized implementing the recommendations (13%–57%). This data suggests a gap between what individuals feel is important and what is actually being prioritized for implementation.

<sup>37</sup> Percentages in this section are presented as a range in order to reflect the different responses participants gave as they evaluated each of the nine recommendations.

COUNTY PRIORITY VS. IMPLEMENTATION PRIORITY

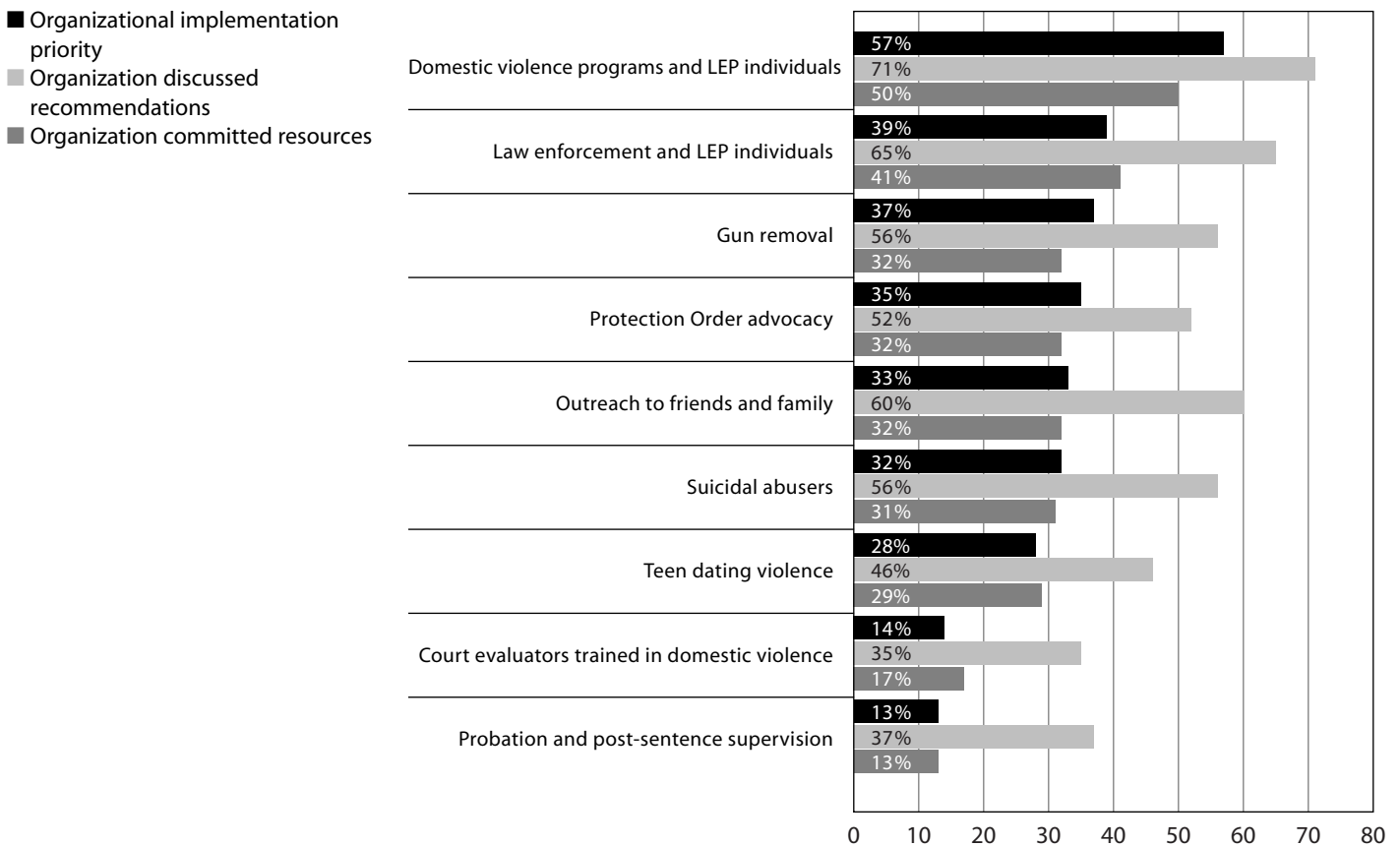


Respondents were also asked to report whether any steps had been taken toward the actual implementation of each of the nine recommendations. Thirty-five to seventy-one percent of respondents reported that their organization/institution had either discussed the various recommendations internally or with other organizations/institutions, and 13%–50% reported that their organization/institution committed resources to support the implementation of the recommendations. The majority of respondents



(77%) reported that their organization/institution participates in some kind of collaboration with others in their county to address domestic violence, and 67% of respondents stated that they have collaborated with others to discuss the implementation of the DVFR recommendations. This data suggests that while implementation of the DVFR recommendations has not been widely achieved, many communities are utilizing the reports and taking steps toward implementing the recommendations in their efforts to improve the community response to domestic violence.

ORGANIZATIONAL IMPLEMENTATION PRIORITY VS. IMPLEMENTATION EFFORT



Also of note, responses from participants working in rural parts of the state differed on some points when compared to those working in urban areas. Counties were classified as either Rural or Urban, based on the Rural-Urban Continuum Codes created by the Economic Research Service of the United States Department of Agriculture.<sup>38</sup> Respondents from Rural versus Urban counties differed in how they prioritized some of the recommendations, but prioritized others in the same way. This suggests that there is not a statewide consensus on the change agenda for domestic violence-related reforms. Rather, local communities need to review all of the DVFR recommendations and prioritize which are most important in their county.

The key informant interviews with local domestic violence community leaders provided specific examples of how communities utilized the DVFR findings and recommendations. One individual stated, "The report can compel people to change because it's looking at cases where somebody died...I think a lot of the value is just in the educational aspect of it. I am constantly quoting it when the media calls, public officials call, funders want fatality statistics...It just helps to really give some direction and

<sup>38</sup> The Rural-Urban Continuum Code classification system is based on the population of a county and its proximity to an urban area.

credibility to the kinds of things that we end up advocating for.” Another participant noted the DVFR has “the possibility of bringing about change...and [is] necessary to help define what changes need to happen.”

One interview highlighted how an inter-disciplinary group of county government employees (including law enforcement, prosecutors and court programs) utilized the Fatality Review reports. They reviewed the recommendations and each discipline reported to the rest of the committee how they were addressing the issues related to their work. Each discipline answered three questions for all of the recommendations pertaining to them:

1. Are we following this recommendation?
2. If not, why aren't we?
3. And how can we move toward implementing this recommendation?

The committee utilized this process as “an internal audit of sorts” and found it to be an effective strategy.

**Survey of courts**

WSCADV conducted a phone survey of all of the Superior, District and Tribal Courts in Washington state that issue civil Protection Orders. We spoke with the individuals whom Protection Order petitioners contact when they access the court (these were most often court clerks, occasionally a domestic violence advocate and, at one court, a bailiff). The phone survey had a 92% (n=90) response rate and included respondents from all 39 counties. The survey asked about one recommendation issued in both the 2000 and 2002 reports:<sup>39</sup>

**Protection Order advocacy:** *All courts issuing civil Protection Orders should establish advocacy in their Protection Order offices and ensure that advocates have extensive training on how to assist women in safety planning.*

This survey illustrated the range of services available to Protection Order petitioners. While very few courts have implemented the ideal set forth in the DVFR recommendation by having a domestic violence advocate available on-site, some courts have taken significant steps toward increasing petitioner safety by routinely providing information and referrals. The majority of courts, however, do not provide any information to petitioners, missing a critical opportunity to address victim safety.

Of the responding courts, 7% (n=6) stated that Protection Order petitioners routinely speak with a domestic violence advocate; at 12% (n=11) of courts, petitioners sometimes speak with a domestic violence advocate; and at 81% (n=73) of courts, petitioners do not speak with a domestic violence advocate. All of the respondents except one reported that, when no advocate is present, petitioners interact with a clerk when they come to court seeking a Protection Order. The one exception reported that petitioners interact with a bailiff.

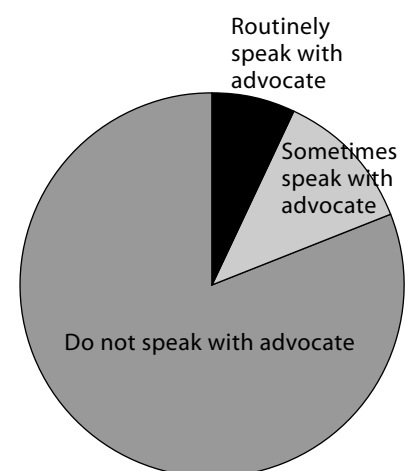
**DOMESTIC VIOLENCE ADVOCACY AT COURTS ISSUING PROTECTION ORDERS**

Total courts: 90

- Protection Order petitioners routinely speak with a domestic violence advocate: 7%
- Protection Order petitioners sometimes speak with a domestic violence advocate: 12%
- Protection Order petitioners do not speak with a domestic violence advocate: 81%

*“[the DVFR has] the possibility of bringing about change...and [is] necessary to help define what changes need to happen.”*

<sup>39</sup> Based on findings from this research project and cases reviewed in the past two years, we have clarified the language of this recommendation for this year's report. The modified recommendation can be found on page 50.



**Responses from advocates at courts on safety planning and referrals:** Of the 17 courts surveyed where Protection Order petitioners always or sometimes speak with a domestic violence advocate, we interviewed advocates at 59% (n=10) of those courts. Eighty percent (n=8) of the advocates reported that they routinely safety plan with petitioners. Ten percent (n=1) reported sometimes safety planning, stating that safety planning occurs “when we feel it’s appropriate.” Ten percent (n=1) of the respondents reported that they do not address safety planning. The advocate at this court stated that she refers petitioners to the local domestic violence program if safety planning “is needed.” One hundred percent (n=10) of the advocates provide petitioners with referrals to community resources. Fatality Review panels have identified the Protection Order process as a critical point of intervention for domestic violence victims. Court-based domestic violence advocates on Fatality Review panels reported that many of the petitioners they work with do not access community-based domestic violence programs, highlighting the critical need for domestic violence advocates to be available on-site at courts to routinely safety plan with all petitioners. Additionally, the level of danger a woman is in may become apparent only through safety planning, highlighting the need to provide this service to all Protection Order petitioners.

**Responses from court clerks on safety planning information:** Of the 84 courts surveyed where Protection Order petitioners sometimes or never speak with an advocate, we interviewed clerks<sup>40</sup> at 100% of these courts. They were asked if petitioners receive any written information or verbal instructions around safety planning. Their responses were grouped into three categories: “routinely,” “sometimes” or “do not” provide safety planning information to petitioners, either written or verbal. Six percent (n=5) of the clerks reported that they routinely provide petitioners with written information about safety planning, and 13% (n=11) routinely provide verbal safety planning information. Twelve percent (n=10) reported sometimes providing written safety planning information, and 1% (n=1) sometimes provide verbal safety planning information. Eighty percent (n=67) of the clerks reported that they do not provide written safety planning information, and 86% (n=72) do not provide verbal safety planning information. Two percent (n=2) of respondents reported not knowing whether the written materials they have available include safety planning information.

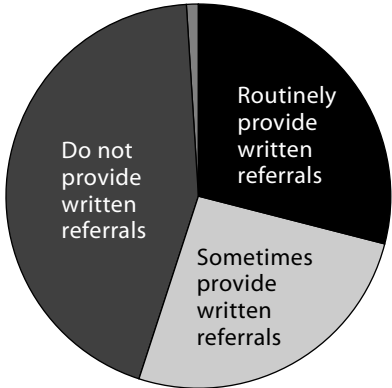
**Responses from court clerks on written and verbal referrals to community resources:** The court clerks were also asked if Protection Order petitioners receive any referrals. Of the 84 surveyed, 29% (n=24) of the clerks reported that they routinely provide petitioners with written referrals to community resources, such as the local domestic violence program, and 58% (n=49) routinely provide verbal referrals. Twenty-six percent (n=22) reported sometimes providing written referral information, and 30% (n=25) sometimes provide verbal referrals. Forty-four percent (n=37) of clerks reported that they do not provide written referrals to community resources, and 12% (n=10) do not provide verbal referrals. One percent (n=1) reported not knowing whether the written materials they have available include referrals to community resources.

<sup>40</sup> “Clerks” in this section will include the 83 clerks and 1 bailiff interviewed.

WRITTEN REFERRALS PROVIDED TO PROTECTION ORDER PETITIONERS

Total courts: 84

- Clerks routinely provide petitioners with written referrals to community resources: 29%
- Clerks sometimes provide petitioners with written referrals to community resources: 26%
- Clerks do not provide petitioners with written referrals to community resources: 44%
- Clerks do not know if their written materials include referrals to community resources: 1%



The survey revealed that clerks often rely on problematic criteria to decide when or if to give Protection Order petitioners information about safety planning, support and services in their communities. Many of the clerks who reported sometimes providing information on safety planning and/or referrals to community resources explained how they determine when to give petitioners such information. The most common criteria clerks reported using were whether the petitioner is distraught or upset, whether the clerk thinks it is necessary, or if the person asks. Others stated that safety planning and referral information is available in the office, and they will point it out to the petitioner if they (the clerks) want to or, as one clerk stated, “if the person looks like they need help... You can tell if they need help.” In fact, 25% (n=21) of the court clerks described using their own judgment to determine whether a petitioner needs information about safety planning or referrals to community resources such as the local domestic violence program.

While the clerks may be well intentioned, relying solely on this sort of criteria may deny information to people who need it, since a victim’s demeanor is not a reliable indication of the level of danger she may face or the kind of resources she may need. Victims who present themselves at court in a calm manner may be in extreme danger. In addition, victims may not ask for safety planning information or referrals from court clerks not because they do not need services, but because they are unaware of what resources are available to them. When courts fail to instruct clerks to routinely provide this information to all petitioners, and clerks rely on outward appearances or their own judgments to assess a petitioner’s need for information, some victims in critical need of resources to protect themselves and their children do not get that information. It is preferable to offer resources to people who may not need them than to fail to provide information to those in need.

Some local domestic violence programs have collaborated with courts issuing Protection Orders in an apparent effort to provide petitioners with safety planning and referral information. However, when courts and programs do not consistently maintain these efforts over time, or when court staff do not routinely offer the information, many petitioners miss the opportunity to receive critical safety planning messages. One clerk reported that the local domestic violence program has provided the clerks with bags for petitioners that contain safety planning information and a cell phone. The clerk stated that they distribute these bags “only if the petitioner asks for it or is upset” and went on to say, “I haven’t had to give one out yet.” And yet, the fact that women are requesting Protection Orders is itself evidence that they are in danger and need resources. Clerks at three courts reported that they used to have brochures from the local domestic violence program and routinely distributed them to petitioners, but ran out of the brochures and now no longer provide the information.

Two different courts reported that they used to have a domestic violence advocate on-site to work with petitioners, but due to a loss of funding no longer have advocates available. In these counties, funding cuts have impacted the courts' ability to address the safety needs of petitioners by no longer connecting them with a trained domestic violence advocate.

Several clerks explained that their job requires them to be impartial and not to give legal advice to petitioners, but varied widely in their interpretation of these requirements. Some clerks routinely provide petitioners with assistance filling out their paperwork, explain what to expect from the court process, and provide them with written information and referrals to community resources. Other clerks stated clearly that providing petitioners with information about safety planning, referrals or court procedures was not their job or that they could not provide information because, as one clerk put it, "We're not supposed to refer to anyone [or] give verbal instructions." When courts do not clearly instruct clerks on the difference between routinely providing general information and offering legal advice,<sup>41</sup> they fail domestic violence victims who access the court in an effort to improve their safety and the safety of their children.

<sup>41</sup> As stated in Washington State Court General Rule 24(b), Definition of the practice of law, Exceptions and exclusions, the following are permitted: "providing assistance to another to complete a form provided by a court for protection under RCW chapters 10.14 (harassment) or 26.50 (domestic violence prevention) when no fee is charged to do so" and "serving in a neutral capacity as a clerk or court employee providing information to the public pursuant to Supreme Court Order."

Some courts gave examples of steps they had taken to routinely provide safety planning information and referrals to community domestic violence programs. One court reported that in addition to having information available in their lobby, they posted domestic violence flyers in the women's restroom so the information can be accessed discreetly. Another court reported that all Protection Order petitioners are routinely referred to the local domestic violence program's drop-in center. A third court reported that "judges have required clerks to refer all petitioners to [the local domestic violence agency]." Courts that do not have domestic violence advocates on-site should utilize these examples of strategies that support victim safety without additional funding.

### Survey of law enforcement agencies

WSCADV distributed an online survey through the Washington Association of Sheriffs and Police Chiefs (WASPC) to all sheriffs and police chiefs in Washington. This survey had a 9% (n=26) response rate, with respondents from 15 counties representing both urban and rural counties and a range of geographical areas in western, central and eastern Washington. The response rate was low; however, because respondents represented such a wide range of counties, the results provide some valuable information and an opportunity for learning about what is occurring around the state.<sup>42</sup> Forty-two percent (n=11) of respondents reported having seen the recommendations issued in the Fatality Review reports prior to receiving the survey. Eighty-one percent (n=21) of respondents stated that they saw the reports as a valuable source of information. When asked, "Has your agency taken any steps, large or small, toward implementing any of the recommendations from the DVFR reports," 46% (n=12) of respondents answered yes. The survey asked about steps taken to implement two specific recommendations issued in previous reports.<sup>43</sup>

<sup>42</sup> Agencies can contact WSCADV at 206-389-2515 for assistance connecting with a law enforcement agency that has taken steps discussed in this section to implement DVFR recommendations.

<sup>43</sup> Based on findings from this research project and cases reviewed in the past two years, we have clarified the language of some of these recommendations for this year's report. The modified recommendations can be found on pages 49-50.

#### **1. Access to justice for Limited English Proficient domestic violence victims:**

*Law enforcement agencies should conduct investigations of domestic violence crimes with qualified interpreters.*

Sixty-two percent (n=16) of respondents stated that all patrol officers at their agency received training regarding the use of qualified interpreters at the initial crime

scene to investigate domestic violence calls, but only 8% (n=2) stated that their agency had a policy regarding the initial response to domestic violence crimes when the victim has limited English proficiency. Fatality reviews have identified a lack of quality interpretation at domestic violence crime scenes as a significant gap in the community response to domestic violence. This data suggests that an acute need still exists for many law enforcement agencies to address this issue.

One of the law enforcement agencies that reported having a policy regarding the initial response to domestic violence crimes when the victim has limited English proficiency described the development of this policy as a collaboration between “law enforcement agencies, deputy prosecutor, [and] the communications center (911), with input from the county-wide domestic violence and sexual assault task force.” This process of prioritizing the issue, collaborating with a range of community partners including domestic violence advocates, and developing a policy to address the need for qualified interpreters at the initial crime scene, when combined with a process that involves representatives from Limited English Proficient communities, is a model for how law enforcement agencies can address this complex and pressing issue.

**2. Monitoring incident reports:** *Police and sheriff's departments should have mechanisms in place to monitor the quality of domestic violence incident reports.*

Ninety-six percent (n=25) of respondents reported that all patrol officers have received training regarding what questions to ask and what information to document when taking a domestic violence report. Eighty-five percent (n=22) stated that their agency has created a mechanism or policy for monitoring the quality of domestic violence incident reports. Of those with a policy, 77% (n=17) stated that the policy includes a process for addressing non-compliance with the standards set forth by the agency and 36% (n=8) stated that the policy includes a process for rewarding good performance in complying with the standards. This data suggests that many law enforcement agencies have taken steps to improve the quality of domestic violence incident reports, and agencies that have not taken action around this recommendation can examine these viable models.

Many of the policies described included some type of an internal review process in which all domestic violence incident reports are reviewed to ensure quality and compliance with departmental policy. The individuals responsible for reviewing reports varied across agencies, and included: detective captain; a dedicated domestic violence investigation team consisting of a detective sergeant, detective and deputy; detective lieutenant; Family Violence Unit officer; and a domestic violence advocate. A few agencies include regular meetings with the prosecutor as a means of monitoring the quality of domestic violence reports and identifying areas for improvement. One agency described the following multi-faceted model:

“The Department Training Bulletin outlines investigative guidelines/policy requirements and expectations. Use of DV [Domestic Violence] Supplemental Form is mandatory. Patrol supervisors review reports for accuracy/completeness. Many reports are then routed to the Domestic Violence Intervention Unit. Reports are again reviewed for thoroughness, assessed for need to conduct follow-up or return[ed] to patrol deputy for clarification/corrections. Feedback is provided to patrol deputy on corrections needed [and] additional documentation that would improve the case investigation. On-going process of system improvement.”

*“[Police] reports are... reviewed for thoroughness, assessed for need to conduct follow-up or return[ed] to patrol deputy for clarification/corrections.”*

Responding law enforcement agencies also described multiple steps they had taken to implement other DVFR recommendations, including: translating forms into multiple languages; creating stalking booklets to document incidents of stalking; and revising forms to prompt the collection of detailed information on domestic violence history, alcohol or other drug use, mental health issues, children present, firearms and obtaining photographs for documentation. One agency reported, "We have provided specific training around suicide threats this year." Another agency described "an ongoing effort to attempt to address the 'holes' in the system, specifically taking steps to ensure timely offender accountability." One example of this effort includes assigning a domestic violence detective for next-day follow-up to domestic violence incidents when probable cause existed to arrest, but the responding officers could not locate the abuser. A third agency reported that a "DV [Domestic Violence] Firearm Forfeiture Protocol [was] implemented in 2003 to gather information on the possession of firearms by perpetrators and to facilitate the 'safekeeping and/or forfeiture' via on-scene investigations and court orders for surrender. [This protocol] includes a centralized point of contact for perpetrators to surrender their firearms to our evidence room."<sup>44</sup>

<sup>44</sup> The King County Firearms Forfeiture Program has created a model protocol for the removal and storage of firearms in domestic violence criminal investigations and domestic violence Protection Order cases. The King County Firearms Forfeiture Program provides statewide consultation; contact Mark Hanna at mark.hanna@metrokc.gov or WSCADV at 206-389-2515 for additional information.

<sup>45</sup> Agencies can contact WSCADV at 206-389-2515 for assistance connecting with a domestic violence program that has taken steps discussed in this section to implement DVFR recommendations.

<sup>46</sup> Based on findings from this research project and cases reviewed in the past two years, we have clarified the language of some of these recommendations for this year's report. The modified recommendations can be found on page 49.

### Survey of domestic violence programs

WSCADV distributed an online survey to all of the executive directors of community-based domestic violence programs in the state of Washington. This survey had a 27% (n=16) response rate, with respondents from fifteen counties representing both urban and rural counties and a range of geographical areas in western, central and eastern Washington. The response rate for this survey was fairly low; however, because respondents represented such a wide range of counties, the results provide some valuable information and an opportunity for learning about what is occurring around the state.<sup>45</sup> Seventy-five percent (n=12) of respondents reported having seen the recommendations issued in the DVFR reports prior to receiving the survey. Eighty-eight percent (n=14) of respondents stated that they saw the reports as a valuable source of information. When asked, "Has your agency taken any steps, large or small, toward implementing any of the recommendations from the Fatality Review reports," 63% (n=10) of respondents answered yes.

The survey asked about steps taken to implement five specific recommendations issued in previous reports.<sup>46</sup>

**1. Suicidal abusers:** *Advocates should always ask a victim about the abuser's suicidal behaviors. If there is a history of suicidal ideation, they should inform and educate women about the risk of homicide and intensify safety planning.*

Sixty-nine percent (n=11) of respondents reported that all advocates and crisis line volunteers received training regarding the increased risk of homicide when an abuser is suicidal; 44% (n=7) of the responding agencies' safety planning tools include a question about the abuser's history of suicidal threats or behaviors; and 6% (n=1) of their crisis line forms include a prompt to ask all callers about the abuser's history of suicidal threats or behaviors. Thirty-two percent of homicide cases since 1997 involved a suicidal abuser, indicating a clear need for domestic violence victims to receive information about the increased risk of homicide when an abuser is suicidal. While the majority of responding domestic violence programs train staff on this issue, most have not updated their forms to remind advocates to routinely address the abuser's suicidal threats or behaviors with victims. Many programs could take additional steps to ensure

that all domestic violence victims accessing services receive information about the increased risk and need for additional safety planning when an abuser is suicidal.

Some responding agencies reported taking steps to increase awareness of the risk of suicidal abusers, including sponsoring a community workshop on the issue and including this information in “all of our community presentations, task force meetings, and inter-disciplinary collaborations.” One agency reported, “Since the report we... are much more cognizant of the lethality risk when threats of suicide are a form of power and control. We encourage the client not to take this lightly and safety plan appropriately.”

**2. Outreach to friends and family:** *Domestic violence programs should increase their outreach and services to friends and family of domestic violence victims in order to increase the capacity of people in the community to support victims.*

Eighty-eight percent (n=14) of responding agencies reported that they provide services to friends and family of domestic violence victims. These services include support, information and safety planning either over the phone via crisis lines or in person. Eighty-one percent (n=13) of agencies routinely ask victims about their support system; 50% (n=8) of their advocates offer to assist victims with talking to their support system; and 13% (n=2) of responding agencies have implemented a model or protocol for working with friends and family of domestic violence victims.<sup>47</sup>

Additionally, several responding agencies reported having written materials available. One agency reported, “We have created hand-outs on how to help a friend or family member that are distributed to the community.” Another described developing and distributing a “Friends and Neighbors Packet” to community members. This data suggests that significant steps have been taken by many programs to work with friends and family of domestic violence victims, and that many models exist which could assist agencies that have not taken action around this recommendation to implement similar changes.

**3. Resolving warrants:** *Domestic violence programs should offer victims help in resolving outstanding warrants, and should become familiar with the process for doing so.*

Nineteen percent (n=3) of responding agencies reported that all advocates have received training on how to resolve outstanding warrants and routinely ask victims if they need assistance resolving outstanding warrants. Fatality Review panels continue to highlight outstanding warrants as a significant barrier to victims accessing the criminal legal system for their own protection. This data suggests a continued and acute need for domestic violence programs to assist victims in resolving outstanding warrants as part of their work around safety planning.

One agency reported, “When we safety plan with each victim, we discuss law enforcement and ask if there is any reason that the victim would be hesitant in calling them.” Routinely asking such a question and informing all program participants how they can resolve outstanding warrants is a model practice that all domestic violence programs should implement.

**4. Chemical dependency and domestic violence:** *Domestic violence programs should develop policies and procedures that maintain safety for all program participants while providing services to substance-abusing domestic violence victims.*

Fifty-six percent (n=9) of responding agencies routinely screen for substance abuse and 63% (n=10) provide services to those who identify substance abuse as an issue. Nineteen percent (n=3) of agencies have partnered with a chemical dependency

*“Since the report we...are much more cognizant of the lethality risk when threats of suicide are a form of power and control. We encourage the client not to take this lightly and safety plan appropriately.”*

*“We have created hand-outs on how to help a friend or family member that are distributed to the community.”*

<sup>47</sup> WSCADV has developed and distributed a *Model Protocol on Working with Friends and Family of Domestic Violence Victims* (April 2004), which is available at [www.wscadv.org](http://www.wscadv.org). The protocol was authored by Connie Burk, director of the Northwest Network of Bisexual, Trans, Lesbian and Gay Survivors of Abuse.



program to provide cross-training to one another; 50% (n=8) have partnered with a chemical dependency program to provide services to one another's clients; and 19% (n=3) of agencies' safety planning tools address substance abuse. Fatality Review panels have repeatedly noted that chemically dependent battered women face significant barriers to accessing services that address issues of safety and sobriety. Experts from previous DVFR advisory committees have emphasized that when domestic violence agencies and chemical dependency providers fail to address both the impact of substance abuse on victims' self-determination and safety and the impact of domestic violence on sobriety, both recovery and domestic violence interventions are less effective. Many programs responding to this survey appear to have taken some steps to address this issue; however, very few safety plans (a critical point of intervention) address substance abuse, indicating a continued critical need for domestic violence agencies to improve efforts to serve substance-abusing victims.<sup>48</sup>

<sup>48</sup> The Alcohol/Drug Help Line Domestic Violence Outreach Project (contact at [dvop@adhl.org](mailto:dvop@adhl.org)) has developed tools for working with substance-abusing domestic violence victims and is available for statewide consultation on a non-emergency basis.

<sup>49</sup> WSCADV has developed and distributed a *Model Protocol for Working with Battered Women Impacted by Substance Abuse* (February 2003), which is available at [www.wscadv.org](http://www.wscadv.org). This protocol was authored primarily by Patricia Bland, Train the Trainer Project Co-Director, Alaska Network on Domestic Violence and Sexual Assault.

<sup>50</sup> WSCADV has developed and distributed a *Model Protocol on Services for Limited English Proficient Immigrant and Refugee Victims of Domestic Violence* (November 2002), which is available at [www.wscadv.org](http://www.wscadv.org).

Some agencies have taken additional steps toward implementing this recommendation. One agency reported, "We have based staff trainings on the *Model Protocol for Working with Battered Women Impacted by Substance Abuse* to increase staff knowledge of the escalated danger when DV [domestic violence] and CD [chemical dependency] co-exist. The internal training has also focused on local resources available to clients who may be experiencing CD/DV victimization."<sup>49</sup>

**5. Limited English Proficient victims:** *Domestic violence programs should work to make their services relevant and accessible for battered women with limited English proficiency.*

One hundred percent (n=16) of respondents stated that all advocates and crisis line volunteers received training on how to access a qualified interpreter or a telephonic interpretation service. Twenty-five percent (n=4) of the agencies reported that their safety planning tool addresses language access and a plan for maintaining contact with their agency; 44% (n=7) have partnered with a grassroots organization in a Limited English Proficient (LEP) community to provide domestic violence outreach and services. Additionally, 75% (n=12) of responding agencies have at least one bilingual advocate on staff.

Some agencies have taken significant steps to implement this recommendation. One respondent reported participation in a "Co-Advocacy Project to help make programs more accessible and less isolating for Non-English speakers and to clarify roles between Shelters [mainstream programs] and Specialized Providers [programs that work with a specific population or community]." Another stated, "We are implementing policies and procedures recommended in the [WSCADV model] protocol."<sup>50</sup> We are also offering our volunteer training in Spanish—the primary second language spoken in our community—and actively working to recruit Russian-speaking advocates and others representing marginalized communities in our county." However, the survey data indicates that the majority of responding domestic violence programs have not participated in such collaborations, and findings from fatality reviews indicate this recommendation is still relevant and critical.

Responding domestic violence programs also described a range of steps they had taken to implement DVFR recommendations in general. One agency reported, "Each staff receives a copy of the reports, reads them and then we discuss them at our staff meetings and then do what we can to implement the recommendations." Another agency stated, "We have spread the report far and wide in our communities through

every network we can think of. We have included pertinent information from the reports in every presentation we have made since the reports came out. We have recommended the incorporation of the recommendations in every group we meet with. We have added the recommendations to training of new advocates and incorporated most recommendations into every activity of our program.” A third respondent described incorporating DVFR findings and recommendations into their program’s advocate training: “Although informal, we have used the information provided by the DVFR in training, articles and as a resource.”

Overall, our findings indicated that the recommendations we focused on in our four research projects remain relevant and need to be addressed in many communities. Therefore, we are highlighting these recommendations again in this report.<sup>51</sup>

<sup>51</sup> Based on findings from these research projects and cases reviewed in the past two years, we have clarified the language of some of these recommendations for this year’s report.

#### RECOMMENDATIONS:

- Domestic violence programs should prioritize resources and work to make their services relevant and accessible for domestic violence victims with limited English proficiency.
- Domestic violence programs that do not provide outreach and services to friends and family of domestic violence victims should consult with programs that do provide such services for assistance implementing similar practices.
- Domestic violence programs should become familiar with the court process for resolving outstanding warrants and offer victims assistance with this process.
- Domestic violence programs should develop policies and procedures that maintain safety for all program participants while providing services to substance-abusing domestic violence victims.
- Domestic violence advocates should always ask victims about abusers’ suicidal threats or behaviors. If victims reveal a history of suicidal ideation, advocates should inform and educate them about the risk of homicide and intensify safety planning.
- Organizations, institutions and individuals that work with domestic violence victims or abusers need to collaborate on establishing protocols for identifying and minimizing the danger that suicidal domestic violence abusers pose to intimate partners and others.
- People who work with teens in any capacity should receive training regarding teen dating violence and domestic violence, and teen advocacy resources in the community.
- Law enforcement agencies should work with their community to develop and implement a plan for providing equal protection and access to Limited English Proficient individuals in their community.
- Law enforcement agencies should conduct investigations of domestic violence crimes with qualified interpreters.
- The Washington Association of Sheriffs and Police Chiefs (WASPC) should develop an accreditation standard requiring law enforcement agencies to develop and implement a policy regarding the initial response to domestic violence-related crimes when the victim or perpetrator has limited English proficiency.

*“We have spread the report far and wide in our communities through every network we can think of... We have added the recommendations to training of new advocates and incorporated most recommendations into every activity of our program.”*

<sup>52</sup> WSCADV has published model guidelines for all jurisdictions to follow in post-arrest supervision of domestic violence offenders. Washington State Coalition Against Domestic Violence, *Post-Arrest Model Response for the Supervision of Domestic Violence Offenders*, by Roy Carson (Olympia, WA: WSCADV, 1999). To request a copy, call WSCADV at 206-389-2515.

- Every law enforcement agency should establish policies and procedures for gun removal and storage for convicted domestic violence offenders and domestic violence offenders subject to protective orders.
- Police and sheriffs' departments without a mechanism or policy in place to monitor the accuracy and completeness of domestic violence incident reports should consult with departments that have an existing mechanism or policy for assistance developing and implementing similar standards.
- Additional funding available for improving the domestic violence response in the criminal legal system should be directed to probation and post-sentence supervision for misdemeanor domestic violence cases.<sup>52</sup>
- All courts issuing civil Protection Orders should have domestic violence advocacy services available on-site and ensure that advocates have extensive training on how to assist women with safety planning. If resources are limited, courts should minimally require, as mandated by RCW 26.50.035, that clerks routinely provide all petitioners with referral information to the local domestic violence program for assistance with safety planning.
- Courts should employ well-trained evaluators, or work with their guardian ad litem (GAL) or court-appointed special advocate (CASA) registries to identify and train individuals to specialize in domestic violence cases. These specialists should provide assistance to judges in civil proceedings by conducting thorough assessments for domestic violence cases and providing recommendations regarding residential time and visitation which protect the safety of domestic violence victims and minimize the effects of domestic violence on their children. These evaluators, CASAs and GALs should receive extensive training, similar to that required of state-certified batterer's intervention providers as outlined in WAC 388-60 and RCW 26.50.150, on the manipulative and coercive tactics abusers use.

*“Our biggest hurdle... is trying to do more with a lot less. We are sometimes left breathless while we endeavor to work on new DV [domestic violence] projects, serve on DV committees, work DV cases, and train our employees on best DV practices.”*

### Barriers to implementation

The surveys distributed to Fatality Review panel members, law enforcement agencies and domestic violence programs all asked respondents what barriers they experienced to implementing the recommendations issued in the DVFR reports. The key informant interviews and a Fatality Review statewide advisory committee discussed this topic as well. One respondent reported, “We have experienced no barriers to our efforts”; however, others identified a range of barriers that fell into four general categories.

**Lack of resources:** The most commonly cited barriers to implementing recommendations were related to limited resources, specifically: funding cuts, inadequate number of staff and not enough time to dedicate to reforms. Several respondents from rural areas noted that their geographic location additionally limited the resources they were able to access. As one respondent stated, “Our biggest hurdle... is trying to do more with a lot less. We are sometimes left breathless while we endeavor to work on new DV [domestic violence] projects, serve on DV committees, work DV cases, and train our employees on best DV practices.”

Several research and advisory committee participants discussed the complex impact of limited resources on a community's ability to implement change. However, the actual lack of resources was only part of the story. People from diverse disciplines also identified that the fear of reduction or elimination of existing resources creates a barrier,

resulting in the immobilization of individuals and whole organizations/institutions. This fear can obstruct attempts to implement any recommendation, even if the change does not require significant resources. One participant stated, “There is a general fear that funding will go away, so there is a tremendous amount of time spent on funding issues, and currently the advocacy agenda is dominated by preserving funding, since there is little local funding in the state going to human services. People’s level of energy, willingness to follow through, belief that the work will continue, etc. is way down due to the current financial status.”

Another barrier identified was the fact that adequate resources do not currently exist to meet victims’ basic needs for shelter, low-income housing, health care, food, livable-wage jobs and child care. As one respondent stated, “When public funding for critical services is as unstable as it is now in Washington, it is very difficult to sustain proactive efforts to end violence.” Survey responses highlighted the critical need for stable and adequate public funding for these core services for domestic violence victims and their children.

**Resistance to change:** Many respondents identified resistance to change on the part of particular individuals, organizations, institutions and in the general political climate as a barrier to implementing DVFR recommendations. Examples were given of individuals in positions of power at an agency or in the community, or those with a key role in the community response to domestic violence (e.g., prosecutors), who either: are “not very interested” in domestic violence; “don’t take domestic violence seriously”; or “for one reason or another don’t buy into the changes, don’t think that they’re important, or are simply not wanting to” implement recommendations because of a general reluctance to change.

Some participants discussed specific aspects of organizations or institutions that created barriers to change. In agencies with multiple branches or jurisdictions, a lack of communication and cooperation was commonly cited as a barrier to implementation. Implementing recommendations in such organizations is “extremely difficult due to divisional controls and power issues.” Others talked of an “institutional resistance to change,” due to “the complex nature of racism and gender oppression” and a “backlash” around domestic violence issues. Respondents described a perception in some organizations, institutions and communities that domestic violence has already been addressed in multiple arenas, and it is time to move on to another issue. This has resulted in resistance to addressing the improvements that can and should be made in the community response to domestic violence.

**Competing demands:** Many research participants discussed the multiple issues their organizations/institutions deal with on a daily basis. This can result in a constant state of competing demands on time and resources, creating a significant barrier to implement reforms in any one area. Even agencies that address domestic violence exclusively reported challenges with competing demands. As one respondent stated, “With all the...pressing crises we all deal with, [the DVFR report] often gets filed away, unfortunately. And I often think, ‘Ah, if only I had the time!’”

**Lack of information and skills about how to create change:** A lack of information, both about the existence of the Fatality Review reports and the knowledge and skills needed to facilitate action steps toward change, was also highlighted as a barrier. Respondents reported that they had not initiated steps toward implementing DVFR recommendations either at their agency or in their community because they had not

*“People’s level of energy, willingness to follow through, belief that the work will continue, etc. is way down due to the current financial status.”*

*“When public funding for critical services is as unstable as it is now in Washington, it is very difficult to sustain proactive efforts to end violence.”*

*“The biggest problem right now is not having a plan and not having the time to work on putting a plan together.”*

*“Getting people in leadership positions to a presentation of the report clearly impacted them.”*

seen the reports prior to receiving the survey or they did not remember the reports as a resource. Others reported knowing of the recommendations, and having individuals in the community who “are willing to change, [but]...we just don’t know what to do exactly...The biggest problem right now is not having a plan and not having the time to work on putting a plan together.”

#### **What facilitates implementation**

Respondents to the Fatality Review panel participant, law enforcement and domestic violence program surveys were all asked to discuss what has helped, or might help, overcome some of the barriers that exist to implementing DVFR recommendations. Key informant interviewees and participants on a Fatality Review advisory committee also discussed what might facilitate implementation. The responses fell into five general categories, although many discussed a combination of these factors as the most powerful formula for successful reforms. As one participant stated, “I think in general it takes...a combination of things to bring about change and sometimes you can...create those conditions and sometimes it’s sort of serendipitous that you have someone who has power who gets interested...as well as...worker bees who will be able to do things, as well as a chunk of money and that kind of thing.”

**Collaboration:** Many respondents reported that the greatest supports they found in their efforts to implement DVFR recommendations came from inter-disciplinary collaborations in their community. Collaborative efforts reportedly led to networking, information sharing and the development of relationships across disciplines. As one research participant reported, “The relationships we’ve developed over time...have enabled us to be able to discuss the recommendations with those groups and to push for changes to be made.” Additionally, the results from the survey distributed to Fatality Review panel participants found there was a correlation between collaboration and organizational prioritization for the majority of recommendations discussed in the survey. Respondents who indicated they had collaborated with others in their community reported that their organization/institution had prioritized implementing recommendations more often than those who did not collaborate with others.

**Supportive leaders:** Respondents reported that individuals in positions of power (e.g., community leaders, agency administrators) had the ability to mobilize the implementation process. Communities or agencies that had this type of “buy-in” and commitment from leaders reported this as a powerful support for reforms. One of the key informant interviews specifically addressed this issue, describing the impact of sharing the findings and recommendations from the 2002 Fatality Review report: “Getting people in leadership positions to a presentation of the report clearly impacted them.” Taking steps to elicit “buy-in” from leaders can influence the local domestic violence agenda and ultimately facilitate implementation.

**Commitment of motivated individuals:** Not all agencies and communities that successfully implemented recommendations had adequate resources or the support of those in leadership positions. Some reported that a strong commitment to the reforms from one or two individuals, regardless of their position in the agency or community, facilitated implementation. One respondent attributed much of their community’s success to the fact that they have “dedicated people who continue to push for change despite the political climate and lack of resources.” When one or two individuals consistently brought the Fatality Review report to the attention of others—at internal staff

meetings, community trainings, and county-wide task force meetings—it increased people’s awareness and commitment to the recommendations.

**Learning from fatalities:** Reviews of fatalities and the DVFR reports were seen by some as an effective tool for impacting the domestic violence agenda for an agency or community. One respondent described a domestic violence homicide that occurred in the community, and the fatality review that eventually followed, as “a catalyst for change,” with the result that “now all of our core people are very invested.”

Several respondents felt that, in addition to the DVFR reports, a consultant was needed to facilitate implementation. They proposed having an individual from outside of the community educate a variety of disciplines about the findings and recommendations of the Fatality Review reports, and then work with the community on concrete steps toward implementation.

**Incentives and accountability:** Several respondents discussed a need for concrete incentives for organizations to implement the recommendations, as well as some formalized plan for accountability if recommendations are not implemented. The specific incentives discussed included financial incentives, such as additional resources for a community to carry out some of the recommendations and serve as pilot projects that other communities could then model. Respondents also discussed public recognition as an incentive, suggesting the Fatality Review recognize particular agencies or communities that have successfully implemented recommendations and, conversely, publicize the organizations or communities that have taken no action. Some respondents argued that incentives like these have the potential to play a role in not only overcoming organizational resistance, but also in fostering accountability to the agency offering the incentives.

### **How to use the Fatality Review reports**

Despite the many barriers to implementing DVFR recommendations discussed in this chapter, many communities have successfully addressed these issues and utilized the information learned from the many lives lost to domestic violence to improve the response for others. Some of these successful strategies are outlined below with the hope that other communities will benefit from the work that has been done.

No community has implemented all of the Fatality Review recommendations and, in fact, this is not the intent of the reports. Reviews of fatalities have been conducted in both rural and urban areas in eastern, central and western Washington. Not all recommendations will apply to the diverse communities across the state; rather, the reports are designed to be a set of tools for agencies and communities to use in identifying what is working well in their communities, and what areas need improvement. Even if your community has been fortunate enough to never have a domestic violence homicide, the reports can be used to improve the local response to domestic violence by learning from the tragedies that have occurred in other parts of the state. Prioritize a few areas to address, and make these the focus of local change efforts.

#### **Use the reports as a “road map” for change:**

1. Read the reports and remember the stories of those who have lost their lives to domestic violence.
2. Share the reports with others. Copies of the 2000 and 2002 Fatality Review reports can be ordered at [www.wscadv.org](http://www.wscadv.org); the full text of the reports is also available on the website to read and print for free. Email the link to co-workers, advocates,

- judges, police officers, mental health professionals, chemical dependency counselors, prosecutors, healthcare workers, religious institutions, schools, friends, family and victims of domestic violence. Print a specific section that you think would be particularly relevant to another individual's work, and share it with them.
3. Make a discussion of the report the focus of a staff meeting at your workplace. As an agency, identify five to ten recommendations particularly relevant to your community and work toward their implementation. View the recommendations as an ideal to strive for and identify steps to move toward that goal. Utilize the recommendations for strategic planning.
  4. For non-profit agencies: Share the report with your board and offer it as a tool for education and strategic planning.
  5. Create discussion groups in your community to talk about the report. These groups can be inter-disciplinary groups of professionals, or a group of community members interested in making their communities safer and healthier (e.g., religious groups, neighborhood watch). As a group, identify a few recommendations to prioritize and plan action steps toward achieving them.
  6. If your community has a domestic violence task force or commission, share the report with the group's facilitator and make it a topic for a future meeting. As a community task force, identify areas where the community is doing well and which areas need improvement. Identify a few key recommendations for your local task force to address. Start a fatality review work group to report back to the task force as a whole on its progress.
  7. Use the Fatality Review findings, recommendations and statistics in community education, with the media and in grant proposals.

Even if your community cannot fully achieve all aspects of a recommendation, steps can be taken toward implementation that will improve the community response to domestic violence. The court survey asking about the implementation of the recommendation addressing the need for all courts issuing civil Protection Orders to have on-site domestic violence advocates available to assist petitioners with safety planning is an example of this point. The majority of courts do not have domestic violence advocates on-site; yet, some courts have taken meaningful steps to connect petitioners with advocacy services (e.g., routinely provide referrals to the local domestic violence program and have written safety planning information available). This highlights how, even with no additional resources, an agency or community can take significant steps toward implementing a DVFR recommendation.

# The Role of the Department of Social and Health Services

## Economic barriers for domestic violence victims

The Washington State Department of Social and Health Services (DSHS) responds to poverty and economic instability through a variety of programs, such as food stamps, the Women, Infants and Children (WIC) nutrition program, and Temporary Aid to Needy Families (TANF). A disproportionate number of battered women and their abusers in recently reviewed fatality cases were economically unstable. Therefore, it is important to examine DSHS programs as part of the community response to domestic violence.

In recently reviewed Domestic Violence Fatality Review (DVFR) cases with female domestic violence victims (n=12), 75% (n=9) of the women worked outside the home, but only two (17%) of the women had well-established professions: one in medicine, the other in education. The other female domestic violence victims had low-wage and/or unstable employment. Their work histories included daycare, clerical work, bartending, poultry factory work, fast food service, waitressing and teacher's assistant. Most of the women struggled with maintaining employment, and in almost half of the cases in which the battered woman was employed, the abuser's actions negatively impacted the victim at work. In three cases, co-workers described observing stalking, abusive and disruptive behaviors (like abusive phone calls) on the part of the abuser. In a fourth case, a victim's workplace had to be put in "lockdown" for an afternoon because of the threat the abuser posed.

In one case, police had not interviewed the victim's co-workers, but the Fatality Review panel discussing the case surmised that the victim's spotty work history indicated a common pattern in abusive relationships in which the abuser prevents the victim from performing consistently or well on the job, or urges them to quit. In another case, the victim's letters indicated that her financial struggles made it difficult to leave her abuser and provide for her children. In one letter, she wrote, "Before I can do anything I have to find a new job that pays more and save some money so I can take care of my girls and pay the rent for a few months until I get some sort of child support." But then she went on to describe a common batterer tactic: "[He] works under the table...so it will appear that he doesn't have any income. That's why he says I will never get any money from him." Finally, she articulated a difficult bind many abused women face: "I don't have the money to take care of my girls without him, [but] with him not paying his portion of the bills and taking money out of the bank, I can't save any." Advocates on the Fatality Review panel found these problems very familiar. For women with limited earning capacity, issues such as difficulty gathering resources to leave (e.g., deposits for apartment rental and utilities) and well-placed fears of not being able to provide for their children's needs all too often represent substantial barriers to leaving, even when they think it is in their best interest.

*"Before I can do anything I have to find a new job that pays more and save some money so I can take care of my girls and pay the rent for a few months until I get some sort of child support."*



**RECOMMENDATIONS:**

- The Washington State Legislature should increase resources for domestic violence programs to provide material support for victims, such as childcare assistance, transportation, deposits for housing and attorney fees. In addition, the Legislature and state agencies should increase access to financial resources in the Temporary Aid to Needy Families (TANF) program and Crime Victims Compensation Program.
- Employers should proactively implement workplace safety policies to specifically address abuse and stalking of their employees, as well as supporting victims of domestic violence in retaining their employment while receiving support for coping with the abuse.
- Employers should support (and not penalize) victims who need to take time off work to attend civil and criminal proceedings, or go to medical or counseling appointments related to domestic violence.

**TANF, child support and other public benefits**

A victim's sources of income and/or use of public benefits are rarely documented in police investigations of domestic violence assaults and homicides, or in other public records. Washington Administrative Code and state statutes prevent DSHS from releasing information about individual women's use of public benefits. Consequently, Fatality Review panels cannot always know with certainty whether a victim accessed Temporary Aid to Needy Families (TANF) or other public benefits.

However, our findings suggest that many domestic violence homicide victims and many battered women in dangerous but not lethal relationships may access DSHS services at some point in the course of their relationship. Their need for DSHS services may be closely tied to the pattern of abuse they are experiencing. A significant number of female homicide victims in the recently reviewed cases were struggling to support children while at the same time experiencing economic vulnerability and instability brought about by the abuse, and it is likely they would have turned to some program of DSHS for help.

Public records in several cases reviewed since 2002 pointed to contact with DSHS via WorkFirst (Washington's name for its TANF program), Employment Security, WIC or the Division of Child Support Enforcement. In these cases, Fatality Review panels sought information about policy and common practice in the DSHS offices that victims accessed.

In some cases, victims came into contact with Community Service Offices (called CSOs or welfare offices) before a consistent policy of screening for domestic violence had been implemented. Although Washington has adopted the federal Family Violence Option in WorkFirst (which mandates screening for domestic violence and other specific actions), implementation is still inconsistent across DSHS offices. In one case, the victim had used the WorkFirst program well after a policy of domestic violence screening had been established, but people familiar with the office's practices agreed that workers did not routinely follow the policy, and it was quite likely no one asked the victim about domestic violence.

Washington's state legislature adopted the Family Violence Option out of recognition that domestic violence victims require particular attention to safety needs and that federal TANF requirements (and imposition of sanctions) should not place women

in danger or penalize them for the abuser’s behavior.<sup>53</sup> However, the Family Violence Option only mandates screening by DSHS workers in Community Service Offices (CSOs) and not by any of DSHS’s “WorkFirst partners” (other agencies which provide services to WorkFirst participants), such as Employment Security. Our findings show that many battered women seek employment, only to find that their abuser stalks them at work or sabotages their work performance. Employment Security programs (where WorkFirst program participants go to talk with employment counselors) do not currently screen for domestic violence and do not know how to respond or help problem-solve if a battered woman discloses abuse. This is a significant gap in the system, as lack of attention to the impact of the batterer’s tactics of control undermines a battered woman’s efforts to attain autonomy by:

- leaving her vulnerable to sanctions (penalties assessed against her already small welfare grant), which further threatens her hope of economic stability; or
- requiring her to participate in activities which place her at further risk from the abuser (for example, requiring attendance at a job training class despite the abuser stalking her at that location).

<sup>53</sup> By adopting the Family Violence Option, Washington state agreed to: screen TANF recipients for domestic violence; refer identified individuals to counseling and supportive services; and waive program requirements which would make it more difficult for individuals receiving assistance to escape domestic violence, unfairly penalize them for the violence they have experienced or put them at risk for future violence. See Public Law 104-193, section 402(a)(7) and WAC 388-61-001.

**RECOMMENDATIONS:**

- The Governor’s Office should ensure collaboration among state agencies to develop and implement consistent policies to support and protect domestic violence victims.
- DSHS should ensure implementation of its policy of screening all WorkFirst program participants for domestic violence and providing an appropriate response (in the form of resources and workplans) for domestic violence victims.
- DSHS training and practices should support effective, individualized and compassionate implementation of their policies consistently across all programs.
- Employment Security offices should create programs and institutionalize practice to customize services for domestic violence victims to ensure their safety and success in seeking employment.
- The Division of Child Support should implement policies for identifying and serving domestic violence victims which include screening for domestic violence and ensuring domestic violence victims’ safety when enforcing support.
  - In establishing policy, DSHS should look to programs in other states (for example, Massachusetts) which create a specialized caseload with workers knowledgeable about domestic violence and empowered to respond quickly and effectively to abusive tactics and safety concerns in the context of child support enforcement.
- Employment Security should institute programs designed to ensure wage progression (meaning participants make more money from one year to the next), so that domestic violence victims are not trapped in abusive relationships by economic instability.
- DSHS should devise a system to measure Community Service Office accountability to providing domestic violence screens for WorkFirst program participants. This measurement system should:
  - Place the emphasis on the worker doing the screening, not the victim disclosing.
  - Communicate to Community Service Offices (through policy directives) the agency’s expectation that a certain number of participants will be identified as

domestic violence victims and need exemptions from some of the WorkFirst program requirements in response to their safety or trauma issues related to the abuse and provide offices with a benchmark against which they can measure their performance in terms of quality screening for, and response to, domestic violence.

- Be created in consultation with state-level groups possessing domestic violence and welfare advocacy expertise to design a system which ensures (as much as possible) that recipients are not penalized or characterized negatively for disclosing (or choosing not to disclose) abuse.

### **Protection for abused children**

The other significant point of contact with DSHS for domestic violence victims and abusers in recently reviewed cases by Fatality Review panels was the Division of Children and Family Services (commonly called Child Protective Services or CPS). Findings from reviewed cases make it clear that many of the domestic violence abusers were also abusive to children or engaged in abusive behaviors in front of them. Out of the thirteen cases reviewed since the 2002 Fatality Review report, panels were able to ascertain that someone had contacted CPS about the abuser's behavior in four cases. One abuser had beaten his thirteen-year-old child with a 2" x 4" piece of wood. Another abuser (who was awarded custody of his young children after his wife left him) beat his daughters, tossed them around by their hair, and threatened suicide to them. Finally, one of the girls called CPS (in another state, not Washington) on her own behalf; when a worker arrived, she interviewed the girls in front of their father, so they felt unsafe revealing any of their fears or his history of abuse. A third abuser had been accused of molesting his children and was under orders to stay away from them. In another case, a teen son of the abuser had sexually assaulted another child.

Experts on the panel agreed in each of these cases that it was highly unlikely that the domestic violence abuser's violence toward these children's mothers was addressed, or that the CPS workers recognized the difficulty these women faced in providing a safe and healthy environment for their children as long as their partner's abuse went unchecked. In the case involving the teen boy, the worker noted that the boy was similar to his father in that he was "aggressive." Even so, the case plan called for the parents to cooperate with each other to ensure his supervision and other children's safety, and did not consider how the father's aggression might negatively impact the mother's ability to follow the plan.

The only woman in a reviewed case who murdered her partner also had documented contact with CPS. She had been suicidal, and the hospital had contacted CPS regarding concerns for her children's safety. Also, one of her children had participated in setting small fires around their apartment complex and police responded to the scene. On one occasion, after treating the children for smoke inhalation due to a fire in their home, hospital personnel reported the case to CPS. In spite of these contacts, no significant intervention took place.

Out of the multiple CPS contacts tracked in reviewed cases, two took place out of state, but most occurred in Washington. In discussing CPS interventions, experts on Fatality Review panels noted that while CPS intake and investigation forms include questions regarding domestic violence, workers do not consistently pose these ques-

tions. Workers do not have adequate training in asking the questions and interpreting victims' answers, or understanding the level of violence and its impact on victims and their children. Many workers' understanding of child abuse does not include:

- an analysis of the role of domestic violence in that abuse;
- the protective and help-seeking strategies utilized by the adult victim of domestic violence; or
- the ways in which failing to address the abuser's violence toward the other parent will almost certainly undermine efforts to craft an effective intervention for child abuse.

Sanctioning a domestic violence victim for the consequences of the abuser's violence may undermine the victim's willingness to contact existing services to help protect her from the violence. Additionally, when CPS workers determine how to intervene in child maltreatment cases, they often fail to take into account whether the primary custodial parent's cooperation with the plan may increase her risk of danger.

The DVFR's 2000 report, *Honoring Their Lives, Learning from Their Deaths*, included several recommendations regarding CPS. Since then, DSHS has made some efforts to move toward developing analysis and policy regarding the relationship between domestic violence and child abuse, but those efforts are in the beginning stages, and system-wide change has not taken place.

Thus, the following recommendations from our 2000 report are still relevant:<sup>54</sup>

#### RECOMMENDATIONS

- The DSHS Children's Administration (which encompasses the Division of Children and Family Services) should engage in community partnerships to develop philosophy, policy and protocols for identifying and responding to domestic violence between adult intimate partners. Policies should include:
  - Universal and effective screening for domestic violence with both parents, including screening for suicidal and homicidal threats.
  - Checking for the existence of current or defunct Protection Orders and domestic violence convictions and obtaining copies of Protection Orders.
  - Establishing collaborative, information-sharing relationships with Family Court Services and other workers who provide civil courts with parenting and domestic violence evaluations.
  - Routine referral to local resources for battered women when domestic violence is identified.
- The Division of Children and Family Services' (DCFS) policies should emphasize an approach in which the worker's interactions and interventions with family members attempt to meet the following three goals:
  - to protect the child;
  - to help the abused parent protect herself and her children, using non-coercive, supportive and empowering interventions whenever possible; and
  - to hold the domestic violence abuser, not the adult victim, responsible for stopping the abusive behavior.<sup>55</sup>
- New DCFS policies on domestic violence should be backed up with intensive training for staff to ensure their appropriate implementation.
- Training of DCFS staff should involve locally based domestic violence advocates and emphasize the importance of forging links with local resources.

<sup>54</sup> Washington State Coalition Against Domestic Violence, *Honoring Their Lives, Learning from Their Deaths: Findings and Recommendations from the Washington State Domestic Violence Fatality Review*, by Margaret Hobart (Seattle: WSCADV, 2000), p. 51-52. To obtain a copy of the report, go to [www.wscadv.org](http://www.wscadv.org).

<sup>55</sup> Family Violence Prevention Fund, *Child Abuse and Domestic Violence: Creating Community Partnerships For Safe Families—Suggested Components of an Effective Child Welfare Response to Domestic Violence*, by Janet Carter and Susan Schechter (San Francisco: FVPF, 1997).

### **DSHS as an important point of contact for domestic violence victims**

The economic results of abuse (e.g., unstable employment, sabotaged education and job performance, needing to leave employment in order to hide or escape), the propensity of domestic violence abusers to abuse their children as well as their partners, and the likelihood that women who leave abusive relationships will need child support and economic assistance all contribute to the conclusion that many battered women will come into contact with a subsidiary program of DSHS at some point. Having a better understanding of how often this occurs, and how battered women differ from the larger DSHS caseload, would be useful in identifying the gaps in DSHS' response to domestic violence.

#### **RECOMMENDATION:**

- DSHS should collaborate with the Washington State Coalition Against Domestic Violence (WSCADV) and other researchers to analyze how many domestic violence victims in domestic violence fatality cases had come into contact with DSHS services prior to the fatality, whether they were screened for domestic violence, what intervention they received, how such interventions affected their safety and how this group compares to the larger DSHS caseload.

## Civil Legal Issues

<sup>56</sup> The previous DVFR reports, *Honoring Their Lives, Learning from Their Deaths* (2000) and *Tell the World What Happened to Me* (2002) are available at [www.wscadv.org](http://www.wscadv.org).

The Domestic Violence Fatality Review (DVFR) issued multiple recommendations around the civil legal system in both our 2000 and 2002 reports.<sup>56</sup> The 2002 report contained a chapter on "Civil Issues" that explored the trouble victims had in accessing the civil legal system, and the gaps in that system's ability to adequately respond to domestic violence and to address the safety of domestic violence victims and their children. Fatality reviews of the past two years have continued to highlight gaps in the civil legal response to domestic violence, and illustrated that the recommendations issued in previous reports still need to be addressed. This chapter will not repeat all issues and recommendations discussed in the other reports, but will build on previous information and highlight a few key recommendations based on the reviews of the past two years.

Fatality Review panels identified civil legal issues in five of the thirteen cases reviewed since September 2002. In three of these cases, the domestic violence victim was the petitioner or respondent to a civil action, including Protection Orders, marriage dissolutions, child custody and housing evictions. The other two cases involved civil orders filed by others: in one, the domestic violence victim's mother, sister and brother-in-law all petitioned for Protection Orders against the victim's husband; and in the other, the female domestic violence abuser petitioned for Protection Orders (one on her children's behalf) against two previous partners.

In two of the cases, the victim had a distinct need for civil legal representation (around evictions and child custody issues), but did not obtain it. Fatality Review panels in both of these cases identified a lack of adequate civil legal resources for low-income

individuals as a gap in their community's response to domestic violence. The case involving child custody highlighted the confusion that exists when parents are not married and no action regarding paternity has been taken. The abuser in this case repeatedly took the infant from the victim and refused to return her unless the victim agreed to move back in with him. The victim turned to the police for help, but they informed her that without a parenting plan or court order, they could not take any action regarding custodial interference. The lack of adequate resources available to help this victim with custody issues ultimately jeopardized her safety, as well as the safety of her family and child.

**RECOMMENDATIONS:**

- Funding should be increased for legal aid programs to assist with representation of domestic violence victims in domestic violence and family law matters, and legal aid programs should collaborate with domestic violence advocacy programs to provide comprehensive advocacy services.
- Funding should be allocated for domestic violence advocacy programs to hire or contract with attorneys trained on domestic violence to represent victims.
- The Washington State Bar Association and local bar associations should partner with local domestic violence programs to create pro bono panels to represent domestic violence victims in domestic violence and family law cases. Individuals who participate should be recognized for their efforts, and receive free continuing legal education (CLE) credits for taking these cases.
- Law schools should prioritize the creation and support of legal clinics for representation of domestic violence victims in domestic violence and family law cases, and incorporate domestic violence education in core courses.
- Low-cost and free legal representation services should work to ensure their intake processes are accessible to domestic violence victims (e.g., provide flexible times for intake appointments). Also, they should prioritize assisting domestic violence victims so that they are not "conflicted out" by their abuser (if the abuser contacts the available local resources and secures legal representation or legal advice first, then the victim can be denied services because of rules governing attorneys that prohibit conflicts of interest).

In one reviewed case, the victim obtained a Protection Order and, a month later, filed for a dissolution of her marriage. In her Protection Order petition, she mentioned several previous incidents of physical violence (including one incident that involved their daughter), and stated that the abuser had loaded guns, had repeatedly threatened suicide and had issues with substance abuse. Even so, the Protection Order did not specifically address the removal of weapons. The victim in this case had an attorney for the dissolution, yet there was very little mention of the history of abuse in the divorce petition. The temporary parenting plan did not address the abuser's use of violence or restrict his contact with the victim or the children in any way. An interview with the victim's attorney indicated that he, like many attorneys, had not received any training on domestic violence and did not recognize the prevalence and potential lethality of domestic violence. He described this situation as a "one in a million" case, revealing a common ignorance of the risks many domestic violence victims face, particularly as they are trying to leave an abusive partner.<sup>57</sup>

<sup>57</sup> According to one study, separation from an abuser increased the risk of fatality seven times and this risk jumped nine-fold when the abuser exhibited controlling behavior and verbal aggression. See J. Campbell et al., "Assessing Risk Factors for Intimate Partner Homicide," *NIJ Journal* 250 (2003), p. 14-19.

**RECOMMENDATIONS:**

- Judges should specifically inquire about the existence of firearms and order that abusers surrender their firearms when granting Protection Orders.
- Judges, attorneys, advocates and court staff should ensure that Protection Order petitioners who mention an abuser's homicide or suicide threats are connected to advocacy services, made aware of their increased danger given these threats and supported to engage in immediate and detailed safety planning.
- All players in the civil legal system should receive education regarding: identifying domestic violence; resources for support; lethality indicators and what to do if lethality seems high. Training should include examples of appropriate action for varied roles (e.g., attorney, judge, commissioner, advocate).
- To determine parenting plan arrangements, courts should utilize neutral, well-trained evaluators who can: assess for the existence of domestic violence; obtain all available prior civil and criminal legal records which may pertain to the existence of domestic violence, including Protection Orders, arrest records and information regarding the offender's history of compliance with court orders; speak to corroborating sources; assess for the domestic violence victim's and children's safety; and provide the judge with well-informed recommendations.

In another reviewed case, the court granted a Protection Order for an abuser's two children, stating that "visitation shall be restricted" and named a supervisor "or agreeable supervisor." The Fatality Review panel in this case identified that their community lacked adequate supervised visitation resources with supervisors trained on the particular safety concerns in domestic violence cases, and this left many families without a safe visitation option.

**RECOMMENDATION:**

- The Washington State Legislature should prioritize funding for supervised visitation and exchange resources for domestic violence cases. Supervisors should receive specialized training on the dynamics of domestic violence, the potential for abusers to use visitation to stalk and control their partners, and the risk to children when one parent has a history of perpetrating domestic violence.

## Batterer's Intervention

Although victims or someone else called law enforcement for assistance with the thirteen abusers in recently reviewed cases a total of twenty times, only one abuser was court ordered to attend state-certified batterer's intervention. This is consistent with overall findings of reviews conducted since 1997. Of the fifty-four abusers in all cases reviewed since 1997, only three were ordered to state-certified batterer's intervention programs, none of them completed an intervention program and none faced any consequences for their failure to complete these programs. In the most recently reviewed case, the abuser had begun a program, been non-compliant and been given another chance to go to intervention a couple of months before he killed his wife.

A slightly larger group of abusers had been court ordered to anger management, which Fatality Review panels consistently noted is inappropriate and ineffective for domestic violence abusers, and sends the wrong message to both the abuser and the victim. One abuser was sentenced to an anger management class primarily focused on road rage as part of his conviction for a domestic violence assault.

Judges face several problems in making appropriate court orders to batterer's intervention. First, in many communities, certified batterer's intervention programs do not exist for every language spoken in the community, leaving the judge with no viable options for sentencing to an appropriate program. In these situations, judges should attempt to think more broadly about their sentencing options, and ensure the abuser is held accountable for the abuse in some way. Creative ideas may come out of dialogue with domestic violence experts and leaders from immigrant communities.

Second, judges cannot name the specific batterer's intervention program the abuser must attend (they *can* indicate that it must be state certified). Thus, they cannot respond to information provided by victims whose partners use the programs, concerns from the probation department, or their own knowledge of programs which do not quickly report non-compliance to the court. State law prohibits judges from excluding weak programs from lists of acceptable providers as long as the state continues to certify them, which results in abusers "shopping around" for the most lenient program. The best programs are the ones with stringent attendance requirements, clear expectations about behavior and a close working relationship with the court. Because batterer's intervention programs are funded primarily by user fees, economic incentives function to put pressure on providers to loosen their requirements.

As long as significant discrepancies exist among state-certified programs in terms of attendance requirements, reporting to the court and clarity about what constitutes abusive behavior, the existence of poor-quality programs jeopardizes the effectiveness of batterer's intervention in general. The authors of a National Institute of Justice study on batterer's intervention argue that "because of the complexity of the field—and the seriousness of the ongoing threat posed to battered women when offenders are mishandled—criminal justice professionals who handle domestic violence cases have increased responsibility to be knowledgeable about the content and structure of batterer programs in their jurisdictions in order to make informed choices among the interventions being offered."<sup>58</sup> Our current state law undermines the ability of judges and probation officers to do just this.

<sup>58</sup> Kerry Healey, Ph.D. and Christine Smith, with Chris O'Sullivan, Ph.D., *Batterer Intervention: Program Approaches and Criminal Justice Strategies*, Issues and Practices in Criminal Justice series, National Institute of Justice, February 1998, p. 2. Available at [ncjrs.org/pdffiles/168683.pdf](http://ncjrs.org/pdffiles/168683.pdf).



Finally, prosecutors report that judges are sometimes reluctant to impose batterer's intervention, which they perceive as a substantial burden on the batterer. Fatality reviews make clear that court orders to intervention programs do not correlate neatly with injuries, victims' expressed fear or abusers' histories of violence. Judges may be particularly reluctant to order batterer's intervention for domestic violence incidents that did not involve physical assault, such as violations of Protection Orders, malicious mischief or stalking. In one reviewed case, the abuser had broken the window and slashed all the tires of his girlfriend's car, which was parked at his house. When the victim's family members were attempting to recover the car, the abuser came to the door of his house holding a rifle. The abuser was sentenced to anger management. The Fatality Review panel in this case observed that some judges order abusers to attend anger management courses if they think the assault was not "too bad" or the charges are "just" domestic violence-related malicious mischief. This sort of thinking rests on the common but inaccurate assumption that the case coming before the criminal legal system is the worst or first incident of domestic violence in the relationship. Frequently, it is not. In this case, the report about the damage to the car followed a period of stalking, harassment and threats. It also reflects the inaccurate belief that domestic violence is an anger problem. But, as author Lundy Bancroft writes, "he isn't abusive because he is angry, he is angry because he is abusive."<sup>59</sup>

<sup>59</sup> Bancroft continues: "The abuser's unfair and unrealistic expectations ensure that his partner can never follow all his rules or meet his demands. The result is that he is frequently angry or enraged. This dynamic was illustrated on a talk show by a young man who was discussing his abuse of his present wife. He said his definition of a good relationship was 'never arguing and saying you love each other every day.' He told the audience that his wife 'deserved' his mistreatment because she wasn't living up to this unrealistic image. It would not do any good to send this young man, or any other abuser, to an anger management program, because his entitlements would just keep producing more anger. His attitudes are what needs to change." Lundy Bancroft, *Why Does He Do That: Inside the Minds of Angry and Controlling Men* (New York, NY: G.P. Putnam's Sons, 2002), p. 60-61.

Even when abusers are ordered to a certified batterer's intervention program, significant problems exist. Monitoring of enrollment, attendance and follow-up reporting to the court is inconsistent or nonexistent, resulting in abusers refusing to go or attending irregularly with little fear of court sanction. If completing the program is not actually enforced, this sends the wrong message to both the victim and abuser. Since the batterer's intervention program may be the only tangible outcome from the victim calling the police, it appears that in the end, no one will hold the abuser accountable.

A recently reviewed case in which the abuser was ordered to a batterer's intervention program illustrates how poor enforcement of batterer's intervention can become a symbol of the criminal legal system's weak response to domestic violence in the eyes of both the victim and the abuser. In this case, the abuser squeezed the battered woman's chest to the point that she could not breathe and prevented her from calling 911. He was arrested and released the next day, after his arraignment. Two months later, the court issued a Stipulated Order of Continuance (SOC), which required him to report to probation and attend a batterer's intervention program. The intention of an SOC is to give the offender the opportunity to seek intervention and change behavior, with the threat that if they do not follow the order, the SOC can be revoked and result in incarceration. In the two months following the court order, the probation department alerted the court twice that the abuser was out of compliance with the court's order, first for not reporting to probation in the designated time period, and second for not attending batterer's intervention consistently. Within a month, the court found the abuser out of compliance and scheduled a new review hearing. Another month later, the abuser was again found out of compliance and the court again ordered him to probation rather than revoking the SOC and ordering increased sanctions. Sometimes judges justify giving multiple chances with SOCs by saying they do not want the abuser to lose his job or interrupt his wage earning, but in this particular case, jail time would not have been a hardship on the family as the victim was the primary wage earner.

Nine months after the original assault, the abuser still had not complied with the court order. The court did not impose additional consequences on the abuser for this lack of compliance with the SOC; in fact, the court did not put any force behind the order for intervention. Ultimately, the abuser never complied with court orders, never faced significant sanctions, and killed his wife about six weeks after appearing in court for a review hearing in which he was given yet another chance to comply with the SOC.

This case illustrates that enforcement of court orders and attention to the battered woman's safety are critical, but often neglected, parts of the criminal legal process. As Andrew Klein (Chief Probation Officer in Quincy, Massachusetts) points out in the National Institute of Justice study, "Batterer intervention is a public safety program, not treatment; you must keep the focus on victim safety. Otherwise, the criminal justice system is only offering the batterer a safe haven to escape the consequences of his offense."<sup>60</sup>

The Fatality Review panel pointed out when reviewing this case how hopeful battered women frequently are that batterer's intervention will actually make a difference in the abuser's behavior. Battered women often make the assumption that batterer's intervention holds promise for change because both the prosecutor and judge demonstrate belief in it as an appropriate response to even serious assaults. They may be more likely to stay with the abuser because they hope batterer's intervention will make a positive difference. In fact, the outcome literature on batterer's intervention does not support such faith. One major study found that only one in five men who enter a batterer's intervention program complete it and are reported to be nonviolent for eighteen months.<sup>61</sup> The study did not evaluate whether or not non-criminal forms of abuse (e.g., emotional, economic, psychological) also subsided. These findings are consistent with other batterer's intervention outcome studies. Studies which have indicated small but statistically significant reductions in recidivism as a result of batterer's intervention may also reflect the strongest programs, rather than the average batterer's intervention program, as they are programs which have the organization, infrastructure and motivation to participate in research.<sup>62</sup>

Partners of abusers ordered to batterer's intervention frequently do not have the opportunity to talk to someone who could help them anticipate what the program may and may not accomplish, and factor that into a larger safety plan. While the Washington Administrative Code requires that batterer's intervention programs make contact with victims, most programs do not have a designated victim liaison to make a phone or in-person contact. Contacts with victims are generally made via a letter or phone call, and by the same person who is working with the abuser. The policy of the intervention program in the reviewed case described above is to mail out a packet of information, including victim resources. Because it is easy for an abuser to intercept mail, it is difficult to ascertain how often the victim receives this packet. Generally, batterer's intervention programs that attempt contact only by mail have settled for a method of victim contact which severely limits their ability to actually connect with victims, support their safety planning and inform them about the practices of the intervention program. Additionally, victim contact by mail assumes the victim's primary language is English, and that the victim does not need the information in an alternative format (e.g., enlarged text for those with low vision). Finally, it also assumes that the abuser is not screening mail and limiting the victim's access to information.

<sup>60</sup> Healey, *Batterer Intervention: Program Approaches and Criminal Justice Strategies*, p. 10.

<sup>61</sup> Jeffrey Edleson and M. Syers, "The Relative Effectiveness of Group Treatments for Men Who Batter," *Social Work Research and Abstracts* 26 (1990), p. 10-17.

<sup>62</sup> The National Institute of Justice paper summarizes, "While numerous evaluations of batterer interventions have been conducted, domestic violence researchers concur that findings from the majority of these studies are inconclusive because of methodological problems, such as small samples, lack of random assignment or control groups, high attrition rates, short or representative program curriculums, short follow-up periods, or unreliable or inadequate sources of follow-up data (e.g., only arrest data, only self-reported data, or only data from the original victim)." Healey, *Batterer Intervention: Program Approaches and Criminal Justice Strategies*, p. 8.

**RECOMMENDATIONS:**

- Judges should have access to in-depth pre-sentencing reports to inform decision making about sentencing conditions and options.
- Jurisdictions should implement specialized domestic violence probation units, with caseloads which allow officers adequate time for monitoring and responding to lack of compliance by abusers.
- Probation officers and/or judges should be empowered to require attendance at a specific batterer's intervention program, or minimally, specify programs to avoid.
- Probation offices should have domestic violence victim advocates on staff who can contact partners of abusers, and provide resources and safety planning.
- The Washington Administrative Code should require batterer's intervention programs to have a victim liaison who contacts women by phone or in person. This person should be separate from the abuser group leader.
- Batterer's intervention programs should be required by the Washington Administrative Code to give victims accurate information in plain language about the limitations of batterer's intervention and the conditions under which it is more likely to be effective, including complete citations to research literature on the topic.

## Criminal Legal System

<sup>63</sup> The previous DVFR reports, *Honoring Their Lives, Learning from Their Deaths* (2000) and *Tell the World What Happened to Me* (2002) are available at [www.wscadv.org](http://www.wscadv.org).

The Domestic Violence Fatality Review (DVFR) has identified gaps in the criminal legal response to domestic violence and has issued many recommendations for the criminal legal system in both our 2000 and 2002 reports.<sup>63</sup> Fatality Review panels since 2002 have continued to highlight many opportunities for the criminal legal system's response to domestic violence to be more consistent, more effective, more accessible and more accountable. Information from reviews illustrates that the recommendations issued in previous reports still need to be addressed. Rather than repeating all issues and recommendations discussed in the other reports (though these remain relevant), this chapter will highlight key recommendations based on the reviews of the past two years.

The criminal legal system issues identified by Fatality Review panels were most often failures in basic police work: conducting separate interviews with the victim and perpetrator at domestic violence crime scenes; obtaining complete and accurate statements (including histories of violence); accurately identifying domestic violence; completing the Domestic Violence Supplemental Form at every domestic violence call; pursuing and arresting abusers suspected of domestic violence crimes; identifying patterns of abuse and lethality factors; and encouraging victims to get connected with advocacy and other community resources.

Domestic violence advocates on Fatality Review panels and advisory committees have observed that victims often feel a profound disconnect between their experience of domestic violence as a pattern of behavior and the incident-based response of the criminal legal system. Abusers in reviewed cases used a broad range of tactics to control, exploit and dominate their partners. Some of these were illegal, including

physical violence, threats of violence and stalking. Many more abusive tactics used in these cases were not illegal and did not warrant a criminal legal response. These included isolating a woman from her friends and undermining her relationship with her family, controlling the household finances, constantly degrading and humiliating her, and threatening suicide in order to manipulate her. When law enforcement responded to an incident of domestic violence in these cases, they came into contact with one piece of an ongoing history of abuse involving both criminal and non-criminal actions. This disconnect—between victims’ experience of an ongoing, everyday pattern of abuse that includes both criminal and non-criminal behaviors, and the framework of the criminal legal system designed to respond to specific incidents—often created challenges for the criminal legal system in understanding the full context of the incident.

Some reviewed cases illustrate strategies for addressing this challenge. For example, documenting a past history of abuse, including criminal and non-criminal tactics, improves police, prosecutor and judicial response to any criminal incident under investigation. In one example from a reviewed case, a police officer documented a history of abuse when responding to an incident of assault. The officer wrote in the police report, “Although this was the first time [the abuser] had been physical with [the victim], their relationship was one in which [he] would often verbally and psychologically abuse her.” This police report established how a single incident of physical abuse was part of a prior history of abuse that was likely to be repeated.

Overall, however, Fatality Review panels indicated that such strategies were not used consistently, resulting in the criminal legal system having a limited understanding of the full context of abuse, and therefore missing opportunities to recognize escalating danger and respond effectively to meet the safety needs of victims. Fatality Review panels in these cases emphasized that police, prosecutors and judges should develop strategies for routinely identifying and integrating information about a past history of abuse in documenting domestic violence incidents, filing charges and judicial processing of cases.

### **The need for consistent practices**

Accurate and complete law enforcement reports of domestic violence incidents were identified as a critical tool for connecting a single incident to a pattern of historic and current abuse. Even though Fatality Review panels noted that some law enforcement agencies have comprehensive policies in place governing how officers are to respond to domestic violence incidents, they continued to identify the need for consistent and well-documented responses to domestic violence victims and their abusers. Panels noted that documenting connections between individual incidents and between criminal and non-criminal acts of abuse provides necessary information for police, prosecutors and judges to assess the impact and lethality of each incident and determine appropriate action for holding abusers accountable and providing for the safety of victims.

Two incidents in one recently reviewed case illustrate the importance of a consistent and high-quality police response. The first time law enforcement responded to an incident of domestic violence at their home, Ashley<sup>64</sup> and Rafael had been dating for two years and had lived together about three months. Following that incident, Ashley decided to move out of their apartment and stay with family members. When Rafael found out that she was planning to move out, he began stalking her at work—watching her from a distance, videotaping her, calling her many times a day. He repeatedly

<sup>64</sup> All names used throughout this section are pseudonyms.

threatened to kill one of her co-workers. One evening he came to her workplace and threatened to kill himself if she did not come home with him. Ashley contacted the police, who responded at her workplace and took a statement. While the officer was talking with Ashley, Rafael called her workplace again from a phone nearby. The officer placed Rafael in handcuffs and took him to the hospital for a mental health evaluation. The officer completed a Mental Health Contact Report, but did not include a Domestic Violence Supplemental Form with the police report. It did not appear that Ashley received any information about domestic violence or about the increased risk to her safety that Rafael's suicide threats represented. Since Rafael was not determined to be mentally unstable, he could not be held against his will and was released.

<sup>65</sup> RCW 10.99.020(3).

<sup>66</sup> RCW 10.99.030(7).

<sup>67</sup> RCW 10.99.030(6)(b).

Ashley and Rafael met the legal definition of "family and household members,"<sup>65</sup> one of the elements officers use to determine whether they are responding to a domestic violence call. However, in this instance, the officer failed to note in his report that he was responding to a domestic violence incident. In all domestic violence calls, state law requires that domestic violence information must be given to the victim,<sup>66</sup> and that law enforcement must take a complete offense report.<sup>67</sup> It was not clear from the offense report that either of these mandates was met. The officer noted in the report that Ashley and Rafael had been "having problems with their relationship," but did not document any history of abuse or refer to the previous incident that required a police response.

**RECOMMENDATIONS:**

- Law enforcement agencies should require the completion of a Domestic Violence Supplemental Form at all domestic violence calls that prompts officers to document the history of abuse, including both criminal and non-criminal tactics, and to identify signs of escalating violence.
- Law enforcement officers should always document threats of homicide and suicide in their reports. When domestic violence and suicide threats co-exist, officers should recognize the increased danger to the victim and should provide the victim with information about the increased risk of homicide and refer to a community-based domestic violence program for safety planning and other services.

Ten days after this suicide threat, Rafael attacked Ashley and strangled her. Just before the assault, they had watched a movie Rafael bought for her about a boyfriend who strangles his girlfriend to death. After she got away from Rafael, Ashley called 911. She told police she thought he was trying to kill her. Officers completed a Domestic Violence Supplemental Form, but inaccurately indicated on the form that there was no prior history of domestic violence. Rafael had fled by the time officers arrived at their apartment. They looked for him, but did not find him that night. Before officers left Ashley, they offered to transport her to the hospital (which she declined), and provided her with a case number and a domestic violence information packet. A few days after the assault, Ashley told a friend that Rafael strangled her again and threatened her repeatedly.

In the discussion of this case, Fatality Review panel members identified Domestic Violence Supplemental Forms as an important tool in tracking the escalation of domestic violence, and identified the need for information to be accurately and completely

documented on these forms. According to the police report documenting the strangulation, the responding officers did not know about the prior history of abuse by Rafael toward Ashley.

Police officers did not continue looking for Rafael after that night, and never arrested him for this assault. Fifteen days after the strangulation, an investigating officer called Ashley to follow up. Ashley told the officer that Rafael was still living with her, and that things had been “fine” between them lately. She also told the officer that she was planning to move out of their apartment at the end of the month, which was one week away, and that she would get a Protection Order against Rafael after she moved out. Ashley did not tell the officer about the recent assault that she had described to her friend. The officer gave Ashley contact information and instructions to call “if she had any questions or anything to add to her case.” The panel noted that it was positive that the department followed up with Ashley after this dangerous assault. However, since two weeks had passed with no arrest and no action by the criminal legal system to limit Rafael’s capacity to stalk and hurt her, Ashley may have concluded it was not worthwhile to give the officer additional information about Rafael’s violence.

The officer then contacted Rafael at his workplace and took a statement from him. He denied strangling Ashley, but told the officer that he “cradled her face in his hands and made her look at him so that he could talk to her.” Rafael was issued a criminal citation for fourth-degree assault (a misdemeanor), but was not taken into physical custody. He was released immediately on his own signature. The officer apparently missed an opportunity to recognize signs of lethal danger, including the recent strangulation, Rafael’s history of violence, and Ashley’s imminent plans to leave Rafael and to get a Protection Order against him. Strangulation should always be treated as a life-threatening assault; however, officers in this case appeared to minimize the danger it represented. A full documentation of Rafael’s history of violence may have made his lethal potential more apparent.

Five days after Rafael was served with the citation for assault, prosecutors filed criminal charges. The court scheduled arraignment for nine days later. The day he was charged, Angela told a friend she was afraid to go home because Rafael had received papers saying she was going to testify against him in court. Rafael strangled Ashley to death later that night.

### **Limiting abusers’ access to firearms**

Fatality Review panels have consistently identified abusers’ access to firearms as a major factor increasing the danger to domestic violence victims. In ten of the thirteen cases reviewed for this report, abusers used a firearm to commit homicide. In one additional case, the abuser used a handgun to commit suicide after strangling the victim.

In one reviewed case, the abuser had threatened the victim with a gun and told her that he had a gun hidden on her property. In her petition for a temporary Protection Order, she wrote, “In the past we have fought over loaded guns. I have tried a couple of times to get a loaded gun out of his hands.” However, neither the temporary nor the permanent Protection Order required the removal of the abuser’s weapons.

The panel reviewing this case identified a need for judicial education regarding the court’s authority to restrict weapon possession and for community pressure on judges to do so. Protection Order respondents may not possess a gun or ammunition.<sup>68</sup> Washington state and federal law allow—but do not require—the court to remove guns

<sup>68</sup> RCW 9.41.800 and 18 U.S.C. § 922(g)(8).

<sup>69</sup> RCW 26.50.060, RCW 26.50.070 and RCW 9.41.800.

<sup>70</sup> RCW 9.41.040 and 18 U.S.C. § 921(a)(33)(A); 18 U.S.C. § 922(g)(9).

The crime need not specifically fall under a domestic violence statute; any assault or battery against a domestic partner is enough. See *U.S. v. Ball*, 7 Fed. Appx. 210 (4th Cir. Apr 4, 2001), cert. denied 122 S. Ct. 226 (2002) and *U.S. v. Barnes*, 295 F.3d. 1354 (DC Cir. 2002). Information on status of court cases is accurate as of June 2003.

from respondents of Protection Orders.<sup>69</sup> Anyone convicted of a felony or a misdemeanor crime of domestic violence may have legal limits set on their right to obtain or possess a gun.<sup>70</sup>

**RECOMMENDATION:**

- Judges should inquire specifically about abusers' access to weapons, should order abusers to surrender weapons as part of temporary and permanent Protection Orders, and should make surrender of weapons a condition of pre-trial release for domestic violence charges.

Police department representatives who participated on one Fatality Review panel stated that officers responding to a domestic violence call generally ask if there are guns in the home, or receive this information from 911 dispatchers in that jurisdiction. However, police departments' Domestic Violence Supplemental Forms do not always prompt officers to ask about weapons or to document this information. When they do include questions about weapons, the panel identified these forms as a helpful tool to remind officers to document abusers' access to lethal weapons, and to create a mechanism for judges to see this information.

**RECOMMENDATION:**

- Officers should attempt to remove guns from the home when the abuser has a history of homicidal or suicidal threats. Domestic Violence Supplemental Forms should include questions that prompt officers to ask suspects about access to, location of and use of weapons.

### Sentencing and judicial discretion

Fatality Review panels have repeatedly seen that abusers who are prosecuted for domestic violence crimes are not held accountable by the criminal legal system. In cases where an abuser has no criminal history, judges commonly cite the abuser's "first offense" as a reason for not ordering jail time, probation or batterer's intervention. Fatality Review panels noted that the first time an abuser is prosecuted for a domestic violence crime is almost certainly not the first incident of abuse. Therefore, panelists often expressed concern at these missed opportunities to impose consequences for abuse. The 2002 DVFR report highlights incidents in which abusers who had several prior domestic violence arrests were not sentenced to meaningful consequences. One case reviewed for the current report illustrates the lack of accountability even for a batterer with an extensive criminal history, including extreme violence. Fatality Review panelists reviewing this case were frustrated that a lack of accountability for batterers seemed consistent regardless of the batterer's criminal history.

The abuser in this recently reviewed case, Ronald,<sup>71</sup> committed many violent crimes over a period of years. He was described as a "serial batterer"—he abused multiple women throughout his life. He made frequent threats of violence and was known to his friends and community to follow through on many of his threats. Ronald had a history of many arrests and prosecutions, beginning when he was a juvenile. Even given

<sup>71</sup> All names used throughout this section are pseudonyms.

his extensive criminal history, he did not face significant consequences for his abuse. Despite multiple arrests for violent assaults against intimate partners and others as well as many nonviolent crimes, the criminal legal system proved ineffective in holding him accountable for his violence or providing safety for the women he abused.

By the age of twenty-three, Ronald had been charged with fifty Municipal Court violations; however, he never received Municipal Court probation. Two-thirds of these fifty cases were dismissed, including all of the assault and harassment charges. Several of the women Ronald threatened and abused did not feel safe testifying against him, or wanted to be sure he knew that they were not the ones who called the police. The Fatality Review panel noted that it is possible that none of the victims of the assaults or harassment felt safe enough to give statements to law enforcement or testify against him in court.

The panel saw that without appropriate sanctions, Ronald was not deterred from his abusive acts. Furthermore, the many dismissed cases reinforced that his violence and threats were effective tools for deterring victims from testifying which, in turn, resulted in cases being dismissed.

Inappropriate use of judicial discretion played a significant role in undermining the efforts of police and prosecutors to hold Ronald accountable for his domestic violence-related crimes. In several cases, law enforcement and prosecutors requested that Ronald not be released or recommended high bail, based on his history of violence and repeated failures to appear in court. Despite an extensive criminal history, multiple failures to appear in court, law enforcement officers' documentation of their objections to release, and prosecutors' requests for high cash-only bail amounts, the court reduced Ronald's bail or released him on personal recognizance on multiple occasions. The panel found it problematic that judges repeatedly used their discretion to disregard police and prosecutors' recommendations during bail hearings and did not impose significant consequences on Ronald for his behavior.

#### **RECOMMENDATIONS:**

- Judges should receive mandated training on domestic violence and on assessing danger and lethality in domestic violence cases. Judges should routinely examine histories and patterns of behavior in domestic violence cases when considering how to proceed (e.g., they should ask the prosecutor, victim and advocate about the batterer's abuse history and consistently make use of computerized databases that track criminal histories).<sup>72</sup>
- The Washington State Legislature should direct the Washington Association of Prosecuting Attorneys, in collaboration with domestic violence advocates, to develop model guidelines on the prosecution of domestic violence cases.

<sup>72</sup> See *Domestic Violence Cases in Municipal Court: Judicial Decision-Making* for further guidance. This bench card was produced by the Washington State Supreme Court's Gender and Justice Commission in 2004 and is posted on the Washington Courts' Intranet under "Judges' Resources."

Fatality Review panel members discussed that, even with consistent law enforcement response and prosecution, batterers often do not receive significant negative consequences for their violence. For example, in one reviewed case, the abuser was arrested and prosecuted multiple times on domestic violence charges. Prosecutors filed charges for every incident the victim reported. These included assault, two violations of Protection Orders, and a violation of probation. However, each time the abuser was arrested, the court released him without issuing a No Contact Order. He



was never ordered to batterer's intervention and served minimal jail time (a total of three days in jail and twenty days of home detention).

While jail time may not stop future violence, it can be seen as serving two functions. First, imposing jail time can send a message to both victims and offenders that the court will treat domestic violence crimes seriously. Second, jail time for abusers may provide victims with time and opportunity to plan for their safety or get connected to advocacy. For this reason, every effort should be made to connect domestic violence victims to community-based advocacy resources when jail time is imposed on their abusers.

**RECOMMENDATION:**

- Prosecutors should employ well-trained domestic violence advocates in their offices, or should work closely with community-based domestic violence programs in order to provide advocacy to victims.

Fatality Review panelists and advisory committee members identified a need for courts to order convicted domestic violence offenders to participate in intervention programs that may prevent future violence, in addition to imposing consequences for past offenses. There is a need for a range of intervention strategies, both in communities and in jails and prisons. These should include batterer's intervention, as well as other programs aimed at promoting nonviolence both within and outside jail and prison.

**RECOMMENDATION:**

- Jails and prisons should designate resources to develop programs for inmates aimed at prevention or reduction of domestic violence incidents, such as certified batterer's intervention, chemical dependency treatment and mental health treatment.

Even when batterers are convicted of homicide, they are not typically sentenced to life prison terms. Most abusers who are convicted of killing their partners will eventually be released from prison and will likely have intimate partner relationships in the future. Of the DVFR cases with conviction data available in which an abuser was sentenced to jail or prison, 16% were sentenced to life in prison or the death penalty. Fifty-three percent were sentenced to less than thirty years' confinement; 31% less than twenty years, and 8% to sentences ranging from one to ten years. This reality highlights the critical need for interventions designed to address offenders who have used homicidal violence. Community dialogue and further research are needed to develop such programs and strategies.

# Challenges for Communities of Color in the Criminal Legal System

## Overview

Out of the thirteen in-depth reviews conducted since the 2002 Domestic Violence Fatality Review (DVFR) report, police reports indicated that four abusers were men of color and three victims were women of color. DVFR findings have indicated that women of color face a greater relative risk of domestic violence homicide than white women.<sup>73</sup>

In-depth analysis of these cases by Fatality Review panels have indicated that abused women of color and communities of color in general face particular challenges in responding to domestic violence. Specifically, fatality reviews have repeatedly and dramatically illustrated the multiple barriers communities of color face in using criminal legal strategies to keep victims safe and hold batterers accountable. These barriers include:

- a history of strained police/community relations;
- disproportionately high rates of incarceration;
- challenges posed by immigration status;
- law enforcement cooperation with immigration enforcement; and
- inadequate options for language interpretation.

In thinking about what interventions victims and abusers needed in reviewed cases, Fatality Review panels and advisory committees identified significant limitations to focusing reform efforts primarily on the criminal legal system. This highlights the need to create community-based responses to domestic violence that engage victims, abusers, and their friends and families.

## Histories of strained police/community relationships

Experts from communities of color on our panels and advisory committees emphasized that the history of difficult relationships between communities of color and government institutions must be taken into account when considering how to create effective interventions and when identifying strategies and targets for change. They emphasized that histories of police bias and brutality, racial profiling, and policies which criminalize and stereotype portions of the community create distrust in communities of color and deter victims in those communities from participating fully in the criminal legal system.

Two cases reviewed by Fatality Review panels since September 2002 involved victims and abusers from the African American community. Discussing why the domestic violence victims in these cases may have been reluctant to call the police for help even though the violence and threats they faced were extreme, our advisory committee and experts on Fatality Review panels noted that it is unrealistic to expect African American victims of domestic violence to place much trust in the criminal legal system, although they may turn to it when they feel they have no other way to end a violent incident.

Carrie's<sup>74</sup> story was told in "The Complexity of Victims' Lives and Multiple Barriers" chapter to illustrate the power of abusers' threats toward their partners' family members. Her story also illustrates the difficult choices women of color may face when considering whether or not to seek law enforcement intervention. Carrie's partner, Daniel, was very abusive, and Carrie was aware that he had killed someone in the past.

<sup>73</sup> See the 2002 DVFR report, "Tell the World What Happened To Me": Findings and Recommendations from the Washington State Domestic Violence Fatality Review, by Margaret Hobart for the Washington State Coalition Against Domestic Violence (Seattle: WSCADV, 2002), p. 35. The report is available at [www.wscadv.org](http://www.wscadv.org).

<sup>74</sup> All names used in this section are pseudonyms.

When Daniel's control and jealousy turned violent, it appeared that Carrie's family had encouraged her to find other ways besides the legal system to cope with his abuse.

Carrie never called police to report Daniel's violence toward herself, although he had abused her extensively. Instead, she made plans for her safety with family and friends, and sought refuge at family members' homes. After she left, Daniel began to take their three-month-old daughter from her as a means to coerce Carrie to move back in with him. On one occasion, he took their baby and refused to return her after keeping her overnight, demanding that Carrie retrieve the infant at his apartment. She did so out of concern for her child, at which time Daniel forced her into his car and drove her and the infant out of state, essentially kidnapping them. They returned a few days later, only after Carrie agreed to reunite with him. She escaped with the help of family and did not report the incident to the police.

A week after that incident, Daniel again had their baby and refused to return her, and then threatened Carrie with a gun. It was only when she could not persuade him to return the child and felt that her own and her daughter's life were in danger that Carrie called the police and reported the history of abuse. Police were not able to provide much assistance because no court orders were in place, but a family member succeeded in retrieving the child from Daniel on that occasion. Afterwards, Carrie's family told her she no longer needed to call the police since she had her child back. Two days later, Daniel took the infant from Carrie again and refused to return her for two days. As Carrie worked with police to try to get her child back, she faced pressure from Daniel's parents to make sure any charges against Daniel resulting from her contact with police were dropped.

This story and incidents in other reviewed cases illustrate themes familiar to advocates who work with women of color: calling the police only when they could not identify any other options for stopping the abuse or protecting their children; community pressure to resolve conflicts outside the legal system; and a lack of trust in the legal system as a source of justice for wrongs done to them. Women abused by African American men may face community pressure to resolve the abuse outside the criminal legal system because of the community's perception that the system has unjustly targeted African American men. Also, victims may themselves be reluctant to participate in a system they see as biased.

Although violent crime rates overall in the U.S. have dropped,<sup>75</sup> incarceration rates for African Americans, especially African American men, have risen dramatically over the last twenty years. The proportion of adult black males who have been or are incarcerated in state or federal prison nearly doubled between 1974 and 2001, going from 8.7% to 16.6%. Hispanics also face fast-rising incarceration rates. In 1974, 2.3% of Hispanic males had been or were currently in state or federal prison. By 2001, this proportion increased over three times to 7.7%.<sup>76</sup> Because of the high incarceration rates for communities of color, these communities are acutely aware of the price families and children pay when men are imprisoned and when they return to the community from prison. According to an Urban Institute study of prisoner reintegration, families bear the brunt of the burden of reintegration, being the primary providers of both economic and emotional support to released prisoners.<sup>77</sup>

Additionally, women battered by men of color may feel that the cost of involving the criminal legal system (e.g., batterers using escalating violence in retaliation,

<sup>75</sup> According to the Bureau of Justice Statistics, "Criminal victimization estimates in 2001 are the lowest recorded since 1973, when the National Crime Victim Survey was initiated." Similarly, property crimes were also at record lows. From *Criminal Victimization 2001: Changes 2000-2001 with trends 1993-2001*, by Callie Rennison, Ph.D., NCJ 194610 (Washington, D.C.: U.S. Department of Justice, September 2002).

<sup>76</sup> According to the Bureau of Justice Statistics, if current incarceration rates continue, one in three black males and one in six Hispanic males can expect to go to prison in their lifetime. This is in contrast to one in seventeen white males. From *Prevalence of Imprisonment in the U.S. Population, 1974-2001*, by Thomas P. Bonczar, NCJ 197976 (Washington, D.C.: U.S. Department of Justice, August 2003).

<sup>77</sup> Christy Visser, Nancy LaVigne and Jeremy Travis, *Returning Home: Understanding the Challenges of Prisoner Reentry*, The Urban Institute - Justice Policy Center, January 2004.

community disapproval, batterers experiencing violence or abuse at the hands of other prisoners or guards<sup>78</sup>) is not worth any benefits which may come out of that involvement. Carrie and her family seemed to think that involving the police would place her and her child at greater risk of further violence. They did not trust that police involvement would make any of them safer. One Fatality Review advisory committee member who works to expand discussion of black-on-black crime talked about the difficult decision that confronts victims: they want the violence to stop, but do not want the perpetrator of that violence subjected to potential police and prison brutality.

### **Immigration issues and police cooperation with immigration enforcement**

Two out of the thirteen cases reviewed since the 2002 DVFR report involved non-U.S. citizens. In one case, both the victim and the abuser were legal permanent residents, but not U.S. citizens (both were free to work legally and to leave and return to the U.S. at will). In another case, the abuser was a legal permanent resident and the victim was a U.S. citizen.

Fatality Review panels noted that in cases where either the victim or abuser are not citizens, victims may avoid reporting the abuse because of fear of deportation or jeopardizing their own or their partner's immigration status. The cooperation many law enforcement agencies extend to the Bureau of Immigration and Customs Enforcement (ICE)<sup>79</sup> compounds these fears. For non-citizens, involving the police comes with a real risk of detention or deportation. This risk discourages non-citizen victims of domestic violence from calling on law enforcement or other government programs for help.

Policies that protect victims but not abusers from immigration investigation are not sufficient to overcome the fear of involving police. If domestic violence victims believe that their partners will be detained or deported, they may be reluctant to call law enforcement for protection. In one reviewed case, the Fatality Review panel identified several reasons the victim may have chosen not to call law enforcement to report abuse: her immigration status or her family's income may have depended on the abuser; she may have feared that the abuser would retaliate against her family in their home country; or she may have feared deportation herself, particularly if she had ever used violence to defend herself from his abuse.

While some law enforcement agencies' policies state that their officers will not question victims' immigration status or report them to immigration enforcement, others do so routinely. A 2002 newspaper article quotes one Washington police official describing his department's procedure: "If we interview people we think have issues about immigration, we always call the border patrol or INS."<sup>80</sup> Fatality Review panel participants reported that some law enforcement agencies rely on ICE agents to provide language interpretation with Limited English Proficient individuals. Such practices influence immigrants' perception of law enforcement, even beyond the jurisdictions in which they occur. At one review, in a jurisdiction where police did not collaborate with ICE, representatives from that law enforcement agency had difficulty understanding why non-citizen victims may hesitate to call them, since they felt their department had established a policy sensitive to non-citizens' concerns. People on the panel who work closely with immigrant communities pointed out most people are not familiar with policy differences among law enforcement agencies across jurisdictions. When immigrants hear about a problematic law enforcement practice, they assume

<sup>78</sup> Both Amnesty International and Human Rights Watch have condemned conditions in U.S. prisons, documenting poor physical conditions, oppressive rules, abuses of power by prison guards, and the common occurrence of inmate vs. inmate physical and sexual violence. See, for example, *No Escape: Male Rape in U.S. Prisons* by Human Rights Watch, April 2001 (<http://www.hrw.org/reports/2001/prison/report.html>), or Amnesty International's *A Briefing for the UN Committee Against Torture*, May 4, 2000, AI Index: AMR 51/056/2000 (<http://web.amnesty.org/library/index/engamr510562000>).

<sup>79</sup> The Bureau of Immigration and Customs Enforcement (ICE), a new division of the Department of Homeland Security, is charged with enforcement functions of the former Immigration and Naturalization Service (INS).

<sup>80</sup> Chris McGann and Lise Olsen, "A Mother's Odyssey Ends in Tragedy," *Seattle Post-Intelligencer*, 20 November 2002.

the response will be similar next time, regardless of where they are. This belief will not change unless law enforcement jurisdictions make visible and active efforts to educate all segments of the community about their policies and practices, particularly around domestic violence and cooperation with ICE.

**RECOMMENDATIONS:**

- Local law enforcement officers should not inquire about citizenship status when responding to a crime scene.
- Local law enforcement agencies should not coordinate efforts with the Bureau of Immigration and Customs Enforcement (ICE) in patrol, investigation and follow-up work on non-federal, non-terrorism-related crimes.
- Local law enforcement agencies should not be involved in enforcing immigration law.
- Local law enforcement should work with immigrant communities to publicize and clarify their policies regarding when and if they cooperate with ICE and what non-citizens can expect to happen when they call 911.
- Local law enforcement agencies who have actively decided not to enforce immigration law should be in dialogue with other law enforcement agencies (particularly those in the same region) with differing policies, educating them about the safety concerns and increased danger to battered women and children that collaborative enforcement relationships raise in immigrant communities.

**Inadequate options for language interpretation**

When responding to domestic violence crimes that involve people who are not fluent in English, high-quality language interpretation is critical. Limited English Proficient (LEP) individuals are likely to anticipate communication problems with law enforcement and they are accurate in their assumptions. Although our state's legislative history indicates support for access to the criminal legal system by LEP individuals,<sup>81</sup> local jurisdictions do not have systems in place to consistently make certified interpreters available. Limited English speakers may encounter 911 operators who are slow to recognize their need for interpretation; law enforcement officers who either do not obtain interpretation at the scene or ask the abuser, children or neighbors to interpret for the victim; or officers who attempt to communicate with them via written English.

Fatality reviews repeatedly illustrate the costs to domestic violence victims and their communities when law enforcement agencies do not invest in language access for limited English speakers. In one recently reviewed case, the lack of a court-certified interpreter at the homicide scene seriously undermined the integrity of the law enforcement investigation. The abuser, who was Spanish-speaking, had shot and killed his wife at home. A police officer who spoke both English and Spanish interviewed the abuser and documented his statement and reenactment of the homicide in which he claimed he had acted in self-defense. According to the medical examiner, the abuser's claim that the shooting was in self-defense was inconsistent with the physical evidence. Based on that evidence, he was charged with second-degree murder. However, the defense in this case questioned the accuracy of the abuser's statement and reenactment of the

<sup>81</sup> For example, see RCW 26.50.035.

homicide because the bilingual interviewing officer was not a court-certified interpreter, weakening the prosecutor's case. The court accepted a guilty plea from the abuser for the reduced charge of second-degree manslaughter, and sentenced him to twenty-three months. He was released after only nine months.

The 2002 DVFR report contains a series of detailed recommendations regarding access to law enforcement for Limited English Proficient individuals, all of which are still relevant.<sup>82</sup>

#### RECOMMENDATIONS:

- Law enforcement agencies should budget for telephonic interpretation services for all Limited English Proficient (LEP) calls and prioritize hiring employees who are qualified to provide services and intervention in relevant languages.
- Consistent with Washington state law, law enforcement agencies should conduct investigations of domestic violence crimes with qualified interpreters (either in person or via telephonic services) for all LEP individuals, with the goal of obtaining complete victim, perpetrator and witness statements at the initial crime scene, as well as high-quality investigative and follow-up work.
- Law enforcement agencies should hold officers accountable for conducting inadequate investigations when they fail to follow policies regarding interpretation and translation.

<sup>82</sup> Washington State Coalition Against Domestic Violence, "Tell the World What Happened To Me": Findings and Recommendations from the Washington State Domestic Violence Fatality Review, p. 65-66.

### Juvenile justice system

Disenchantment with the criminal legal system is also driven by the experiences of communities of color with the juvenile justice system. The DVFR has reviewed several cases in which it was clear that the abuser had an extensive history in the juvenile justice system. In one recently reviewed case involving an abuser of color, a relative of the abuser talked to police about how the abuser had changed after spending time in the juvenile justice system. The relative said he came out of juvenile incarceration with a new identity and then continued to build up a persona of a "tough, streetwise thug." Also, that after his release, he became involved in "drugs and everything that goes along with that—the money, women, violence, etc."

Fatality Review panels speculated that abusers who entered the juvenile justice system early in their lives were themselves abused or living with domestic violence. In fact, the federal Office of Juvenile Justice and Delinquency Prevention reports that research in this area consistently finds:

- Maltreated children are significantly more likely than non-maltreated children to become involved in delinquent and criminal behavior.
- The prevalence of childhood abuse or neglect among delinquent and criminal populations is substantially greater than in the general population.
- Delinquent youth with a history of abuse or neglect are at higher risk of continuing their delinquent behavior than delinquents without such a history.<sup>83</sup>

Particularly if they are from communities of color facing intensive policing, young people acting out because of the pain of living with domestic violence (or other forms of violence and abuse) can become criminalized within a system set up primarily to punish misbehavior (versus offer resources and rehabilitation). Our experts on Fatality Review panels and advisory committees expressed little hope that the juvenile justice

<sup>83</sup> Richard Wiebush, Raelene Freitag and Christopher Baird, *Preventing Delinquency Through Improved Child Protection Services*, Office of Juvenile Justice and Delinquency Prevention, *Juvenile Justice Bulletin*, NCJ 187759 (Washington, D.C.: U.S. Department of Justice, July 2001).

system could be provided with adequate resources and make the shifts in programming and philosophy necessary to avoid exacerbating the problems of the youth who are sent into it. Implementing comprehensive system reform in juvenile (and adult) criminal legal systems is a difficult and daunting task. As an alternative, advisory committees recommended a focus on strong community-based efforts addressing multiple forms of violence (domestic violence, child abuse, street violence, bullying) aimed at preventing children from entering the juvenile justice system in the first place.<sup>84</sup>

<sup>84</sup> Studies by the RAND Corporation argue that the costs of such prevention programs would be more than saved over the long term because of reductions in crimes committed and incarceration rates. See *Diverting Children From a Life of Crime: Measuring Costs and Benefits*, by Peter W. Greenwood et al., RAND Corporation, 1996 and *Investing in Our Children: What We Know and Don't Know about the Costs and Benefits of Early Childhood Interventions*, by Lynn A. Karoly et al., RAND Corporation, 1998.

**RECOMMENDATION:**

- The Washington State Legislature should fund innovative, community-based child abuse prevention and juvenile delinquency prevention programs based in agencies which already have trust and credibility within their target communities.

**The need for more dialogue about violence within communities of color**

In addition to the barriers discussed above, communities of color face two more substantial challenges in responding to domestic violence.

The first challenge is a legacy of coping with and responding to histories of institutional bias, differential incarceration rates and other forms of racism. As several of our advisory committee members pointed out, this history has resulted in a particular reluctance to discuss violence *within* a community (i.e., perpetrated by members of that community against other people in the community). Communities of color have generally been more comfortable discussing violence perpetrated *against* their communities than the gender-based violence perpetrated *within* them because of the self-protective attitude created as a result of being embattled.

The second challenge is one shared by all communities: A lack of models for intervening as a friend, family member, neighbor or co-worker of the victim or abuser. In every case involving people of color, people surrounding the victim knew of or observed abuse. Although family and friends may be aware of the abuse, they are often unclear about what they can do to help the victim, and do not have the information to determine whether the abuse is potentially lethal.

**Building community-based strategies**

Fatality Review panels and advisory committees repeatedly returned to the theme of building community-based support and accountability strategies. These strategies are especially relevant for communities of color. The next chapter, "A Wider Safety Net—Friends, Family and Communities" elaborates on Fatality Review panel findings regarding the need for strategies that increase communities' capacity to support victims and hold batterers accountable for abuse.

## A Wider Safety Net— Friends, Family and Communities

Domestic violence experts have long recognized social isolation as a cornerstone of battering.<sup>85</sup> Domestic violence victims often find themselves alienated from friends and family as a consequence of abuse. What may be less recognized, however, is that despite the efforts of their abusers, most victims retain at least some contact with other people in their lives. These can include friends, family, neighbors, co-workers, people in religious communities, and their children’s teachers or daycare providers. In the thirteen fatalities reviewed since 2002, all of the victims had some routine contact with friends, family, co-workers or people at church. In nine cases, a friend or family member actively tried to offer support or help the victim become safe from the abuser.

In addition to the criminal and civil legal systems and social service agencies, it is vital to engage domestic violence victims’ and abusers’ communities in efforts to understand, prevent and respond to domestic violence. Friends, families, co-workers and community members can play a critical and unique role in efforts to support domestic violence victims’ self-determination and safety and to promote accountability for abusers. Domestic violence programs and others already working to address domestic violence should work to build the capacity of communities to respond effectively to domestic violence.

One important reason to actively involve friends and family members in safety planning is that these support people are very often themselves at risk of violence from abusers, particularly when the abuser has access to a firearm. Out of the 281 individuals killed by domestic violence abusers in Washington since 1997, 53 were the friends, family members, co-workers or new intimate partners of domestic violence victims. The majority of these homicides (68%) were committed with firearms. While the need to involve communities is critical, Fatality Review panels and advisory committees have consistently emphasized that the widespread use of guns radically undermines the ability of friends, family members and neighbors to feel safe in confronting abusers or intervening to prevent violence. In order to create an environment in which community members can support domestic violence victims and discourage one another from engaging in violence and abuse, communities need strong, well-enforced gun control laws. Gun control supports communities in efforts to enforce social norms and resist a culture of violence.

Past Domestic Violence Fatality Review (DVFR) reports have identified the need for people working to end domestic violence to develop strategies that include the friends, family and community members of victims in that work. In response to these findings, the Washington State Coalition Against Domestic Violence (WSCADV) published a *Model Protocol on Working with Friends and Family of Domestic Violence Victims*<sup>86</sup> in April 2004 to help domestic violence advocates and others take steps toward including friends and family in their work with victims of domestic violence.<sup>87</sup> The protocol outlines three major reasons (paraphrased here) to prioritize strategies for working with friends and family:

- Victims often turn to people they already know for support before they try to access service agencies.
- Victims and their families require deeply rooted, varied and complex support networks that cannot be replaced by any service system.

<sup>85</sup> See Ginny NiCarthy, *Getting Free: A Handbook for Women in Abusive Relationships* (Seattle, WA: Seal Press, 1982), p. 287-288.

<sup>86</sup> This protocol is available at [www.wscadv.org](http://www.wscadv.org). It was authored by Connie Burk, director of the Northwest Network of Bisexual, Trans, Lesbian and Gay Survivors of Abuse.

<sup>87</sup> A further resource is the report *Preventing Family Violence: Community Engagement Makes the Difference*, written by P. Catlin Fullwood and produced by the Family Violence Prevention Fund, 2002. See [www.endabuse.org](http://www.endabuse.org) to obtain a copy.



- When friends and family members are included as allies in anti-violence work, they can help to change the culture that supports abuse.

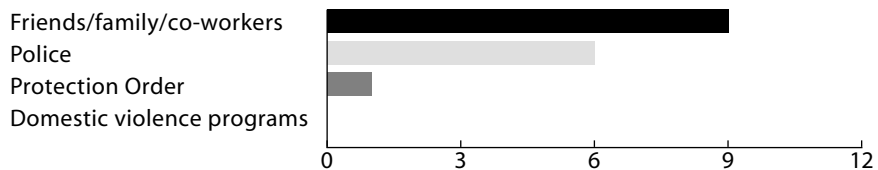
In the thirteen fatality cases reviewed since September 2002, Fatality Review panels repeatedly identified circumstances in victims' lives that are consistent with these three principles.

**Victims often turn to people they already know for support before they try to access service agencies.** Out of thirteen cases, nine victims tried to access friends and family for support; five of those victims also talked with co-workers about the abuse. In comparison, six called police and one sought a Protection Order. It did not appear that any of the victims accessed a community-based domestic violence program.<sup>88</sup>

<sup>88</sup> Because confidentiality policies prohibit community-based domestic violence programs from disclosing the provision of services unless the individual signed a release, we cannot be absolutely certain that none of these victims accessed such a program. However, there was no indication throughout the investigation of the homicides or interviews with family members or friends that they did.

WHERE DID DOMESTIC VIOLENCE VICTIMS TURN FOR SUPPORT?

Total: 13 cases



In one reviewed case, the domestic violence victim's friends, family and other community members were aware of the abuser's violence and had witnessed his violence toward her on several occasions. In one incident, the abuser attacked the victim in front of several of her friends while she sat in his car. One friend described the group's efforts to help get her to safety: "She was scared...and we tried to get her out of the car. It was like, come on, we'll just get you help...but she...was scared. She wouldn't go...She stayed with him."

The Fatality Review panel reviewing this case identified a need for community education and outreach that gives friends and family members tools for understanding the dynamics of domestic violence, and that identify where people can turn for information about safety planning and how to support a friend or family member in an abusive relationship. The panel also saw a need for ongoing, community-wide discussions about healthy relationships.

In another reviewed case, a victim wrote letters to her friend describing her husband's abuse and her fear that the abuse would escalate as she prepared to leave him. She wrote, "He's mean to me and our girls...He has threatened suicide on me countless times...I have fought to get a loaded gun out of his hands a few times... The divorce is going to be bad. It scares me to think about it, but it has to happen." In the months before she attempted to leave her husband, she talked with her friend and her mother about her plans. In addition to law enforcement and civil Protection Orders (which she also utilized), her connection with friends and family represented an important opportunity to increase her options for self-determination and safety.

These examples illustrate some of the ways that domestic violence victims reach out to their friends and family, and ways in which friends and family attempt to support victims. Rather than trying to replace support from friends and family with support from other systems, organizations working to end domestic violence should

prioritize increasing friends' and families' capacity to provide effective, informed and successful support.

**Victims and their families require deeply rooted, varied and complex support networks that cannot be replaced by any service system.** Because domestic violence occurs in all communities, domestic violence victims and abusers come from every cultural context and have a vast range of needs, skills and challenges. No “one size fits all” strategy can increase victims’ self-determination and safety and create accountability for abusers.

Services available from domestic violence programs, law enforcement or civil legal systems respond to particular aspects of a victim's experience and are necessarily limited in their scope. Many of the things domestic violence victims in reviewed cases needed when surviving abuse could not be provided by such services—for example, a place to stay while actively using drugs. In addition to the legal system and social services, victims needed culturally relevant, flexible and multi-layered responses to abuse from their friends, family and community. However, providing support to victims can be challenging, and support people often needed help to increase their skills and resources for this work.

In one reviewed case, the victim was addicted to alcohol and methamphetamines. The Fatality Review panel pointed out that because of her drug and alcohol use, no social service agency in her community was equipped to provide services to her. While a number of her friends and family were making efforts to help her, her struggles with the consequences of abuse, poverty and addiction repeatedly undermined her connections with potential support people. Shortly before her death, she appeared to her family and friends to be “depressed” and “delusional.” After the victim was evicted from her apartment, one family member was reluctant to give her a place to live because the victim had been violent in the past and her family's efforts to help her had backfired. Shortly after being evicted, the victim cashed two bad checks at a convenience store. The clerk who accepted the checks trusted her because she lived nearby and had worked at a local tavern. A few days later, when she returned to the store, the clerk asked her about the checks. She never returned to the store after that, and was consequently cut off from another person she knew who might otherwise have offered support, information or resources.

Friends and family often need help in the difficult work of supporting a victim of domestic violence. In this case, the victim's friends and family may have benefited from help to identify what support or resources they could offer the victim, as well as how to identify their own limits and set boundaries with her. In addition, the victim may have benefited from support to maintain or repair her relationships with potential support people. The Fatality Review panel identified a need for community outreach and services to support friends and family, in addition to focusing solely on the domestic violence victim as the person in need of services.

In another reviewed case, both the victim and abuser had many social connections within their community. The abuser had an extensive criminal history, beginning when he was a juvenile. However, the criminal legal system was not an effective tool to hold him accountable or to increase the victim's safety. The panel speculated that if family or community-based interventions had been available to him as a boy or young man,

these might have been more relevant to him than criminal legal sanctions and might have been more effective in changing his behavior. Likewise, the panel suggested that support from the victim's friends, family and community (in addition to criminal legal consequences for the abuser) could have been more effective in increasing her safety than a reliance solely on the criminal legal system, which repeatedly failed to hold her abuser accountable or prevent his violence. This highlighted the need for a response to domestic violence that engages the victim's and abuser's community connections.

**When friends and family members are included as allies in anti-violence work, they can help to change the culture that supports abuse.** Fatality Review panels and advisory committees have consistently identified ways in which cultural beliefs, family practices and community institutions can support abusers' violence and undermine victims' efforts to achieve safety and self-determination. For example, in several recently reviewed cases, cultural, family or religious messages that family violence is a private issue seemed to contribute to victims' reluctance to talk about abuse. Fatality Review panels found in several cases that the abuser's family and friends were aware of his violence, yet did not intervene to respond to the abuse. In two of the reviewed cases, the abuser asked a friend to help him get a weapon that he intended to use in a homicide or suicide. Family and friends of both victims and abusers often continued to provide support and assistance to abusers even when they knew of the abuse, and often misunderstood the danger that the abuser's behavior created for the victim. One victim's friend reported that the abuser got financial help, including bail money, from his family and his mother's church.

Fatality Review panels suggested that if people were engaged by anti-violence education to think critically about the culture that supports domestic violence, then communities would be better equipped to support victims and to promote accountability for abusers. Panels identified a need for specific work that would inform community members about the dynamics of domestic violence, encourage people to have open dialogue about abuse, and provide tools for supporting victims and holding abusers accountable.

### **Promising practices**

Several programs in Washington state have developed innovative approaches to working with friends, family and community members.<sup>89</sup> Often, this work is based in communities that are underserved by mainstream domestic violence services. Below are a few brief examples of this emerging work.

The Asian and Pacific Islander Women and Family Safety Center has developed a model of engaging community members to address domestic violence in an ongoing and everyday way. The Safety Center trains and supports "natural helpers": volunteers who have domestic violence information and basic support skills and can act as "eyes and ears of the community" to connect any victim they meet in the course of their daily life to appropriate resources and support.

The Northwest Network of Bisexual, Trans, Lesbian and Gay Survivors of Abuse has implemented comprehensive support planning strategies in all program services, program outreach and community education. Advocates help victims determine how and when to involve support people in safety planning or other help, and are prepared to talk with friends and family about how to plan for their own safety while supporting a loved one who is in danger.

<sup>89</sup> Agencies can contact WSCADV at 206-389-2515 for assistance connecting with a community organization that has taken steps discussed in this section to engage local communities in addressing domestic violence.

Amigas Unidas is a grassroots community organizing project working with farmworker women in Central and Eastern Washington. The project uses community education and word-of-mouth outreach to get information and support to Spanish-speaking victims of domestic violence. The project assumes that many victims never contact a community service agency, and therefore trains community members to provide support and information about domestic violence on a daily basis, wherever it may be needed.

Communities Against Rape and Abuse identifies the connections between interpersonal violence and other issues of concern, such as police violence, poverty and the institutionalization of people with disabilities. Community Action Teams organize a variety of forums, such as popular education workshops, discussion groups and community events, where connections between issues are explored.

**RECOMMENDATIONS:**

- All agencies, programs and institutions that respond to domestic violence (including domestic violence programs, law enforcement, courts, social service agencies and community organizations) should identify ways to improve support for friends and family of domestic violence victims.
- Domestic violence advocates should develop safety planning tools to assist friends and family members of victims who call domestic violence crisis lines.
- Domestic violence programs should evaluate how their own program policies reinforce isolation for victims, and make changes in order to promote victims' connection with their friends, family and community.
- Domestic violence advocates should strategize with shelter residents to help them maintain or rebuild connections with friends and family while living in confidential shelter.
- Police officers should hand out domestic violence information to friends, family and neighbors at the scene of domestic violence crimes.
- Police, prosecutors and judges should make every effort to identify and remove abusers' guns at each step of the criminal and civil legal process.
- Community groups (such as neighborhood associations, block watch groups, fraternal and volunteer organizations) should create opportunities for members to learn about domestic violence.
- Funders should prioritize strategies that engage friends and family of domestic violence victims and that support victims to build and maintain connection with their communities. Funders should offer grants to fund innovative projects to develop such strategies, including those that address the needs of particular neighborhoods and marginalized communities.
- Funding should be made available for community organizing projects aimed at building safety and accountability strategies outside of the criminal legal system, particularly within marginalized communities and communities of color. Funding for such projects should go to organizations with established credibility and trust within the communities that will be the focus of organizing efforts.
- Funders and domestic violence programs should recognize community education and prevention efforts as a part of core services.



# Appendix A: History and Description of the Domestic Violence Fatality Review

(Adapted and updated from *Honoring Their Lives, Learning from Their Deaths: Findings and Recommendations from the Washington State Domestic Violence Fatality Review*, December 2000)<sup>90</sup>

## History, background and funding of the Washington State Domestic Violence Fatality Review

The Washington State Domestic Violence Fatality Review came about because battered women's advocates were puzzled that after twenty-five years of reforms aimed at improving community response to domestic violence, the death toll arising from this social problem has held relatively steady. Advocates thought that by conducting in-depth examinations of domestic violence fatalities, communities would be able to identify persistent gaps in the response to domestic violence, examine what prevents communities from holding abusers accountable, understand the barriers battered women face as they seek to end the violence in their lives, as well as define directions for change and improvement. Advocates also hoped to compile statistics on domestic violence fatalities which were more detailed and complete than those available from criminal justice resources.

The Domestic Violence Fatality Review (DVFR) began in 1997 with federal Violence Against Women Act (VAWA) funds, administered through the Office for Crime Victims Advocacy in the Department of Community, Trade, and Economic Development, and was originally housed in the Department of Social and Health Services. The first eighteen months focused on creating a statewide model for domestic violence fatality reviews, and starting three pilot review panels to test the model. The model itself and the process used to develop it are fully documented in the report *Homicide at Home*.<sup>91</sup>

In January 2000, the DVFR moved from DSHS to the Washington State Coalition Against Domestic Violence (WSCADV). A second VAWA grant allowed the DVFR to begin implementing the model. The Washington State Legislature has allocated funding for the DVFR since the

2000 legislative session. These monies are administered through DSHS Children's Administration.

## An overview of the Domestic Violence Fatality Review

### Purpose

The Washington State Domestic Violence Fatality Review's primary goals are to promote cooperation, communication and collaboration among agencies investigating and intervening in domestic violence; identify patterns in domestic violence-related fatalities; and formulate recommendations regarding the investigation, intervention and prevention of domestic violence.

The DVFR seeks to accomplish these goals by bringing together key actors in local social service, advocacy and justice systems for detailed examination of fatalities. Focusing on public records, fatality review panels analyze community resources and responses to prior violence, and generate information relevant to policy debates about domestic violence.

The DVFR does not assign blame for fatalities to individuals, agencies or institutions. Instead, the perpetrator of the homicide or suicide is assumed ultimately responsible for the fatality. It also does not seek to identify patterns of individual pathology on the part of the batterer or battered woman. Rather, the DVFR focuses on problems in community response to domestic violence: gaps in services, policy, practice, training, information, communication, collaboration or resources.

The Fatality Review also tracks domestic violence-related fatalities throughout the state using a variety of data sources, including news accounts, crime statistics and vital statistics in order to provide an analysis of patterns. Extensive data is kept on reviewed cases and a limited set of data on unreviewed cases.

<sup>90</sup> Washington State Coalition Against Domestic Violence, *Honoring Their Lives, Learning from Their Deaths: Findings and Recommendations from the Washington State Domestic Violence Fatality Review*, by Margaret Hobart (Seattle, WA: WSCADV, 2000). To obtain a copy of the report, go to [www.wscadv.org](http://www.wscadv.org).

<sup>91</sup> Washington State Department of Social and Health Services, Children's Administration, *Homicide at Home: Washington State's Domestic Violence Fatality Review Project*, by Margaret Hobart (Olympia, WA: DSHS, December 1999). This publication is available from the Washington State Coalition Against Domestic Violence at 206-389-2515 and on the Coalition's website at [www.wscadv.org](http://www.wscadv.org).

### **What is a domestic violence fatality?**

#### ***How the DVFR defines a domestic violence fatality:***

We define a domestic violence fatality as: *those fatalities which arise from an abuser's efforts to seek power and control over his intimate partner.*

In creating a definition of "domestic violence fatality" and setting criteria for review, we wanted to capture the scope of the problem more fully and accurately than legal definitions and existing crime statistics.

Law enforcement agencies and FBI crime reports identify domestic violence homicides through the victim/offender relationship. "Domestic violence" crimes are those in which the relationship of the victim to the perpetrator is that of a family or household member, or someone whom the victim is dating or has dated.<sup>92</sup> Some states, like Washington, include same-sex relationships in their definition. "Intimate partner homicides" form a significant subgroup of the larger category of "domestic violence homicides." These are the homicides in which the victim is the current or former wife, husband, boyfriend or girlfriend of the perpetrator. Homicides in which the victim was the child, parent, sibling, or any family relationship other than marriage are excluded from this category. Defined this narrowly, cases in which homicidal batterers kill law enforcement officers, their former partner's new love interests, or bystanders do not count as domestic violence fatalities.

*In contrast to the legislative definition's reliance on the victim/perpetrator relationship, the DVFR focuses on the context of the fatality. This allows us to capture more fully the human cost of domestic violence.*

***Why our definition is broader/narrower than the criminal definition:*** This definition of a domestic violence fatality is both wider and narrower than the one used by most criminal justice system reporting agencies. It is

*wider*, in that it takes into account that abusers sometimes kill non-family members. It is *narrower* in that the DVFR definition excludes some cases in which family members and co-habitants kill one another but the deaths do not take place in the context of intimate partner violence. Thus, cases where siblings kill siblings, or children kill parents, and death by child abuse cases are excluded (unless it is clear that intimate partner violence was also involved).

Using this definition, domestic violence fatalities include:

1. All homicides in which the victim was a current or former intimate partner of the perpetrator.
2. Homicides of people other than the intimate partner which occur in the context of domestic violence or in the context of attempting to kill the intimate partner. For example, situations in which an abuser kills his current/former intimate partner's friend, family or new intimate partner, or those in which a law enforcement officer is killed while intervening in domestic violence.
3. Homicides occurring as an extension of or in response to ongoing abuse between intimate partners. For example, when an individual kills children in order to exact revenge on his partner.
4. Suicides which may be a response to abuse.

### Central activities of the Domestic Violence Fatality Review

#### **In-depth review of domestic violence fatalities**

***Composition of Fatality Review panels:*** The best information about fatalities is generated at the local level, with panel members who are closely involved in the community response to domestic violence. Thus, locally based, multi-disciplinary panels conduct the in-depth reviews of fatalities.

<sup>92</sup> RCW 10.99.020 and RCW 26.50.010.

Review panels are generally convened at the county level. In some cases, multi-county review panels exist.

Core panel participants include:

- Municipal, District and Superior Court judges
- Municipal, District and county-level prosecutors
- Municipal and county-level law enforcement agencies
- Court and/or prosecutor-based domestic violence advocates
- Local hospital staff
- Battered women’s shelters and advocacy organizations
- Child protective services
- Community corrections/probation officers
- Health Department workers, often from First Steps programs or community clinics
- Agencies/organizations serving specialized populations: people of color, limited English-speaking, immigrant/refugees, gay/lesbian/bisexual/transgendered
- Military liaisons for areas close to military bases
- Humane Societies and animal cruelty investigators
- Batterer’s intervention programs

Whenever possible, we also include local mental health and substance abuse treatment providers, schools, and leaders of religious communities. If, in preparing for a case it becomes clear that either individual had contacts with a particular agency, doctor, attorney, religious leader, etc., we contact that professional and invite them to the review.

**Where review panels exist:** The Domestic Violence Fatality Review has operated review panels covering twelve of Washington state’s counties since 1997. Staffing constraints prevent us from operating review panels in more than a few counties at one time; thus, panels meet for a while and then go on hiatus. Panels currently operate in Snohomish, King, Clark and Benton/Franklin/Walla Walla counties.

LOCATION OF REVIEW PANELS	FROM	TO
Chelan/Douglas/Okanogan Counties	6/1998	7/1999
Spokane County	6/1998	11/2000
Pierce County	6/1998	2/2003
Yakima/Kittitas Counties	4/1999	11/2000
King County	6/1999	Present
Clark County	11/2001	Present
Benton/Franklin/Walla Walla Counties	4/2002	Present
Snohomish County	2/2004	Present

**Confidentiality and access to information:** Proceedings of DVFR panels are confidential and protected from discovery by a third party, as mandated by RCW 43.235, and participants in Fatality Review panels are protected from any liability arising from their participation on the panel.

Currently, the DVFR does not have access to confidential information, such as batterer’s intervention, medical or mental health records, unless the information is releasable for research purposes or we have obtained a release from next of kin. This poses some limitations for panels, but we have also found that a wealth of information exists in public records.

**Criteria for in-depth review by a Domestic Violence**

**Fatality Review panel:** Because of review panel members’ reluctance to influence civil or criminal adjudication, and limitations on access to information, the following criteria were developed for case selection:

- the death fits with the DVFR’s definition of a domestic violence fatality
- the criminal justice system has identified the perpetrator
- the case is closed with no appeal pending (or the prosecutor in charge of the appeal agrees that a fatality review will not affect issues under appeal and gives his or her permission to the review)
- the fatality was as recent as possible, given the other constraints



At present, the Fatality Review's criteria rule out unsolved homicides, deaths which never triggered a criminal investigation because they were classified as accidental, and cases in which prosecution or a civil suit is pending.

**The process for review:** Review panels generally meet quarterly. Panels identify which cases they would like to review.<sup>93</sup>

Once the panel has identified a death for review, DVFR staff requests all public records related to the individuals involved. This includes Protection Orders, dissolution filings, parenting plans, court records related to criminal convictions, law enforcement incident reports, and the homicide investigation. In some cases, we are able to establish research agreements with law enforcement agencies, easing access to incident reports related to events which did not result in a conviction. When we are able to identify surviving family members, the Fatality Review sends them a letter explaining the purpose of the DVFR and inviting them to share any information they would like by contacting the Fatality Review's staff. Staff synthesize the events described in these public documents (and by family members) into a Case Chronology and distribute this document to review panel members prior to the review.

Review panel members read the Case Chronology and examine their own agency's records for contacts with the domestic violence victim, the domestic violence abuser, or the children. If the agency has served any member of the family, it is up to the panel member to identify how much information is disclosed about those contacts during the review, given the profession's or agency's confidentiality constraints.

The panel meets for several hours to discuss each case. Additions and corrections to the Case Chronology are noted, and the panel works to identify missed opportunities for intervention, barriers to battered women obtaining

safety and the ability of the system to hold abusers accountable for their violence. Two products are generated from the review: a detailed summary of the discussion, which is sent out to all attendees for their approval, and a completed Case Information Form (our data collection instrument) for entry into the DVFR's database.

Review panel members do not generate recommendations. Instead, they generate information and identify issues and problems. The recommendations in this report are based on a careful reading and synthesis of all the issues and problems identified in reviewed deaths.

### **Data collection and identification of domestic violence-related deaths**

The second central task of the DVFR consists of tracking and collecting data on both reviewed and unreviewed domestic violence fatalities. The Fatality Review has developed a detailed data collection tool, with the goal of tracking the circumstances of domestic violence fatalities.

The DVFR seeks to identify all domestic violence fatalities in the state and collect a limited amount of information on each one, including the names and birth dates of the victim and perpetrator, their relationship, the date of the fatality, weapon used, charges filed regarding homicides and outcomes, prior domestic violence convictions and protective order filings, and a brief summary of the circumstances of each homicide or suicide. We use a variety of means to identify domestic violence fatalities: news accounts of homicides and suicides, Washington Association of Sheriffs and Police Chiefs crime reports, medical examiner records (when available), citizen request for review and vital statistics data from the Health Department.

**Limits of the DVFR's data collection:** While combining these records yields a more complete count of domestic violence fatalities than any one source alone, several problems still exist in accurately tracking the human toll of domestic violence. For one, a significant number of

<sup>93</sup> Citizens can request a review of a particular death, per RCW 43.235. The "Citizen Protocol for Requesting Review" can be found in Appendix C of the 2002 DVFR report (available at [www.wscadv.org](http://www.wscadv.org)).

women commit suicide each year. Experiencing domestic violence may increase women's risk of depression and suicidal behavior, but without access to more confidential information than we currently have, it is very difficult for review panels to determine when women's suicides are related to the despair and hopelessness some women feel in abusive relationships. Secondly, anecdotal information suggests that some homicides are misidentified as "accidental deaths." Again, without access to confidential information, it may be difficult to identify these cases. Third, a significant portion of murders go unsolved, and many missing person cases exist involving women which also remain unsolved. It is likely that some portion of these murders and missing person cases involve domestic violence homicides, and these are missing from our data. Finally, it is likely the Fatality Review's data minimizes the incidence of murder in same-sex relationships. Without in-depth examination, it is not possible to know if homicides in which the perpetrator is listed as an acquaintance or roommate involve same-sex intimate partners or not. The Fatality Review has not undertaken the sort of detailed examination which would allow us to identify which of those cases involve intimate partnerships.



## Appendix B: Glossary of Terms

### **Case**

All cases involve one domestic violence victim and one domestic violence abuser and at least one fatality which meets the Domestic Violence Fatality Review (DVFR) criteria for domestic violence fatality (see definition below and also Appendix A). All cases involve a fatality which occurred in Washington. Cases may involve multiple fatalities, because an abuser may kill more than one person, or they may commit suicide in addition to the murder.

### **All cases**

All cases tracked since the inception of the Domestic Violence Fatality Review in 1997 which meet the DVFR's criteria for a domestic violence fatality.

### **Domestic violence fatality**

Any fatality which comes about as a result of an abuser's efforts to gain power and control over their intimate partner. A fatality refers to the death of an individual person. A fatality may be the result of homicide, suicide or self-defense. The individual killed may be the domestic violence abuser, domestic violence victim, the domestic violence victim's children, friends or family, bystanders or law enforcement officers.

### **All domestic violence fatalities**

All fatalities tracked by the Domestic Violence Fatality Review since January 1, 1997. There are more fatalities than cases, since some cases involve multiple fatalities.

### **All reviewed cases**

All cases which have been subject to an in-depth review by a community-based panel since the DVFR's inception in 1997.

### **Recently reviewed cases**

Cases reviewed from September 2002 through June 2004.

### **Domestic violence perpetrator, abuser or batterer**

One person in an intimate relationship who uses an ongoing pattern of behavior to control their partner, including using such tactics as violence, threats, economic exploitation or control, and emotional abuse. Domestic violence abusers are responsible for most of the domestic violence fatalities tracked by the DVFR, but they may also be homicide victims (when, for example, their partners kill them in self-defense).

### **Domestic violence victim**

The person in an intimate relationship who experiences a pattern of abuse from her or his partner; the intimate partner of a domestic violence abuser. Frequently, the domestic violence victim is also the homicide victim in the cases we examine, but sometimes the homicide victim is another person (e.g., a victim's new boyfriend), and the domestic violence victim survives. While every case involves a domestic violence victim, that person has not been killed in every case.

### **Homicide victim**

A person who has been deliberately killed by someone else. Homicide victims include domestic violence victims, domestic violence abusers, and/or friends, family or children of domestic violence victims.

### **Homicide perpetrator**

A person who has deliberately caused the death of another person. In most of our cases, this person is also the domestic violence abuser. However, in some cases, the domestic violence victim kills their abuser in self-defense, and in some cases, a friend or family member of the domestic violence victim kills the domestic violence abuser.

### **Homicide victims killed by domestic violence abusers**

A subset of homicide victims, excluding abusers who were killed.

### **Suicide by police**

When an abuser essentially forces law enforcement officers to shoot him (e.g., by pointing a weapon at the police, or continuing to stab his partner in front of police after being ordered to stop). We treat these cases like suicides, and do not count them as homicides.

## Appendix C: Copy-Ready Pages for Handouts

The key recommendations and a summary of data from this report can be found on the following pages in an easy-to-use photocopy format. Individuals and organizations are encouraged to utilize the material as informational handouts, provided the description crediting the Washington State Coalition Against Domestic Violence is retained on all pages.

**Key Recommendations from *Every Life Lost Is a Call for Change***  
Findings and Recommendations from the Washington State Domestic Violence Fatality Review,  
December 2004

**All Disciplines**

People who work with teens in any capacity should receive training regarding teen dating violence and domestic violence, and teen advocacy resources in the community.

**Domestic Violence Programs**

Domestic violence programs should develop policies and procedures that maintain safety for all program participants while providing services to substance-abusing domestic violence victims.

**Law Enforcement Agencies**

Consistent with our state law, law enforcement agencies should conduct investigations of domestic violence crimes with qualified interpreters (either in person or via telephonic services) for all Limited English Proficient individuals, with the goal of obtaining complete victim, perpetrator and witness statements at the initial crime scene, as well as high-quality investigative and follow-up work.

**Civil Courts**

All courts issuing civil Protection Orders should have domestic violence advocacy services available on-site and ensure that advocates have extensive training on how to assist women with safety planning. If resources are limited, courts should minimally require, as mandated by RCW 26.50.035, that clerks routinely provide all petitioners with referral information to the local domestic violence program for assistance with safety planning.

**Prosecutors and Probation**

Prosecutors and probation offices should employ well-trained domestic violence victim advocates who can contact partners of abusers, and provide resources and safety planning. If resources are limited, prosecutors and probation offices should work closely with community-based domestic violence programs in order to provide advocacy to victims.

**Judges**

Judges in both civil and criminal courts should receive mandated training on domestic violence and on assessing danger and lethality in domestic violence cases. Judges should routinely examine histories and patterns of behavior in domestic violence cases when considering how to proceed (e.g., they should ask the prosecutor, victim and advocate about the batterer's abuse history and consistently make use of computerized databases that track criminal histories).

**Department of Social and Health Services (DSHS)**

DSHS should ensure implementation of its policy of screening all WorkFirst program participants for domestic violence and providing appropriate response (in the form of resources and workplans) for domestic violence victims.

**Legislature and State Agencies**

Funding should be made available for community organizing projects aimed at building safety and accountability strategies outside of the criminal legal system, particularly within marginalized communities and communities of color. Funding for such projects should go to organizations with established credibility and trust within the communities that will be the focus of organizing efforts.

## Domestic Violence Fatalities

281 people in Washington were killed by domestic violence abusers between January 1, 1997 and June 30, 2004. These included domestic violence victims, their children, friends, family, co-workers and new partners, as well as law enforcement officers.

ALL DOMESTIC VIOLENCE FATALITIES	1/1/97–6/30/04
1. Female domestic violence victim killed by current/former husband/boyfriend	176
2. Female domestic violence victim killed by other male intimate (e.g., caregiver)	4
3. Female domestic violence victim killed by female intimate partner	1
4. Female domestic violence victim killed by abuser's associate	2
5. Male domestic violence victim killed by current/former wife/girlfriend	20
6. Male domestic violence victim killed by male intimate partner	1
7. Children killed by male domestic violence abuser	21
8. Friends/family killed by male domestic violence abuser	32
9. Friends/family killed by female domestic violence abuser	1
10. New boyfriend of female domestic violence victim killed by male domestic violence abuser	19
11. Co-worker of female domestic violence victim killed by male domestic violence abuser	1
12. Law enforcement killed by male domestic violence abuser	3
13. Male domestic violence abuser killed by female domestic violence victim in self-defense, no prosecution	7
14. Male domestic violence abuser killed by female domestic violence victim, case prosecuted, but history of abuse claimed	8
15. Male domestic violence abuser killed by female domestic violence victim, not in self-defense	6
16. Male domestic violence abuser killed by friend or family of female domestic violence victim	10
17. Male domestic violence abuser killed by law enforcement	9
18. Male domestic violence abuser suicide	93
19. Children killed by female domestic violence victim	2
<b>Totals</b>	
20. All domestic violence fatalities (rows 1-19)	416
21. All homicide victims (rows 1-16 and 19, excludes suicides and abusers killed by law enforcement)	314
22. All homicides committed by domestic violence abusers or their associates (rows 1-12)	281

## Homicide-Suicides

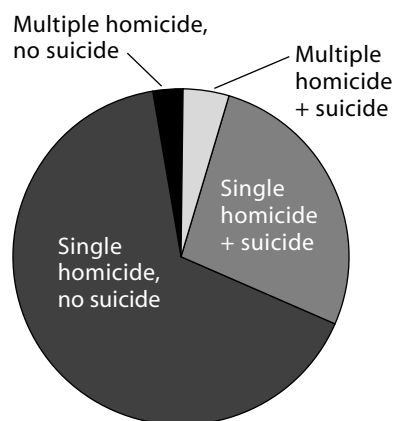
Almost a third (32%) of the 260 abusers who committed homicides from January 1, 1997 to June 30, 2004 committed homicide-suicides. An additional six abusers killed themselves after attempting homicide.

### HOMICIDES COMMITTED BY DOMESTIC VIOLENCE ABUSERS BETWEEN 1/1/97 AND 6/30/04

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Total cases: 260

- Multiple homicide + suicide: 4%
- Single homicide + suicide: 27%
- Single homicide, no suicide: 66%
- Multiple homicide, no suicide: 3%



## Separation Violence

News reports or in-depth fatality reviews made clear that in at least 44% of the cases in which the domestic violence abuser killed someone (most often their intimate partner, but also including children, family members, friends and new love interests of the victim), the domestic violence victim had left, divorced or separated from the abuser, or was attempting to leave or break up with the abuser.\*

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\* It is possible that a higher percentage were in the process of breaking up or leaving. For cases not reviewed in depth, information on the status of the relationship and whether or not the victim was attempting to break up or leave is often incomplete.

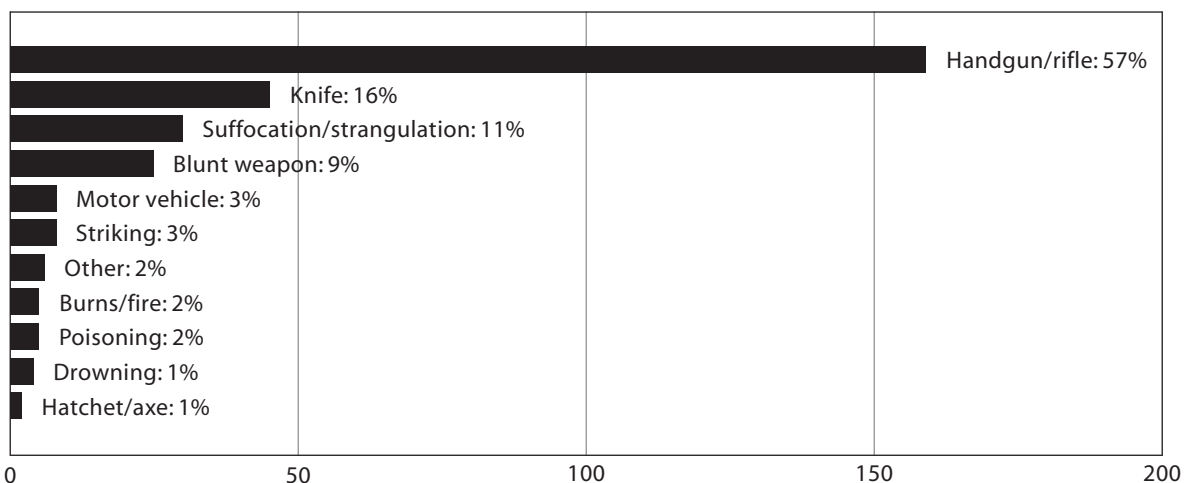


## Weapons

Consistent with prior Domestic Violence Fatality Review reports and national crime trends, the majority of domestic violence homicides have been committed with firearms. Since 1997, abusers used firearms to kill 57% (n=159) of domestic violence homicide victims.

### WEAPONS USED BY DOMESTIC VIOLENCE ABUSERS TO KILL 281 VICTIMS IN DOMESTIC VIOLENCE HOMICIDES COMMITTED BETWEEN 1/1/97 AND 6/30/04

Total weapons: 297\*



\*Some homicides involved multiple weapons; therefore, percentages total greater than 100%.

**Washington State Coalition  
Against Domestic Violence**

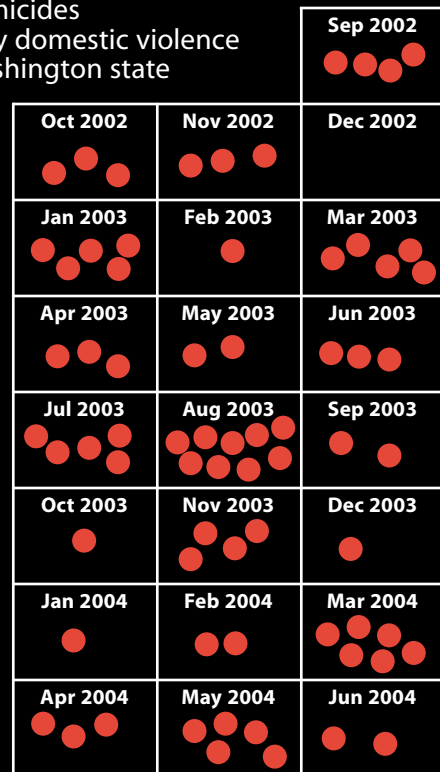
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Victims of homicides  
perpetrated by domestic violence  
abusers in Washington state

22 months ending  
in June 2004



*The names on the cover represent the lives taken by domestic violence abusers in Washington between September 1, 2002 and June 30, 2004. Also included in the list is one case from August 2002 which we were unable to include in our previous report and analysis.*