

If I had one more day...

Findings and Recommendations from the Washington State Domestic Violence Fatality Review
December 2006

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

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If I had one more day...

"If I could be so lucky and Angela had one more day, perhaps she would be alive today."

Charleen Holcomb, mother of Angela Marie Holcomb-[Alden] (1971–2003)

The title of this year's report comes from the words of a mother whose daughter, Angela Marie Holcomb-(Alden), was killed by her estranged husband in July 2003. Angela's name was included on a list of people killed by domestic violence abusers on the cover of our 2004 report, Every Life Lost Is a Call for Change. Angela's mother, Charleen Holcomb, contacted the Domestic Violence Fatality Review after seeing our report to let us know that we had incorrectly listed the date of Angela's death as July 5th. In fact, Angela died one day earlier, on July 4th, 2003. In her letter to us, Charleen reflected, "If I could be so lucky and Angela had one more day, perhaps she would be alive today." Charleen went on to say, "I've read your report...finding the facts revolting...leaving me wondering what I can do to help others be safe from domestic violence."

Angela had separated from her abusive husband and was trying to find a life free of violence for herself and her children. In the months before her murder, Angela contacted the police on three separate occasions when her husband threatened or assaulted her. Following the murder, journalists reported that Angela's three police reports were among 184 domestic violence cases prosecutors had not looked at due to a backlog of cases awaiting review and a stack of case files that had been misplaced. Angela reached out for help and she did not get it. Consequently, her two children, her mother, her grandmother, her two sisters, her brother, her entire family, and her community are left without her.

Unfortunately, Angela's story is not unique. Through the Fatality Review, communities around Washington State have been examining domestic violence homicides since 1997, and bringing to light the system failures these deaths expose. After ten years, we continue to see many of the same issues as when the project began. Much more needs to be done—we simply cannot wait one more day.

There is hope in Angela's story as well. Angela's mother did not just wonder about what she could do to help others—she took action. She became involved with local domestic violence programs as a volunteer. Her commitment to help others, to end domestic violence, to promote change in her community honors the memory of her daughter, inspires others, and creates a safer world for Angela's and all of our children.

We do not have one more day for Angela and all those who have been killed by domestic violence abusers. We do have one more day for all of the domestic violence survivors in our family, among our friends, co-workers, neighbors, and our community.

*The question, then, is this: **What will we do today?***

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We would like to offer our sincere gratitude to the domestic violence survivors, and the families and friends of domestic violence homicide victims, who generously shared their personal experiences with us and provided insights and perspectives to guide our efforts.

The Domestic Violence Fatality Review conducts extensive data collection and analysis to generate the statistics discussed in this report. We gratefully acknowledge the **Gender and Justice Commission of the Washington State Supreme Court** for funding the design and implementation of a new Fatality Review database and **Communities Connect Network** for funding consultation services that ensure the integrity of our data analysis. We also thank the **U.S. Department of Health and Human Services, Office on Women's Health, Region X** for supporting our efforts to conduct research exploring the connection between suicide and other untimely deaths and domestic violence.

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In This Report

Executive Summary A brief overview of the Domestic Violence Fatality Review's goals, key findings and 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 domestic violence fatalities in Washington State, including descriptive information such as who was killed, how frequently homicidal domestic violence abusers were also suicidal, and what weapons were used.

Spotlight on Suicide: Exploring the Connection Between Suicide and Domestic Violence

An exploratory study conducted by the Domestic Violence Fatality Review to estimate the number of suicide victims who had a history of domestic violence.

Findings and Recommendations Findings and recommendations based on the eleven domestic violence fatalities reviewed in depth by Fatality Review panels between July 2004 and June 2006. Each chapter includes narrative explaining the findings, followed by detailed recommendations which respond directly to those findings.

Epilogue Kelsey and Hayley Byrne, ages 11 and 9, were killed by their father in November 2004. The epilogue was written by their mother, Suzanne Dawson.

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. Appendix D is an index of the topic areas covered in Fatality Review reports.

Definition of a domestic violence fatality The Domestic Violence Fatality Review defines a domestic violence fatality as a death which arises from an abuser's efforts to seek power and control over their 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 midst of a perpetrator's attempt to kill their intimate partner. For example, situations in which an abuser kills their current/former intimate partner's friend, family member, or new intimate partner, or those in which a law enforcement officer is killed while intervening in a domestic violence incident.
3. Homicides occurring as an extension of or in response to ongoing intimate partner abuse. For example, when an ex-spouse kills their children in order to exact revenge on their partner.
4. Suicides which occur in the context of intimate partner violence.

Relationship of this report to previous reports The Domestic Violence Fatality Review has published three previous reports.¹ This report builds on the findings and recommendations issued in these reports and is intended to complement, not replace, them.

¹ *Honoring Their Lives, Learning from Their Deaths* (2000); *"Tell the World What Happened to Me"* (2002); *Every Life Lost Is a Call for Change* (2004). All reports are available at www.wscadv.org.

Executive Summary

Introduction

Between January 1, 1997 and June 30, 2006, 359 people were killed by domestic violence abusers in Washington State. In 2005, 50% of women who were murdered in Washington were killed by their current or former husband or boyfriend.¹ The Domestic Violence Fatality Review (DVFR) examines domestic violence-related fatalities statewide 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 and insist that the domestic violence victims, their children, and their friends and family members killed by abusers are not forgotten. Second, to direct attention to the struggles and challenges faced by all of the domestic violence victims in our state who are living with abuse and can still be helped by our efforts to respond more effectively to domestic violence.

The DVFR brings together locally based, multi-disciplinary review panels for a detailed examination of individual domestic violence fatalities. These panels focus on the events leading up to the homicide; they seek to identify gaps in policy, practice, training, resources, information, and collaboration. What we have learned from these in-depth reviews is that domestic violence fatalities are not isolated, inexplicable tragedies. They are often preceded by multiple attempts by the victim to find safety and support, and multiple opportunities for other people to respond to the abuser's violence. All of the homicide perpetrators are responsible for their actions and ultimately responsible for the murder(s) they committed. However, the responsibility for responding to an abuser's violence prior to a murder—including providing options for the victim to obtain some measure of safety, self-determination, and economic self-sufficiency—belongs to all of us.

The individuals discussed in the pages of this report were people in our communities. They were victims who needed to talk and to be heard, supported, and offered resources. They were abusers who needed to know that others in the community care about violence and are working hard to hold perpetrators accountable. They were family members, friends, and colleagues who wanted to help, but did not know how. Together, they tell us a great deal about what we must do to build safer communities for all women, children, and men.

Building a community-wide safety net is a formidable task, but it is within our reach. With *If I Had One More Day...*, our fourth biennial report, we ask every person "What will you do today?" The stories of those who have lost their lives to domestic violence remind us that each and every one of us needs to take action, and we need to do so right away.

Throughout this report, you will find specific recommendations for various institutions and disciplines. Each of these recommendations is related directly to findings from eleven in-depth reviews of domestic violence fatalities conducted by the DVFR between July 1, 2004 and June 30, 2006. This report builds on the findings and recommendations issued in our previous reports,² and is intended to complement, not replace, them.

1 *Crime in Washington State 2005*, Uniform Crime Reporting Project, Washington Association of Sheriffs and Police Chiefs (2006) and Domestic Violence Fatality Review data.

2 *Honoring Their Lives, Learning from Their Deaths* (2000); *"Tell the World What Happened to Me"* (2002); *Every Life Lost Is a Call for Change* (2004). All three reports are available at www.wscadv.org.

While the findings in this report come directly from the observations of Fatality Review panel members, the recommendations do not. Review panels 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 by analyzing the issues raised by all of the review panels and convening advisory committees over the last year. WSCADV takes full responsibility for the recommendations contained herein, and the reader should note that the recommendations do not necessarily represent the opinions of individual DVFR panel or advisory committee members.

How to use this report as a tool for implementing change

1. Read the report and remember the stories of those who have lost their lives to domestic violence.
2. Each chapter answers the question *What can you do today?* with a simple action step that anyone can take as a starting point to improving your community's knowledge about and response to domestic violence. Work your way through these action steps and invite others to join you.
3. Share the report with others. Copies of this report and our three previous reports can be ordered at www.wscadv.org. The reports are 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, attorneys, healthcare workers, religious institutions, schools, family members, and friends. Print a specific section that you think would be particularly relevant to another individual's work and share it with them.
4. Make a discussion of the report the focus of a staff meeting at your workplace. As an agency, identify five to ten recommendations that are particularly relevant to your community and work toward their implementation. View the recommendations as goals and identify steps for moving forward. Utilize the recommendations for strategic planning.
5. For non-profit agencies: share the report with your board and offer it as a tool for education and strategic planning.
6. Create discussion groups in your community to talk about the report. These groups can be interdisciplinary 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.
7. 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.
8. Use the Fatality Review findings, recommendations, and statistics in community education, with the media, and in grant proposals.

Key data findings

Overview of domestic violence cases July 1, 2004 to June 30, 2006, and all cases since 1997

A total of 113 people died in domestic violence-related fatalities in Washington State between July 1, 2004 and June 30, 2006. This number includes eighty-three homicide victims, twenty-six abuser suicides, and four cases in which abusers were killed by law enforcement officers while threatening lethal force against the officers or a victim. Domestic violence abusers or their associates killed almost all of the homicide victims (93%). They include domestic violence victims, their children, friends, and family members.

All domestic violence fatalities

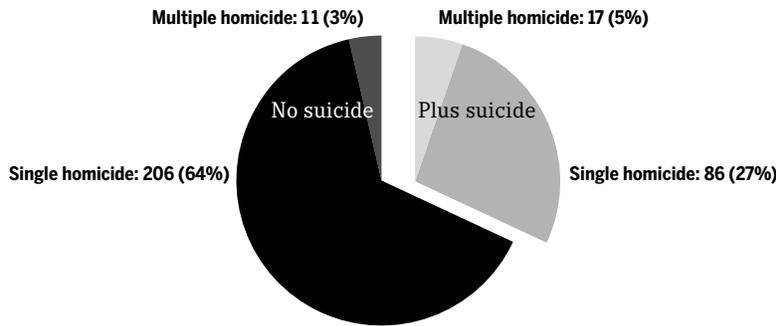
Homicide victim: KILLED BY WHOM	7/1/04– 6/30/06	1/1/97– 6/30/06
1. Female domestic violence victim: CURRENT/FORMER HUSBAND/BOYFRIEND	48	224
2. Female domestic violence victim: OTHER MALE INTIMATE (E.G., CAREGIVER)	0	5
3. Female domestic violence victim: MALE ABUSER'S ASSOCIATE	0	2
4. Male domestic violence victim: CURRENT/FORMER WIFE/GIRLFRIEND	7	26
5. Male domestic violence victim: FEMALE ABUSER'S ASSOCIATE	2	3
6. Male domestic violence victim: MALE INTIMATE PARTNER	0	1
7. Children: MALE ABUSER	10	32
8. Friend or family of female domestic violence victim: MALE ABUSER	3	35
9. Friend or family of male domestic violence victim: FEMALE ABUSER	0	1
10. New boyfriend of female domestic violence victim: MALE ABUSER	5	24
11. Co-worker of female domestic violence victim: MALE ABUSER	1	2
12. Law enforcement: MALE ABUSER	1	4
13. Male abuser: FEMALE DOMESTIC VIOLENCE VICTIM IN SELF-DEFENSE	2	9
14. Male abuser: FEMALE DOMESTIC VIOLENCE VICTIM IN PROBABLE SELF-DEFENSE	0	8
15. Male abuser: FEMALE DOMESTIC VIOLENCE VICTIM, NOT IN SELF-DEFENSE	1	7
16. Male abuser: FRIEND OR FAMILY OF FEMALE DOMESTIC VIOLENCE VICTIM	2	12
17. Male abuser: LAW ENFORCEMENT	4	13
18. Male abuser: SUICIDE	26	118
19. Female abuser: SUICIDE	0	1
20. Children: FEMALE DOMESTIC VIOLENCE VICTIM	1	3
Totals		
21. All domestic violence fatalities (rows 1-20)	113	530
22. All homicide victims (rows 1-16 and 20, excludes suicides and abusers killed by law enforcement)	83	398
23. All homicides committed by abusers or their associates (rows 1-12)	77	359

Homicide-suicides

Almost a third (32%) of the 320 abusers who committed homicides since January 1, 1997 committed homicide-suicides. An additional twelve abusers killed themselves after attempting homicide.

Homicides committed by domestic violence abusers: January 1, 1997 to June 30, 2006

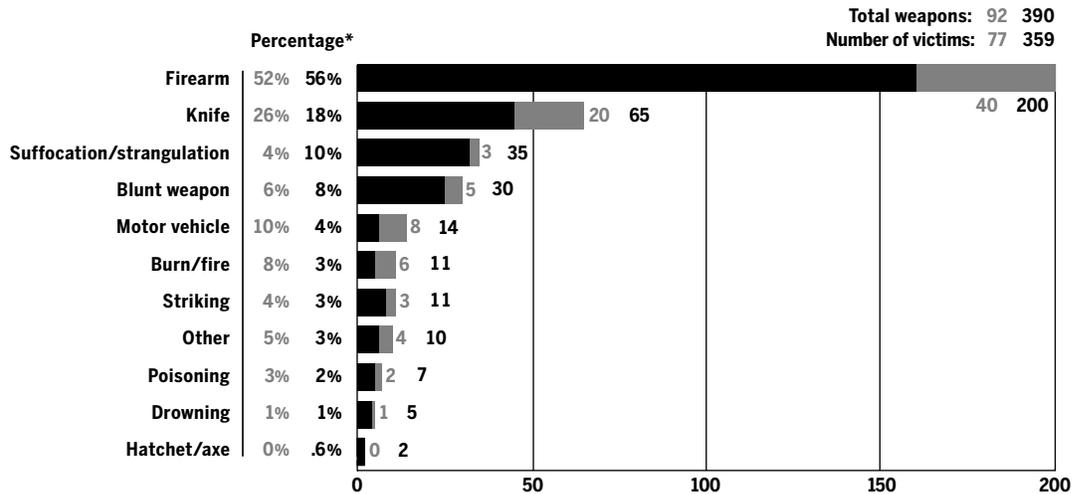
Total cases: 320



Weapons

The majority of domestic violence homicides in Washington State have been committed with firearms. Since 1997, abusers used firearms to kill 56% (n=200) of domestic violence homicide victims. Between July 1, 2004 and June 30, 2006, abusers used firearms to kill 52% (n=40) of homicide victims.

Weapons used by domestic violence abusers in homicides committed January 1, 1997 to June 30, 2006
 July 1, 2004 to June 30, 2006 rendered in gray



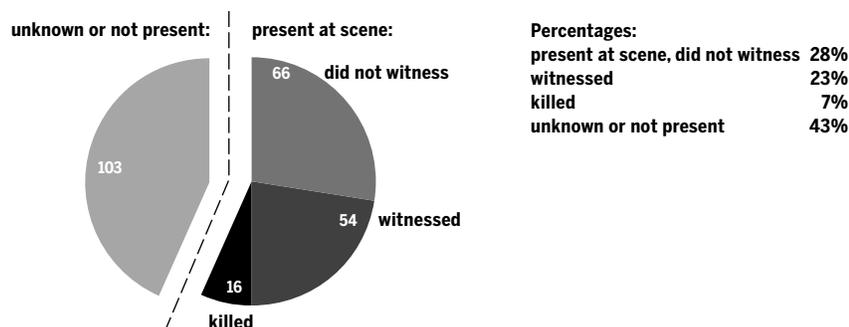
*Percentage total is greater than 100% due to use of multiple weapons in some homicides.

Children

Of the 261 domestic violence victims killed by abusers or their associates since 1997, at least 114 (44%) had children living in the home with them at the time they were murdered. The majority (57%) of the victims' children were present at the time of the homicide.

Location of children at the time of domestic violence victim's murder: January 1, 1997 to June 30, 2006

Total: 239 children of 114 domestic violence victims



Key recommendations

We have identified nine key recommendations out of the many that appear in this report. These recommendations merit priority because they relate to issues identified repeatedly in reviewed domestic violence fatality cases and speak to a range of professional disciplines. However, please keep in mind that all recommendations in this report are relevant to the ability of our communities to support domestic violence victims and hold abusers accountable, and are rooted in the close examination of a domestic violence fatality.

1. Mental health professionals, suicide specialists, and domestic violence programs should collaborate to provide cross-training to each other and to increase their ability to provide the appropriate range of services to domestic violence victims who are suicidal or have other mental health concerns.
2. Middle schools and high schools should identify strategies for providing ongoing information to all students, multiple times throughout their education, about healthy relationships, interpersonal boundary setting, how to recognize abusive tactics, and the support resources available. Schools should involve students in the discussion and development of these strategies in an effort to ensure their relevancy.
3. Domestic violence programs and task forces should engage community informants, such as friends and family of domestic violence victims, to learn how to increase the visibility of the range of services available. Such efforts should address the distinct opportunities and challenges for rural and remote communities and for marginalized populations.
4. Programs providing support to parents and children in our communities, such as parenting classes, prenatal education, Head Start, and other programs aimed at strengthening families and children, should obtain information and establish collaborations with local, community-

based domestic violence programs to include attention to domestic violence in the services they provide.

5. DSHS should routinely provide information about local domestic violence resources to participants across all public benefit programs.
6. Domestic violence programs should collaborate with people who routinely come into contact with homeless and transient individuals, such as food bank workers, railroad police, and community organizers, in order to build community capacity to provide this population with safety planning information and referrals to domestic violence resources.
7. Chemical dependency treatment and batterer's intervention programs should collaborate to offer groups that simultaneously address both issues. These groups should be collaboratively run by a state-certified chemical dependency provider and a state-certified batterer's intervention provider.
8. Law enforcement officers, prosecutors, judges, and probation officers should routinely examine histories and patterns of behavior in domestic violence cases and make full use of the resources available to do this when assessing for danger and considering how to proceed.
9. Dissolution forms, "Do-It-Yourself Divorce" packets, and classes required by the courts for divorcing parents with children should include information about domestic violence and domestic violence resources.

Recommendations categorized by discipline

The following is a compilation of the Fatality Review recommendations in this report, organized by professional 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.

1. All disciplines

- 1.1 Domestic violence advocates and everyone working with domestic violence victims should receive training on how to routinely screen for suicidality, how to recognize suicide warning signs, and what to do when these signs are identified. (p.36)
- 1.2 Domestic violence advocates and other professionals working with domestic violence victims should talk to victims about increased safety risks at the time of separation from an abuser and continue to regularly discuss safety planning after a victim has ended an abusive relationship. (p.43)
- 1.3 The goal of safety planning should not be to encourage the victim to end all contact with the abuser; rather, efforts should focus on how to be as safe as possible even when contact with the abuser is ongoing. (p.43)
- 1.4 All professionals working with domestic violence victims should: routinely ask about the abuser's access to firearms; talk with victims about the increased homicide risk posed by the availability of firearms; and connect victims with an advocate to talk about safety planning. (p.44)

- 1.5 Domestic violence advocates and others engaged in problem solving or safety planning with victims should routinely ask victims if calling 911 is a viable option for them. If barriers to calling 911 exist, advocates should work with victims to address these barriers as well as identify alternative safety planning strategies. (p.45)
- 1.6 Professionals interacting with domestic violence victims whose abusers use non-physical methods of control should recognize the need for safety planning even in these cases, and support victims in calling a domestic violence advocate for help with safety planning. (p.46)
- 1.7 People who work with teens in any capacity should receive training regarding teen dating violence, how to talk to teens about relationships, and the resources available to them. (p.48)
- 1.8 All perinatal health care providers and all professionals providing parenting education to teens should partner with a local domestic violence program to receive training on the dynamics of control in abusive relationships, and how to discuss abuse using language that is relevant and accessible to teens. (p.50)
- 1.9 Due to the prevalence of domestic violence among teen parents, information about dating violence, safety planning, and resources available should routinely be provided to all pregnant teens by health care providers, caseworkers, educators, and any other professionals working with pregnant teens. This practice should be adopted rather than screening for abuse and waiting for a teen to self-identify as a domestic violence victim. (p.50)
- 1.10 All programs that provide social service resource information to the community, such as the new Washington Information Network 211 (WIN 211) and crime victim service centers, should receive domestic violence training and be aware of the range of resources available to victims, abusers, and their friends and family. (p.52)
- 1.11 All government agencies, social service programs, and courts that collect identifying information should routinely inform people utilizing their services of how personal information about them is stored, who can access it, and their right to opt out of having this information collected, so that victims of domestic violence and stalking can make informed choices regarding when and what they choose to disclose. (p.54)
- 1.12 Domestic violence programs and other services designed to support victims should acknowledge that victims may be using alcohol, other drugs, and/or violence and address the impact of these issues on their safety, sobriety, and ability to access resources.³ (p.65)
- 1.13 Domestic violence programs, law enforcement, prosecutors, court clerks, and civil attorneys should routinely provide information to domestic violence victims that describes the differences between various types of civil and criminal protective orders.⁴ (p.79)

3 The Alcohol/Drug Help Line Domestic Violence Outreach Project has developed tools for working with substance-abusing domestic violence victims and is available for statewide consultation on a non-emergency basis. Contact dvop@adhl.org or WSCADV at 206-389-2515 for more information. The Alaska Network on Domestic Violence and Sexual Assault has developed a practical tool kit for use with substance-abusing domestic violence and sexual assault survivors: *Getting Safe and Sober, Real Tools You Can Use* by Patti Bland and Debi Edmund. Contact pbland.andvsa@alaska.com or www.andvsa.org for more information. Also, WSCADV has developed and distributed a *Model Protocol for Working with Battered Women Impacted by Substance Abuse* (2003), which is available at www.wscadv.org.

4 For a hand-out that describes the different types of court orders in a copy-ready format, see www.wscadv.org.

2. Domestic violence programs

- 2.1** Mental health professionals should partner with domestic violence programs to connect domestic violence victims to advocacy and safety planning in addition to mental health services. All domestic violence programs should have relationships with mental health care providers who are well trained in domestic violence and can provide appropriate services to victims. (p.36)
- 2.2** Domestic violence programs should incorporate suicide prevention into community engagement strategies for domestic violence prevention, and should include information about suicide and depression in outreach to victims.⁵ (p.37)
- 2.3** Domestic violence programs should include questions on their crisis line, intake, and safety planning forms to ensure that advocates routinely ask about abusers' suicidal attempts or threats and safety plan accordingly. (p.40)
- 2.4** Domestic violence programs should include discussion of abusers' suicidal threats or attempts and the danger these pose to victims in their community education efforts. (p.41)
- 2.5** Domestic violence programs should include questions on their crisis line, intake, and safety planning forms to ensure that all advocates routinely ask victims about the presence of, and abusers' access to, firearms and discuss safety planning strategies specifically related to firearms. (p.44)
- 2.6** Domestic violence advocates should routinely discuss safety planning with all domestic violence victims, even if the abuser has not used physical abuse as a tactic of control. (p.46)
- 2.7** Funders and domestic violence programs should recognize teen dating violence education, peer advocacy, and prevention efforts as a part of core services. (p.48)
- 2.8** Domestic violence programs should collaborate with those in the community already working with teens, such as camp counselors and youth group leaders, to build community capacity to provide information and support around teen dating violence. Individuals who have developed expertise in this area should be visible in the community and at events where teens gather. (p.48)
- 2.9** Domestic violence coalitions and community-based programs should work together to develop model materials for parents of teens who are being abused and develop best practice models for providing outreach and services to families of teen victims. (p.49)
- 2.10** Domestic violence programs and their funders should include community education, outreach, prevention efforts, public awareness campaigns, and other strategies for building the capacity of communities to respond to domestic violence as a core part of their work. (p.52)
- 2.11** Community education about domestic violence should include tools and strategies for how to: identify abuse, talk to victims or abusers, report abuse, and stay safe. (p.52)
- 2.12** Domestic violence programs and task forces should engage community informants, such as friends and family of domestic violence victims, to learn how to increase the visibility of the range of services available. Such efforts should address the distinct opportunities and challenges for rural and remote communities and for marginalized populations. Funders should support pilot projects to begin this process. (p.52)

⁵ The National Suicide Prevention Lifeline has developed a Media Outreach Toolkit to help organizations promote suicide prevention efforts. The toolkit is available at: www.suicidepreventionlifeline.org/campaign/kit.

- 2.13** Domestic violence programs should include stalking information in brochures and other outreach materials to increase awareness that anyone can call a domestic violence program for support and safety planning regarding stalking. (p.53)
- 2.14** Domestic violence programs should receive ongoing training and consult with national resources, such as the Stalking Resource Center,⁶ to build their capacity to address stalking. (p.53)
- 2.15** Domestic violence programs, law enforcement agencies, and prosecutors should collaborate and cross-train one another on issues related to domestic violence stalking, including how to assist victims in documenting the stalking, the use of technology to stalk, an overview of statutes on domestic violence and stalking, and safety planning.⁷ (p.53)
- 2.16** Domestic violence programs should create strong linkages with grassroots organizations serving marginalized communities to build these organizations' capacity to address domestic violence in their community. (p.55)
- 2.17** Domestic violence programs' community education and outreach materials should include information about what to expect when calling 911 to report a domestic violence crime, what information 911 operators collect from callers, and strategies for how to report a crime anonymously. (p.56)
- 2.18** Domestic violence programs should collaborate with those in the community already working with children to build their capacity to provide domestic violence information and support. (p.56)
- 2.19** Domestic violence programs should collaborate with people who routinely come into contact with homeless and transient individuals, such as food bank workers, railroad police, and community organizers, in order to build community capacity to provide this population with safety planning information and referrals to domestic violence resources. (p.61)
- 2.20** Domestic violence programs should develop and implement a plan for engaging their community in work aimed at increasing economic security and the availability of financial education for domestic violence victims.⁸ Funders and domestic violence programs should recognize this work as a part of core services. (p.62)
- 2.21** Domestic violence programs' outreach materials, community education, and safety plans should inform people of the increased lethality risks when the abuser is using alcohol or other drugs, and should include referrals to community resources available for abusers, victims, and their friends and family. (p.63)
- 2.22** Domestic violence programs should provide services to substance-using domestic violence victims by developing policies and procedures that maintain safety for all program participants while addressing the needs of substance-using victims. (p.65)

⁶ The Stalking Resource Center is a part of the National Center for Victims of Crime. For more information, see www.ncvc.org/src/Main.aspx.

⁷ Good models of such collaborations exist. See, for example, *Links in the Chain: Two Communities Respond to Stalking*, a video produced by the National Center for Victims of Crime and the Office of Community Oriented Policing Services, U.S. Department of Justice. Available for purchase at www.ncvc.org.

⁸ See *In Our Shoes: The Next Steps – A Domestic Violence Advocate's Guide to Working for Economic Justice in Your Community*, Washington State Coalition Against Domestic Violence (2005), www.wscadv.org. This step-by-step workbook can be used by advocates to develop and sustain a community-based effort to advance economic security, especially for those affected by domestic violence.

- 2.23** Domestic violence and chemical dependency programs should collaborate to provide cross-training to providers and services to individuals struggling with both domestic violence and chemical dependency. Because so many individuals face both challenges and because so many barriers exist to disclosing either domestic violence or substance abuse, domestic violence and chemical dependency programs should make information about one another's programs consistently available to everyone using their services. (p.65)
- 2.24** Domestic violence and chemical dependency providers need to be aware of the increased safety risk when a domestic violence victim is working toward sobriety, thereby reducing the abuser's control. Domestic violence and chemical dependency programs should coordinate safety planning and relapse prevention planning accordingly. (p.65)
- 2.25** Domestic violence programs should have clear protocols to determine eligibility for victim services, rather than relying on the legal system's identification of the victim and abuser, or other methods. Programs should receive training in the use of domestic violence assessment tools designed to identify the victim of an ongoing pattern of power and control in a relationship, and programs should have policies that direct advocates on how and when to use such tools.⁹ (p.74)
- 2.26** Domestic violence programs should conduct outreach to the jails in their community to provide information and resources to domestic violence victims in custody. (p.74)

3. Mental health, chemical dependency, and batterer's intervention professionals

- 3.1** Mental health professionals should routinely screen for domestic violence when women present as depressed and/or suicidal.¹⁰ (p.36)
- 3.2** Mental health professionals should partner with domestic violence programs to connect domestic violence victims to advocacy and safety planning in addition to mental health services. All domestic violence programs should have relationships with mental health care providers who are well trained in domestic violence and can provide appropriate services to victims. (p.36)
- 3.3** Mental health professionals, suicide specialists, and domestic violence programs should collaborate to provide cross-training to each other and to increase their ability to provide the appropriate range of services to domestic violence victims who are suicidal or have other mental health concerns. (p.36)
- 3.4** Suicide specialists should work collaboratively with domestic violence experts to develop suicide prevention strategies and public awareness campaigns specifically directed at victims of domestic violence. (p.37)
- 3.5** Suicide prevention efforts should include prevention strategies and outreach campaigns specifically directed at men who abuse their partners. (p.39)

⁹ The Northwest Network of Bisexual, Trans, Lesbian and Gay Survivors of Abuse has developed an assessment tool that is used as a model nationwide. The NW Network provides training on this tool for other domestic violence service providers. For more information, contact The NW Network at www.nwnetwork.org or WSCADV at 206-389-2515.

¹⁰ For examples of screening tools, see the New York State Office for the Prevention of Domestic Violence, "Guidelines for Mental Health Professionals," available at www.opdv.state.ny.us/health_humsvc/mental_health/guidelines.html, and the Washington State Department of Health, "Domestic Violence and Pregnancy: Guidelines for Screening and Referral" (2004), available at www.doh.wa.gov/cfh/mch/documents/dv_for_web.pdf.

- 3.6** Mental health providers and treatment developers should collaborate with domestic violence batterer's intervention and victim service experts to develop a best practice model for simultaneously addressing suicidality and domestic violence perpetration. (p.39)
- 3.7** Mental health professionals should routinely screen depressed and suicidal clients for domestic violence. Therapists should recognize that suicidal abusers may present an acute danger to their partners, ex-partners, and others, even if they have not made homicidal threats. (p.40)
- 3.8** In collaboration with domestic violence experts, mental health professionals should establish clear guidelines regarding when the combination of domestic violence and suicidal threats signals clear danger to others and triggers providers' duty to warn potential victims. (p.40)
- 3.9** Therapists and other mental health professionals should be aware of the prevalence of manipulative suicide threats as a tactic of domestic violence. When mental health care providers identify that a client has used suicidal threats or attempts as a tactic of establishing a pattern of power and control over an intimate partner, they should refer the client to a certified batterer's intervention program. (p.40)
- 3.10** Suicide outreach and prevention programs should target friends, families, and partners of suicidal abusers, and provide specific strategies that address domestic violence and suicide. (p.41)
- 3.11** Experts in chemical dependency, suicide, and domestic violence should work together to coordinate prevention and intervention efforts. (p.41)
- 3.12** Domestic violence and chemical dependency programs should collaborate to provide cross-training to providers and services to individuals struggling with both domestic violence and chemical dependency. Because so many individuals face both challenges and because so many barriers exist to disclosing either domestic violence or substance abuse, domestic violence and chemical dependency programs should make information about one another's programs consistently available to everyone using their services. (p.65)
- 3.13** Domestic violence and chemical dependency providers need to be aware of the increased safety risk when a domestic violence victim is working toward sobriety, thereby reducing the abuser's control. Domestic violence and chemical dependency programs should coordinate safety planning and relapse prevention planning accordingly. (p.65)
- 3.14** Chemical dependency programs should screen and check criminal histories for domestic violence and refer abusers to state-certified batterer's intervention programs when it is identified. (p.66)
- 3.15** Chemical dependency treatment and batterer's intervention programs should collaborate to offer groups that simultaneously address both issues. These groups should be collaboratively run by a state-certified chemical dependency provider and a state-certified batterer's intervention provider.¹¹ (p.66)

¹¹ Good models exist for this type of group. Contact WSCADV at 206-389-2515 to be connected with providers doing this work.

4. Law enforcement

- 4.1 Law enforcement should immediately contact mental health professionals when a domestic violence abuser threatens suicide. Officers should provide the victim with information regarding the increased risk of homicide when an abuser is suicidal, and offer referrals to a domestic violence program for intensive safety planning. (p.39)
- 4.2 Every law enforcement agency should establish policies and procedures for gun removal and storage for convicted domestic violence offenders and domestic violence abusers subject to criminal or civil protective orders.¹² (p.44)
- 4.3 Police officers should distribute domestic violence information to friends, family, neighbors, and witnesses at the scene of all domestic violence crimes. (p.52)
- 4.4 Domestic violence programs, law enforcement agencies, and prosecutors should collaborate and cross-train one another on issues related to domestic violence stalking, including how to assist victims in documenting the stalking, the use of technology to stalk, an overview of statutes on domestic violence and stalking, and safety planning.¹³ (p.53)
- 4.5 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. Law enforcement agencies 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 when they call 911. (p.55)
- 4.6 Law enforcement officers, prosecutors, judges, and probation officers should routinely examine histories and patterns of behavior in domestic violence cases and make full use of the resources available to do this when assessing for danger and considering how to proceed.¹⁴ (p.71)
- 4.7 Law enforcement officers should routinely ask victims and other witnesses reporting protective order violations about previous reported and unreported violations in order to help assess danger and to identify patterns. When the respondent of an order is repeatedly contacting the petitioner, officers should investigate and document the violations as a stalking crime. (p.71)
- 4.8 State-level agencies, such as the Washington Association of Sheriffs and Police Chiefs and the Washington Association of Prosecuting Attorneys, should work collaboratively with state-level domestic violence advocacy experts to develop model protocols for the criminal legal response to stalking. (p.71)
- 4.9 In order to increase access to interpretation and translation services at the local level, law enforcement should partner with domestic violence and other social service programs to share and advocate for additional resources. (p.73)

12 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. This program provides statewide consultation; contact Mark Hanna at mark.hanna@metrokc.gov or WSCADV at 206-389-2515 for additional information.

13 Good models of such collaborations exist. See, for example, *Links in the Chain: Two Communities Respond to Stalking*, a video produced by the National Center for Victims of Crime and the Office of Community Oriented Policing Services, U.S. Department of Justice. Available for purchase at www.ncvc.org.

14 Judges should reference *Domestic Violence Cases in Municipal Court: Judicial Decision Making* (2004) for further guidance. To obtain copies of this bench card, contact the Gender and Justice Commission, Washington State Administrative Office of the Courts at 360-705-5290.

- 4.10** Local law enforcement agencies should consider utilizing federal STOP grant funds to support language access resources for investigating domestic violence crimes. (p.73)
- 4.11** Law enforcement should never use children as interpreters; telephonic interpretation services should be used when qualified interpreters are not available at the scene. (p.73)
- 4.12** Courts and law enforcement agencies should develop language access plans consistent with the guidelines developed by the U.S. Department of Justice.¹⁵ (p.73)
- 4.13** Law enforcement agencies should review their policies and practices for monitoring the accuracy and completeness of domestic violence incident reports, including steps taken to identify the primary aggressor at the scene. Law enforcement agencies should consult with the Washington Association of Sheriffs and Police Chiefs when developing, implementing, or modifying policies and practices regarding monitoring the documentation of domestic violence investigations. (p.74)

5. Prosecuting attorneys, judges, criminal courts, and corrections

- 5.1** Those in the criminal legal system who have ongoing contact with domestic violence abusers, such as probation officers and defense attorneys, should screen offenders for suicidal behavior or intention, and refer suicidal abusers to appropriate mental health and batterer's intervention programs. (p.39)
- 5.2** Police, prosecutors, judges, and probation officers should consistently make every effort to identify and remove abusers' guns possessed in violation of the law at each step of the criminal or civil legal process. (p.44)
- 5.3** Domestic violence programs, law enforcement agencies, and prosecutors should collaborate and cross-train one another on issues related to domestic violence stalking, including how to assist victims in documenting the stalking, the use of technology to stalk, an overview of statutes on domestic violence and stalking, and safety planning.¹⁶ (p.53)
- 5.4** Prosecutors should routinely request that a criminal No Contact Order be issued in all domestic violence cases and implement a practice of routinely checking for the existence of other protective orders and consulting with victims about their desire for such an order. (p.68)
- 5.5** Prosecutors and advocates should routinely talk to victims about a civil Protection Order as an option in addition to a No Contact Order in case the criminal case is dismissed or the No Contact Order is rescinded for some other reason. (p.68)
- 5.6** Criminal courts and prosecutors should collaborate with domestic violence advocates and family law attorneys to develop model language to use in No Contact Orders that involve defendants who have visitation rights to any children in common with the victim to avoid conflicting orders and to ensure that the safety of the victim and children is addressed in the order. (p.68)
- 5.7** If an abuser or defense attorney requests the termination of a criminal No Contact Order, the prosecutor handling the case should routinely contact the victim to inform her of the process and her options, which include having the prosecutor oppose lifting the order. (p.68)

¹⁵ See www.lep.gov for these policy guidelines.

¹⁶ Good models of such collaborations exist. See, for example, *Links in the Chain: Two Communities Respond to Stalking*, a video produced by the National Center for Victims of Crime and the Office of Community Oriented Policing Services, U.S. Department of Justice. Available for purchase at www.ncvc.org.

- 5.8** The Washington Association of Prosecuting Attorneys should create and disseminate model guidelines for prosecutors regarding the admissibility of 911 tapes and victim statements in the prosecution of domestic violence cases even when the victim is unavailable to appear in court. (p.69)
- 5.9** Jails and prisons should develop policies and mechanisms for preventing inmates from calling victims or witnesses listed in police reports and/or civil and criminal protective orders. (p.69)
- 5.10** Judges should hold frequent post-sentencing reviews, and impose timely and meaningful consequences for non-compliant defendants. (p.71)
- 5.11** Probation departments should place a high priority on monitoring domestic violence cases and all jurisdictions should focus additional resources on the supervision of these offenders.¹⁷ (p.71)
- 5.12** Jail space should be prioritized for violent offenders with a high likelihood of recidivism, including domestic violence offenders. (p.71)
- 5.13** Judges should not base bail determinations and release decisions for violent offenders on the availability of jail space. (p.71)
- 5.14** Law enforcement officers, prosecutors, judges, and probation officers should routinely examine histories and patterns of behavior in domestic violence cases and make full use of the resources available to do this when assessing for danger and considering how to proceed.¹⁸ (p.71)
- 5.15** Prosecutors' offices should consider innovative strategies for effectively prosecuting repeat offenders, such as assigning one prosecutor to handle all charges for a particular defendant and "packaging" multiple charges.¹⁹ (p.71)
- 5.16** Prior to accepting plea agreements in domestic violence cases, courts should require the prosecutor's office to provide the defendant's criminal history. (p.71)
- 5.17** State-level agencies, such as the Washington Association of Sheriffs and Police Chiefs and the Washington Association of Prosecuting Attorneys, should work collaboratively with state-level domestic violence advocacy experts to develop model protocols for the criminal legal response to stalking. (p.71)
- 5.18** The Washington Association of Prosecuting Attorneys should create and disseminate model guidelines for prosecutors on how to bring prior acts of domestic violence before the court when charging, making bail recommendations, prosecuting, and sentencing domestic violence-related crimes. (p.72)
- 5.19** The Washington Association of Prosecuting Attorneys should make a recommendation to the Washington State Supreme Court regarding changing the evidentiary rules to increase the admissibility of prior domestic violence acts in court, as they are for sex offenses and Driving Under the Influence offenses. (p.72)

17 For model guidelines that all jurisdictions can follow in post-arrest supervision of domestic violence offenders, see *Post-Arrest Model Response for the Supervision of Domestic Violence Offenders*, Washington State Coalition Against Domestic Violence (1999). To request a copy, call WSCADV at 206-389-2515.

18 Judges should reference *Domestic Violence Cases in Municipal Court: Judicial Decision Making* (2004) for further guidance. To obtain copies of this bench card, contact the Gender and Justice Commission, Washington State Administrative Office of the Courts at 360-705-5290.

19 The Thurston County Prosecutor's Office has recently implemented such a strategy. Contact Christy Peters at petersc@co.thurston.wa.us or WSCADV at 206-389-2515 for additional information.

- 5.20 Courts and law enforcement agencies should develop language access plans consistent with the guidelines developed by the U.S. Department of Justice.²⁰ (p.73)
- 5.21 Judges should routinely order domestic violence offenders to attend a state-certified batterer's intervention program. (p.76)
- 5.22 Batterer's evaluations should never be court ordered in lieu of batterer's intervention, or in any way be a part of the criminal legal response to domestic violence. (p.76)
- 5.23 Judges should increase their awareness of the state standards for batterer's intervention programs and should not accept an offender's enrollment in a program that fails to meet these standards. (p.76)
- 5.24 Judges and probation departments should collaborate to develop a mechanism to extend probation or use judicial hearings if an abuser has not completed court-ordered batterer's intervention by the end of their probation period. (p.76)
- 5.25 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.²¹ (p.76)
- 5.26 Courts should have domestic violence resource information available throughout the courthouse (e.g., in bathrooms, waiting areas, clerks' offices, Protection Order offices). (p.80)

6. Civil attorneys, judges, and civil courts

- 6.1 Police, prosecutors, judges, and probation officers should consistently make every effort to identify and remove abusers' guns possessed in violation of the law at each step of the criminal or civil legal process. (p.44)
- 6.2 All courts issuing civil Protection Orders should have domestic violence advocacy services available on-site and ensure that such advocates have extensive training on how to assist victims with safety planning. If resources are limited, courts should minimally require that clerks routinely provide all petitioners with referral information to the local domestic violence program for assistance with safety planning, as mandated by RCW 26.50.035. (p.78)
- 6.3 Judges and commissioners should utilize their access to court histories to obtain as much background information as possible about other proceedings involving civil Protection Order respondents and petitioners.²² (p.79)
- 6.4 Courts should have domestic violence resource information available throughout the courthouse (e.g., in bathrooms, waiting areas, clerks' offices, Protection Order offices). (p.80)
- 6.5 Dissolution forms, "Do-It-Yourself Divorce" packets, and classes required by the courts for divorcing parents with children should include information about domestic violence and domestic violence resources. (p.80)
- 6.6 Due to the prevalence of domestic violence, law schools should incorporate domestic violence education in core courses for all attorneys, regardless of their area of specialty.²³ (p.80)

²⁰ See www.lep.gov for these policy guidelines.

²¹ Good models exist for such programs. For example, see Manalive Violence Prevention Programs at www.manaliveinternational.org.

²² The Kitsap County District Court, in partnership with the YWCA of Kitsap County, has developed and implemented a model court project, A New Beginning: Protecting Victims by Preventing Conflicting Domestic Violence Orders (Protecting Victims Project), to resolve problems that result when multiple orders exist for petitioners and respondents. As a part of this work, they scan every court order in the county (civil, criminal, and tribal court) to ensure continuous access to information on all orders. To learn more about the Protecting Victims Project or to discuss the availability of consultation services, contact Maury Baker at 360-337-4959 or WSCADV at 206-389-2515.

²³ For a report on integration of domestic violence into law school curricula, as well as sample course materials for use by legal educators, see *Teach Your Students Well: Incorporating Domestic Violence Into Law School Curricula—A Law School Report*, American Bar Association Commission on Domestic Violence (2003).

- 6.7** Civil attorneys should routinely tell their clients going through the dissolution process about available domestic violence advocacy services, where to receive assistance planning for their safety, and Protection Orders. (p.80)
- 6.8** All attorneys practicing family law should receive training on how to identify when domestic violence is an issue and what factors indicate an increased risk for serious injury or lethality. (p.80)
- 6.9** Civil Protection Orders should specify visitation arrangements which address safety for domestic violence victims and their children. (p.82)
- 6.10** All professionals working in the civil legal system, including judges, attorneys, court clerks, court facilitators, family court evaluators, guardians ad litem (GALs), and court-appointed special advocates (CASAs), should receive initial training and continuing education on domestic violence. (p.82)
- 6.11** The Washington State Bar Association should collaborate with agencies with expertise in domestic violence and family law to create and disseminate the following practice guides: how to raise the issue of domestic violence in custody cases; making the connections between domestic violence and harm to children, including a literature review to help attorneys bring the research in this area to judges' attention; and how to construct a parenting plan which addresses safety for victims and their children. (p.82)
- 6.12** 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; and assess for the safety needs of victims and their children. (p.82)

7. Legislature, state and local government agencies, and schools

- 7.1** The Washington State Legislature should require all middle schools and high schools to develop and implement a policy for responding to domestic and dating violence when it is identified as an issue for students, faculty, or staff. Schools should partner with local, community-based domestic violence programs when developing these policies and the Legislature should provide schools and domestic violence programs with funding to support this work. (p.47)
- 7.2** The state Office of the Superintendent of Public Instruction (OSPI) should collaborate with state-level domestic violence advocacy experts to review how its healthy relationships curriculum addresses domestic and dating violence, and develop a plan for promoting and training on the use of this curriculum.²⁴ (p.48)
- 7.3** Middle schools and high schools should identify strategies for providing ongoing information to all students, multiple times throughout their education, about healthy relationships, interpersonal boundary setting, how to recognize abusive tactics, and the support resources available. Schools should involve students in the discussion and development of these strategies in an effort to ensure their relevancy. (p.48)
- 7.4** Teen dating violence prevention education should include development of peer advocacy and a partnership with a local domestic violence agency. (p.48)
- 7.5** School resource officers, school counselors, and school nurses should all have written information available on healthy relationships, tactics of abuse, and support resources in language that is clear, relevant, and accessible to young people. (p.48)

²⁴ In 2005, the Washington State Legislature passed ESHB 1252, which mandated the OSPI to develop this curriculum (called "family preservation education program model curriculum" in the legislation) for school district boards around the state to adopt on a voluntary basis, and to include instruction on domestic and dating violence in the curriculum.

- 7.6** Funders and domestic violence programs should recognize teen dating violence education, peer advocacy, and prevention efforts as a part of core services. (p.48)
- 7.7** The Department of Social and Health Services Juvenile Rehabilitation Administration and Children's Administration, in collaboration with juvenile courts, youth advocates, and domestic violence experts, should develop policies and protocols for professionals working in the juvenile justice system to address domestic and dating violence. (p.50)
- 7.8** Domestic violence programs and their funders should include community education, outreach, prevention efforts, public awareness campaigns, and other strategies for building the capacity of communities to respond to domestic violence as a core part of their work. (p.52)
- 7.9** State and local governments should make funding available to marginalized communities—such as communities of color, immigrant and refugee, Native, disabled, and lesbian, gay, bisexual and trans (LGBT) communities—to develop targeted and culturally specific community education campaigns and community organizing projects regarding domestic violence. Funding should be directed to organizations with established credibility and trust within the communities that will be the focus of the education and organizing efforts. (p.55)
- 7.10** The Washington State Legislature and Governor's Office should discourage the adoption of inter-local agreements between local law enforcement agencies and ICE that allow for local enforcement of federal immigration law. (p.55)
- 7.11** Crime prevention public education campaigns should address people's concerns regarding who will have access to their identity when they call 911 to report a crime. (p.56)
- 7.12** State government and local communities should commit time and resources to collaborate with domestic violence advocacy programs to develop and implement early interventions for children exposed to domestic violence and support for non-abusive parents. (p.56)
- 7.13** All programs that are a part of the Department of Social and Health Services (DSHS) Children's Administration, including the Foster Care program and Child Protective Services, should collaborate with locally based domestic violence advocates for training and to develop policies and protocols for identifying and responding to domestic violence.²⁵ (p.57)
- 7.14** DSHS should ensure that all WorkFirst participants are screened for domestic violence in accordance with existing policy, using the specific screening questions in e-JAS. (p.59)
- 7.15** DSHS should ensure that all identified domestic violence victims who participate in WorkFirst are provided with information and referrals to local domestic violence resources. (p.59)
- 7.16** DSHS should ensure that WorkFirst staff waive program requirements as needed and develop safe and appropriate work and individual responsibility plans for domestic violence victims participating in the WorkFirst program. (p.59)
- 7.17** As DSHS communicates with CSOs about the new federal TANF regulations issued in June 2006, they should remind workers that domestic violence victims can be counted outside of federal participation rate requirements and recognize this as an incentive for the accurate use of the Family Violence Option. (p.59)
- 7.18** DSHS should expand its current partnerships with locally contracted domestic violence programs to place experienced domestic violence advocates in all CSOs to provide

²⁵ See the 2004 DVFR report, *Every Life Lost Is a Call for Change*, p. 59, for a detailed discussion of findings and recommendations for the DSHS Children's Administration.

information, advocacy, and support to all victims accessing public benefits.²⁶ Clients should be able to access these advocates directly, regardless of how they answer screening questions about domestic violence. (p.60)

- 7.19** DSHS should routinely provide information about local domestic violence resources to participants across all public benefit programs. (p.60)
- 7.20** Due to the prevalence of domestic violence and the many barriers that exist to disclosing abuse, DSHS should require all of its offices and programs to have domestic violence information (e.g., safety planning pocket guides, brochures from the local domestic violence agency) consistently available in areas where individuals can help themselves to the information, such as in restrooms, in the front office waiting area, and on the desks of all case managers and social workers. (p.60)
- 7.21** DSHS should ensure adequate support services are routinely available to clients who have mental health issues. (p.60)
- 7.22** Domestic violence programs should develop and implement a plan for engaging their community in work aimed at increasing economic security and the availability of financial education for domestic violence victims.²⁷ Funders and domestic violence programs should recognize this work as a part of core services. (p.62)
- 7.23** The Washington State Legislature should amend RCW 10.99 to direct judges to examine a complete criminal history before releasing a defendant in a domestic violence case on personal recognizance or when determining the level of bail. (p.72)
- 7.24** The Washington State Legislature should amend the state sentencing guidelines to provide for more serious sentences for recidivist domestic violence offenders, as has been done for repeat offenders in Driving Under the Influence convictions. (p.72)
- 7.25** The state should provide more resources to DSHS for the oversight of certified batterer's intervention programs in order to monitor their compliance with the standards set forth in the Washington Administrative Code (WAC), including increased authority to decertify noncompliant programs and funding to reconvene an advisory group. (p.76)
- 7.26** The Washington State Legislature should amend RCW 26.09.191 to provide more specificity around the types of restrictions on residential time with children that can be ordered for domestic violence abusers (e.g., supervised visitation or exchange, completion of batterer's intervention program).²⁸ (p.82)
- 7.27** The Washington State Legislature should increase funding for safe, affordable, and language-accessible supervised visitation and exchange resources for family law cases involving domestic violence. Supervisors should receive specialized training on the dynamics of domestic violence, how to recognize the manipulative tactics an abuser might use during visitation, the potential for an abuser to use visitation to stalk and control their partner, and the risk to children when one parent has a history of perpetrating domestic violence. (p.82)

²⁶ Currently, 70% of CSOs have on-site domestic violence advocates on contract from local domestic violence programs.

²⁷ See *In Our Shoes: The Next Steps – A Domestic Violence Advocate's Guide to Working for Economic Justice in Your Community*, Washington State Coalition Against Domestic Violence (2005), www.wscadv.org. This step-by-step workbook can be used by advocates to develop and sustain a community-based effort to advance economic security, especially for those affected by domestic violence.

²⁸ Examples of such language can be found in the *Model Code on Domestic and Family Violence*, National Council of Juvenile and Family Court Judges (1994). For copies of this publication, see www.ncjfcj.org.

8. Community organizations

- 8.1 Community groups and volunteer organizations (e.g., neighborhood associations, block watch, parenting groups, religious congregations) should contact their local domestic violence program to learn about domestic violence. (p.52)
- 8.2 Crime prevention public education campaigns should address people's concerns regarding who will have access to their identity when they call 911 to report a crime. (p.56)
- 8.3 Programs providing support to parents and children, such as parenting classes, prenatal education, Head Start, and other programs aimed at strengthening families and children, should obtain information about and establish collaborations with local, community-based domestic violence programs to include attention to domestic violence in the services they provide.²⁹ (p.56)
- 8.4 State government and local communities should commit time and resources to collaborate with domestic violence advocacy programs to develop and implement early interventions for children exposed to domestic violence and support for non-abusive parents. (p.56)
- 8.5 Housing organizations, from emergency shelters to long-term transitional housing programs and housing authorities, should evaluate policies that deny housing to people who use psychiatric medications to determine whether victims of domestic violence and their children are being adversely harmed by such policies, and coordinate with domestic violence programs to provide supportive services. (p.60)

9. Employers

- 9.1 Employers should develop, implement, and train staff on policies that specifically address how they will support employees who are being abused and/or stalked, in order to assist them in safely maintaining their employment.³⁰ (p.62)
- 9.2 Employers should contact their local domestic violence program to learn about resources available and routinely share this information with their employees by a variety of methods (e.g., attach a list of resources to paychecks, have information available in restrooms, invite an advocate from a local domestic violence program to give a presentation at a staff meeting). (p.62)

10. Media

- 10.1 All media coverage of domestic violence homicides or other domestic violence-related stories should inform the audience that anyone (e.g., victims, friends, family, co-workers) can call a domestic violence program for free and confidential information, support, and assistance with safety planning.³¹ (p.52)

²⁹ Head Start has created a model curriculum to address domestic violence called Safe Families–Safe Homes. See www.glenwoodresearch.com/domestic_violence.php for more information and a curriculum sample.

³⁰ For employer resources on strategies to address domestic violence and examples of best practice at a variety of companies, see the Family Violence Prevention Fund's website at www.endabuse.org/workplace or the Corporate Alliance to End Partner Violence at www.caepv.org.

³¹ WSCADV has developed and distributed *Covering Domestic Violence: A Guide for Journalists and Other Media Professionals* (2002, revised 2006), which includes local and national statistics, tips for accurately covering domestic violence crimes, and resource information reporters can incorporate into their coverage. This guide is available at www.wscadv.org.

What can you do today?

Each chapter of this report ends with a simple step every one of us can take today to begin to impact change in our community. The following is a list of these suggested steps, with the page number indicating where they can be found in the text of the report.

- Become a trained suicide prevention gatekeeper. Eastern Washington University offers a one-hour online QPR Suicide Triage Training. Find more information and enroll at the QPR Institute website: www.qprinstitute.com. (p.41)
- Go to the Family Violence Prevention Fund's website to learn more about safety planning: www.endabuse.org/resources/gethelp. (p.46)
- Contact someone you know who works with or interacts with teens, and ask them to call their local domestic violence program. They can talk with an advocate about teen dating violence to learn about the tactics of abuse, safety planning, and the information and resources that are available to teens. (p.50)
- Identify one group of people you are involved with in your community (e.g., your workplace, a parenting group, a book club) and inform the group of the prevalence of domestic violence and the critical role friends, family, co-workers, and neighbors play in responding to abuse. Provide contact information for your local domestic violence program. Let them know that anyone can call this number for free, confidential information and support if they or someone they know is experiencing stalking or emotional, verbal, physical, and/or sexual abuse. (p.57)
- Every county in the state was required to develop a ten-year plan by June 2006 to address homelessness as a part of the Washington State Homelessness Act. The plans are coordinated by the state Department of Community, Trade and Economic Development (CTED) and can be found on their website at www.cted.wa.gov under Housing/Homeless/Homelessness Act. Call the local contact person for your county and inquire about how the county's plan is addressing the needs of homeless domestic violence victims. (p.62)
- Contact one domestic violence, one chemical dependency, and one mental health program in your community to learn about their services and collect an agency brochure. Then share with each program the information and brochure you collected from the other two. (p.66)
- Contact your local law enforcement agency to learn about their policies and practices regarding how officers utilize interpreters when responding to domestic violence incidents. If they lack a clear policy, refer them to www.lep.gov and ask them to develop a language access plan. (p.76)
- Go to a court in your area and see if there is domestic violence resource information in multiple languages available at the front window, in the Protection Order office, by the court clerk, or in some other accessible area. If there is, thank the court for having that information available. If there is not, contact your local domestic violence program and ask them to contact the court and routinely provide them with resource information, or write a letter to the presiding judge requesting that the court make this information available. (p.82)

Overview of Fatalities

Domestic violence fatalities discussed in this report

This report makes reference to four different sets of domestic violence-related fatalities in Washington State:

1. All fatalities which have occurred since January 1, 1997.
2. Fatalities which occurred since the 2004 Domestic Violence Fatality Review report (between July 1, 2004 and June 30, 2006).
3. All reviewed cases: The sixty-five cases reviewed in depth with locally based, multi-disciplinary review panels (as described in Appendix A) since 1998.
4. Recently reviewed cases: The eleven cases examined in depth by Fatality Review panels in the two years since our 2004 report.

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

While the Domestic Violence Fatality Review (DVFR) tracks all domestic violence fatalities occurring in the state (as described in Appendix A), staffing constraints dictate that we can review only a small portion of these fatalities in detail. We gather a great deal of information on reviewed cases from Fatality Review panel members and public records, including civil and criminal histories from the Administrative Office of the Courts’ Judicial Information System. 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 name, age, gender, and relationship of those involved.

Domestic violence fatalities discussed in this report

	Number of cases	Total number of fatalities*	Cases drawn from which counties
All cases (reviewed and unreviewed)			
All fatalities which occurred from January 1997 through June 2006	393	530	Entire state
Fatalities which occurred from July 2004 through June 2006	80	113	Entire state
Reviewed cases			
All cases reviewed in depth	65	102	Benton, Chelan, Clark, Douglas, Franklin, King, Kittitas, Okanogan, Pierce, Snohomish, Spokane, Thurston, Walla Walla, and Yakima
Cases reviewed in depth from July 2004 through June 2006	11	14	Benton, Clark, Franklin, Snohomish, Thurston, and Walla Walla

* includes abuser suicides

Overview of domestic violence cases July 1, 2004 to June 30, 2006, and all cases since 1997

A total of 113 people died in domestic violence-related fatalities in Washington State between July 1, 2004 and June 30, 2006. This number includes eighty-three homicide victims, twenty-six abuser suicides, and four cases in which abusers were killed by law enforcement officers while threatening lethal force against the officers or a victim. Domestic violence abusers or their associates killed almost all of the homicide victims (93%). They include domestic violence victims, their children, friends, and family members.

All domestic violence fatalities¹

Homicide victim: KILLED BY WHOM	7/1/04- 6/30/06	1/1/97- 6/30/06
1. Female domestic violence victim: CURRENT/FORMER HUSBAND/BOYFRIEND	48	224
2. Female domestic violence victim: OTHER MALE INTIMATE (E.G., CAREGIVER)	0	5
3. Female domestic violence victim: MALE ABUSER'S ASSOCIATE	0	2
4. Male domestic violence victim: CURRENT/FORMER WIFE/GIRLFRIEND	7	26
5. Male domestic violence victim: FEMALE ABUSER'S ASSOCIATE	2	3
6. Male domestic violence victim: MALE INTIMATE PARTNER	0	1
7. Children: MALE ABUSER	10	32
8. Friend or family of female domestic violence victim: MALE ABUSER	3	35
9. Friend or family of male domestic violence victim: FEMALE ABUSER	0	1
10. New boyfriend of female domestic violence victim: MALE ABUSER	5	24
11. Co-worker of female domestic violence victim: MALE ABUSER	1	2
12. Law enforcement: MALE ABUSER	1	4
13. Male abuser: FEMALE DOMESTIC VIOLENCE VICTIM IN SELF-DEFENSE	2	9
14. Male abuser: FEMALE DOMESTIC VIOLENCE VICTIM IN PROBABLE SELF-DEFENSE	0	8
15. Male abuser: FEMALE DOMESTIC VIOLENCE VICTIM, NOT IN SELF-DEFENSE	1	7
16. Male abuser: FRIEND OR FAMILY OF FEMALE DOMESTIC VIOLENCE VICTIM	2	12
17. Male abuser: LAW ENFORCEMENT ²	4	13
18. Male abuser: SUICIDE	26	118
19. Female abuser: SUICIDE	0	1
20. Children: FEMALE DOMESTIC VIOLENCE VICTIM	1	3
Totals		
21. All domestic violence fatalities (rows 1-20)	113	530
22. All homicide victims (rows 1-16 and 20, excludes suicides and abusers killed by law enforcement)	83	398
23. All homicides committed by abusers or their associates (rows 1-12)	77	359

¹ Discrepancies from counts in the 2004 DVFR report reflect corrected and updated information since that time.

² Abusers' actions in these cases essentially forced law enforcement officers to shoot them.

Undercounts

The DVFR tracks domestic violence fatalities primarily by collecting news accounts of murders around the state and referring to the domestic violence homicide section of the *Crime in Washington State* 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 the domestic violence victim 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 the other, 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 the DVFR undercounts domestic violence homicides committed by same-sex partners. According to WASPC's *Crime in Washington State* report, 5% (n=13) of homicide perpetrators in 2005 were "friends" of the victim. It is possible that these cases include gay or lesbian relationships which were not accurately identified at the time of reporting. Same-sex relationships may also be classified as "other known to victim" (6% of homicide perpetrators) or even "unknown relationship" (17% of homicide perpetrators).³

3. Suicides of battered women

Far more women die by suicide each year in Washington than are murdered. For example, according to the Washington State Department of Health's Center for Health Statistics, 190 women died by suicide in 2004, over three times the number of women murdered that year.⁴ Without more in-depth examination of these cases, we cannot be sure how many of these women experienced despair that was directly tied to feeling trapped and abused at the hands of their partners. In order to gather more data about this possible connection, the DVFR conducted an exploratory research study to estimate the number of suicide victims who had a history of domestic violence (see "Spotlight on Suicide" chapter).

4. Homicides mistakenly classified as suicides or accidents

The DVFR count relies on cases identified as homicides by law enforcement; therefore, any homicide mistakenly classified as a suicide or accident is not included.

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

Many women are reported missing each year in Washington State. 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.

³ *Crime in Washington State 2005*, Uniform Crime Reporting Project, Washington Association of Sheriffs and Police Chiefs (2006).

⁴ *Washington State Vital Statistics 2004*, Center for Health Statistics, Washington State Department of Health (2005).

Men killed by female intimate partners

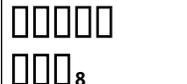
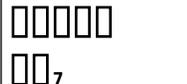
A number of women in Washington State kill their male intimate partners each year. Research into this phenomenon has consistently indicated that most women who kill their male partners have been victims of that partner’s abuse prior to the homicide.⁵ However, the circumstances of these homicides are not always consistent with legal definitions of self-defense; thus, a significant number of battered women who kill their abusers are prosecuted, most for second-degree murder or manslaughter. The DVFR does not have extensive details on all of these homicides, but we utilize the information we do have to determine who is the victim and abuser in each case.

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

1. **Female domestic violence victims 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. **Female domestic violence victims who killed their abusers in 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. **Female domestic violence victims 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 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.

Men killed by female intimate partners: January 1, 1997 to June 30, 2006

Total cases: 53

 <p>29</p>	 <p>9</p>	 <p>8</p>	 <p>7</p>
<p>Male victim killed by female abuser or associate 55%</p>	<p>Abuser killed by victim in self-defense 17%</p>	<p>Abuser killed by victim in probable self-defense 15%</p>	<p>Abuser killed by victim, not in self-defense 13%</p>

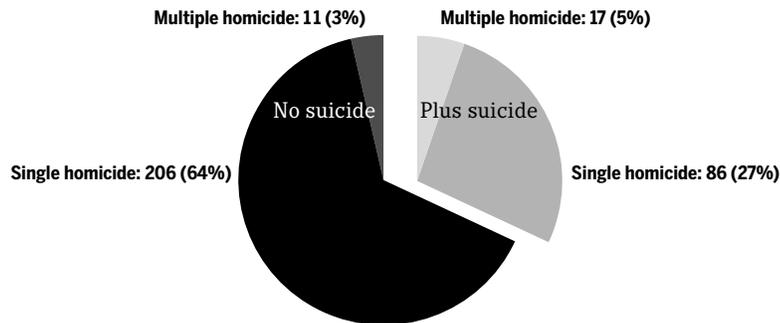
⁵ Christine Rasche, “‘Given’ Reasons for Violence in Intimate Relationships,” *Homicide: The Victim/Offender Connection*, ed. Anna Wilson (Cincinnati, OH: Anderson Publishing Co., 1993), p. 88, and Nancy Jurik and Russ Winn, “Gender and Homicide: A Comparison of Men and Women Who Kill,” *Violence and Victims* 5, no. 4 (1990), p. 236.

Homicide-suicides

Almost a third (32%) of the 320 abusers who committed homicides since January 1, 1997 committed homicide-suicides. An additional twelve abusers killed themselves after attempting homicide.⁶

Homicides committed by domestic violence abusers: January 1, 1997 to June 30, 2006

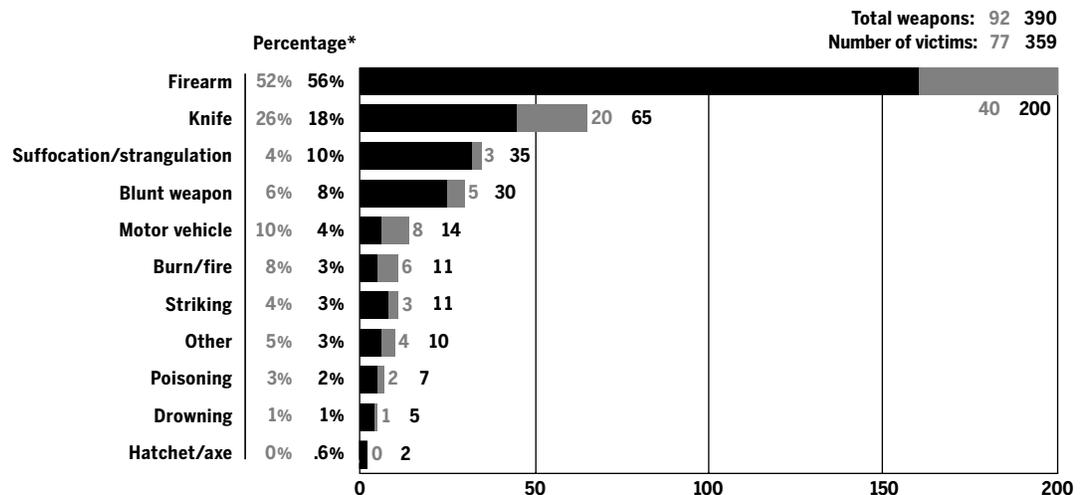
Total cases: 320⁷



Weapons

The majority of domestic violence homicides in Washington State have been committed with firearms. Since 1997, abusers used firearms to kill 56% (n=200) of domestic violence homicide victims. Between July 1, 2004 and June 30, 2006, abusers used firearms to kill 52% (n=40) of homicide victims.

Weapons used by domestic violence abusers in homicides committed January 1, 1997 to June 30, 2006
 July 1, 2004 to June 30, 2006 rendered in gray



*Percentage total is greater than 100% due to use of multiple weapons in some homicides.

⁶ We included the deaths of abusers killed by law enforcement in counts of suicidal abusers. In all of these cases, abusers acted deliberately in a life-threatening manner 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.

⁷ Total number of abusers who committed homicides (some abusers committed multiple homicides), excluding the five cases in which the victim was killed by their abuser’s associate.

Separation violence

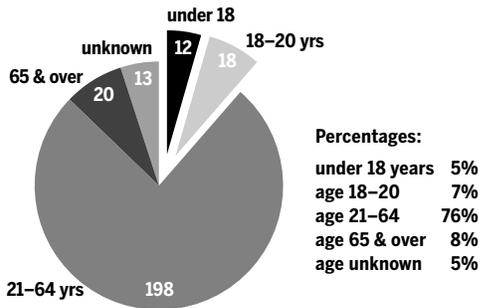
News reports or in-depth fatality reviews made clear that in at least 47% of the homicides committed by the domestic violence abuser, the domestic violence victim had left, divorced, or separated from the abuser, or was attempting to leave or break up with the abuser.⁸

Age of victims

Twelve percent of the domestic violence victims killed by their abuser or their abuser’s associate since 1997 were under 21 years old, and of those, 40% were not yet 18.

Domestic violence victim’s age at time of murder: January 1, 1997 to June 30, 2006

Total domestic violence victims killed: 261

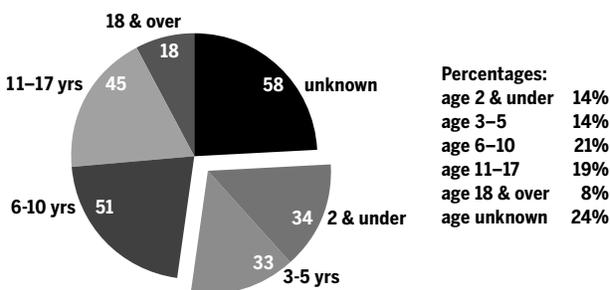


Children

Of the 261 domestic violence victims killed by abusers or their associates since 1997, at least 114⁹ (44%) had children living in the home with them at the time they were murdered. Of the children for whom we have age information, 37% were age five or younger. The DVFR is aware of at least six women killed by their current or former intimate partner who were pregnant at the time of their murder; it is possible that more homicide victims were pregnant and this fact was not covered in news accounts. The majority (57%) of the victims’ children were present at the time of the homicide. News reports indicated that of the children present, 40% witnessed the murder. Abusers killed sixteen children alongside their mothers, and attempted to kill more.

Age of children living with domestic violence victim at the time of the murder: January 1, 1997 to June 30, 2006

Total: 239 children of 114 domestic violence victims

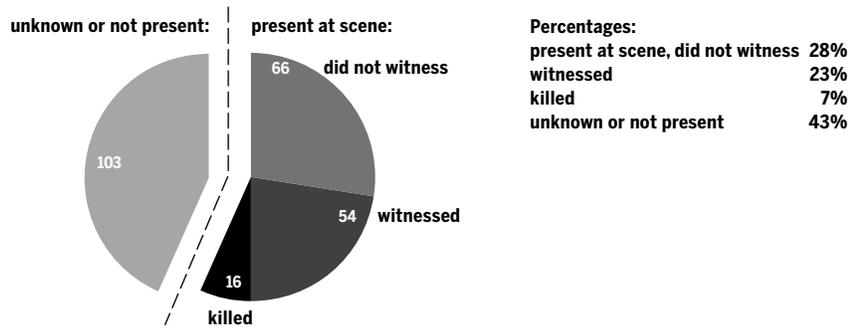


⁸ For cases not reviewed in depth, information on the status of the relationship is often incomplete, so the percentage of victims who were in the process of breaking up or leaving may be even higher.

⁹ This number includes 102 female and 12 male domestic violence victims.

Location of children at the time of domestic violence victim’s murder: January 1, 1997 to June 30, 2006

Total: 239 children of 114 domestic violence victims



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.¹⁰ These deaths include homicides of domestic violence victims, their children, friends, family members, and 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. *Please note that the data for 2006 reflects only the first six months of the year, January 1 through June 30.* 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.

¹⁰ Discrepancies from counts in the 2004 DVFR report reflect corrected and updated information (for example, one woman killed in 2000 was listed as a missing person until her abuser confessed to killing her in 2005).

Domestic violence homicides by county

County	1997		1998		1999		2000		2001		2002	
	Homicides	Abuser suicides										
Adams												
Asotin							1	1				
Benton					1	1			1	1		
Chelan			1									
Clallam	2		1				1		1		1	
Clark	3	2	2	2	1				5	2	2	
Columbia											1	
Cowlitz					1						2	1
Douglas												
Ferry												
Franklin			2				2		3	1	1	
Garfield												
Grant			2								1	
Grays Harbor							2	2			2	
Island	1				2		1		1		2	2
Jefferson											1	
King	13	2	16	5	15	1	6	1	10	3	12	4
Kitsap	5	2	2		1	1	1		2			
Kittitas					1						1	
Klickitat									1	1		
Lewis							1					
Lincoln									1			
Mason			1		1							
Okanogan	1		1		1	1						1
Pacific			1									
Pend Oreille		1							1			
Pierce	6	3	8	2	4	2	4	1	8	4	7	
San Juan			1	1								
Skagit		1					1		1		2	
Skamania					1	1						
Snohomish	4		2		3	1	3		4	3	5	
Spokane	2	2	3	1	3	2	3	1	1	1	3	
Stevens												
Thurston			3	1	3	1			2	1		
Wahkiakum												
Walla Walla	2	1										
Whatcom	1						1	1		1	2	
Whitman												
Yakima	1	1	2				3	2	4	2	2	2
Total fatalities	41	15	48	12	38	11	30	9	46	20	47	10

Domestic violence homicides by county

2003		2004		2005		2006*		10-year total		County
Homicides	Abuser suicides	Homicides	Abuser suicides							
								0	0	Adams
				1				2	1	Asotin
4	1	3		4		1		14	3	Benton
		1						2	0	Chelan
	1	2	1					8	2	Clallam
2	2	5	1	5	3			25	12	Clark
								1	0	Columbia
		1	1	1	1			5	3	Cowlitz
		1						1	0	Douglas
								0	0	Ferry
1	1							9	2	Franklin
								0	0	Garfield
								3	0	Grant
								4	2	Grays Harbor
		1						8	2	Island
1								2	0	Jefferson
18	4	9	4	9	6	1		109	30	King
1				3	2			15	5	Kitsap
								2	0	Kittitas
								1	1	Klickitat
								1	0	Lewis
								1	0	Lincoln
1	3			3	1			6	4	Mason
		1	1					4	3	Okanogan
								1	0	Pacific
1						1		3	1	Pend Oreille
10	2	10	2	9	1	5	2	71	19	Pierce
								1	1	San Juan
								4	1	Skagit
								1	1	Skamania
4	2	6	3	1	1		1	32	11	Snohomish
1		4	1	3			1	23	9	Spokane
								0	0	Stevens
1			1	2	1			11	5	Thurston
								0	0	Wahkiakum
								2	1	Walla Walla
1	1	1		1	1			7	4	Whatcom
				2	1			2	1	Whitman
		3	1	1		1		17	8	Yakima
46	17	48	16	45	18	9	4	398	132	Total fatalities

*data through June 30, 2006

Spotlight on Suicide: Exploring the Connection Between Suicide and Domestic Violence

Abusers' tactics of control systematically exacerbate suicide risk factors for victims.

In Washington State and nationwide, far more women die by suicide each year than are murdered. In 2003, 161 women died by suicide in Washington, more than three times the number of women murdered.¹

Documented risk factors for suicide include depression, hopelessness, isolation from community, barriers to accessing mental health treatment, and unwillingness to seek assistance due to the stigma attached to mental health disorders.² Several studies indicate that domestic violence increases women's risk of suicide attempts and of death by suicide.³ Whether or not victims have any of the common risk factors before being abused, abusers' tactics of control systematically exacerbate suicide risk factors by increasing victims' social isolation, undermining their sense of self-worth, and creating barriers to accessing support and resources. Institutional barriers to accessing support—such as lack of language interpretation or childcare resources—can reinforce victims' sense that they have little hope of regaining control over their own lives.

The Domestic Violence Fatality Review (DVFR) is dedicated to learning from domestic violence-related deaths, and using the knowledge gained to improve our communities' response to domestic violence. As noted in the chapter "Overview of Fatalities," many domestic violence-related fatalities are not identified. Suicide deaths in particular—both of domestic violence victims and of abusers—have not been fully represented in DVFR data.

The DVFR does not include a count of suicides by domestic violence victims in the fatality statistics because no good mechanism exists for identifying these cases. Although we occasionally become aware of suicide deaths of women who were clearly domestic violence victims, most suicides go unreported in the media. Since the DVFR relies primarily on news reports of deaths for our initial data, we generally only know about the suicide deaths of domestic violence victims in cases where the death was investigated as a homicide, or when newspapers report the case because of other extraordinary circumstances.

Similarly, the count of suicides of abusers includes only those that were reported in the news and that clearly occurred in the context of abuse. All of the suicides of abusers represented in our statistics are included because the abusers had committed a domestic violence-related homicide or other assault before taking their own lives. But our data does not help us identify how frequently abusers commit suicide without attempting or completing a homicide first.

In order to address the gap in the data on suicide deaths related to domestic violence, the DVFR conducted an exploratory study to estimate the number of suicide victims who had a history of domestic violence. We used data from death certificates to identify all individuals who died by suicide in Washington in 2003. We then searched court records to determine if there was

1 There were 52 female deaths attributed to homicide in 2003. *Washington State Vital Statistics 2003*, Center for Health Statistics, Washington State Department of Health (2005).

2 U.S. Public Health Service, *The Surgeon General's Call To Action To Prevent Suicide* (Washington, D.C.: U.S. Department of Health and Human Services, 1999), p. 9. Available at www.surgeongeneral.gov/library/calltoaction/default.htm.

3 Evan Stark and Anne Flitcraft, "Killing the Beast Within: Woman Battering and Female Suicidality," in Stark and Flitcraft, *Women at Risk: Domestic Violence and Women's Health* (Thousand Oaks, CA: Sage Publications, 1996), p. 99–120; Robert Muelleman et al., "Nonbattering Presentations to the ED of Women in Physically Abusive Relationships," *American Journal of Emergency Medicine* 16 (1998), p. 128–131; Gina Wingood et al., "Adverse Consequences of Intimate Partner Abuse Among Women in Non-Urban Domestic Violence Shelters," *American Journal of Preventive Medicine* 19 (2000), p. 270–275.

any court-documented domestic violence history for those individuals. Men were identified as domestic violence abusers if they had either a domestic violence criminal charge or a domestic violence civil Protection Order issued against them any time before their death. Women were identified as domestic violence victims if they were protected by a domestic violence criminal No Contact Order in the five years before their death or by a domestic violence civil Protection Order any time before their death.⁴

Previous DVFR reports have illuminated a connection between abusers' homicidal and suicidal behavior, and have included many recommendations for responding to suicidal abusers.⁵ Recent fatality reviews illustrate that these recommendations remain relevant. This chapter highlights data from the suicide research study, as well as issues raised in cases reviewed from July 2004 through June 2006. The eleven recently reviewed cases include five suicide deaths: three homicide-suicides by abusers, one suicide and attempted homicide by an abuser, and one suicide of a domestic violence victim.

Finding: Many women who die by suicide have experienced a history of abuse. Domestic violence victim services and mental health services do not adequately address the intersection of suicidality and abuse for women.

The suicide research study focused on 127 women ages 18–60 who died by suicide in Washington in 2003. Of these, 13% (n=16) had a court-documented history of domestic violence victimization.⁶ Although the data does not tell us whether or how experiencing abuse contributed to these women's deaths, it does demonstrate an overlap between the experience of domestic violence and suicide for women.

The true percentage of suicide victims who were domestic violence victims is most likely much higher than 13%. The large majority of domestic violence victims do not seek civil Protection Orders or see their abusers prosecuted for domestic violence crimes.⁷ Examining domestic violence homicides can clearly illustrate the under-documentation of domestic violence generally in the legal system. In 2003, thirty-five women ages 18–60 were murdered in Washington State. By studying news accounts and law enforcement data, the DVFR identified that eighteen (51%) of these women were domestic violence victims killed by their abusers. However, when we applied the same research methods to look for homicide victims' domestic violence history as we used for suicide victims, we found that none of the eighteen domestic violence homicide victims had a court-documented history of abuse.

4 The study did not include information about male victims or female perpetrators. The overwhelming majority of domestic violence victims are women. See, for example, Patricia Tjaden and Nancy Thoennes, "Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey," National Institute of Justice (Washington, D.C.: U.S. Department of Justice, November 1998), NCJ 172837, and *Bureau of Justice Statistics, Intimate Partner Violence, 1993–2001*, by Callie Rennison (Washington, D.C.: U.S. Department of Justice, February 2003), NCJ 197838. Of the 103 perpetrators of a domestic violence homicide-suicide in Washington since 1997, 102 (99%) are men.

5 See especially *Honoring Their Lives, Learning from Their Deaths* (2000), p. 31–38 and "Tell the World What Happened to Me" (2002), p. 49–53, available at www.wscadv.org.

6 The suicide study was an exploratory research project that also looked at women who died of other external injuries. We found that 13% of accident victims, 9% of homicide victims, and 3% of women who died of undetermined injuries had a documented history of domestic violence.

7 Patricia Tjaden and Nancy Thoennes, "Extent, Nature, and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey," National Institute of Justice (Washington, D.C.: U.S. Department of Justice, July 2000), NCJ 181867.

Experts reviewing the DVFR data emphasized that while domestic violence advocates and others are acutely attuned to the danger victims face from abusers, relatively little attention has been paid to the danger women who are being abused face from suicide. The lack of focused efforts to prevent suicide among domestic violence victims represents a critical missed opportunity to address this substantial risk. Further, Fatality Review panel members and other experts identified that existing mental health services are often inaccessible to domestic violence victims. They also found that the majority of mental health care providers are not adequately trained about domestic violence, and are ill prepared to address the consequences of abuse, understand victims' safety needs, and support victims' self-determination.

Other research demonstrates that abuse is a contributing cause of mental health disorders for women, finding that women who experienced an abusive relationship have significantly higher rates of depression, anxiety, and post-traumatic stress disorder after the abuse than they did before.⁸ The critical insight that a woman's mental health issues may emerge as a consequence of abuse but are not the cause of the abuse should inform mental health clinicians' work with domestic violence victims, including conveying this potentially empowering insight to women experiencing abuse.

Recommendations:

- Mental health professionals should routinely screen for domestic violence when women present as depressed and/or suicidal.⁹
- Mental health professionals should partner with domestic violence programs to connect domestic violence victims to advocacy and safety planning in addition to mental health services. All domestic violence programs should have relationships with mental health care providers who are well trained in domestic violence and can provide appropriate services to victims.
- Mental health professionals, suicide specialists, and domestic violence programs should collaborate to provide cross-training to each other and to increase their ability to provide the appropriate range of services to domestic violence victims who are suicidal or have other mental health concerns.
- Domestic violence advocates and everyone working with domestic violence victims should receive training on how to routinely screen for suicidality, how to recognize suicide warning signs, and what to do when these signs are identified.

Finding: Communities need information and skill development to identify suicide risk and intervene effectively.

In the one recently reviewed case in which a domestic violence victim died by suicide, the victim's husband of over twenty years used a range of abusive tactics against her throughout their marriage, including isolating her, shaming her, blaming her for his alcohol abuse, and exploiting her financially.

8 Miriam Ehrensaft, Terrie Moffitt, and Avshalom Caspi, "Is Domestic Violence Followed by an Increased Risk of Psychiatric Disorders Among Women But Not Among Men? A Longitudinal Cohort Study," *American Journal of Psychiatry* 163, no. 5 (2006), p. 885-892.

9 For examples of screening tools, see the New York State Office for the Prevention of Domestic Violence, "Guidelines for Mental Health Professionals," available at www.opdv.state.ny.us/health_humsvc/mental_health/guidelines.html, and the Washington State Department of Health, "Domestic Violence and Pregnancy: Guidelines for Screening and Referral" (2004), available at www.doh.wa.gov/cfh/mch/documents/dv_for_web.pdf.

According to accounts from her family, the victim had attempted suicide about a month before her death in the same manner that she died. Though they were aware of her suicide attempt, it did not appear that the victim's adult children had information about how to intervene, or about what resources might have been available to them or to their mother. This experience is a common one—many suicide victims tell at least one person about their intention to die.¹⁰ Yet community members generally lack the information and skills to respond to suicide warning signs, including overt suicide threats and suicide attempts.¹¹

Research indicates that family and community support, easy access to mental health care, and support for seeking help can reduce women's risk of suicide.¹² However, most of the prevention strategies currently promoted in public health campaigns to prevent suicide fail to take into account the social isolation domestic violence victims experience as a consequence of abuse. Suicide prevention campaigns emphasize strategies that rely on friends, family, or other support people to intervene on behalf of those at risk for suicide. The Surgeon General's 2001 *National Strategy for Suicide Prevention* recommends training "key gatekeepers"—that is, those "who regularly come into contact with individuals or families in distress"—in suicide prevention.¹³ QPR Gatekeeper training, the most widely used model for training professionals and community members to prevent suicide attempts, prioritizes training for family members, friends, neighbors, clergy, and co-workers, based on the observation that the people most likely to prevent suicide for someone at risk are those already connected to the potential victim.¹⁴ Domestic violence victims are more likely to be isolated from these potential sources of community support, reducing the effectiveness of this important prevention strategy. Therefore, strategies that break isolation are critical for preventing victim suicides as well as undermining the power of abusers.

In addition to having fewer social relationships as a consequence of domestic violence, suicidal victims may also face the additional danger of having a partner indifferent to or encouraging their death. In the reviewed case involving a victim's suicide, her abusive husband was present at the scene of her death. The victim's decision to harm herself and her actions leading to her death took place over a period of time, not suddenly. Review panel members familiar with the case noted that the victim's husband, while not the direct cause of her death, was "not uninvolved" in her suicide and likely contributed to her actions.

Recommendations:

- Domestic violence programs should incorporate suicide prevention into community engagement strategies for domestic violence prevention, and should include information about suicide and depression in outreach to victims.¹⁵
- Suicide specialists should work collaboratively with domestic violence experts to develop suicide prevention strategies and public awareness campaigns specifically directed at victims of domestic violence.

10 Todd Zwillich, "Suicide, Homicide Oft Follow Conflicts," WebMD.com, 7/6/06.

11 Paul Quinnett, "QPR Gatekeeper Training for Suicide Prevention: The Model, Rationale and Theory," 2005 (unpublished manuscript).

12 *The Surgeon General's Call To Action To Prevent Suicide*, p. 10.

13 U.S. Public Health Service, *National Strategy for Suicide Prevention: Goals and Objectives for Action* (Rockville, MD: U.S. Department of Health and Human Services, 2001), SMA 3517. Available at www.surgeongeneral.gov/library.

14 Quinnett, "QPR Gatekeeper Training for Suicide Prevention."

15 The National Suicide Prevention Lifeline has developed a Media Outreach Toolkit to help organizations promote suicide prevention efforts. The toolkit is available at: www.suicidepreventionlifeline.org/campaign/kit.

Finding: One in five men ages 18-60 who died by suicide had a documented history of perpetrating domestic violence.

The suicide research study focused on 457 men ages 18–60 who died by suicide in Washington in 2003. Of these, 19% (n=87) had a court-documented history of perpetrating domestic violence. Because this study only identified domestic violence history through court records, it undoubtedly underestimates the number of men in the sample who had perpetrated domestic violence.¹⁶ Combining the men from the suicide research study who had a history of perpetrating domestic violence prior to committing suicide with Fatality Review data on abusers who committed domestic violence homicide and then suicide, we found that at least 21% (n=96¹⁷) of men ages 18–60 who died by suicide in 2003 had previously perpetrated domestic violence.

The suicide research study data suggests a strong link between having perpetrated domestic violence and committing suicide for men ages 18–60. Illustrating this link, one promising recent study demonstrated that an intervention aimed at preventing suicide also significantly reduced domestic violence.¹⁸ This ongoing suicide prevention program among U.S. Air Force personnel (84% of whom were men) emphasized increasing community awareness of suicide risk factors, increasing access to support resources, and changing social norms to reduce the stigma of seeking help. The study found that these interventions reduced the risk of suicide among personnel by 33%. They also reduced the risk of moderate family violence by 30% and reduced severe family violence by 54%.

The Air Force study results suggest that suicide and domestic violence share some underlying risk factors. Experts on Fatality Review advisory committees noted that while suicidal domestic violence abusers may share some risk factors, they also differ from other suicidal men in terms of what drives their decision to die. This sub-group might need more focused interventions to prevent suicide and/or to end their violence. For instance, the specific circumstance of loss of control over an intimate partner may trigger a suicidal abuser's despair. Because of this, both the impulse to control another person and the suicidal impulse must be addressed in order for the abuser or his partner to be safe.

One recently reviewed case illustrates how an abuser's decision to kill himself was connected to his need to control his intimate partner. In this case, the abuser demonstrated a pattern of presenting himself as a victim whenever his efforts to control his partner were met with resistance or attempts to hold him accountable. Prior to being sentenced for a domestic violence assault, the abuser wrote a letter to the court portraying the assault charge as an injustice that had happened to him: "After all, the only one who gets hurt by this is me." This pattern extended to rationalizing his decision to kill himself and his estranged wife after she left him. The abuser left suicide notes describing his belief that homicide-suicide was his only option, and that the victim had caused her own death and his death as well.

16 One researcher who interviewed 49 women whose husbands died by suicide found that 65% of respondents had been abused by their husbands. Rose Constantino, Laura Sutton, and Jeffrey Rohay, "Assessing Abuse in Female Suicide Survivors," *Holistic Nursing Practice* 11, no. 2 (1997), p. 60–68.

17 This number includes 87 male suicide decedents who had documented domestic violence charges or a Protection Order against them, and 10 men who committed domestic violence homicide prior to their suicide. One of the ten homicide-suicide perpetrators also had a previous history of Protection Orders or domestic violence criminal charges filed against him. The other nine had no documented domestic violence perpetration history.

18 Kerry Knox et al., "Risk of Suicide and Related Adverse Outcomes After Exposure to a Suicide Prevention Programme in the US Air Force: Cohort Study," *British Medical Journal* 327, no. 7428 (2003).

Recommendations:

- Suicide prevention efforts should include prevention strategies and outreach campaigns specifically directed at men who abuse their partners.
- Mental health providers and treatment developers should collaborate with domestic violence batterer's intervention¹⁹ and victim service experts to develop a best practice model for simultaneously addressing suicidality and domestic violence perpetration.
- Those in the criminal legal system who have ongoing contact with domestic violence abusers, such as probation officers and defense attorneys, should screen offenders for suicidal behavior or intention, and refer suicidal abusers to appropriate mental health and batterer's intervention programs.
- Law enforcement should immediately contact mental health professionals when a domestic violence abuser threatens suicide. Officers should provide the victim with information regarding the increased risk of homicide when an abuser is suicidal, and offer referrals to a domestic violence program for intensive safety planning.

Finding: Mental health professionals do not routinely: screen depressed and suicidal clients for domestic violence; address the increased risk that suicidality in abusers indicates for victims; or recognize how abusers might use suicidal threats as a tactic of control.

In five of the nine recently reviewed cases in which the abuser committed a homicide or attempted homicide, the abuser had previously made suicidal threats. Four of these abusers also killed themselves. Out of these five cases, it was clear that one abuser had seen several mental health professionals related to suicidality; one abuser had seen a counselor along with the victim; and one abuser had accessed crisis hotlines related to his depression and suicidal thoughts. Since mental health treatment records are not publicly accessible, the DVR does not routinely have access to this information, and therefore we do not know if any of the other abusers in reviewed cases accessed mental health services.

In one case, the abuser threatened suicide and attempted suicide on multiple occasions before killing the domestic violence victim. One such attempt occurred after a previous girlfriend sought to end their relationship. The abuser left a note to the victim blaming her decision to leave the relationship for the abuser's suicide attempt. The abuser spent a week in a psychiatric unit following the suicide attempt, but succeeded in continuing contact with the victim against her wishes, calling her at home with the permission of one of the unit's nurses. After being released, the abuser continued to stalk the victim at her home and workplace. The victim said, "I walked out of my shower into my front room and [the abuser] was standing in my front room. ... I'd come to work and [the abuser] would be in the parking lot waiting for me." The abuser continued to call and send mail to the victim, making statements such as "I can't live without you," implicit suicide threats intended to convince her to return to the relationship.

In addition to personnel in the hospital psychiatric unit, three other mental health professionals saw the abuser in this case over a period of several years. Some of this contact came about as a

¹⁹ Batterer's intervention programs are described in the Washington Administrative Code as "domestic violence perpetrator treatment programs" (WAC 388-60).

result of two suicide attempts. On at least two occasions, mental health professionals identified the abuser's suicide attempts as "superficial" and "attempts at manipulation." However, it did not appear that their assessments or treatment recommendations explicitly discussed domestic violence, or recognized the abuser's suicidal threats as a sign of danger to the victim involved.

Another abuser had a history of depression since he was a teenager, and had threatened suicide a number of times. He had a long history of controlling and stalking his estranged wife as well as previous partners. He appeared to manipulate partners with his depression, and used suicide threats to maintain contact with them. For example, he went to counseling briefly about one week before killing the victim and himself. He agreed to see a counselor on the condition that his estranged wife go with him, and told a friend that he went to counseling "just to get at her."

Previous Fatality Review reports have demonstrated that, even in cases where the abuser had extensive contact with psychologists, therapists, or social workers, the professionals involved did not identify the danger that the combination of suicidal thoughts and domestic violence represented, particularly to the victim of domestic violence.

Recommendations:

- Mental health professionals should routinely screen depressed and suicidal clients for domestic violence. Therapists should recognize that suicidal abusers may present an acute danger to their partners, ex-partners, and others, even if they have not made homicidal threats.
- In collaboration with domestic violence experts, mental health professionals should establish clear guidelines regarding when the combination of domestic violence and suicidal threats signals clear danger to others and triggers providers' duty to warn potential victims.
- Therapists and other mental health professionals should be aware of the prevalence of manipulative suicide threats as a tactic of domestic violence. When mental health care providers identify that a client has used suicidal threats or attempts as a tactic of establishing a pattern of power and control over an intimate partner, they should refer the client to a certified batterer's intervention program.
- Domestic violence programs should include questions on their crisis line, intake, and safety planning forms to ensure that advocates routinely ask about abusers' suicidal attempts or threats and safety plan accordingly.

Finding: Friends and family are often aware of abusers' suicide threats, but lack the information and tools needed to intervene.

In three of the four recently reviewed cases in which the abuser committed suicide, friends and family members knew about the abuser's suicidal threats or suicidal ideation. In the one remaining case, the abuser talked with family members about his depression and excessive drinking multiple times in the weeks before he attempted to kill the victim and then killed himself. In one additional case in which the abuser killed the victim but did not commit suicide, the abuser had made multiple suicide threats and previous suicide attempts that were known to friends, co-workers, and mental health professionals.

One abuser threatened suicide to his estranged wife multiple times in the months before he killed her and himself. In this time period, he also talked with two ex-girlfriends several times about being depressed and about suicide. One of these women recalled, “I talked to him about getting a counselor, get some medication. He needed to get out [of the relationship]. He needed to let her go. He wouldn’t do any of that.” The abuser’s ex-girlfriend was justifiably reluctant to get involved with him again, and worried that responding to his suicide threats would encourage him to keep contacting her. This case illustrates the particular challenges that friends or family members face when intervening with a suicidal abuser: they may be at risk of experiencing abuse themselves.

Recommendations:

- Suicide outreach and prevention programs should target friends, families, and partners of suicidal abusers, and provide specific strategies that address domestic violence and suicide.
- Domestic violence programs should include discussion of abusers’ suicidal threats or attempts and the danger these pose to victims in their community education efforts.

Finding: Abusers’ suicidality often co-occurs with substance abuse, increasing the risk of both suicide and homicide.

Fatality Review panels have discussed the increased danger to victims when suicidal abusers are also abusing substances. Research shows that abusers who misuse alcohol are more likely to commit or attempt domestic violence homicide.²⁰ In three of the four recently reviewed cases involving an abuser’s suicide, the abuser also abused substances in the days leading up to the fatality.

Recommendation:

- Experts in chemical dependency, suicide, and domestic violence should work together to coordinate prevention and intervention efforts.

What can you do today?

Become a trained suicide prevention gatekeeper. Eastern Washington University offers a one-hour online QPR Suicide Triage Training. Find more information and enroll at the QPR Institute website: www.qprinstitute.com.

²⁰ Phyllis Sharps et al., “The Role of Alcohol Use in Intimate Partner Femicide,” *American Journal on Addictions* 10, no. 2 (2001), p. 122–135.

Planning for Safety

Planning for safety is arguably the most fundamental domestic violence intervention. The term “safety planning” generally refers to a collaborative effort between a domestic violence advocate or other professional with expertise on domestic violence, and a victim, who is the expert regarding their own unique situation. Effective safety planning works from the recognition that domestic violence is a pattern of behavior and our communities do not adequately hold abusers accountable or prevent their ability to abuse again. Thus, victims continue to be at risk. Safety planning recognizes that the victim’s actions do not cause, and therefore cannot prevent, the abuse; instead, planning focuses on increasing awareness and developing strategies for staying as safe as possible in any given situation. It is an ongoing process that advocates and other professionals working with domestic violence victims should continuously discuss, knowing that as circumstances change and as the abuser reacts to the victim’s strategies, safety planning will also need to evolve.

Many victims plan for safety on their own as a part of their daily strategies for surviving an abusive relationship, although they may not formally label what they are doing “safety planning.” In six of the eleven cases reviewed by Domestic Violence Fatality Review (DVFR) panels from July 2004 through June 2006, the victims clearly did some safety planning in an effort to be as safe as possible, either in their relationship or after they separated from the abuser. It did not appear that any of these victims talked with an advocate about safety planning, although we cannot be certain. Panels agreed the victims probably would have benefited from some assistance to build on their efforts.

In one case, the victim had ended her relationship with the abuser, but continued to see him after their divorce. She used several safety planning strategies, including having someone accompany her when she was going to see the abuser the day of the fatal incident. The abuser shot her in the presence of the other person, who helped her exit the residence. The abuser then shot and killed himself. The victim survived the shooting, likely because of the assistance provided to her by the person she had brought along, reinforcing how life-saving safety planning strategies can be.

Finding: Domestic violence victims are at increased risk at the time of separation from an abuser, and continue to be at risk after a relationship has ended.

Consistent with other research,²¹ DVFR data indicates that a large number of homicides take place after separation. News reports or in-depth reviews of fatalities made clear that in at least 47% of the homicides committed by the domestic violence abuser, the domestic violence victim had either already left, divorced, or separated from the abuser, or was attempting to leave or break up with the abuser.²² Many studies of non-fatal domestic violence also indicate that abuse

Safety planning is an ongoing process that focuses on developing strategies for staying as safe as possible.

²¹ Carolyn Rebecca Block, “How Can Practitioners Help an Abused Woman Lower Her Risk of Death?” *NIJ Journal* no. 250 (November 2003), p. 4–7, NCJ 196545.

²² It is likely that a higher percentage of victims 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.

escalates after the victim leaves an abusive partner.²³ Safety planning is clearly needed to address separation violence and the reality that many abusers intensify their violence when a victim is trying to leave.

Fatality reviews found that some victims and abusers continue to live together or maintain contact even if they have formally ended their relationship. In one case, the victim maintained a significant amount of contact with the abuser following their separation because they had three children together. The abuser regularly came to the home to see the children. In another case, the victim moved out of the home she shared with the abuser, but he had most of her belongings in his possession, stalked her, harassed her at her workplace, and regularly threatened suicide. The victim continued to maintain a significant amount of contact with him as a strategy to keep his abuse tactics from escalating and in an effort to retrieve her belongings. Two additional victims in recently reviewed cases continued to live with the abuser after they divorced. All of these cases highlight the reality that the end of the relationship does not necessarily signal either the end of contact with the abuser or the end of the need for safety planning.

Recommendations:

- Domestic violence advocates and other professionals working with domestic violence victims should talk to victims about increased safety risks at the time of separation from an abuser and continue to regularly discuss safety planning after a victim has ended an abusive relationship.
- The goal of safety planning should not be to encourage the victim to end all contact with the abuser; rather, efforts should focus on how to be as safe as possible even when contact with the abuser is ongoing.

Finding: The presence of firearms increases risk for victims. The majority of domestic violence homicides are committed with firearms.

Fatality Review data consistently shows that the majority of domestic violence homicides are committed with firearms. Since 1997, abusers used firearms to kill 56% of domestic violence homicide victims. Several national studies have found that the presence of a gun in the home significantly increases a woman's risk of being killed by her intimate partner.²⁴

In eight of the eleven recently reviewed cases, the abuser used a firearm to commit the homicide and/or suicide. In 75% (n=6) of these cases, the abuser's possession of the firearm was illegal for at least a portion of the time prior to the fatality. Despite being the respondent in a civil domestic violence Protection Order, one abuser purchased the murder weapon from a store that conducted a background check during the required waiting period for a firearm purchase. It was not clear why the background check did not include information about this court order.

²³ See Block, 2003; also, Bureau of Justice Statistics, *Intimate Partner Violence and Age of Victim, 1993–99*, by Callie Rennison (Washington, D.C.: U.S. Department of Justice, 2001), NCJ 187635. This report found that married but separated women reported the highest rate of intimate partner violence, and divorced women reported the next highest rate.

²⁴ See, for example, Jacquelyn Campbell et al., "Assessing Risk Factors for Intimate Partner Homicide," *NIJ Journal* no. 250 (November 2003), p. 14–19, NCJ 196547, and Ann Crowe and Linda Sydney, "Domestic Violence and Firearms," *Perspectives* (Journal of the American Probation and Parole Association), Fall 2004, p. 30–40.

In another case, the court ordered an abuser not to possess any firearms after he pleaded guilty to domestic violence assault charges. The Fatality Review panel examining this case noted that, despite such an order and federal law prohibiting convicted domestic violence offenders from possessing firearms,²⁵ no mechanism existed to confiscate abusers' weapons in that county. In the absence of proactive steps by law enforcement to retrieve weapons or judicial monitoring of weapons relinquishment, the courts rely on offenders to voluntarily turn in their firearms upon receipt of a court order to surrender weapons. The day of the fatal incident, the abuser in this case came to the victim's home armed with four firearms and shot and killed the victim's new husband. The victim and her three-year-old child managed to escape. The abuser then shot and killed himself.

Law enforcement officers in a third case confiscated the abuser's weapon at the scene of a domestic violence assault, but when charges were not filed against the abuser, the police planned to return the weapon. In the meantime, the victim petitioned for a civil Protection Order against the abuser. Two weeks later, on the same day the court issued the permanent Protection Order against the abuser, the police returned the weapon. The lack of mechanisms in place for the courts to inform law enforcement of the order or for law enforcement to check updated court records resulted in a serious threat to the victim's safety.

Recommendations:

- Every law enforcement agency should establish policies and procedures for gun removal and storage for convicted domestic violence offenders and domestic violence abusers subject to criminal or civil protective orders.²⁶
- Police, prosecutors, judges, and probation officers should consistently make every effort to identify and remove abusers' guns possessed in violation of the law at each step of the criminal or civil legal process.²⁷
- Domestic violence programs should include questions on their crisis line, intake, and safety planning forms to ensure that all advocates routinely ask victims about the presence of, and abusers' access to, firearms and discuss safety planning strategies specifically related to firearms.
- All professionals working with domestic violence victims should: routinely ask about the abuser's access to firearms; talk with victims about the increased homicide risk posed by the availability of firearms; and connect victims with an advocate to talk about safety planning.

²⁵ 18 U.S.C. § 922(g).

²⁶ 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. This program provides statewide consultation; contact Mark Hanna at mark.hanna@metrokc.gov or WSCADV at 206-389-2515 for additional information.

²⁷ The Washington State Child Death Review State Committee included "Explore barriers to enforcing laws about illegal possession of firearms" as one of four key recommendations in their report *Child Firearm Death Prevention* (Washington State Department of Health, 2003).

Finding: Alternatives to calling 911 need to be explored as a part of safety planning.

Domestic violence victims are routinely encouraged to call 911 if they are in immediate danger. Yet, in ten of the eleven recently reviewed cases, Fatality Review panels identified barriers that the victims faced to calling 911. In one case, after the domestic violence victim ended her relationship with the abuser, he threatened to kill her and several of her friends on multiple occasions, and he continuously stalked and harassed her. The victim did a significant amount of safety planning, including telling others about the abuse and homicide threats, staying with different friends rather than at her own home, and making plans to temporarily relocate to a different city.

Before her murder, the victim told her friends that she did not want to call the police because she feared the abuser or his friends would retaliate against her if she did. Her abuser had a very extensive criminal history (thirty-two cases, including multiple domestic violence charges). Even though the abuser was a violent repeat offender, the criminal legal system had not consistently held him accountable for his crimes. For example, following a sixth domestic violence assault charge in less than a three-month period, the court released him on personal recognizance.

When the system does not respond to abusers in a consistent manner, it gives victims the message that reporting crimes does not result in meaningful consequences. When the abuser, on the other hand, is consistent in his use of violence, then fear of retaliation (a predictable outcome) may outweigh the potential benefits of calling the police and involving the legal system (an unpredictable outcome).

Other barriers to calling 911 in this and other cases included: language barriers; fear of deportation in cases where either the victim or the abuser was an immigrant; living in a rural area with limited law enforcement to cover large geographic areas and a fear that a slow response time would allow for the abuse to escalate (as a result of calling 911) before officers could respond; fear that calling the police might lead to Child Protective Services (CPS) involvement; and a history of strained police/community relationships in cases where either the victim or abuser was from a marginalized community. Additionally, in multiple cases the victims had: a criminal history, including arrest for domestic violence as a result of the abuser successfully manipulating the legal system; outstanding warrants; and/or substance use issues. These factors significantly undermined the victims' willingness to call 911 as a way to address the abuse they were experiencing.

Recommendation:

- Domestic violence advocates and others engaged in problem solving or safety planning with victims should routinely ask victims if calling 911 is a viable option for them. If barriers to calling 911 exist, advocates should work with victims to address these barriers as well as identify alternative safety planning strategies.

Finding: Safety planning is a critical intervention, even if the abuse a victim is experiencing is not physical.

Planning for safety readily comes to mind when working with a victim facing physical abuse or threats of physical abuse. But safety planning should also take place with victims experiencing non-physical abuse. In one recently reviewed case, the abuser verbally and emotionally abused the victim throughout their relationship, but did not physically abuse the victim before shooting her. In a second case, the abuser used physical violence on one occasion before the homicide, but primarily engaged in non-physical tactics of control, such as threatening suicide, verbal abuse, stalking, and isolating the victim from her family and friends.

Recommendations:

- Domestic violence advocates should routinely discuss safety planning with all domestic violence victims, even if the abuser has not used physical abuse as a tactic of control.
- Professionals interacting with domestic violence victims whose abusers use non-physical methods of control should recognize the need for safety planning even in these cases, and support victims in calling a domestic violence advocate for help with safety planning.

What can you do today?

Go to the Family Violence

Prevention Fund's website to learn

more about safety planning:

www.endabuse.org/resources/gethelp.

A significant number of homicide victims became involved with their abusers as teens.

Teens

The Domestic Violence Fatality Review's data, tracking all domestic violence-related fatalities in the state, reveals that a significant number of domestic violence homicide victims were teenagers when they became involved with their abusers. In some cases this is clear, because the victims were still teenagers at the time of their death. Twelve domestic violence victims (5%) killed by abusers since 1997 were under the age of eighteen. An additional eighteen (7%) were ages 18–20.

In other cases, a victim's age at the onset of the relationship with the abuser can be estimated based on their age at the birth of their first child in common. At least seventy-six victims²⁸ killed by their intimate partners since 1997 had children in common with their abusers. Of those victims, twenty-two (29%) were twenty or younger when they had their first child with the abuser.

In two of the eleven cases reviewed since July 2004, the domestic violence victim was a teenager when she met the abuser. One victim began dating the abuser when she was approximately thirteen years old and he was nineteen; she was sixteen years old when they married and eighteen when their first child was born.²⁹ The other victim began dating the abuser when she was fourteen years old and he was fifteen. She was pregnant at the age of fifteen, and was seventeen at the time of her death.

In another reviewed case, the abuser married his first wife a week after his eighteenth birthday (his first wife's age when they married is unknown). Documentation revealed his history of abusive behavior in that relationship, as well as several others he had prior to marrying his second wife. He murdered his second wife and then committed suicide.

Finding: Despite the prevalence of dating violence in teenage relationships, schools do not routinely provide education or resources to address this issue.

In one of the recently reviewed cases, the victim and abuser met and began dating when they were in middle school. Throughout their relationship, the abuser was possessive, jealous, controlling, and consistently manipulated the victim in an effort to isolate and divide her from her family. Fatality Review panels examining deaths of teens and deaths of women who became involved with their abuser as teens identified that few schools have dating violence support groups or other services available to students. Education about healthy relationships and dating violence, when it does exist in schools, usually does not begin until high school, which may be too late for some. By high school, many young people have already established serious dating relationships. Experts on our panels and advisory groups also pointed out that, developmentally, high schoolers are less receptive to messages from parents and teachers about their social lives and relationships than are younger children.

Recommendations:

- The Washington State Legislature should require all middle schools and high schools to develop and implement a policy for responding to domestic and dating violence when it is

²⁸ This number includes 70 women and 6 men. All of the men whose ages are known were over 21 at the time of the birth of their first child with the abuser.

²⁹ National research shows that a large percentage of teen pregnancies are fathered by adult men. For a recent summary of this research area, see Michael Males, "Teens and Older Partners," Resource Center for Adolescent Pregnancy Prevention (ETR Associates, 2004), www.etr.org/recapp/research.

identified as an issue for students, faculty, or staff. Schools should partner with local, community-based domestic violence programs when developing these policies and the Legislature should provide schools and domestic violence programs with funding to support this work.

- The state Office of the Superintendent of Public Instruction (OSPI) should collaborate with state-level domestic violence advocacy experts to review how its healthy relationships curriculum addresses domestic and dating violence, and develop a plan for promoting and training on the use of this curriculum.³⁰
- Middle schools and high schools should identify strategies for providing ongoing information to all students, multiple times throughout their education, about healthy relationships, interpersonal boundary setting, how to recognize abusive tactics, and the support resources available. Schools should involve students in the discussion and development of these strategies in an effort to ensure their relevancy.
- Teen dating violence prevention education should include development of peer advocacy and a partnership with a local domestic violence agency.
- School resource officers, school counselors, and school nurses should all have written information available on healthy relationships, tactics of abuse, and support resources in language that is clear, relevant, and accessible to young people.

Finding: The majority of teens do not access the legal system or community-based domestic violence programs around issues of dating violence.

Neither of the two teen domestic violence victims in recently reviewed cases accessed the legal system or a domestic violence program as a teen. One of the victims obtained a Protection Order and accessed domestic violence services when she was twenty-three, although the abuse started when she was sixteen. Fatality Review panels identified multiple barriers to teens accessing legal and social service systems and resources, including: lack of information that would help them identify their relationship as abusive; fear of getting their partner arrested; concern that if they attend the same school as their abuser, protective orders would not be effectively enforced; and knowledge that some information they share with others would not be kept confidential from their parents.

Recommendations:

- People who work with teens in any capacity should receive training regarding teen dating violence, how to talk to teens about relationships, and the resources available to them.
- Funders and domestic violence programs should recognize teen dating violence education, peer advocacy, and prevention efforts as a part of core services.
- Domestic violence programs should collaborate with those in the community already working with teens, such as camp counselors and youth group leaders, to build community capacity to provide information and support around teen dating violence. Individuals who have developed expertise in this area should be visible in the community and at events where teens gather.

³⁰ In 2005, the Washington State Legislature passed ESHB 1252, which mandated the OSPI to develop this curriculum (called “family preservation education program model curriculum” in the legislation) for school district boards around the state to adopt on a voluntary basis, and to include instruction on domestic and dating violence in the curriculum.

Finding: There is a widespread lack of information and resources available to parents whose children are experiencing violence in their relationships.

In both of the recently reviewed cases involving teens, the parent(s) of the domestic violence victims knew of the abuse their daughters were experiencing and wanted to support them in ending the abusive relationship. In one case, the abuser used his tactics of manipulation and control to effectively isolate and divide the teen victim from her family. At the time she was killed, she was living at home, trying to end her relationship with the abuser, and reconnecting with her family.

Fatality Review panels identified a lack of information, support, and assistance with safety planning for families of young women in abusive relationships. Discussions with Fatality Review panels and advisory groups highlighted that providing information to supportive parents is essential; however, interventions which are independent of parents are also necessary for those teens whose parents are not supportive, absent, or abusive themselves.

Recommendation:

- Domestic violence coalitions and community-based programs should work together to develop model materials for parents of teens who are being abused and develop best practice models for providing outreach and services to families of teen victims.

Finding: The estimated rate of domestic violence among teenage parents is extremely high; prenatal care and parenting education with teens are critical points of intervention.

Research has indicated that approximately 25% of teens experience dating violence, and that pregnant and parenting teens experience even higher levels of violence in their relationships.³¹ In a 2005 study of 474 teen mothers receiving Temporary Aid to Needy Families (TANF), 55% reported having experienced domestic violence in their relationship within the previous twelve months, and 66% of that group experienced some form of birth control sabotage by their boyfriend as well.³²

In both recently reviewed cases involving teens, the domestic violence victim was pregnant as a teen. In both cases, the medical providers in the health care setting missed an opportunity for intervention. In one case, the fifteen-year-old pregnant victim received prenatal health care and had a surgery related to her pregnancy. The abuser was very involved with her pregnancy, and health care providers misinterpreted his controlling behaviors as a positive sign that he would be an involved father.

In the other case, health care providers asked the victim some questions referring indirectly to domestic violence during her pregnancy, such as “Is everything all right at home?” but did not directly ask about abuse. The victim, who is still alive (her new partner was killed by her abuser), spoke with Fatality Review staff and stated that she was reluctant to talk to her health care provider about the abuse she was experiencing. She did not disclose abuse in response to the vague questions, but felt that she most likely would have disclosed abuse if her provider had asked a more direct question, such as “Has your husband ever hit you?”³³

31 See studies cited in Jody Raphael, “Teens Having Babies: The Unexplored Role of Domestic Violence,” *The Prevention Researcher* 12, no. 1 (2005), p. 15–17.

32 Raphael, “Teens Having Babies.”

33 The Washington State Department of Health has developed universal domestic violence screening protocols for perinatal providers. See “Domestic Violence and Pregnancy: Guidelines for Screening and Referral” (2004). Available at www.doh.wa.gov/cfh/mch/documents/dv_for_web.pdf.

Recommendations:

- All perinatal health care providers and all professionals providing parenting education to teens should partner with a local domestic violence program to receive training on the dynamics of control in abusive relationships, and how to discuss abuse using language that is relevant and accessible to teens.
- Due to the prevalence of domestic violence among teen parents, information about dating violence, safety planning, and resources available should routinely be provided to all pregnant teens by health care providers, caseworkers, educators, and any other professionals working with pregnant teens. This practice should be adopted rather than screening for abuse and waiting for a teen to self-identify as a domestic violence victim.

Finding: Domestic violence is not routinely addressed throughout the juvenile justice system.

At least four of the abusers and one domestic violence victim in recently reviewed cases were involved with the juvenile justice system as teens. The lack of tools to address domestic violence as an issue for teens involved with the juvenile justice system was identified by Fatality Review panels as a significant gap at a critical point of potential intervention.

Recommendation:

- The Department of Social and Health Services Juvenile Rehabilitation Administration and Children's Administration, in collaboration with juvenile courts, youth advocates, and domestic violence experts, should develop policies and protocols for professionals working in the juvenile justice system to address domestic and dating violence.

What can you do today?

Contact someone you know who works with or interacts with teens, and ask them to call their local domestic violence program. They can talk with an advocate about teen dating violence to learn about the tactics of abuse, safety planning, and the information and resources that are available to teens.

Friends, family, and neighbors had far more knowledge of the abuse than any intervening professional.

Building Community Capacity

In every one of the eleven cases reviewed by Domestic Violence Fatality Review (DVFR) panels since July 2004, friends, family, neighbors, co-workers, or other members of the community, such as a store owner, church member, teacher, or daycare provider knew about the abuse prior to the fatality. In 64% (n=7) of the cases, at least one person was aware of specific threats of homicide or suicide. Fatality Review panels consistently noted that victims and abusers alike turned to their community for information and support far more often than they turned to professionals in the legal or social service systems.³⁴ Law enforcement investigations following fatalities repeatedly revealed that friends, family, and neighbors had far more knowledge of the abuse, the range of tactics the abuser employed, and a better sense of “the big picture” of what was happening than any intervening professional. This information highlighted for panels the need to increase the capacity of friends, family, neighbors, co-workers, and the community in general to respond to domestic violence.

Finding: Community members need information and support regarding how to respond when they witness or hear about abuse.

All of the Fatality Review panels over the past two years identified a need for community engagement strategies that would help people recognize abuse and know how to act on the information they have. Reviewed cases included examples of times in which friends, family, and others provided help and support to the victim. In one case, the victim’s adult children, co-workers, and friends all offered support and assisted with safety planning strategies, including talking with her about packing a bag in case she needed to flee the home quickly and allowing her to live with them temporarily.

In most cases, however, many people knew of the abuse and, while it appeared that they wanted to be helpful, they did not know how to intervene. In one such case, in the weeks prior to the homicide, the victim told family members, her attorney, a co-worker, and her supervisors at work that the abuser had threatened to kill her and was stalking her. She also reported a violation of the Protection Order she had against the abuser and mentioned the abuser’s homicide threats in her statement to police. In those same few weeks before the murder, the abuser talked to several friends on multiple occasions about wanting to kill the victim and offered one friend \$10,000 to kill her. Friends also recalled observing the abuser drinking large amounts of alcohol, purchasing a gun and ammunition, going to target practice, giving away personal possessions, renting a car, buying latex gloves, and making statements such as, “By the end of next week it’ll all be over... either I’ll be in prison or jail or dead in a hail of bullets.” The abuser’s friends were concerned, but did not contact the police or the victim. One friend told the abuser “Don’t do anything stupid” and another pointed out that murder would result in jail time, to which the abuser responded “I don’t care.”

In 36% (n=4) of the recently reviewed cases, the victim lived in a rural or remote area. For these victims, geographic isolation from the resources and programs serving their county made friends, co-workers, and neighbors an especially important source of support.

³⁴ Other research supports this finding, indicating that domestic violence victims try to cope with the abuse through informal support networks before turning to professionals. See Rebecca Macy et al., “Battered Women’s Profiles Associated with Service Help-Seeking Efforts: Illuminating Opportunities for Intervention,” *Social Work Research* 29, no. 3 (2005).

In the past, Fatality Review panels have noted that many domestic violence programs only work with domestic violence victims, not with their friends and family members. Prior DVFR reports have recommended that programs provide information, support, and safety planning strategies to friends and family of domestic violence victims as a part of their work. Panels reviewing cases over the past two years have observed that the domestic violence programs in their community now do offer these services to friends and family.³⁵ Unfortunately, many people in the community still do not know about this resource, and a general perception persists that domestic violence programs only provide shelter and serve only victims. People are unaware that anyone can call a domestic violence program twenty-four hours a day for free and confidential information, support, and assistance with safety planning. The use of the term “crisis line” or “hotline” to describe this service can further contribute to the misconception that this resource is only for victims in crisis.

Recommendations:

- Domestic violence programs and their funders should include community education, outreach, prevention efforts, public awareness campaigns, and other strategies for building the capacity of communities to respond to domestic violence as a core part of their work.
- Community education about domestic violence should include tools and strategies for how to: identify abuse, talk to victims or abusers, report abuse, and stay safe.
- All media coverage of domestic violence homicides or other domestic violence-related stories should inform the audience that anyone (e.g., victims, friends, family, co-workers) can call a domestic violence program for free and confidential information, support, and assistance with safety planning.³⁶
- Police officers should distribute domestic violence information to friends, family, neighbors, and witnesses at the scene of all domestic violence crimes.
- Community groups and volunteer organizations (e.g., neighborhood associations, block watch, parenting groups, religious congregations) should contact their local domestic violence program to learn about domestic violence.
- Domestic violence programs and task forces should engage community informants, such as friends and family of domestic violence victims, to learn how to increase the visibility of the range of services available. Such efforts should address the distinct opportunities and challenges for rural and remote communities and for marginalized populations. Funders should support pilot projects to begin this process.
- All programs that provide social service resource information to the community, such as the new Washington Information Network 211 (WIN 211)³⁷ and crime victim service centers,³⁸ should receive domestic violence training and be aware of the range of resources available to victims, abusers, and their friends and family.

35 WSCADV has developed and distributed a *Model Protocol on Working with Friends and Family of Domestic Violence Victims* (2004) for domestic violence programs, which is available at www.wscadv.org.

36 WSCADV has developed and distributed *Covering Domestic Violence: A Guide for Journalists and Other Media Professionals* (2002, revised 2006), which includes local and national statistics, tips for accurately covering domestic violence crimes, and resource information reporters can incorporate into their coverage. This guide is available at www.wscadv.org.

37 211 is the telephone number assigned by the Federal Communications Commission for the purpose of providing quick and easy access to information about health and human services. This resource is currently being implemented at a local level throughout Washington State. For more information, see www.win211.org.

38 Thirteen centers throughout Washington that can assist victims of a variety of crimes (e.g., kidnapping, assault, child abuse, vehicular crimes) or their survivors.

Finding: Stalking is a powerful and dangerous tactic many abusers engage in to control their partners, yet many people do not know where to turn for help when someone they know is being stalked.

Of the eight recently reviewed cases in which an abuser committed a homicide, 75% (n=6) stalked the victim. In each of these cases, at least one other person knew about the stalking, and in three of the cases the abuser recruited others to assist in stalking the victim. Each of the abusers used a variety of stalking tactics, including: tapping the victim's phone; following her to and from work; using court proceedings to maintain contact; following her after court appearances to discover where she was temporarily residing; and camping out in the woods behind the victim's home. In three cases, after the victim ended the relationship, the abuser denied her access to her personal possessions and used this as a manipulative strategy to maintain contact. Two of these homicides occurred when the victim agreed to meet with the abuser in an effort to retrieve some of her belongings.

Four of the stalking victims had a protective order against the abuser at some point, but only one contacted law enforcement about violations by the abuser. In that case, the victim reported several violations in the months before the homicide; however, prosecutors did not file stalking charges against the abuser until after the homicide (as part of the investigation to file murder charges). One victim articulated to her family and friends that she thought calling the police to report the stalking and violations of the court order would only escalate the abuse.

Panels reviewing these cases discussed the prevalence of stalking as a part of domestic violence,³⁹ yet identified that because stalking is not in itself physically violent, and may even consist of otherwise benign acts (e.g., sending flowers or driving by the victim's house), it is not always taken as seriously as other forms of domestic violence. The reviewed cases showed that acts of stalking were part of abusers' escalating pattern of power and control, and identified a need for increased awareness of the seriousness of stalking and resources available for stalking victims, their friends, and family.

Recommendations:

- Domestic violence programs should include stalking information in brochures and other outreach materials to increase awareness that anyone can call a domestic violence program for support and safety planning regarding stalking.
- Domestic violence programs should receive ongoing training and consult with national resources, such as the Stalking Resource Center,⁴⁰ to build their capacity to address stalking.
- Domestic violence programs, law enforcement agencies, and prosecutors should collaborate and cross-train one another on issues related to domestic violence stalking, including how

³⁹ Several national studies have shown that at least half of stalking victims are stalked by a current or former intimate partner. See Kris Mohandie et al., "The RECON Typology of Stalking: Reliability and Validity Based Upon a Large Sample of North American Stalkers," *Journal of Forensic Sciences* 51, no. 1 (2006), and Patricia Tjaden and Nancy Thoennes, "Stalking in America: Findings from the National Violence Against Women Survey," National Institute of Justice (Washington, D.C.: U.S. Department of Justice, 1998), NCJ 169592.

⁴⁰ The Stalking Resource Center is a part of the National Center for Victims of Crime. For more information, see www.ncvc.org/src/Main.aspx.

to assist victims in documenting the stalking, the use of technology to stalk,⁴¹ an overview of statutes on domestic violence and stalking, and safety planning.⁴²

- All government agencies, social service programs, and courts that collect identifying information should routinely inform people utilizing their services of how personal information about them is stored, who can access it, and their right to opt out of having this information collected, so that victims of domestic violence and stalking can make informed choices regarding when and what they choose to disclose.

Finding: Domestic violence victims in marginalized communities face significant barriers to accessing resources. This makes increasing the capacity of marginalized communities to respond to domestic violence necessary and urgent.

In several cases, the victims or abusers were members of marginalized communities that panels identified as underserved by governmental or social service agencies. Two of the abusers and at least one of the victims in recently reviewed cases were immigrants.⁴³ One of the victims and one abuser had limited English proficiency. In these cases, Fatality Review panels identified fear of immigration enforcement and deportation as tremendous barriers to reporting abuse for both victims and others in the community who witnessed the abuse.

In one case, the majority of the victim's and abuser's neighbors, friends, and family were immigrants, many of whom were undocumented. Consequently, it is unlikely that any of them felt comfortable reaching out to government-related agencies or mainstream non-profit organizations for intervention. Many people in the general population lack information about what they can expect when they call law enforcement or social service agencies. This is compounded for individuals with limited English proficiency. The lack of information makes it difficult for victims, their friends, family, and neighbors to make informed choices about how to respond to abuse.

A victim with limited English proficiency in a recently reviewed case reported that throughout her marriage to the abuser, she had no information about her rights as a victim of domestic violence or resources that might be available to her either in her native language (Spanish) or via an interpreter. After enduring the abuse for seven years, the victim received some helpful information and referrals from a teacher who had attended a presentation in Spanish by a bilingual, bicultural domestic violence advocate to a group of parents and teachers at a local daycare center. The panel identified this as an excellent example of how increasing the knowledge of community members in general is an effective strategy to inform victims of the options available to them.

41 A recent study in Washington indicated that the majority of domestic violence victims who are stalked are harassed and monitored through the use of technology. *Technology Safety Program Second Year Report*, Washington State Coalition Against Domestic Violence (2005), available at www.wscadv.org.

42 Good models of such collaborations exist. See, for example, *Links in the Chain: Two Communities Respond to Stalking*, a video produced by the National Center for Victims of Crime and the Office of Community Oriented Policing Services, U.S. Department of Justice. Available for purchase at www.ncvc.org.

43 In an additional case, the panel identified that the victim may have been an immigrant, but this was not clear in the public records available.

Recommendations:

- State and local governments should make funding available to marginalized communities—such as communities of color, immigrant and refugee, Native, disabled, and lesbian, gay, bisexual and trans (LGBT) communities—to develop targeted and culturally specific community education campaigns and community organizing projects regarding domestic violence. Funding should be directed to organizations with established credibility and trust within the communities that will be the focus of the education and organizing efforts.
- Domestic violence programs should create strong linkages with grassroots organizations serving marginalized communities to build these organizations' capacity to address domestic violence in their community.
- Law enforcement agencies should not coordinate efforts with the Bureau of Immigration and Customs Enforcement (ICE)⁴⁴ in patrol, investigation, and follow-up work on non-federal, non-terrorism-related crimes. Law enforcement agencies 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 when they call 911.
- The Washington State Legislature and Governor's Office should discourage the adoption of inter-local agreements between local law enforcement agencies and ICE that allow for local enforcement of federal immigration law.

Finding: The presence of guns and fear of the abuser significantly impacts community members' willingness and ability to effectively intervene.

In at least 73% (n=8) of the recently reviewed cases, the abuser used a firearm to commit the homicide and/or suicide. (See the chapter "Planning for Safety" for findings and recommendations related to firearms.) In two cases, friends clearly stated that the abuser had at least one gun with them at all times. When friends, family, neighbors, and co-workers know the abuser has access to a gun, it becomes very difficult and potentially unsafe for them to intervene or even consider calling law enforcement for fear of retaliation from the abuser.

Reviewed cases provided several examples of people clearly articulating fear of the abuser as a factor that contributed to their decision not to intervene. In one such case, a number of neighbors and acquaintances witnessed the abuser, armed with a gun, assaulting the victim outside their apartment shortly before the homicide-suicide. The fact that the abuser had a gun clearly impacted witnesses' ability to intervene. In a statement made to police, one neighbor described the victim running past him, being chased by the abuser. The neighbor "contemplated stopping him until he realized [the abuser] was holding a handgun... [The abuser] raised and pointed the gun toward [the neighbor]." The neighbor stepped aside and allowed the abuser to pass by him. The abuser caught up to the victim, forced her back into their apartment, and killed her and himself.

⁴⁴ ICE is the division of the Department of Homeland Security that is charged with enforcement functions of the former Immigration and Naturalization Service (INS).

Recommendations:

- Crime prevention public education campaigns should address people's concerns regarding who will have access to their identity when they call 911 to report a crime.
- Domestic violence programs' community education and outreach materials should include information about what to expect when calling 911 to report a domestic violence crime, what information 911 operators collect from callers, and strategies for how to report a crime anonymously.

Finding: Many children are affected by domestic violence and domestic violence homicide, but the capacity of communities to provide support to these children and their non-abusing parent is inadequate.

Of the 261 domestic violence victims killed by abusers between January 1, 1997 and June 30, 2006, at least 114 had children living in the home with them at the time they were murdered. The victims in seven of the ten recently reviewed cases involving adult intimate partners had children living with them for at least a portion of the time they were with the abuser. Several research studies document the psychological and developmental impact on children when they witness domestic violence.⁴⁵

Research also indicates that a strong bond with the non-abusive parent and supportive relationships with other adults in the community (such as teachers, coaches, librarians, and tutors) increases the resiliency of children who witness abuse.⁴⁶ The prevalence of domestic violence and the large number of children impacted by it highlights the need to increase the wider community's capacity to respond to children impacted by domestic violence.

Fatality Review panels noted that few resources exist in their communities to support children who have witnessed domestic abuse or a domestic violence homicide, or to support their non-abusive parent.

Recommendations:

- Programs providing support to parents and children, such as parenting classes, prenatal education, Head Start, and other programs aimed at strengthening families and children, should obtain information and establish collaborations with local, community-based domestic violence programs to include attention to domestic violence in the services they provide.⁴⁷
- Domestic violence programs should collaborate with those in the community already working with children to build their capacity to provide domestic violence information and support.
- State government and local communities should commit time and resources to collaborate with domestic violence advocacy programs to develop and implement early interventions for children exposed to domestic violence and support for non-abusive parents.

⁴⁵ For a review of these studies, see Jeffrey Edleson, "Children's Witnessing of Adult Domestic Violence," *Journal of Interpersonal Violence* 14, no. 8 (1999), p. 839-870.

⁴⁶ For a summary of studies that identify a secure attachment to a non-violent parent or other significant adult as the most important protective resource for children exposed to domestic violence, see Z. Ruby White, "Tapping Innate Resilience in Children Exposed to Domestic Violence," *Synergy* (Newsletter of the National Council of Juvenile and Family Court Judges) 7, no. 2 (2003), p. 4-7.

⁴⁷ Head Start has created a model curriculum to address domestic violence called Safe Families - Safe Homes. See www.glenwoodresearch.com/domestic_violence.php for more information and a curriculum sample.

- All programs that are a part of the Department of Social and Health Services (DSHS) Children's Administration, including the Foster Care program and Child Protective Services, should collaborate with locally based domestic violence advocates for training and to develop policies and protocols for identifying and responding to domestic violence.⁴⁸

What can you do today?

Identify one group of people you are involved with in your community (e.g., your workplace, a parenting group, a book club) and inform the group of the prevalence of domestic violence and the critical role friends, family, co-workers, and neighbors play in responding to abuse. Provide contact information for your local domestic violence program. Let them know that anyone can call this number for free, confidential information and support if they or someone they know is experiencing stalking or emotional, verbal, physical, and/or sexual abuse.

⁴⁸ See the 2004 DVFR report, *Every Life Lost Is a Call for Change*, p. 59, for a detailed discussion of findings and recommendations for the DSHS Children's Administration.

Economic Issues

Multiple reviews by Domestic Violence Fatality Review (DVFR) panels found economic instability to be a significant barrier to victim safety and self-determination. This is consistent with research findings that report a lack of financial resources as one of the most commonly given reasons domestic violence victims stay with or return to an abusive partner.⁴⁹ In five of the ten (50%) recently reviewed cases involving adult domestic violence victims, the victim was not employed at the time of the fatal incident. In four of those cases (or 80% of victims not employed at the time of the fatality), the domestic violence victim had not been employed throughout her entire relationship with the abuser, and thus did not have an independent means to support herself or her children.

One of the domestic violence victims who is still alive (her new partner was killed by her abuser) explained to DVFR staff that economic issues, primarily the lack of affordable housing, were the main barriers she faced in trying to keep herself and her three children safe. She stayed with her abuser because she knew she would be unable to afford a place to live and food for her children, particularly when she had two young children and was pregnant with her third and unable to work full time. At one point, she did start working outside of the home, but the abuser's jealousy and control over her increased, and he regularly accused her of having affairs. As she took steps to increase her autonomy, the abuser escalated his controlling tactics to try to prevent her from working outside the home. Because abusers interfere with their partners' ability to be financially secure, many victims turn to government public assistance programs for help meeting their economic needs.

Lack of financial resources is a significant barrier to safety for victims and their children.

Finding: As the primary source of financial assistance in Washington, the state Department of Social and Health Services (DSHS) is a critical point of intervention in the community response to domestic violence.

All five of the domestic violence victims who were not employed at the time of the fatal incident had accessed some type of public assistance. DSHS provides a variety of programs to address poverty and economic instability, including the Basic Food Program, Temporary Aid to Needy Families (TANF), General Assistance (GA), Medical Assistance, and childcare subsidies. State statutes prevent DSHS from confirming whether any of the victims in reviewed cases applied for or received public benefits, and this information is rarely documented as a part of a homicide investigation or in other public records. As a result, Fatality Review panels did not always know which specific DSHS program victims accessed. It was clear, however, that at least one victim received food stamps (because it was documented that the abuser stole them at one point), one victim received medical benefits for her daughter, another victim received disability benefits, and one victim reported participation in WorkFirst (Washington State's TANF program).

⁴⁹ Martha Davis, "The Economics of Abuse: How Violence Perpetuates Women's Poverty," in Ruth Brandwein, ed., *Battered Women, Children, and Welfare Reform: The Ties that Bind* (Thousand Oaks, CA: Sage Publications, 1999), and Eleanor Lyon, *Poverty, Welfare and Battered Women: What Does the Research Tell Us?* Welfare and Domestic Violence Technical Assistance Initiative (Harrisburg, PA: National Resource Center on Domestic Violence, 1997). See also Jill Davies, Eleanor Lyon, and Diane Monti-Catania, *Safety Planning with Battered Women: Complex Lives/Difficult Choices* (Thousand Oaks, CA: Sage Publications, 1998), p. 78–79.

In 1997, the Washington State Legislature and the Governor's Office adopted the federal Family Violence Option in WorkFirst. In doing so, the state agreed to: screen WorkFirst recipients for domestic violence; refer identified individuals to counseling and supportive services; and waive program requirements that 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.⁵⁰ While the policy for routinely screening all WorkFirst participants has been in place since 1997, Fatality Review panels have identified that implementation remains inconsistent among Community Service Offices (CSOs) across the state.

Panels reviewing cases in which the victims accessed public benefits identified routine screening for domestic violence as an important intervention, but emphasized that the way questions are worded is crucial to the effectiveness of screening. Since many victims do not identify their experiences as domestic violence, screening questions like "Are you a victim of domestic violence?" are not likely to be as effective as asking individuals whether they have experienced specific tactics (both physical and non-physical) that abusers commonly use. Specific screening questions have been developed and are a part of e-JAS (the computer program used by case managers and others who screen WorkFirst applicants for issues that might interfere with their ability to work);⁵¹ however, a recent study indicated that few workers actually use these questions routinely.⁵²

Fatality Review findings indicate that domestic violence victims who access public benefits may use a variety of DSHS programs.⁵³ As noted above, several of the victims in recently reviewed cases did not participate in WorkFirst, but did access other services (Basic Food Program, medical benefits, disability benefits). The panels reviewing these cases identified victims' involvement with DSHS programs as an important opportunity for intervention; however, DSHS policy related to domestic violence does not extend beyond the WorkFirst program, and DSHS has few other mechanisms in place to routinely provide all clients with domestic violence information and resources.

Recommendations:

- DSHS should ensure that all WorkFirst participants are screened for domestic violence in accordance with existing policy, using the specific screening questions in e-JAS.
- DSHS should ensure that all identified domestic violence victims who participate in WorkFirst are provided with information and referrals to local domestic violence resources.
- DSHS should ensure that WorkFirst staff waive program requirements as needed and develop safe and appropriate work and individual responsibility plans for domestic violence victims participating in the WorkFirst program.
- As DSHS communicates with CSOs about the new federal TANF regulations issued in June 2006, they should remind workers that domestic violence victims can be counted outside of federal participation rate requirements and recognize this as an incentive for the accurate use of the Family Violence Option.

⁵⁰ See WAC 388-61-001 and the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, Public Law 104-193 Sec. 402(a)(7).

⁵¹ The screening questions are outlined in the section "Family Violence Screening/Evaluation" in the DSHS WorkFirst Handbook, Chapter 6.5, www1.dshs.wa.gov/esa/wfhand/6_5.htm.

⁵² *How's It Going? A Day in the Life of a Domestic Violence Advocate Out-Stationed at a CSO*, Washington State Coalition Against Domestic Violence (2005).

⁵³ A recent study of a sample of battered women (n=448) conducted in Washington State found that 32% of the victims reported contact with economic services. Rebecca Macy et al., "Battered Women's Profiles Associated with Service Help-Seeking Efforts: Illuminating Opportunities for Intervention," *Social Work Research* 29, no. 3 (2005).

- DSHS should expand its current partnerships with locally contracted domestic violence programs to place experienced domestic violence advocates in all CSOs to provide information, advocacy, and support to all victims accessing public benefits.⁵⁴ Clients should be able to access these advocates directly, regardless of how they answer screening questions about domestic violence.
- DSHS should routinely provide information about local domestic violence resources to participants across all public benefit programs.
- Due to the prevalence of domestic violence and the many barriers that exist to disclosing abuse, DSHS should require all of its offices and programs to have domestic violence information (e.g., safety planning pocket guides, brochures from the local domestic violence agency) consistently available in areas where individuals can help themselves to the information, such as in restrooms, in the front office waiting area, and on the desks of all case managers and social workers.

Finding: Low-income domestic violence victims with mental health issues cannot always access the mental health services they need.

One of the domestic violence victims receiving public benefits in a recently reviewed case had several prescription medications commonly used by individuals with a mental illness. The panel reviewing this case identified a significant gap in the mental health services available for low-income people. In some circumstances, public benefits will pay for medications for mental illness, but will not cover support services (such as counseling or case management). In other cases, individuals are eligible for both, and they receive medication, but they are not connected to counseling or case management services. This occurs because the two types of benefits are administered through separate programs. Not all providers routinely refer clients receiving medication to mental health services or, even when referred, clients may not qualify for services. Providing medication without any accompanying support services fails to meet the needs of individuals with mental health issues who are dealing with additional barriers to safety and self-determination, such as domestic violence.

Additionally, in the county where this homicide occurred, the only existing homeless shelter does not accept people who are taking psychiatric medication into its long-term housing program, although they will provide overnight shelter and food. The lack of long-term shelter or transitional housing support for homeless people who have mental health issues is a significant barrier to safety for domestic violence victims dealing with these multiple issues.

Recommendations:

- DSHS should ensure adequate support services are routinely available to clients who have mental health issues.
- Housing organizations, from emergency shelters to long-term transitional housing programs and housing authorities, should evaluate policies that deny housing to people who use psychiatric medications to determine whether victims of domestic violence and their children are being adversely harmed by such policies, and coordinate with domestic violence programs to provide supportive services.

⁵⁴ Currently, 70% of CSOs have on-site domestic violence advocates on contract from local domestic violence programs.

Finding: Social service agencies have not developed adequate outreach strategies to inform homeless and transient individuals about available domestic violence resources.

In two of the recently reviewed cases, the domestic violence victims were homeless and transient for a significant amount of time in their adult lives. The social service agencies represented on the Fatality Review panels for these cases stated that their programs generally do not provide services to transient individuals and have not targeted this population in outreach efforts. Panel members noted that transient people have difficulty accessing even the most basic resources, such as food. Many food banks require identification in order to ensure that their resources go to people who live in their service area, and may deny services to people who lack identification cards or utility bills in their name. Victims facing such barriers may choose to stay with an abuser in order to have food and housing.

Recommendation:

- Domestic violence programs should collaborate with people who routinely come into contact with homeless and transient individuals, such as food bank workers, railroad police,⁵⁵ and community organizers, in order to build community capacity to provide this population with safety planning information and referrals to domestic violence resources.

Finding: Domestic violence victims who have jobs and earn a living wage are still vulnerable to economic instability.

Of the five domestic violence victims who were working at the time of the fatal incident, it was clear that all but one of their abusers were actively sabotaging their efforts to succeed at the workplace or sustain economic independence. In one case, the abuser and victim worked together at a large organization with several sites. The abuser threatened, harassed, and assaulted multiple people at the workplace, including the domestic violence victim. The abuser managed to stay employed by effectively manipulating co-workers, supervisors, and upper management. At one point, the employer demoted the domestic violence victim as a result of an incident during which the abuser assaulted her. After the victim ended the relationship with the abuser, she transferred to a different site. The abuser continued to stalk her at the workplace, called her multiple times to harass her there, and eventually killed her as she was on her way home from work.

In a different case, the abuser regularly stalked the victim at her workplace. Her supervisor was aware of this, but the workplace lacked a clear plan for addressing domestic violence and supporting the victim. In another case, the abuser wrote a letter to the victim's employer accusing the victim of stealing from her workplace, presumably in an attempt to get her fired.

Reviewed cases illustrate the multiple methods used by abusers seeking to control their victims through financial means. Some, as discussed above, focused on sabotaging the victim's successful employment. In another case, the abuser employed the tactic of undermining the victim's economic stability by overspending and ruining her credit. In that case, the victim had worked for the same employer for over twenty years and earned a good wage. However, her abuser had

⁵⁵ Specialized officers employed by private railroad companies to prevent and investigate crimes on their property. See RCW 81.60 for statutory authority governing railroad police officers in Washington State.

a history of economically exploiting his female intimate partners. Some of the consequences for the women he became involved with included debt, poor credit, and other financial difficulty. In the victim's divorce petition, she described having to take money out of her retirement account to make payments on multiple vehicles her husband had purchased that they could not afford. Despite her stable income, she documented that her abuser's economic control over her resulted in a "struggle with creditors" and "bad credit primarily resulting from my husband's financial irresponsibility."

Recommendations:

- Employers should develop, implement, and train staff on policies that specifically address how they will support employees who are being abused and/or stalked, in order to assist them in safely maintaining their employment.⁵⁶
- Employers should contact their local domestic violence program to learn about resources available and routinely share this information with their employees by a variety of methods (e.g., attach a list of resources to paychecks, have information available in restrooms, invite an advocate from a local domestic violence program to give a presentation at a staff meeting).
- Domestic violence programs should develop and implement a plan for engaging their community in work aimed at increasing economic security and the availability of financial education for domestic violence victims.⁵⁷ Funders and domestic violence programs should recognize this work as a part of core services.

What can you do today?

Every county in the state was required to develop a ten-year plan by June 2006 to address homelessness as a part of the Washington State Homelessness Act. The plans are coordinated by the state Department of Community, Trade and Economic Development (CTED) and can be found on their website at www.cted.wa.gov under Housing/Homeless/Homelessness Act. Call the local contact person for your county and inquire about how the county's plan is addressing the needs of homeless domestic violence victims.

⁵⁶ For employer resources on strategies to address domestic violence and examples of best practice at a variety of companies, see the Family Violence Prevention Fund's website at www.endabuse.org/workplace or the Corporate Alliance to End Partner Violence at www.caepv.org.

⁵⁷ *In Our Shoes: The Next Steps – A Domestic Violence Advocate's Guide to Working for Economic Justice in Your Community*, Washington State Coalition Against Domestic Violence (2005), www.wscadv.org. This step-by-step workbook can be used by advocates to develop and sustain a community-based effort to advance economic security, especially for those affected by domestic violence.

The presence of substance abuse and domestic violence increases lethality rates.

Alcohol and Other Drugs

Domestic Violence Fatality Review (DVFR) panels identified the use of alcohol or other drugs as an issue in 73% (n=8) of reviewed cases over the past two years. In those eight cases, all of the abusers and five of the victims struggled with substance use. Although substance use does not cause domestic violence, research shows that the presence of both increases the severity of injuries and lethality rates.⁵⁸

Finding: Abusers' use of alcohol or other drugs increased risk for victims.

In all of the recently reviewed cases in which the abuser committed homicide and substance use was identified as an issue, friends, family, and/or the domestic violence victim noticed that these abusers had increased their use of alcohol or other drugs in the days or weeks leading up to the homicide. Fatality Review panels discussing these cases identified abusers' escalating substance use as a factor that likely increased the risk of lethality. However, panels believed that victims, friends, and family did not have information about this increased risk or about how to intervene effectively. For example, in one case, several of the abuser's friends expressed concern about his drug use. One friend recalled that three days before he committed the homicide-suicide, the abuser was extremely intoxicated, abusing several drugs and prescription medications, and obsessed with the victim's new relationship. In a misguided effort to help, the concerned friend suggested the abuser leave town with five of each type of his pills and try to "come off of this slow."

Recommendation:

- Domestic violence programs' outreach materials, community education, and safety plans should inform people of the increased lethality risks when the abuser is using alcohol or other drugs, and should include referrals to community resources available for abusers, victims, and their friends and family.

Finding: Chemically dependent domestic violence victims face significant barriers to accessing support. When victims interact with criminal legal and social service systems as a result of their substance use, domestic violence is not routinely addressed.

In four of the five cases in which Fatality Review panels identified substance use as an issue for the victim of domestic violence, that person had been arrested at least once for a drug-related crime and had to complete a chemical dependency evaluation as a part of their sentence or deferral program. The fifth victim also had a criminal history, but the charges filed against her were for assaults and crimes related to being homeless, such as criminal trespass for sleeping under an overpass. Panels reviewing these cases identified the victims' interaction with chemical dependency programs as an opportunity for them to receive information about domestic

⁵⁸ Carol Cunradi, Raul Caetano, and John Schafer, "Alcohol-Related Problems, Drug Use, and Male Intimate Partner Violence Severity Among US Couples," *Alcoholism: Clinical and Experimental Research* 26, no. 4 (2002), p. 493–500, and Nancy Glass, Jennifer Manganello, and Jacquelyn Campbell, "Risk for Intimate Partner Femicide in Violent Relationships," *Domestic Violence Report* 9, no. 2 (2004), p.17–18, 30–32.

violence, but noted that chemical dependency providers do not routinely screen for or address domestic violence. Many victims use alcohol or other drugs as a way of coping with abuse. Chemical dependency providers who fail to screen for domestic violence or routinely provide information miss an important opportunity to connect victims with domestic violence resources. In addition, abusers may coerce or facilitate a victim's substance use or undermine her efforts at sobriety as a tactic of maintaining power and control over her.⁵⁹ For example, in one case the victim's friends stated that the abuser "had a tendency to keep her pretty loaded." Abusers may view their partners' sobriety as a threat to their control and try to sabotage recovery efforts or escalate their violence as a result. When chemical dependency programs and relapse prevention plans do not address domestic violence, they fail to strategize around critical challenges to achieving and maintaining safety and sobriety for victims.

Fatality Review panels identified multiple ways in which victims' use of alcohol or other drugs created barriers to accessing support or compounded the impact of the abuse. For example: chemically dependent victims often lost the support of their friends and family, reinforcing their isolation; substance abuse reinforced dependence on the abuser, particularly in cases in which the victim depended on the abuser for access to alcohol or other drugs; victims who were using were less likely to be believed when they disclosed abuse; and victims who were using were not eligible for a range of services, including housing resources. In one case, the victim struggled with both homelessness and alcohol abuse. At the time she needed shelter, both the domestic violence shelter and the one homeless shelter in her community had a "zero tolerance" policy for alcohol and other drugs.⁶⁰

As discussed in the chapter "Planning for Safety," victims using alcohol or other drugs may hesitate to call law enforcement for assistance out of fear of arrest. Having a history of arrests, as all five of these victims did, compounds this concern.

In one case, the substance-abusing victim also had mental health issues. The panel reviewing this case could identify no resources in their community that address the intersection of mental health issues, substance abuse, and domestic violence. When communities fail to address this intersection, it severely compromises victims' safety, sobriety, and self-determination.⁶¹

⁵⁹ A recent review of the literature on substance abuse treatment for women reported that women are often drawn into substance use by their partners. Olivia Silber Ashley, Mary Ellen Marsden, and Thomas Brady, "Effectiveness of Substance Abuse Treatment Programming for Women: A Review," *American Journal of Drug & Alcohol Abuse* 29, no. 1 (2003), p. 19–53.

⁶⁰ Since that time, the domestic violence shelter has modified its policy in recognition that their shelter may be the only safe housing option for victims who are using alcohol or other drugs, and strives to address the needs of individuals on a case-by-case basis. The homeless shelter has implemented the use of breathalyzers and urinalysis to enforce their policy of "zero tolerance."

⁶¹ Triple Play is a group of domestic violence, chemical dependency, and mental health providers who have organized in Washington to increase collaboration and training across these three disciplines. For more information, contact Karen Foley at karenf81092@yahoo.com or WSCADV at 206-389-2515.

Recommendations:

- Domestic violence programs and other services designed to support victims should acknowledge that victims may be using alcohol, other drugs, and/or violence and address the impact of these issues on their safety, sobriety, and ability to access resources.⁶²
- Domestic violence programs should provide services to substance-using domestic violence victims by developing policies and procedures that maintain safety for all program participants while addressing the needs of substance-using victims.
- Domestic violence and chemical dependency programs should collaborate to provide cross-training to providers and services to individuals struggling with both domestic violence and chemical dependency. Because so many individuals face both challenges⁶³ and because so many barriers exist to disclosing either domestic violence or substance abuse, domestic violence and chemical dependency programs should make information about one another's programs consistently available to everyone using their services.
- Domestic violence and chemical dependency providers need to be aware of the increased safety risk when a domestic violence victim is working toward sobriety, thereby reducing the abuser's control. Domestic violence and chemical dependency programs should coordinate safety planning and relapse prevention planning accordingly.

Finding: Chemical dependency treatment and batterer's intervention programs⁶⁴ do not routinely collaborate with one another.

In four of the eight cases in which Fatality Review panels identified substance use as an issue for the abuser, records indicated that the abuser had participated in a chemical dependency treatment program. Courts ordered one of these abusers to also attend a batterer's intervention program and another abuser to get a batterer's evaluation. Panels reviewing these cases noted that chemical dependency programs rarely screen or check criminal histories for domestic violence. Even in cases where domestic violence is identified as an issue, chemical dependency programs do not routinely refer the abuser to a batterer's intervention program. Instead, they may assume (inaccurately) that the problem will go away when the substance abuse ends, address the issue internally, or refer an abuser to anger management counseling—a problematic practice as anger management fails to address the abuser's use of power and control. Many batterer's intervention programs require abusers using alcohol or other drugs to complete chemical dependency treatment prior to enrolling in their program. This means that the many abusers who never successfully address their substance abuse receive no intervention for domestic violence.

⁶² The Alcohol/Drug Help Line Domestic Violence Outreach Project has developed tools for working with substance-abusing domestic violence victims and is available for statewide consultation on a non-emergency basis. Contact dvop@adhl.org or WSCADV at 206-389-2515 for more information. The Alaska Network on Domestic Violence and Sexual Assault has developed a practical tool kit for use with substance-abusing domestic violence and sexual assault survivors: *Getting Safe and Sober, Real Tools You Can Use* by Patti Bland and Debi Edmund. Contact pbland.andvsa@alaska.com or www.andvsa.org for more information. Also, WSCADV has developed and distributed a *Model Protocol for Working with Battered Women Impacted by Substance Abuse* (2003), which is available at www.wscadv.org.

⁶³ In one recent study, 59% of women who screened positive for alcohol problems experienced severe intimate partner violence within the previous year. R. Weinsheimer et al., "Severe Intimate Partner Violence and Alcohol Use Among Female Trauma Patients," *Journal of Trauma, Injury, Infection and Critical Care* 58, no. 1 (2005), p. 22–29.

⁶⁴ Batterer's intervention programs are described in the Washington Administrative Code as "domestic violence perpetrator treatment programs" (WAC 388-60).

Recommendations:

- Chemical dependency programs should screen and check criminal histories for domestic violence and refer abusers to state-certified batterer's intervention programs when it is identified.
- Chemical dependency treatment and batterer's intervention programs should collaborate to offer groups that simultaneously address both issues. These groups should be collaboratively run by a state-certified chemical dependency provider and a state-certified batterer's intervention provider.⁶⁵

What can you do today?

Contact one domestic violence, one chemical dependency, and one mental health program in your community to learn about their services and collect an agency brochure. Then share with each program the information and brochure you collected from the other two.

⁶⁵ Good models exist for this type of group. Contact WSCADV at 206-389-2515 to be connected with providers doing this work.

Fatality reviews show a system ineffective at consistently holding abusers accountable.

Criminal Legal System

The Domestic Violence Fatality Review (DVFR) has identified multiple gaps in the criminal legal response to domestic violence and has issued many recommendations for the criminal legal system in our three previous reports.⁶⁶ Fatality reviews over the past two years have continued to highlight gaps in the criminal response and illustrate that the recommendations in previous reports still need to be addressed. This chapter will not repeat all issues and recommendations discussed in earlier reports, but will focus on specific findings from the eleven cases reviewed since July 2004.

Recently reviewed cases provide examples of excellent responses from a range of disciplines within the criminal legal system, including: several examples of thorough and well-documented police reports; effective communication across probation departments, resulting in the prosecution of an abuser for probation violations on cases from a neighboring state; and one case in which the victim of an assault received a referral to the local domestic violence program on three separate occasions (a very helpful intervention, given that it can be difficult to keep track of information and referrals during times of crisis). These model practices illustrate how the system can be effective when mechanisms are in place to ensure a high-quality response to domestic violence. Unfortunately, these types of responses were not the norm in reviewed cases. Fatality reviews repeatedly show a criminal legal system inaccessible to people who clearly needed assistance and ineffective at consistently holding dangerous abusers accountable.

Finding: No Contact Orders are not routinely issued as a part of criminal domestic violence cases.

In one recently reviewed case, the abuser had three domestic violence convictions, yet the court never issued a “stand-alone” criminal No Contact Order⁶⁷ during any part of the criminal process. In one of his cases, the court did include “no contact with the victim” as a condition of the abuser’s pre-trial release after the victim specifically requested that he be prohibited from contacting her. At sentencing, the court again did not issue a “stand-alone” No Contact Order. Instead, the court listed “no contact with the victim” as a condition of sentencing, and included a broad and general exception allowing him contact with her at her home “as is necessary to effect child visitation,” making the order essentially impossible to enforce.

In a different case, the court ordered an abuser to have “no hostile contact” with the victim as a condition of release, but did not issue a “stand-alone” No Contact Order in any of three separate domestic violence assault charges. The panel reviewing this case found this practice extremely problematic for two key reasons: (1) if the abuser violated the order, it would result in a violation only of the conditions of release rather than an additional criminal charge, and (2) using the language of no hostile contact (as opposed to simply no contact) made this order nearly impossible to enforce, as it creates the burden of having to interpret whether an action is or is not hostile.

⁶⁶ *Honoring Their Lives, Learning from Their Deaths* (2000), *Tell the World What Happened to Me* (2002), and *Every Life Lost Is a Call for Change* (2004) are available at www.wscadv.org.

⁶⁷ As defined by RCW 10.99.040 and 10.99.050.

In a third case, as a part of sentencing, the court did issue a two-year No Contact Order following an abuser's guilty plea to a domestic violence assault. The abuser requested that the court rescind the order on two occasions. The first time, the court denied the motion to rescind the order; the second time, the court granted the request and rescinded the order. The panel reviewing this case discussed the process for rescinding No Contact Orders and noted that judges have considerable discretion in handling these cases. Generally, the court sets a hearing date and notifies the victim by mail of the motion to rescind the order. Victims can attend the hearing and talk to the judge about their wishes for the order, but this takes place in open court in front of the abuser. This process poses problems, as it does not provide the victim a safe way to express concerns to the court. The prosecutor's office can oppose an order being lifted on a victim's behalf, but it did not appear that this happened in this particular case. Most judges will not rescind an order without input from the victim or a victim advocate. However, some judges do lift No Contact Orders without victim input, and the panel identified this as a practice that fails to address victim safety.

Recommendations:

- Prosecutors should routinely request that a criminal No Contact Order be issued in all domestic violence cases and implement a practice of routinely checking for the existence of other protective orders and consulting with victims about their desire for such an order.
- Prosecutors and advocates should routinely talk to victims about a civil Protection Order as an option in addition to a No Contact Order in case the criminal case is dismissed or the No Contact Order is rescinded for some other reason.
- Criminal courts and prosecutors should collaborate with domestic violence advocates and family law attorneys to develop model language to use in No Contact Orders that involve defendants who have visitation rights to any children in common with the victim to avoid conflicting orders and to ensure that the safety of the victim and children is addressed in the order.
- If an abuser or defense attorney requests the termination of a criminal No Contact Order, the prosecutor handling the case should routinely contact the victim to inform her of the process and her options, which include having the prosecutor oppose lifting the order.

Finding: Prosecutors often decline to file charges when the victim is not willing or able to participate in the prosecution.

In one recently reviewed case, the abuser was arrested on two different occasions for domestic violence assault, but prosecutors declined to file charges because the victim did not want to participate in the prosecution. Fatality Review panels noted that practices vary across prosecutors' offices regarding the prosecution of cases without victim involvement. The 2004 U.S. Supreme Court decision in *Crawford v. Washington*⁶⁸ and the 2006 decision in *Hammon v. Indiana*⁶⁹ have made it more difficult to prosecute domestic violence crimes without the victim appearing in court to testify.⁷⁰ Victims may have a variety of reasons for not wanting to be a witness against

⁶⁸ In *Crawford v. Washington*, the Supreme Court held that the Confrontation Clause of the U.S. Constitution's Sixth Amendment requires that the defendant has the opportunity to confront all witnesses. Contact the Battered Women's Justice Project at www.bwjp.org for technical assistance regarding evidence-based prosecution post-*Crawford*.

⁶⁹ In *Hammon v. Indiana*, the Supreme Court concluded that the victim's statements to police were inadmissible at trial because the information she provided police was considered "testimonial" and she did not appear at the trial; therefore, the defense had no opportunity to cross-examine her.

⁷⁰ In the *Davis v. Washington* case (2006), the Supreme Court held that portions of a victim's statements to a 911 operator were admissible at trial, even though the victim did not appear in court, because the statements were made as part of a current and ongoing emergency and were not considered "testimonial."

their abuser, including fear of retaliation, or are unable to participate because they cannot miss work without putting themselves at risk of losing their job. These realities make prosecutors' reliance on victims' participation a barrier to abusers being held accountable for domestic violence crimes.

Additionally, if the prosecution of domestic violence crimes only occurs with victim participation, abusers have an additional incentive to pressure the victim not to speak with prosecutors. Review panels pointed out that abusers wishing to pressure victims face few obstacles to doing so, even when they are in jail. Most jails lack policies and mechanisms for preventing inmates from calling victims, even when current court orders prohibit contact.

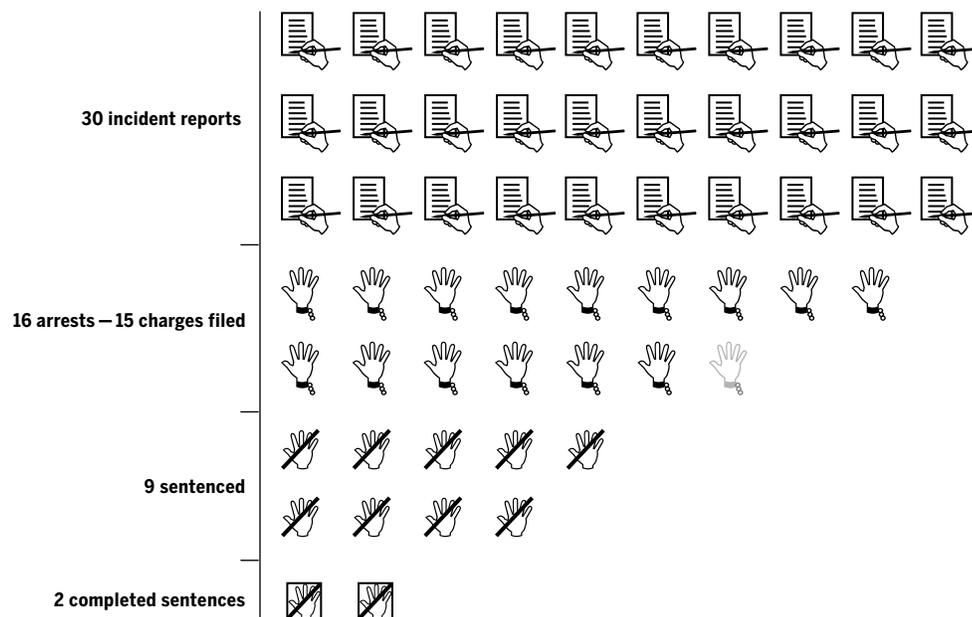
Recommendations:

- The Washington Association of Prosecuting Attorneys should create and disseminate model guidelines for prosecutors regarding the admissibility of 911 tapes and victim statements in the prosecution of domestic violence cases even when the victim is unavailable to appear in court.
- Jails and prisons should develop policies and mechanisms for preventing inmates from calling victims or witnesses listed in police reports and/or civil and criminal protective orders.

Finding: The criminal legal system fails to effectively and consistently hold abusers accountable.

In 64% (n=7) of recently reviewed cases, the abuser had a domestic violence criminal history. The DVFR identified a total of thirty law enforcement incident reports regarding these seven abusers' domestic violence-related crimes. Out of the thirty incident reports, sixteen resulted in arrest and charges were filed in fifteen. Convictions or pleas were obtained on charges relating to nine of the incidents (committed by five abusers). Abusers actually complied with all of the terms of their sentence in only two instances out of the original thirty incidents reported.

Criminal legal system response to domestic violence incidents in reviewed cases



To illustrate, one abuser was involved in multiple criminal cases, in multiple jurisdictions, and under the supervision of multiple probation departments throughout most of his adult life. Panel members observed that prosecutors, judges, and probation officers all failed to see the big picture, handling each incident as an isolated event without consistently checking his criminal history when making decisions. One court released the abuser on personal recognizance following his sixth domestic violence assault charge within three months, a very dangerous decision given his extensive history of violent crimes as well as a long history of failing to appear for court dates. The court also released this same abuser from custody a second time, even waiving bail, following an arrest for a new charge. At the time, he had two outstanding warrants for failing to comply with the conditions of his sentences in two previous domestic violence assault convictions.

Courts faced significant pressure during this time period to release offenders quickly due to the lack of jail space and resources to hold them in custody. When the courts did impose consequences in this abuser's case, an excessive amount of time passed between when the crime occurred and when he was sentenced. This abuser's pattern of failure to appear in court, non-compliance with sentencing requirements, continued use of violence, and illegal possession of firearms continued up until he murdered his girlfriend when she ended her relationship with him.

While there are statutory restrictions that require judges and others in the criminal legal system to view each crime separately, several underutilized strategies exist for identifying patterns of abusive behavior and placing an incident within the context of a larger pattern of abuse. Law enforcement and prosecutors can and should routinely ask victims about a prior history of abuse, pull information from the defendant's criminal history, and document this history in each case. Prosecutors can "package" multiple incidents and file them together for one court to consider. In cases such as the one described above, this practice can result in more serious charges filed with the potential for more significant consequences. Judicial representatives discussing this case observed that the abuser committed so many crimes in the months prior to the homicide that, had all of the information been presented in one court, he might have faced an attempted murder charge. Instead, the incidents were documented as isolated and separate events. Some, such as stealing the victim's car and then abandoning it, never resulted in charges being filed and seemed insignificant outside the context of his extreme stalking and abuse.

In a different case, the victim reported to law enforcement four separate incidents in which the abuser violated a civil Protection Order. Examining each in isolation from the others, police and prosecutors apparently did not perceive these violations as the threatening or dangerous events indicative of an escalating pattern of abuse that they actually were. The legal system took little action in these cases: responding officers did not document searching for the abuser or attempting to make an arrest in any of the four police reports, and prosecutors did not file charges for any of the criminal violations of the civil Protection Order.

Review panels discussing cases involving repeat offenders like these identified significant improvements in judges' access to statewide computer databases over the past five years. Currently, one data system available to judges, the Judicial Access Browser System (JABS), allows judges to view all prior and pending criminal charges for a particular defendant. Judges also have access to every domestic violence order in place for a defendant before them in court, including civil Protection Orders and orders issued in both family court and criminal court. The information includes terminated orders as well as current ones, and lists the names of the parties protected. Judicial representatives on review panels noted that the current problem is not a lack of judges' access to this information, but rather that it is not being routinely utilized.

Recommendations:

- Judges should hold frequent post-sentencing reviews, and impose timely and meaningful consequences for non-compliant defendants.
- Probation departments should place a high priority on monitoring domestic violence cases and all jurisdictions should focus additional resources on the supervision of these offenders.⁷¹
- Jail space should be prioritized for violent offenders with a high likelihood of recidivism, including domestic violence offenders.
- Judges should not base bail determinations and release decisions for violent offenders on the availability of jail space.
- Law enforcement officers, prosecutors, judges, and probation officers should routinely examine histories and patterns of behavior in domestic violence cases and make full use of the resources available to do this when assessing for danger and considering how to proceed.⁷²
- Law enforcement officers should routinely ask victims and other witnesses reporting protective order violations about previous reported and unreported violations in order to help assess danger and to identify patterns. When the respondent of an order is repeatedly contacting the petitioner, officers should investigate and document the violations as a stalking crime.
- Prosecutors' offices should consider innovative strategies for effectively prosecuting repeat offenders, such as assigning one prosecutor to handle all charges for a particular defendant and "packaging" multiple charges.⁷³
- Prior to accepting plea agreements in domestic violence cases, courts should require the prosecutor's office to provide the defendant's criminal history.
- State-level agencies, such as the Washington Association of Sheriffs and Police Chiefs and the Washington Association of Prosecuting Attorneys, should work collaboratively with state-level domestic violence advocacy experts to develop model protocols for the criminal legal response to stalking.

⁷¹ For model guidelines that all jurisdictions can follow in post-arrest supervision of domestic violence offenders, see *Post-Arrest Model Response for the Supervision of Domestic Violence Offenders*, Washington State Coalition Against Domestic Violence (1999). To request a copy, call WSCADV at 206-389-2515.

⁷² Judges should reference *Domestic Violence Cases in Municipal Court: Judicial Decision Making* (2004) for further guidance. To obtain copies of this bench card, contact the Gender and Justice Commission, Washington State Administrative Office of the Courts at 360-705-5290.

⁷³ The Thurston County Prosecutor's Office has recently implemented such a strategy. Contact Christy Peters at petersc@co.thurston.wa.us or WSCADV at 206-389-2515 for additional information.

- The Washington State Legislature should amend RCW 10.99 to direct judges to examine a complete criminal history before releasing a defendant in a domestic violence case on personal recognizance or when determining the level of bail.
- The Washington Association of Prosecuting Attorneys should create and disseminate model guidelines for prosecutors on how to bring prior acts of domestic violence before the court when charging, making bail recommendations, prosecuting, and sentencing domestic violence-related crimes.
- The Washington Association of Prosecuting Attorneys should make a recommendation to the Washington State Supreme Court regarding changing the evidentiary rules to increase the admissibility of prior domestic violence acts in court, as they are for sex offenses and Driving Under the Influence offenses.
- The Washington State Legislature should amend the state sentencing guidelines to provide for more serious sentences for recidivist domestic violence offenders, as has been done for repeat offenders in Driving Under the Influence convictions.

Finding: Domestic violence victims with limited English proficiency do not consistently receive quality interpretation at domestic violence crime scenes.

Despite state and federal laws that support access to the criminal legal system for Limited English Proficient (LEP) individuals,⁷⁴ Fatality Review cases have repeatedly included examples of a lack of interpretation at domestic violence crime scenes even when victims clearly had limited English proficiency.

One of the cases reviewed since July 2004 involved a victim with limited English proficiency. Records indicate that law enforcement responded to a domestic violence call at the home on one occasion. When police officers arrived, the abuser had fled and a neighbor had taken the victim to the hospital. Police tried (without the aid of an interpreter) to speak to the primarily Spanish-speaking neighbors and witnesses, but the language barrier prevented them from gathering much specific information about the incident. The officers did speak with one neighbor using one of her children as an interpreter. A bilingual officer conducted the follow-up investigation, but valuable witness information was probably lost as a result of not having interpretation available at the scene when the incident took place.

The Fatality Review panel identified the use of a child to interpret as extremely problematic and the lack of quality interpretation at the time of initial law enforcement response as a threat to victim and community safety, as well as a barrier to abuser accountability.⁷⁵ Lack of interpretation at a crime scene impedes investigations and results in challenges to effective prosecution. This case highlights the importance of having bilingual officers on the force who are reflective of the community's population. Officers' ability to communicate directly with witnesses with limited English proficiency proves particularly helpful when information critical to victim and community safety must be obtained quickly.⁷⁶

⁷⁴ RCW 26.50.035 (translation of Protection Order forms); RCW 2.43 (providing interpreters in legal proceedings); *Civil Rights Act of 1964*, Title VI, Sec. 601 (prohibiting discrimination on the basis of national origin).

⁷⁵ See *Honoring Their Lives, Learning from Their Deaths* (2000), p. 47–49 for in-depth discussion of the negative ramifications of using children or bystanders to interpret for law enforcement.

⁷⁶ See *"Tell the World What Happened to Me"* (2002), p.34–36, 64–66 for a discussion of barriers for Limited English Proficient communities and disproportionate death rates in communities of color.

Recommendations:

- In order to increase access to interpretation and translation services at the local level, law enforcement should partner with domestic violence and other social service programs to share and advocate for additional resources.
- Local law enforcement agencies should consider utilizing federal STOP grant funds to support language access resources for investigating domestic violence crimes.
- Law enforcement should never use children as interpreters; telephonic interpretation services should be used when qualified interpreters are not available at the scene.
- Courts and law enforcement agencies should develop language access plans consistent with the guidelines developed by the U.S. Department of Justice.⁷⁷

Finding: Domestic violence victims are sometimes arrested as the domestic violence perpetrator.

In two recently reviewed cases, the domestic violence victim was arrested for domestic violence assault. In one case, the panel identified that the responding officers followed a best practice model of determining the primary aggressor in that particular incident and their efforts were well documented in the police report.⁷⁸ They interviewed both parties separately and took statements from both, as well as from a witness to the incident. The report included a domestic violence supplemental report, inquired about prior abuse and threats, and documented both parties' emotional state at the time of the arrest.

In the second case, the abuser raped the victim and assaulted her with a gun. The victim thought she had been shot, and the abuser ran out of the residence and called law enforcement. The responding officers interviewed the abuser and called for the victim to come out of the residence. When she complied, they arrested her before interviewing her and hearing her version of the incident. In this case, the police did not follow a best practice model of interviewing both parties prior to making an arrest. As a result, they mistakenly arrested the victim based on information from the abuser only. Because the police report listed the abuser as the victim, the abuser received domestic violence information and resources. The abuser then petitioned for, and was granted, a Protection Order against the victim as well. Prosecutors declined to file charges against the victims in either of these cases, indicating insufficient evidence that the person arrested was actually the abuser.

As these cases illustrate, law enforcement officers sometimes arrest domestic violence victims. This happens either because the police mistakenly identify the victim as the perpetrator or because the victim of an ongoing pattern of abuse by the other party is the primary aggressor in a particular incident. The cues as to who is abusing power in a relationship are sometimes subtle, and responding officers, as well as others in the legal system, often lack the resources, time, or tools to make accurate assessments. These cases also depict a common pattern: as abusers become more informed about how mandatory arrest works, they are better able to manipulate

⁷⁷ See www.lep.gov for these policy guidelines.

⁷⁸ Fatality Review panels saw a wide range in the quality of police reports across law enforcement agencies. In instances such as this one, with a high-quality, thorough police report, the panel discussed the mechanisms that were in place to support this type of reporting. Law enforcement representatives from those departments stated that every incident report is reviewed by a supervisor and incomplete reports are returned to the officer to be completed.

the system and more domestic violence victims are arrested.⁷⁹ The lack of assessment tools can be particularly problematic in domestic violence cases involving same-sex relationships.

Many domestic violence programs also lack tools for assessing which person is the abuser in a relationship, but have policies that prohibit them from serving both people in a relationship. Some domestic violence programs rely on the legal system to determine who is the abuser and who is the victim. Some serve whomever contacts the program first. These practices can result in an abuser gaining access to resources, tools, and information to control their partner, while the victim experiences further isolation. When an abuser uses the legal system to further their control, it compounds the harm done to a victim inaccurately labeled as the abuser. For example, in one reviewed case, the abuser obtained a civil Protection Order against the victim, stalked and harassed her, called the police to have her arrested for violating the Protection Order, and used the victim's court dates for the Protection Order violation as opportunities to further stalk and harass her.

Recommendations:

- Law enforcement agencies should review their policies and practices for monitoring the accuracy and completeness of domestic violence incident reports, including steps taken to identify the primary aggressor at the scene. Law enforcement agencies should consult with the Washington Association of Sheriffs and Police Chiefs when developing, implementing, or modifying policies and practices regarding monitoring the documentation of domestic violence investigations.
- Domestic violence programs should have clear protocols to determine eligibility for victim services, rather than relying on the legal system's identification of the victim and abuser, or other methods. Programs should receive training in the use of domestic violence assessment tools designed to identify the victim of an ongoing pattern of power and control in a relationship, and programs should have policies that direct advocates on how and when to use such tools.⁸⁰
- Domestic violence programs should conduct outreach to the jails in their community to provide information and resources to domestic violence victims in custody.

Finding: Courts fail to routinely order domestic violence offenders to complete state-certified batterer's intervention programs.⁸¹

Only one of the eleven abusers in recently reviewed cases was ever ordered to complete a certified batterer's intervention program, despite the fact that six of the abusers had domestic violence criminal histories. One abuser was convicted of three domestic violence crimes, including two assaults using deadly weapons, yet the court never ordered him to batterer's intervention. This is consistent with findings from the Fatality Review since its inception in 1997.⁸²

⁷⁹ See, for example, Mary Haviland et al., "The Family Protection and Domestic Violence Intervention Act of 1995: Examining the Effects of Mandatory Arrest in New York City," Family Violence Project of the Urban Justice Center (2001). Available at http://www.connectnyc.org/cnyc_pdf/Mandatory_Arrest_Report.pdf.

⁸⁰ The Northwest Network of Bisexual, Trans, Lesbian and Gay Survivors of Abuse has developed an assessment tool that is used as a model nationwide. The NW Network provides training on this tool for other domestic violence service providers. For more information, contact The NW Network at www.nwnetwork.org or WSCADV at 206-389-2515.

⁸¹ Batterer's intervention programs are described in the Washington Administrative Code as "domestic violence perpetrator treatment programs" (WAC 388-60).

⁸² Of the sixty-five abusers in all cases reviewed since 1997, only four had been ordered to batterer's intervention, and none had actually completed the program.

One abuser in a recently reviewed case had two domestic violence assault convictions and one domestic violence malicious mischief conviction, yet the court never ordered him to complete a batterer's intervention program. The court did order a batterer's evaluation as a part of his sentence in one case; however, at that time, the court did not require the evaluation to be carried out by a batterer's intervention program. Currently, this particular court does require that evaluations come from a state-certified batterer's intervention program, but the court does not have the authority to specify which certified program the abuser will use. This results in abusers "shopping around" and selecting programs likely to give them the evaluation most favorable to their case (this often means programs that do not interview the victim as a part of the process). While state law requires that certified programs meet minimum standards, which are monitored through the Department of Social and Health Services (DSHS), review panels identified a gap between policy and practice. DSHS does not routinely and thoroughly enforce the existing state standards.

Experts reviewing our findings identified the entire practice of ordering batterer's evaluations (as opposed to simply ordering batterer's intervention itself) at any point in the criminal legal process as problematic, even if a state-certified program conducts the evaluation.⁸³ When the court orders an evaluation instead of batterer's intervention, it requires an additional step to monitor if the evaluator recommends batterer's intervention, and if so, then monitor whether or not the abuser actually attends. As our reviewed cases consistently highlight, most courts lack the mechanisms and capacity to effectively monitor compliance with sentencing conditions, let alone follow up on recommendations made by evaluators.

Prior to admitting anyone into a batterer's intervention program, all state-certified programs must complete a detailed intake assessment.⁸⁴ If the defendant meets one of the following criteria in the course of the assessment, the program can notify the court of the need for a different sentence: non-amenable to treatment; a victim who has mistakenly been identified by the legal system as an abuser; or otherwise inappropriate for the program. These assessments are sufficient to address any concerns or reluctance judges may have in ordering a defendant to batterer's intervention, making the practice of first ordering an evaluation unnecessary at best and weakening the court's ability to hold abusers accountable at worst.

The one case in which a court did order the abuser to a batterer's intervention program highlights another gap in the system's ability to hold abusers accountable for completing the program. In this case, the court ordered the abuser to both chemical dependency treatment and batterer's intervention. (See the chapter "Alcohol and Other Drugs" for a discussion of the combined intervention needs of chemically dependent abusers.) Batterer's intervention is a one-year program, and probation for a misdemeanor domestic violence conviction is usually one year as well. Most batterer's intervention programs require substance-abusing participants to complete at least a portion of chemical dependency treatment prior to enrolling in their program. This often results in abusers' probation ending before they have completed the batterer's intervention. Without an incentive to complete the program (the case is closed and probation officers are no longer monitoring compliance), abusers can drop out of the program without completing it and without further consequences.

⁸³ Batterer's evaluations are sometimes ordered prior to sentencing, or defense attorneys advise their clients to get one early in their case in order to use it as part of a defense strategy (implying the defendant could not have committed the domestic violence crime based on the findings of an evaluation). This practice is not recommended, as these evaluations are not designed to assist in determining if a crime has been committed.

⁸⁴ WAC 388-60-0165 outlines the minimum information that state-certified batterer's intervention programs must collect and address during the intake assessment.

None of the abusers in the fatality cases reviewed since 2004 are serving life sentences. In fact, two abusers were sentenced to less than five years in prison. An additional abuser could be released as early as the year he turns thirty. As fatality reviews show, courts release homicidal domestic violence abusers back into the community, and many abusers who have not committed homicides are released every day. Fatality Review panels identified the lack of batterer's intervention programs in jails and prisons as a critical missed opportunity.

Recommendations:

- Judges should routinely order domestic violence offenders to attend a state-certified batterer's intervention program.
- Batterer's evaluations should never be court ordered in lieu of batterer's intervention or in any way be a part of the criminal legal response to domestic violence.
- Judges should increase their awareness of the state standards for batterer's intervention programs and should not accept an offender's enrollment in a program that fails to meet these standards.
- The state should provide more resources to DSHS for the oversight of certified batterer's intervention programs in order to monitor their compliance with the standards set forth in the Washington Administrative Code (WAC), including increased authority to decertify noncompliant programs and funding to reconvene an advisory group.
- Judges and probation departments should collaborate to develop a mechanism to extend probation or use judicial hearings if an abuser has not completed court-ordered batterer's intervention by the end of their probation period.
- 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.⁸⁵

What can you do today?

Contact your local law enforcement agency to learn about their policies and practices regarding how officers utilize interpreters when responding to domestic violence incidents. If they lack a clear policy, refer them to www.lep.gov and ask them to develop a language access plan.

⁸⁵ Good models exist for such programs. For example, see Manalive Violence Prevention Programs at www.manaliveinternational.org.

The system does not adequately address the safety needs of domestic violence victims and their children.

Civil Legal Issues

In all but one of the ten recently reviewed fatality cases involving adults, the victim or abuser had some contact with the civil legal system, regarding either Protection Orders, marriage dissolutions, or child custody issues. 80% (n=8) of the abusers were the respondents in at least one civil protective order (seven Protection Orders and three Restraining Orders) filed by the victim in the fatality case or a previous partner.⁸⁶ Three of the domestic violence victims in reviewed cases petitioned for a Protection Order against their abuser.⁸⁷ One additional victim had a Restraining Order as a part of her divorce.

All of the prior Domestic Violence Fatality Review (DVFR) reports have addressed the challenges victims have faced in accessing the civil legal system and the gaps in that system's ability to adequately respond to domestic violence and address the safety needs of domestic violence victims and their children.⁸⁸ This chapter will not repeat all findings and recommendations discussed in previous reports, but will focus on specific findings from the cases reviewed since the 2004 report.

Finding: The process of petitioning for a civil Protection Order is a critical point of intervention for domestic violence victims.

Fatality Review panels saw victims' petitions for civil Protection Orders as critical opportunities for them to receive safety planning information and referrals to domestic violence resources. Prior Fatality Review reports have recommended that all courts issuing civil Protection Orders establish domestic violence advocacy in their Protection Order offices and ensure that advocates have extensive training on how to assist victims in planning for their safety. Reviews over the past two years have continued to identify this as a need. A 2004 survey conducted by the DVFR of all courts in Washington State that issue civil Protection Orders revealed that in the majority of courts, Protection Order petitioners do not speak with a domestic violence advocate, and interact only with court clerks. The majority of clerks do not routinely provide petitioners with information about safety planning or referrals to community resources such as the local domestic violence program.⁸⁹ When courts do not have domestic violence advocates on-site and fail to instruct clerks to routinely provide this information to all petitioners, some victims in critical need of resources that could enhance safety for themselves and their children do not receive the information.

Three recently reviewed cases highlight the importance of receiving information and referrals at the time of petitioning for a Protection Order. In the first case, the victim's Protection Order petition against a past partner was denied with "no domestic violence" cited as the reason the order was not granted (the narrative did not include any description of physical violence). In the two other cases, panels felt that judges probably would have denied a request for a Protection Order had the victim petitioned for one, because the abuser's tactics were primarily verbal and emotional. However, when victims experiencing this sort of abuse receive assistance from

⁸⁶ One abuser was the respondent in three different Protection Orders prohibiting him from contacting three different women he had abused.

⁸⁷ One of the victims had a Protection Order against an ex-partner, not the abuser who committed the homicide.

⁸⁸ *Honoring Their Lives, Learning from Their Deaths* (2000), *"Tell the World What Happened to Me"* (2002), and *Every Life Lost Is a Call for Change* (2004) are available at www.wscadv.org.

⁸⁹ For a complete discussion of the 2004 survey of Washington State courts, see *Every Life Lost Is a Call for Change* (2004), p. 41-44.

a Protection Order advocate, that advocate can help victims articulate some of the more subtle, non-physical forms of abuse that these women experienced, such as stalking, threats of violence, and suicide threats, and increase the likelihood that the court will understand why they are in fear of imminent harm from the abuser.⁹⁰ Additionally, if the court denies a request for a Protection Order, as in the first case, having an advocate available increases the likelihood that appropriate and timely referrals can give victims the opportunity to access other safety planning tools and resources in the community.

Recommendation:

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

Finding: Courts sometimes grant civil Protection Orders to both the victim and the abuser. These dual orders jeopardize victim safety.

Two abusers in recently reviewed cases petitioned for, and were granted, a total of four civil protective orders (one Anti-Harassment Order and three Protection Orders) against their partners.⁹¹ Both of these abusers were the respondents in Protection Orders as well. In one case, the abuser was the respondent in two Protection Orders from two previous relationships. When a third partner of his petitioned for a Protection Order, he petitioned the court for an order against her the next day. The court granted both of them Temporary Protection Orders. The court then held both of their Permanent Protection Order hearings together and granted both the victim and abuser Permanent Protection Orders against the other. In addition to being the respondent in two other Protection Orders, the abuser in this case also had a documented criminal history of domestic violence-related crimes, including two second-degree domestic violence assault charges. Panel members thought the judge or commissioner who issued these dual Protection Orders most likely did not know about this history, and identified this lack of information as detrimental to the victim.

A similar situation played out in the other case: the victim and abuser both petitioned for orders within two days of one another. The court also granted both Temporary Protection Orders and the permanent order hearings took place on the same date. This court also granted both the victim and abuser Permanent Protection Orders against the other.

The panels reviewing these cases found this practice to be potentially harmful. Dual orders compromise victim safety, create enforcement challenges for police officers, and provide abusers with increased power (in the form of law enforcement and court resources and authority) in

⁹⁰ As an example of how advocate assistance can be beneficial to victims in the Protection Order (PO) filing process, Walla Walla County has reported that since they established a PO clinic staffed with trained domestic violence advocates, the rate of PO petitions that are completed and temporary POs granted has increased 53%. For information about this program, contact Ann Passmore at 509-525-2570 or WSCADV at 206-389-2515.

⁹¹ Two of these orders were against the homicide victims and two were against previous partners.

their quest to manipulate and control the victim.⁹² To illustrate, one of these abusers stalked and harassed the victim, then called police and had her arrested for violating the Protection Order.

Recommendation:

- Judges and commissioners should utilize their access to court histories to obtain as much background information as possible about other proceedings involving civil Protection Order respondents and petitioners.⁹³

Finding: Victims as well as professionals working in the system are confused about the differences between various types of civil and criminal protective orders.

None of the domestic violence victims in reviewed cases who had a Restraining Order, No Contact Order, or other type of order prohibiting contact also petitioned for a Protection Order. Panels reviewing these cases noted that many people, both within and outside of the system, are unaware of the differences between orders and their enforceability. People mistakenly assume that if the court has issued a No Contact Order in a criminal case or a Restraining Order in a civil case, no need exists for a civil Protection Order. Victims often do not realize that if the criminal case gets dismissed, the No Contact Order will disappear.

Recommendation:

- Domestic violence programs, law enforcement, prosecutors, court clerks, and civil attorneys should routinely provide information to domestic violence victims that describes the differences between various types of civil and criminal protective orders.⁹⁴

Finding: Domestic violence is not routinely addressed as a part of the marriage dissolution process.

Four of the victims in recently reviewed cases petitioned for a dissolution of their marriage to the abuser prior to the fatality.⁹⁵ Three of the four victims had an attorney represent them in divorce proceedings. In the fourth case, neither party had an attorney, but the abuser contacted a legal services program to inquire about how he might prevent his wife from divorcing him. Only one of the dissolution petitions specifically addressed the domestic violence in some way.

Panels discussed victims' contact with the civil legal system as a critical time for them to receive information about domestic violence and resources available, particularly because a divorce and the process of ending an abusive relationship can be such a dangerous time.⁹⁶ The dissolution process does not routinely include screening questions, information, or intervention around domestic violence. In the cases in which the victim had legal representation for their divorce, panel members noted that while it was fortunate that these women had the resources

⁹² Washington State statutes discourage courts from issuing mutual court orders in domestic violence cases. As stated in RCW 26.50.030, Notes: Findings – 1992 c 111: “Mutual protection orders label both parties as violent and treat both as being equally at fault: Batterers conclude that the violence is excusable or provoked and victims who are not violent are confused and stigmatized. Enforcement may be ineffective and mutual orders may be used in other proceedings as evidence that the victim is equally at fault.”

⁹³ The Kitsap County District Court, in partnership with the YWCA of Kitsap County, has developed and implemented a model court project, A New Beginning: Protecting Victims by Preventing Conflicting Domestic Violence Orders (Protecting Victims Project), to resolve problems that result when multiple orders exist for petitioners and respondents. As a part of this work, they scan every court order in the county (civil, criminal, and tribal court) to ensure continuous access to information on all orders. To learn more about the Protecting Victims Project or to discuss the availability of consultation services, contact Maury Baker at 360-337-4959 or WSCADV at 206-389-2515.

⁹⁴ For a hand-out that describes the different types of court orders in a copy-ready format, see www.wscadv.org.

⁹⁵ Two additional victims and two abusers had gone through the dissolution process with previous partners.

⁹⁶ See “Planning for Safety” chapter for separation violence risks.

to retain an attorney, many attorneys: do not inquire about the existence of domestic violence; have not received training on the dynamics of domestic violence and the increased risk to victims at the time of separation; and may not have recognized the signs of escalating danger present in these cases.⁹⁷

In each of the three cases involving attorneys, the dissolutions included mutual Restraining Orders with the standard language that prohibits both parties from “molesting or disturbing the peace of the other party.” In the one case in which the victim raised the issue of domestic violence in her petition and documented the abuser’s extensive stalking, the court issued a mutual Restraining Order as a part of the dissolution that specifically stated the order did not “limit peaceable contact between parties.” Such mutual Restraining Orders do not protect victims sufficiently and can give a false sense of security to a victim by supporting an illusion that the order will protect her. Fatality Review panels described these orders as virtually unenforceable because they do not clearly state what kind of contact is prohibited. These cases highlight the need for civil attorneys to routinely provide information about Protection Orders to victims, provide them with a description of the differences between types of orders as described earlier in this chapter, and explain why they may want a Protection Order in addition to a Restraining Order.

Recommendations:

- Courts should have domestic violence resource information available throughout the courthouse (e.g., in bathrooms, waiting areas, clerks’ offices, Protection Order offices).
- Dissolution forms, “Do-It-Yourself Divorce” packets, and classes required by the courts for divorcing parents with children should include information about domestic violence and domestic violence resources.
- Due to the prevalence of domestic violence, law schools should incorporate domestic violence education in core courses for all attorneys, regardless of their area of specialty.⁹⁸
- Civil attorneys should routinely tell their clients going through the dissolution process about available domestic violence advocacy services, where to receive assistance planning for their safety, and Protection Orders.
- All attorneys practicing family law should receive training on how to identify when domestic violence is an issue and what factors indicate an increased risk for serious injury or lethality.

Finding: The civil legal system does not adequately address the safety needs of domestic violence victims and their children, particularly in the areas of child custody and parenting plans.

Fatality reviews brought to light multiple gaps in the civil legal system’s response to custody and visitation issues when domestic violence is involved. For example, one victim with limited English proficiency petitioned for a Protection Order against her abuser on behalf of herself

⁹⁷ The American Bar Association has produced a handbook for attorneys to assist with recognizing domestic violence when representing clients. It provides an overview of domestic violence and the law, as well as guidelines and recommended action steps for all fields of practice. Margaret Drew et al., eds., *The Impact of Domestic Violence On Your Legal Practice: A Lawyer’s Handbook*, 2nd ed., (Washington, D.C.: American Bar Association Commission on Domestic Violence, 2004).

⁹⁸ For a report on integration of domestic violence into law school curricula, as well as sample course materials for use by legal educators, see American Bar Association Commission on Domestic Violence, *Teach Your Students Well: Incorporating Domestic Violence Into Law School Curricula—A Law School Report* (Chicago, 2003).

and her three children. In the order, the court granted the abuser supervised visitation with the children and named the abuser's father as the supervisor. The abuser's father had a violent history himself, had a significant amount of power in the family, and seemed to support his son's abusive behavior. The panel noted that the abuser's father may have been chosen as the supervisor in this case because of the lack of options for supervised visitation, particularly for low-income families and families with limited English proficiency.

Courts take a positive step toward addressing victims' and children's safety by ordering supervised visitation. However, courts must choose supervisors carefully. A violent supervisor or one closely allied with the abuser places victims and children in danger. Multiple Fatality Review panels have identified a lack of adequate supervised visitation resources in their community, leaving many families without safe visitation options.

In a second case, the abuser's ex-girlfriend requested in her Protection Order that he be restrained from having any contact with her or their daughter. However, the court did not limit contact with his daughter in any way. Panel members noted the extreme difficulty of enforcing a Protection Order like this one, which failed to address access to the child. When judges do not include children in Protection Orders or address visitation, they make domestic violence victims vulnerable to continued violence from the abuser.⁹⁹

Parenting plans issued as a part of the dissolution process in family court failed to address the safety needs of victims and children as well. In the final decree of the dissolution in one reviewed case, the court ordered a parenting plan that granted the abuser "unlimited residential time with the child at the mother's residence" despite a documented history of domestic violence. In another case, the court ordered a parenting plan that failed to address safety issues in any way, again despite a documented history of domestic violence. These orders posed a significant barrier to any efforts made by the victim to plan for safety or even limit contact with the abuser.

Judges can impose restrictions on abusers' residential time with children, including visitation, if domestic violence is identified in divorce hearings, even if the parties have apparently agreed on a parenting plan which does not address safety issues. However, attorneys on review panels and advisory committees discussing our findings noted that victims face many barriers to disclosing abuse. In fact, some attorneys advise clients not to address domestic violence in the dissolution process, even though neglecting to do so can undermine the victim's safety. Some attorneys talked about being hesitant to raise the issue of domestic violence because they believe it may work against their client due to judicial bias and assumptions that women lie about domestic violence as a tactic to gain the upper hand in divorce negotiations, despite research indicating that violence may escalate as victims take steps to become independent.¹⁰⁰ Panels identified a need for family law attorneys to routinely ask their clients about a domestic violence history, and for attorneys, commissioners, and judges to obtain training and continuing education about the prevalence of domestic violence and the many reasons why victims may not have third-party documentation of the abuse.¹⁰¹

⁹⁹ The state law enabling Protection Orders makes clear that the court can make residential provisions with regard to minor children in the context of a Protection Order. See RCW 26.50.060(1)(c).

¹⁰⁰ Previous DVFR reports have discussed the issue of judges not believing women who raise domestic violence as a part of their divorce. See "*Tell the World What Happened to Me*" (2002), p. 78-80.

¹⁰¹ For a discussion of the inadequacies of family law to address domestic violence and strategies for improving judicial and legal practice to end violence against women, see Andrea Farney and Roberta Valente, "Creating Justice Through Balance: Integrating Domestic Violence Law into Family Court Practice," *Juvenile and Family Court Journal* (Fall 2003), p. 35-55.

Recommendations:

- Civil Protection Orders should specify visitation arrangements which address safety for domestic violence victims and their children.
- The Washington State Legislature should amend RCW 26.09.191 to provide more specificity around the types of restrictions on residential time with children that can be ordered for domestic violence abusers (e.g., supervised visitation or exchange, completion of batterer's intervention program).¹⁰²
- The Washington State Legislature should increase funding for safe, affordable, and language-accessible supervised visitation and exchange resources for family law cases involving domestic violence. Supervisors should receive specialized training on the dynamics of domestic violence, how to recognize the manipulative tactics an abuser might use during visitation, the potential for an abuser to use visitation to stalk and control their partner, and the risk to children when one parent has a history of perpetrating domestic violence.
- All professionals working in the civil legal system, including judges, attorneys, court clerks, court facilitators, family court evaluators, guardians ad litem (GALs), and court-appointed special advocates (CASAs), should receive initial training and continuing education on domestic violence.
- The Washington State Bar Association should collaborate with agencies with expertise in domestic violence and family law to create and disseminate the following practice guides: how to raise the issue of domestic violence in custody cases; making the connections between domestic violence and harm to children, including a literature review to help attorneys bring the research in this area to judges' attention; and how to construct a parenting plan which addresses safety for victims and their children.
- 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; and assess for the safety needs of victims and their children.

What can you do today?

Go to a court in your area and see if there is domestic violence resource information in multiple languages available at the front window, in the Protection Order office, by the court clerk, or in some other accessible area. If there is, thank the court for having that information available. If there is not, contact your local domestic violence program and ask them to contact the court and routinely provide them with resource information, or write a letter to the presiding judge requesting that the court make this information available.

¹⁰² Examples of such language can be found in the *Model Code on Domestic and Family Violence*, National Council of Juvenile and Family Court Judges (1994). For copies of this publication, see www.ncjfcj.org.

Epilogue

On November 22, 2004, Kelsey and Hayley Byrne, ages 11 and 9, were killed by their father, who then killed himself. We close the 2006 Fatality Review report with an epilogue written by their mother, Suzanne Dawson.

When I look at the following list of seventy-seven people dead and see the names of my two daughters, I am shocked and still do not believe it. How did this happen? What brought their father to the place where he thought the best thing to do was to kill his own children? How could I have been headed toward this tragedy and not even know it? What could I have done? What could anyone have done?

Though I am learning to deal with the pain, I still struggle to find meaning and gain understanding. Much of my pain is not only caused by their deaths, but also with the difficulties that preceded their deaths. I am one of many people who has lived, or is still living, with the fear of violence toward themselves or their children. I sought help. I arranged individual and couples counseling from many therapists. I finally divorced and tried to create a separate life for myself and my children.

Many people have questioned me about their father, about how it was possible for someone who seemed to care so much for his daughters to commit such a despicable act. Though my ex-husband was hostile to me, he appeared to be a loving father. I worried about his future, his increasing anger, and his unchanged circumstances, but did not know what to do or to whom I should turn. He was incredibly good at hiding his issues, even from himself, and was unable to share his troubles with the people who cared about him. My daughters were caught up in his denial and his inability to get help.

It seems that we, as a community, are still unable to see important warning signs of violence, still unable to see what is not right, what does not fit. We need to define these warning signs, pay attention to them, and have systems in place to help those people affected—both the victims and the perpetrators. We need an environment where people with differing perspectives (e.g., therapists, court staff, lawyers and their staff, child services, guardians ad litem, teachers, school officials) can talk to each other during hostile situations. In my case at least, it seemed like no one looked at or talked about the big picture. No one seemed to be in a position to seek input from others that would provide enough information to understand the situation fully.

I am left to define a different life, to try and accommodate the void created by the death of my daughters. This process has allowed me to see how kind and compassionate a community can be, how much support is provided by friends, co-workers, medical professionals, and strangers. This support has taken many forms, including people who come with troubles of their own, troubles that mirror mine. I have learned that one death has an impact that goes way beyond its immediate circle. We are threaded together in ways that we cannot imagine until a thread is pulled, a connection is lost.

My daughters would be amazed and humbled at the outpouring of kindness, love, and support that came from close and far. They were the last to recognize their special gifts: their contagious smiles, their buoyant enthusiasm for anything new to try, and their consideration of other people. Every person on the following list of victims has their own unique qualities that will be forever missed. I do not have any easy answers to my questions, but I do know that we need to look more closely at the causes and effects of domestic violence. I have already learned of many families—our neighbors—who live with the fear of facing a similar tragedy. This violence is preventable. It is through sharing our stories, even through our tears, that we move forward and make a change. Each of us can try—are we ready?

List of Victims

Victims killed by domestic violence abusers: July 1, 2004 to June 30, 2006

- 7/6/04** *Teressa Hilton, 39, beaten by her boyfriend. A court protective order had been in place against him for five months.*
- 7/8/04** *Justin Gordon, 32, shot by his ex-girlfriend's adult son.*
- 7/9/04** *Debra Carr, 49, and Glenn Carr, 55, shot by their daughter's estranged husband while their grandchildren were nearby. He had recently threatened to kill her family if she didn't come back to him. A year later, he killed two other women and then killed himself.*
- 7/14/04** *Antigone Monique Allen, 18, and her children Christine Allen-Garcia, 2½, Kristian Allen-Garcia, 1½, and Adam Allen-Garcia, 6 months, killed by Antigone's boyfriend. He doused them with gasoline and set them on fire, killing them and himself.*
- 7/21/04** *Terry Rohr, 49, shot by his girlfriend's estranged husband. The husband set Terry's house on fire, and then shot him when he ran outside. Terry's girlfriend escaped.*
- 7/30/04** *Brad Crawford, 49, a police officer killed when a domestic violence suspect rammed his police car with a truck as the suspect fled the scene.*
- 8/10/04** *Melissa Saldivar, 19, and Mataya Saldivar, 7 weeks, killed after Melissa's fiancé pushed her from a moving car while she was pregnant with Mataya. Melissa's 2-year-old son was also in the car. Mataya was delivered while Melissa was on life support. Mataya lived for 52 days on life support.*
- 8/23/04** *Sandra Godinez, 24, stabbed multiple times by her husband. A court protective order had been in place against him for several weeks.*
- 10/5/04** *Maria Flesher, 29, stabbed multiple times by her boyfriend.*
- 10/10/04** *Jay Harmon, 36, shot by his girlfriend's former brother-in-law. He shot at Jay's girlfriend, who survived, and he shot and killed her dog.*
- 10/14/04** *Gabriel Meza, 33, shot by his girlfriend's ex-husband.*
- 10/22/04** *Pranee Sukto, 39, stabbed multiple times by her husband in front of their 8-year-old son. Her husband then stabbed their son, who survived.*
- 10/28/04** *Kwang Ja "Annie" Chung, 41, stabbed multiple times by her husband in the restaurant they owned together, one day after he was released from jail following a domestic violence arrest.*
- 11/6/04** *Elaine Sepulveda, 15, suffocated by her boyfriend.*
- 11/20/04** *Sherry Kelley, 50, shot by her husband, who also shot Sherry's brother and then killed himself. Her brother survived the attack.*
- 11/22/04** *Kelsey Byrne, 11, and Hayley Byrne, 9, killed by their father, who gave them a lethal dose of drugs and then fatally shot himself. He was involved in a dispute with the state over his failure to pay child support to their mother.*
- 11/30/04** *Tiffany Benoff, 28, shot by her estranged husband when she met him to talk about their divorce. He then killed himself.*
- 12/14/04** *Amber Rae Bulus-Steed, 26, strangled and beaten in a motel room by her boyfriend, in front of at least one of her two young children.*
- 12/21/04** *Sophia Solomon, 23, strangled by her boyfriend.*
- 12/29/04** *Colleen Avans, 32, shot by her husband in front of her 16-year-old daughter. He shot her daughter in the hand as he broke into the room where she and Colleen were trying to escape from him.*
- 1/21/05** *Nicholas Coan, 28, shot by his girlfriend.*
- 2/1/05** *Kathryn Rodriguez, 45, shot by her husband, who then killed himself. Three of their children (ages 27, 15, and 12) were in the home at the time.*
- 2/8/05** *Eveann Classen, 56, stabbed by her estranged husband. They had been separated for two years, and he recently learned she had a new boyfriend.*
- 2/13/05** *Yong Bright, 36, killed in a fire set by her boyfriend.*
- 2/21/05** *Evelynn Smith, 20, stabbed by her boyfriend.*
- 3/05** *Unnamed woman, 44, stabbed by her boyfriend.*
- 3/5/05** *Charles Thrush, Jr., 40, stabbed by his ex-girlfriend. A court protective order was in place against her.*
- 3/7/05** *George Hartman, 65, shot by his girlfriend, who then set fire to his house in a suicide attempt.*
- 3/18/05** *Ronald Whitehead, 61, shot during a carjacking arranged by his wife.*
- 3/28/05** *Katy Hall, 42, beaten by her boyfriend.*
- 4/12/05** *Brenda Engh, 31, shot by her estranged husband while she held their 7-month-old daughter. They were in the midst of a divorce.*
- 4/22/05** *Erin Donahoo, 21, shot by her boyfriend. He killed himself two days later.*
- 4/23/05** *Nguyet Minh Nguyen, 53, strangled and bludgeoned by her boyfriend.*

- 5/28/05** Roda Bec, 16, stabbed by her boyfriend. Her friend tried to stop him and suffered cuts on her hands. Her friend's 18-month-old child was present during the attack.
- 5/31/05** Michele Morey, 31, and her mother Mary Gates, 54, shot by Michele's estranged husband, who then killed himself. They were in the midst of a divorce.
- 6/1/05** Julie Prather, 31, and her children Alex Prather, 7, and Alysha Prather, 4, stabbed by Julie's husband, the children's father.
- 6/7/05** Rochelle Moore, 20, shot by her ex-boyfriend, who had been stalking her since she ended their relationship. He then killed himself.
- 7/3/05** Idise Holland, 73, stabbed by her boyfriend.
- 7/12/05** Nabila Bare, 18, stabbed multiple times by her husband.
- 7/17/05** Kao Vang Saeturn, 46, stabbed by his girlfriend after telling her he wanted to end their relationship. Their three teenage sons were in the home at the time.
- 7/17/05** April Hall, 30, stabbed and shot by her boyfriend, who then killed himself. They had been dating for several months, and she had recently decided to slow down their relationship.
- 7/28/05** Renee DiLorenzo, 18, shot by her ex-boyfriend after she broke up with him. He then killed himself.
- 8/3/05** Janine Piccolo, 26, and her boyfriend Kenneth DeBord, 26, shot by her estranged husband.
- 8/18/05** Yvonne Lewis, 49, shot by her husband, who then killed himself. Their 11-year old son ran outside and called 911.
- 8/26/05** Patricia Smith, 31, shot by her ex-boyfriend. He had been arrested less than two weeks earlier for assaulting and threatening to kill her, and was released from jail on bond. After killing Patricia, he left with their 2-year-old son.
- 9/8/05** Kit Lucey, 76, shot by her husband, who then killed himself.
- 10/14/05** Nancy Herron, 58, shot by her boyfriend, who then killed himself.
- 10/28/05** Kevin Boyle, 48, shot by his roommate, who was his former girlfriend.
- 10/30/05** Jennifer Martin, 35, shot by her boyfriend in front of her 15-year-old son. Her 4-year-old child and the couple's 1-year-old son were also in the home at the time. Her boyfriend then killed himself.
- 11/4/05** Evelyn Tumbaga Matsen, 34, and her son Wahren Agonoy, 13, shot by her estranged husband. There was an arrest warrant and a court protective order in place against him.
- 11/10/05** Margaret Mitchell, 46, bludgeoned by her boyfriend.
- 11/11/05** Heidi Heath, 28, shot by her husband.
- 11/12/05** Teresa Delisio, 34, shot by her ex-boyfriend. He shot her father, who survived, then shot and killed Teresa and himself. He had been arrested the previous day for intimidating her, and was released from jail on bond. A court protective order was in place against him.
- 11/21/05** Irene Hicks, 65, beaten and stabbed by her ex-boyfriend.
- 12/10/05** Louissa Thompson, 27, and her co-worker Peter Zornes, 25, shot by her ex-boyfriend, who had been stalking and harassing Louissa since she broke up with him.
- 12/12/05** Jesika Poni Wani, 33, stabbed by her husband in their home, who then killed himself by driving into an oncoming truck. Her husband's 17-year-old daughter and the couple's 6-year old and 19-month-old children were in the home at the time Jesika was killed.
- 12/30/05** Jamie Phillips (Braffith), 25, beaten by her husband. Her 10-year-old son and the couple's 7-year-old, 2-year-old, and 7-month-old children were in the home when their mother was killed. Jamie was 3 months pregnant.
- 1/19/06** Barbara Kozak, 43, killed by her estranged husband, who then killed himself.
- 2/24/06** Pepper Jones, 27, beaten and drowned by her husband. She had recently decided to divorce him.
- 3/22/06** Randall Ferguson, 45, shot by his wife.
- 4/3/06** Desandra Dixon, 36, shot by her boyfriend. There were children ages 4 to 19 in the house at the time she was killed.
- 4/6/06** Robert Luea, 21, shot by his mother's husband when he tried to intervene in a fight to protect his mother.
- 4/27/06** Kevin Underwood, 44, stabbed by his girlfriend's ex-boyfriend, who also stabbed her. She survived the attack.
- 5/11/06** Sherrika Wilson, 22, shot by her husband.
- 5/21/06** Robert Gray, 70, shot by his wife and her ex-boyfriend.

Appendix A:**History and Description of the Domestic Violence Fatality Review****History and funding of the Washington State Domestic Violence Fatality Review**

The Washington State Domestic Violence Fatality Review began because battered women's advocates were puzzled that after twenty-five years of reforms aimed at improving the community response to domestic violence, the death toll arising from this social problem remained 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 victims face as they seek to end the violence in their lives, and 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 legal 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 Washington State Department of Community, Trade, and Economic Development, and was originally housed in the Department of Social and Health Services (DSHS). 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*.¹

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, administered through DSHS Children's Administration.

Purpose of the Domestic Violence Fatality Review

The DVFR'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 legal systems for a detailed examination of fatalities. Focusing on public records, Fatality Review panels analyze community resources and responses to abuse prior to the fatality, and generate information relevant to policy debates about domestic violence.

The DVFR does not assign blame for fatalities to agencies, institutions, or individuals working in them. Instead, the perpetrator of the homicide or suicide is assumed ultimately responsible for the fatality. The DVFR also does not seek to identify patterns of individual pathology on the

¹ *Homicide at Home: Washington State's Domestic Violence Fatality Review Project* (1999). This publication is available from the Washington State Coalition Against Domestic Violence at www.wscadv.org.

part of the domestic violence victim or abuser. Rather, the focus is on problems in the 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 cases reviewed by panels and a limited set of data on unreviewed cases.

Definition of domestic violence fatality

The DVFR defines a domestic violence fatality as a death which arises from an abuser's efforts to seek power and control over their intimate partner. In creating this definition 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/perpetrator 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.² 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 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 abusers kill law enforcement officers, their former partner's new love interests, or bystanders do not count as domestic violence fatalities.

In contrast to the legal 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. The DVFR definition of a domestic violence fatality is both broader and narrower than the one used by most criminal legal system reporting agencies. It is broader, in that it takes into account that abusers sometimes kill non-family members in the context of domestic violence. 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, 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 midst of a perpetrator's attempt to kill their intimate partner. For example, situations in which an abuser kills their current/former intimate partner's friend, family member, or new intimate partner, or those in which a law enforcement officer is killed while intervening in a domestic violence incident.

² RCW 10.99.020 and RCW 26.50.010.

3. Homicides occurring as an extension of or in response to ongoing abuse between intimate partners. For example, when an ex-spouse kills their children in order to exact revenge on their partner.
4. Suicides which occur in the context of intimate partner violence.

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

Core panel participants include:

- Municipal, District, Superior, and Tribal Court judges
- City and county prosecutors
- Law enforcement agencies
- Court, law enforcement, and prosecutor-based domestic violence advocates
- Local hospital staff
- Battered women's shelters and advocacy organizations
- Child protective services
- Community corrections/probation officers
- Department of Health representatives
- Agencies and organizations serving specialized populations (e.g., people of color, Limited English Proficient populations, immigrants and refugees, gay, lesbian, bisexual, and transgender people)
- Military liaisons for areas close to military bases
- Humane Society and animal cruelty investigators
- Batterer's intervention programs

Whenever possible, we also include local mental health and substance abuse treatment providers, sexual assault advocates, schools, and leaders of religious communities. If it is clear that either the victim or abuser had contacts with a particular agency, doctor, attorney, religious leader, or other community member, we contact that professional and invite them to the review.

The Domestic Violence Fatality Review has operated review panels covering 14 Washington 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 Benton, Clark, Franklin, Snohomish, Thurston, and Walla Walla counties.

Location of review panels	From	To
Chelan/Douglas/Okanogan Counties	June 1998	July 1999
Spokane County	June 1998	November 2000
Pierce County	June 1998	February 2003
Yakima/Kittitas Counties	April 1999	November 2000
King County	June 1999	February 2005
Clark County	November 2001	Present
Benton/Franklin/Walla Walla Counties	April 2002	Present
Snohomish County	February 2004	Present
Thurston County	October 2005	Present

Confidentiality and criteria for in-depth reviews

Proceedings of Fatality Review panels are confidential and protected from discovery by a third party, as mandated by RCW 43.235, and panel members 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.

In order to avoid influencing civil or criminal adjudication, and limitations on access to information, the following criteria were developed for case selection:

- The death fits within the DVFR's definition of a domestic violence fatality.
- The criminal legal system has identified the perpetrator.
- There is no criminal prosecution (such as a case involving homicide-suicide), or the case is closed with no appeal pending. An exception can be made in the latter circumstance if the prosecutor in charge of the appeal agrees that a fatality review will not affect issues under appeal and gives his or her permission for 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 Fatality Review process

Review panels generally meet quarterly. Panels identify which cases in their county they would like to review. Once the panel has identified a death for review, DVFR staff request 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, enabling access to incident reports related to events which did not result in a conviction. In cases where 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 Fatality Review staff. Staff synthesize the events described in these public documents (along with any information provided by family members) into a case chronology and distribute this document to Fatality Review panel members prior to meeting for the review.

Review panel members read the case chronology and examine their own agency's records for contacts with the domestic violence victim, the 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 the victim obtaining safety, and the ability of the system to hold the abuser accountable for their violence.

Review panel members do not generate recommendations. Instead, they generate information and identify issues and problems. The Washington State Coalition Against Domestic Violence (WSCADV) developed the recommendations in this report by analyzing the issues raised by all of the review panels and in conversation with advisory committees.

Citizen protocol for requesting review

Members of the public may bring a particular death to the attention of the DVFR and request a review, per RCW 43.235. Requests for review should be made in writing within two years of the fatality. Requests may be made anonymously. In case of a citizen request for review, the Fatality Review coordinator will determine whether the fatality meets the project's criteria for review. If the fatality does meet the criteria, Fatality Review staff will take the request to the appropriate review panel, if one exists in the region where the fatality occurred. In cases where no review panel exists, Fatality Review staff will evaluate the possibility of convening a panel to review the case.³

Data collection and identification of domestic violence-related deaths

The DVFR utilizes a detailed data collection tool to track and collect data on both reviewed and unreviewed 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, protective order filings, and a brief summary of the circumstances of each homicide or suicide. Domestic violence fatalities are identified utilizing: news accounts of homicides and suicides, Washington Association of Sheriffs and Police Chiefs crime reports, and vital statistics data from the state Department of Health.

While combining these data sources 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 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 difficult to determine when women's suicides are related to the despair and hopelessness some victims feel in abusive relationships. Secondly, anecdotal information suggests that some homicides are misidentified as suicides or accidental deaths. Again, without access to confidential information, it may be difficult to identify these cases. Third, a significant portion of murders and missing person cases remain unsolved. It is likely that some portion of these cases involve domestic violence homicides. Finally, it is likely the Fatality Review's data minimizes the incidence of domestic violence homicide in same-sex relationships. Without in-depth examination, it is not possible to know whether homicides in which the perpetrator is listed as a friend or roommate involve same-sex intimate partners.

³ The complete Citizen Protocol for Requesting Review can be found in Appendix C of the 2002 DVFR report, available at www.wscadv.org.

Appendix B:**Glossary of Terms**

case All cases involve one domestic violence victim, one domestic violence abuser, and at least one fatality which meets the DVFR criteria for a domestic violence fatality. 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 homicide.

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 homicide in self-defense. The individual killed may be the domestic violence victim, abuser, the domestic violence victim's children, friends or family, co-workers, bystanders, or law enforcement officers.

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 between July 1, 2004 and June 30, 2006.

domestic violence abuser, perpetrator, or batterer One person in an intimate relationship who uses an ongoing pattern of behavior to control their partner, including such tactics as physical 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 can 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. 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 new boyfriend), and the domestic violence victim survives. While every case involves a domestic violence victim, the domestic violence victim has not been killed in every case.

homicide victim A person who has been deliberately killed by someone else. Homicide victims include the domestic violence victim, abuser, the domestic violence victim's children, friends or family, co-workers, bystanders, or law enforcement officers.

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, domestic violence victims kill their abusers in self-defense, and in some cases, friends or family of domestic violence victims kill domestic violence abusers.

suicide by police Situations in which abusers acted with life-threatening violence 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."¹

¹ 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.

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

We have identified nine key recommendations out of the many that appear in this report. These recommendations merit priority because they relate to issues identified repeatedly in reviewed domestic violence fatality cases and speak to a range of professional disciplines. However, please keep in mind that all recommendations in this report are relevant to the ability of our communities to support domestic violence victims and hold abusers accountable, and are rooted in the close examination of a domestic violence fatality.

1. Mental health professionals, suicide specialists, and domestic violence programs should collaborate to provide cross-training to each other and to increase their ability to provide the appropriate range of services to domestic violence victims who are suicidal or have other mental health concerns.
2. Middle schools and high schools should identify strategies for providing ongoing information to all students, multiple times throughout their education, about healthy relationships, interpersonal boundary setting, how to recognize abusive tactics, and the support resources available. Schools should involve students in the discussion and development of these strategies in an effort to ensure their relevancy.
3. Domestic violence programs and task forces should engage community informants, such as friends and family of domestic violence victims, to learn how to increase the visibility of the range of services available. Such efforts should address the distinct opportunities and challenges for rural and remote communities and for marginalized populations.
4. Programs providing support to parents and children in our communities, such as parenting classes, prenatal education, Head Start, and other programs aimed at strengthening families and children, should obtain information and establish collaborations with local, community-based domestic violence programs to include attention to domestic violence in the services they provide.
5. DSHS should routinely provide information about local domestic violence resources to participants across all public benefit programs.
6. Domestic violence programs should collaborate with people who routinely come into contact with homeless and transient individuals, such as food bank workers, railroad police, and community organizers, in order to build community capacity to provide this population with safety planning information and referrals to domestic violence resources.
7. Chemical dependency treatment and batterer's intervention programs should collaborate to offer groups that simultaneously address both issues. These groups should be collaboratively run by a state-certified chemical dependency provider and a state-certified batterer's intervention provider.
8. Law enforcement officers, prosecutors, judges, and probation officers should routinely examine histories and patterns of behavior in domestic violence cases and make full use of the resources available to do this when assessing for danger and considering how to proceed.
9. Dissolution forms, "Do-It-Yourself Divorce" packets, and classes required by the courts for divorcing parents with children should include information about domestic violence and domestic violence resources.

¶¶ Had One More Day: Findings and Recommendations from the Washington State Domestic Violence Fatality Review, December 2006.

To obtain a copy of the full report, contact the Washington State Coalition Against Domestic Violence: www.wscadv.org or 206-389-2515.

Overview of domestic violence cases July 1, 2004 to June 30, 2006, and all cases since 1997

A total of 113 people died in domestic violence-related fatalities in Washington State between July 1, 2004 and June 30, 2006. This number includes eighty-three homicide victims, twenty-six abuser suicides, and four cases in which abusers were killed by law enforcement officers while threatening lethal force against the officers or a victim. Domestic violence abusers or their associates killed almost all of the homicide victims (93%). They include domestic violence victims, their children, friends, and family members.

All domestic violence fatalities

Homicide victim: KILLED BY WHOM	7/1/04– 6/30/06	1/1/97– 6/30/06
1. Female domestic violence victim: CURRENT/FORMER HUSBAND/BOYFRIEND	48	224
2. Female domestic violence victim: OTHER MALE INTIMATE (E.G., CAREGIVER)	0	5
3. Female domestic violence victim: MALE ABUSER'S ASSOCIATE	0	2
4. Male domestic violence victim: CURRENT/FORMER WIFE/GIRLFRIEND	7	26
5. Male domestic violence victim: FEMALE ABUSER'S ASSOCIATE	2	3
6. Male domestic violence victim: MALE INTIMATE PARTNER	0	1
7. Children: MALE ABUSER	10	32
8. Friend or family of female domestic violence victim: MALE ABUSER	3	35
9. Friend or family of male domestic violence victim: FEMALE ABUSER	0	1
10. New boyfriend of female domestic violence victim: MALE ABUSER	5	24
11. Co-worker of female domestic violence victim: MALE ABUSER	1	2
12. Law enforcement: MALE ABUSER	1	4
13. Male abuser: FEMALE DOMESTIC VIOLENCE VICTIM IN SELF-DEFENSE	2	9
14. Male abuser: FEMALE DOMESTIC VIOLENCE VICTIM IN PROBABLE SELF-DEFENSE	0	8
15. Male abuser: FEMALE DOMESTIC VIOLENCE VICTIM, NOT IN SELF-DEFENSE	1	7
16. Male abuser: FRIEND OR FAMILY OF FEMALE DOMESTIC VIOLENCE VICTIM	2	12
17. Male abuser: LAW ENFORCEMENT	4	13
18. Male abuser: SUICIDE	26	118
19. Female abuser: SUICIDE	0	1
20. Children: FEMALE DOMESTIC VIOLENCE VICTIM	1	3
Totals		
21. All domestic violence fatalities (rows 1-20)	113	530
22. All homicide victims (rows 1-16 and 20, excludes suicides and abusers killed by law enforcement)	83	398
23. All homicides committed by abusers or their associates (rows 1-12)	77	359

If I Had One More Day: Findings and Recommendations from the Washington State Domestic Violence Fatality Review, December 2006.

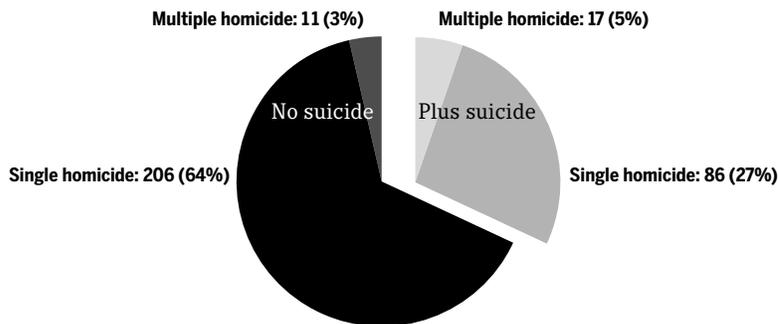
To obtain a copy of the full report, contact the Washington State Coalition Against Domestic Violence: www.wscadv.org or 206-389-2515.

Homicide-suicides

Almost a third (32%) of the 320 abusers who committed homicides since January 1, 1997 committed homicide-suicides. An additional twelve abusers killed themselves after attempting homicide.

Homicides committed by domestic violence abusers: January 1, 1997 to June 30, 2006

Total cases: 320



Separation violence

News reports or in-depth fatality reviews made clear that in at least 47% of the homicides committed by the domestic violence abuser, the domestic violence victim had left, divorced, or separated from the abuser, or was attempting to leave or break up with the abuser.

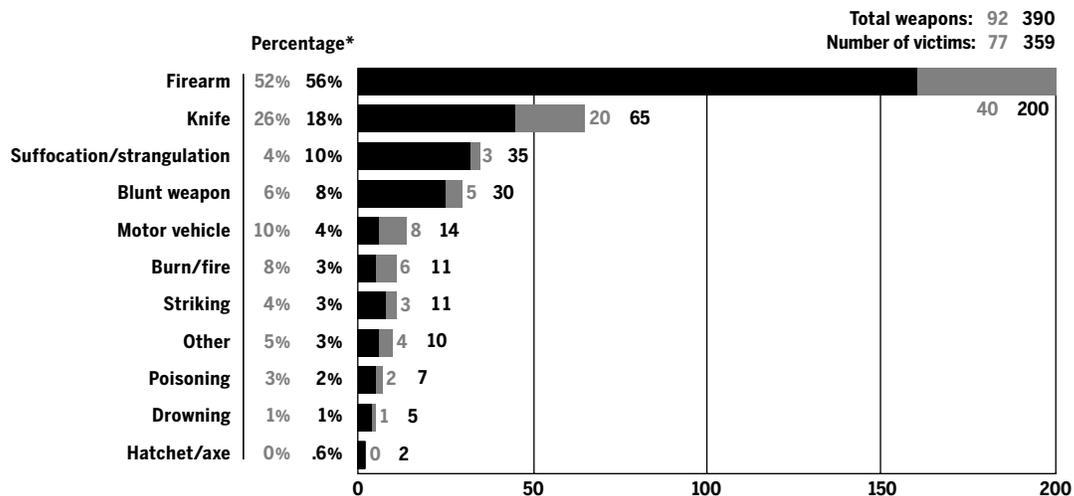
If I Had One More Day: Findings and Recommendations from the Washington State Domestic Violence Fatality Review, December 2006.

To obtain a copy of the full report, contact the Washington State Coalition Against Domestic Violence: www.wscadv.org or 206-389-2515.

Weapons

The majority of domestic violence homicides in Washington State have been committed with firearms. Since 1997, abusers used firearms to kill 56% (n=200) of domestic violence homicide victims. Between July 1, 2004 and June 30, 2006, abusers used firearms to kill 52% (n=40) of homicide victims.

Weapons used by domestic violence abusers in homicides committed January 1, 1997 to June 30, 2006
 July 1, 2004 to June 30, 2006 rendered in gray



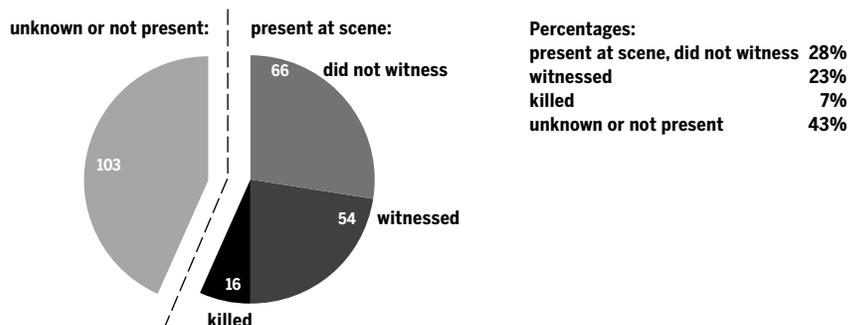
*Percentage total is greater than 100% due to use of multiple weapons in some homicides.

Children

Of the 261 domestic violence victims killed by abusers or their associates since 1997, at least 114 (44%) had children living in the home with them at the time they were murdered. The majority (57%) of the victims’ children were present at the time of the homicide. News reports indicated that of the children present, 40% witnessed the murder. Abusers killed sixteen children alongside their mothers, and attempted to kill more.

Location of children at the time of domestic violence victim’s murder: January 1, 1997 to June 30, 2006

Total: 239 children of 114 domestic violence victims



If I Had One More Day: Findings and Recommendations from the Washington State Domestic Violence Fatality Review, December 2006.

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Appendix D:**Index of Topics in Fatality Review Reports**

This index references topic areas discussed in this report, as well as the three previous Fatality Review reports. Each report is identified by the year in which it was published. All reports are available at www.wscadv.org.

Honoring Their Lives, Learning from Their Deaths (2000)

“Tell the World What Happened to Me” (2002)

Every Life Lost Is a Call for Change (2004)

If I Had One More Day... (2006)

Alcohol and Other Drugs

2000: p.76

2002: p.53-57

2004: p.35-36, 47-48

2006: p.41, 63-66

Batterer’s Intervention

2000: p.35-36, 73-76

2002: p.63-64

2004: p.63-66

2006: p.65-66, 74-76

Children

2000: p.27-28, 37-38, 51-52

2002: p.33-34, 72-73

2004: p.27-28, 58-60

2006: p.30-31, 56-57

Community Prevention and Intervention

2000: p.30-31, 33

2002: p.43-48, 57-58

2004: p.47, 78-83

2006: p.36-37, 40-41, 42-46, 51-57, 61

Criminal Legal System

2000: p.34-36, 62-80

2002: p.33, 46-48, 54-55, 58-73, 76-80, 82

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Economic Issues

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2004: p.55-58, 60

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Family Law (Civil Legal)

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2002: p.73, 77-82

2004: p.60-62

2006: p.79-82

Firearms

2000: p.28, 57-58, 61, 76-77

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2004: p.23-24, 69-70

2006: p.29, 43-44, 55-56

Health Care Providers

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2004: p.28

2006: p.49-50

Implementation of Fatality Review**Recommendations**

2004: p.37-54

Marginalized Communities

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2002: p.34-36, 64-66, 74-75, 79-80

2004: p.48-49, 73-78

2006: p.54-55, 72-73

Mental Health

2000: p.35-36

2002: p.53-57

2006: p.35-36, 39-40, 60

Protection Orders (Civil Legal)

2000: p.59-62

2002: p.51-53, 73-78, 80-82

2004: p.29, 41-44, 60-62

2006: p.77-79

Stalking

2002: p.57-59

2006: p.53-54

Suicide

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2002: p.31-32, 49-53

2004: p.22-23, 46-47

2006: p.29, 34-41

Teens

2000: p.42-45, 55

2004: p.24-25

2006: p.47-50

If I had one more day...

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