Advocates and Fatality Reviews

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The Washington State Coalition Against Domestic Violence is a statewide non-profit organization committed to ending domestic violence through advocacy and action for social change.

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By Margaret Hobart, Washington State Coalition Against Domestic Violence

In This Paper

We believe that advocates have an important role to play in domestic violence fatality reviews. We hope that this paper will help advocates:

- articulate their hopes and expectations for the fatality reviews in their community,
- evaluate their community's review and their participation in it, and
- provide guidance to their communities as they set up fatality reviews.

This paper includes a discussion of our current vision of some key best practices for domestic violence fatality review panels; however, we realize that fatality reviews continue to evolve and advocates have a wide variety of experiences and roles within them. We welcome your feedback and dialogue.

The Potential of Fatality Reviews

Many battered women's advocates have been excited about the concept of fatality reviews. We hoped that they would provide us with an effective tool to make battered women's suffering, pain and extensive efforts to get help that we were so familiar with "real" to decision makers within systems, policy makers and our communities. We also hoped that participants would see that domestic violence-related deaths were preventable, and be inspired to take action to save lives by correcting the community response problems which reviews identified.

The realization that the rate of intimate partner homicide had not dropped to the same extent as rates for all other forms of violent crime fueled the idea of fatality reviews.[1] In other words, even after twenty years of domestic violence reforms, men continue to murder their intimate

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[1] According to the Bureau of Justice Statistics, overall violent crime rates (including homicides) have dropped over 50% between 1993 and 2002. But intimate partner homicide rates have proven much more resistant to change; the number of intimate partner homicides dropped about 22% since 1976, but the bulk of that is accounted for by the dramatically lower numbers of women who kill their male partners. Some categories of intimate partner homicides actually increased in the last 20 years (e.g., the number of white unmarried women killed by their boyfriend).

partners at rates disappointingly similar to those of the 1970s. Advocates hoped that the detailed analysis of individual women's lives in the context of fatality reviews would help identify barriers to battered women's safety and perpetrators' accountability which may have been overlooked previously, result in an improved response to domestic violence, and ultimately, reduce the death toll.

By examining the murders of battered women (and their children, friends and family members) in depth, we hoped to create powerful information that would help catalyze institutional and individual change and generate specific, local information about gaps and shortfalls in system responses. By immersing review panels in the lives of particular battered women, we hoped to de-normalize "business as usual" bureaucratic practices, and illuminate gaps, cracks and shortcomings in responses to domestic violence. Fatality reviews have the potential to bring people together who may otherwise not come together, because when a murder has occurred, there is no ambiguity about the perpetrator's culpability—everyone can agree things went terribly wrong, and they want it to be different in the future.

In the past five years, the concept of a Domestic Violence Fatality Review (DVFR) has become widely accepted. Momentum is building, with fatality reviews forming all over the country. Reviews take place at the city or county level in many states. At least twenty-six states have state-level DVFRs in various stages of development. Many of these teams have done excellent and exciting work, raising previously unexamined issues and problems, promoting stronger collaborations and issuing high-quality reports with thoughtfully produced recommendations. At the same time, advocates' experience and observations on other fatality review teams have raised questions about the utility of some review projects. When DVFRs are ineffective, they consume time and resources but fail to generate quality information or bring about significant changes in policy and practice. In the worst case scenario, DVFRs with poor leadership and weak advocacy voices can result in poorly constructed policy, which then backfires on battered women and their kids. This paper is an attempt to support advocates in identifying best practices for fatality reviews and articulating the critical role of advocates in reviews. The paper addresses four areas: leadership, culture, focus and products of fatality reviews.

Leadership of Fatality Reviews

Effective reviews:

- Have leadership which can bring people together, provide excellent facilitation, support information gathering, and provide the DVFR project with a vision which includes social change and ending violence against women.
- Are housed in an institution/agency that has the capacity to bring people together, elicit broad information, support incisive analysis, and create challenging, high-quality reports.

Culture of Fatality Reviews

Effective reviews:

- Refrain from or effectively respond to the impulse to focus disproportionate attention on the victim and evaluation of her choices.
- Have protocols that encourage a shared attitude of respect toward the victim and sensitivity to the suffering and pain the facts of the case represent.
- Seek to humanize the victims.
- Have protocols which help to "de-normalize" each system's response and encourage thoughtful scrutiny of each response.
- Encourage strong advocacy voices, even when advocates cannot share confidential information
- Address disparities in access to criminal justice and human service response and consider barriers to essential services stemming from institutional biases regarding race, poverty, literacy, language, immigration status, disability, age, culture, gender or sexual orientation.
- Ensure that the voices of marginalized groups, victims and their families are clearly heard.

Focus of Fatality Reviews

Effective reviews:

- Engage in dialogue that addresses the depth and complexity of each case and issue reports which accurately reflect these discussions.
- Collect data and have discussion that encourages analysis of the community's readiness to respond effectively to domestic violence.
- Go beyond examination of the criminal justice system to ensure critical analysis of the broad spectrum of community support and responses battered women may need.

Products of Fatality Reviews

Effective reviews:

- Go beyond counting cases. They provide critical analysis of gaps, barriers and weak points in system and community response, make recommendations and implement changes.
- Instill a sense of responsibility for making change in review team members that goes beyond attendance at meetings.
- Have clear mechanisms for working to implement recommendations.

Leadership of DVFR Projects

Review teams must answer the following questions when they begin organizing:

- Who will "house" the project and any money and staff it may have, if funding becomes available?
- Who will provide leadership in meetings and decision-making processes?
- Who will facilitate reviews?
- Who will interpret findings and refine recommendations?
- Who will take responsibility for writing reports? Who will have approval power regarding content of the reports?

These questions relate to the leadership of review projects, and are often interrelated—especially when funding is available for some staffing of the project. The answers to these questions will inevitably influence the project, including how it is perceived, quality of

facilitation, tone and nature of reports, and the challenges or supports the project may encounter. The location of the DVFR project (i.e., convening organization, who handles any funding the project may have) is often closely aligned with who will provide leadership to the process.

Advocates and organizers should keep in mind that as good as our allies within state agencies may be, they operate in the context of institutions which have their own specific constraints, agendas and disciplinary norms which may impose debilitating limits with respect to the goals we hope to achieve with fatality reviews. We know from our other work on institutional change that although we may have excellent allies within institutions, institutions themselves are frequently self-protective and slow to embrace change. This characteristic of institutions poses a challenge to fatality reviews, which should be a tool to illuminate problems with institutional responses to domestic violence and catalyze change.

In considering where to house a project, or who should be the convener, review teams must carefully evaluate the options within their communities, and consider the following questions:

Does the convener/agency housing the project or offering leadership of the process:

- Have the capacity to bring a diverse, multidisciplinary panel together?
- Provide the independence and authority to produce challenging, focused reports?
- Possess credibility with potential participants as well as the community (particularly marginalized parts of the community, such as people of color, immigrants and people living in poverty)?
- Have high-level leadership who can comprehend and support the vision the panel has for its work?
- Have a commitment to hew closely to a vision of justice for battered women, and respect for their agency and autonomy?
- Have adequate time and resources to devote to the project? (Some projects have stalled as overworked conveners struggle to manage a schedule that only allows for 1/10 of a full-time employee’s time to be spent managing the DVFR project.)
- Have a commitment to support a battered woman-centered, social change-oriented, advocacy perspective?

Additionally:

- What institutional constraints and agendas may influence how the project is managed?
  For example, will the institution be willing to publish a report which is self-critiquing, or is there a strong ethic of bureaucratic self-protectiveness?
- Will reports be subject to multiple layers of review and approval before being distributed?
  Some larger bureaucracies may require this; readers at upper levels may not share the panel's vision or be experts in the area of domestic violence.
- What professional or disciplinary norms may influence how an agency handles the project?
  If the agency is very numbers oriented, it may be difficult to get support to issue reports which attend to the fine grain of women's lives and the complex interactions between intervening agencies. Advocates have been disappointed with the focus on numbers and lack of analysis in some fatality review reports.
- Is the leadership of the agency committed to supporting a project whose goal is to make people uncomfortable with system failures and issue specific and directed demands for change?

Communities around the country have made a variety of decisions about location and leadership of their fatality reviews. If the state domestic violence coalition is strong, has credibility and can speak with a unified voice, it can be an excellent site for fatality reviews. In other cases, organizers have decided the fatality review project would be better served by being based in a government commission, jointly sponsored by courts and medical examiners, judicial administrative office, prosecutor's office, attorney general's office or health department.

Culture of Fatality Reviews

Avoiding Placing Responsibility on the Victim

We have heard from advocates in various parts of the country that in some reviews, jokes about the victim, callousness towards the violence she and her children suffered and placing responsibility on the victim for making "bad choices" go unchallenged. An excessive focus on the victim, especially if it is accompanied by disrespect, undermines the possibility of achieving a positive outcome from a fatality review. A lack of respect and compassion towards the

victims of domestic violence and an over-focus on the "flaws" in her thinking short-circuit analysis and opportunities for learning: if the victim made bad choices, then we need look no further for what could be improved. Placing responsibility on the victim relieves people of responsibility to make change and assuages their feelings of discomfort about the murder, thus undercutting the ability of the review process to inspire change. It is helpful when review panel members take responsibility to tactfully and effectively point out when negative attitudes towards the victim are being expressed or when responsibility for causing the abuser's behavior is placed on her shoulders. When this is pointed out and addressed as one of many flaws in community response, it can be valuable for the group to thoughtfully examine how callousness, misplaced responsibility for the violence and negative attitudes towards victims may manifest in organizational cultures and how that may have contributed to barriers the battered woman faced.

Effective reviews demonstrate respect for the victim by:

- Beginning from the premise that the battered woman did the best she could (to end the abuse, protect herself, protect her children, function within society). To the extent that she failed, this reflects failures of society and various systems to reach out, inform, engage, provide resources and otherwise assist and protect her. Identifying those system/society failings and unmet needs is the work of the panel.
- Asking how the victim may have perceived her choices, or what discouraging messages she may have received from community institutions when she did ask for help.
- Asking how/whether negative attitudes towards victims may have influenced institutional responses to the victim and perpetrator.
- Analyzing what might support negative attitudes towards victims and how norms of placing responsibility on the victim rather than the perpetrator within particular institutions/agencies can be shifted.
- Examining the barriers and biases women of color and poor women encounter when seeking help.
- Challenging themselves to think creatively about how to expand options for people marginalized by poverty, lack of educational attainment, chemical dependency, limited English speaking/reading skills, and prior criminal behavior (particularly poverty-driven crimes).

- Focusing on *system analysis:* Deeply interrogating how incentives and constraints within the system led to failures, and how professionals within the system are held accountable for the quality of their responses to battered women (more on this in the following section).

Domestic violence victims may be drug-involved, abuse alcohol, engage in prostitution, have affairs, possess poor parenting skills, be bad housekeepers, distrust the police, engage in poverty-driven crimes (e.g., welfare fraud), and otherwise fail to measure up as "model victims" who easily gain sympathy. In these cases, effective fatality review teams work to analyze the institutional context and factors which may have affected the victim's choices (e.g., poverty, a history of police brutality in her community, financial barriers to adult education). Panels should consider the ways in which society's failure to provide adequate supports, information and intervention early on may have contributed to these behaviors. Particularly with regard to drug/alcohol use and prior criminal records, effective panels push their thinking about how various systems can better reach out to and serve women who struggle with these challenges, rather than take for granted that they would disqualify a battered woman from easy access to effective intervention.

A shared commitment among panel members to careful attention to these goals can help create a culture within the review team which collectively avoids and resists focus on the victim's flaws. Skilled facilitation is also needed to ensure respectful dialogue and to avoid collusion in discussions which are inappropriately callous or hostile towards the victim. Because discussing the victim's failure to use systems in ways which make our work easier exerts such a strong pull, it takes thoughtful preparation and facilitation to set a respectful tone and ensure that it does not take place. Facilitators of fatality reviews need to be able to identify when the discussion has strayed from an examination of system failures to one of individual failures and help the group move on to more productive ground. Good facilitation can direct group attention to more productive lines of inquiry. This takes assertiveness, knowledge, diplomacy and tact. Advocates should work closely with other organizers of their DVFRs to ensure that facilitators will have these skills.

Denormalizing System Response

Many DVFR protocols rely on individuals reporting on their own institutions' actions in a particular case, but this may not be the most effective model for thinking critically about problems in system response. Even though individual police, prosecutors, doctors and other

social service providers are well-intentioned, many come from institutional cultures that may place too much responsibility on the victim and systematically underestimate the energy and devotion abusers bring to their acts of coercion, entrapment, fear induction and violence. Because of habits borne of working in these environments, individuals' reporting on and interpreting of victim contacts with their system may (unconsciously) leave out relevant information which could turn attention away from scrutinizing the victim and toward institutional accountability.[2]

Some review panels have found that analysis of system response (as opposed to the victim's flaws or "poor" choices) is better when system representatives are not the only source of information about their system's response. This may be especially true when reviews are locally based and participants are not necessarily domestic violence experts. In Washington state, we have found that our locally based review panel members' skills at critical examination of their own agencies' actions vary considerably. Panel members do not always know the best practices for their own discipline; they may accept potentially changeable limitations or practices as inevitable and therefore cannot mount a detailed critique of their own institution. Habits of screening out information irrelevant to one's own purposes can make it hard to anticipate what information will be relevant to people from other disciplines. For that reason, at the Washington State Coalition Against Domestic Violence, we have found that having staff obtain public records (so that we do not have to rely on police or prosecutor disclosure of prior arrests, etc.), and preparing detailed chronologies for review panels to read ahead of time helps set a respectful, non-victim-blaming tone, and allows a fuller, more meaningful examination of the interventions prior to the victim's death. However, this can be labor intensive and not an option for projects with no or minimal funding. As a lower-cost alternative, some DVFR projects have a second reader for each institution who examines the records from that institution. Allowing at least one other person access to an institution's records enhances the review process with better questions and discussion. People from outside an institution or discipline can look at its workings with fresh eyes which do not take for granted "business as usual" norms which may

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[2] For example, in one review in Washington, a law enforcement officer summarizing records described the victim as "hanging out" at a community event all weekend prior to her murder and flirting with another man, implying that she was "loose" and perhaps at fault for inciting her partner's jealousy. However, the written documentation indicated that she was in fact working at the community event, and staying away from home in the evenings because of her fear of her partner. She accepted a ride from another worker at the event after her abusive partner disabled her car. The panel would not have known this if it had relied exclusively on the law enforcement officer's version of the events.

need to be reexamined. On the other hand, some review panels are composed of experts on domestic violence best practices from within each discipline. In these cases, members of the panel may be more skilled at stepping back from their agency's practices and evaluating them critically, and it may be unnecessary have a second reader for records.

Humanizing the Victim

Our culture is generally fascinated with murder and violence. In the context of broad consumption of mystery novels, gory movies, video games and other representations of violence in the form of entertainment, we need to be mindful that a fatality review process may be interesting to people on a number of levels, and resist any callous or prurient consumption of images of victimization. The review process should embody respect for the preciousness of the lives lost in the domestic violence fatality. This includes thoughtfulness about the victim's dignity and trying to bring the victim's voice into the process as much as is possible. We believe review panels should seriously consider whether or not looking at photos of the homicide scene and the victim's body are necessary, and if doing so humanizes the victim and comes from a place of respect. In Washington, we have decided that viewing homicide photos does not contribute in a meaningful way to analyzing gaps in the community response prior to the homicide. If we wish to benefit battered women living in our communities, our work should be focused on everything that preceded the homicide, not the moment of the homicide itself. On the other hand, photos of the battered woman or victim when she was alive (if they are available) can be beneficial to the process because they can humanize the victim. Quoting the victim verbatim from protection order narratives, police reports or journals all bring the victim's voice into the process, as does listening to 911 tapes. These sources of information all help humanize the victim and keep focus on system failures, rather than the physical details of the deadly injuries the abuser inflicted on the victim.

Strong Advocacy Voices in DVFRs

Everyone on a review panel brings specialized knowledge to the process. Each person brings expertise about their institution, its norms, policies and protocols. Many people may bring expertise about domestic violence from various disciplinary points of views. Still, advocates bring a critical specialized knowledge to the review process, even when confidentiality requirements prohibit their discussion of specific cases.

Of all the people likely to sit upon a review panel, the people who have consistently had the most wide-ranging, least constrained conversations with battered women are battered women's advocates. Generally police, prosecutors, medical professionals, TANF workers and others who encounter battered women do not have time to hear all the details of battered women's stories; they need to focus on the current incident or the information necessary to take action at the moment. Advocates, in the course of safety planning, answering the hotline, facilitating groups, and providing support to women are likely to hear women's stories in greater length and detail, and thus have a fuller sense of the struggles women face in their community with police, courts, housing and other systems. Advocates can often offer important insights into the complexities and nuances of how batterers function to control their partners; batterers' sense of entitlement to their partners' bodies, minds and time; and how batterers make "rules" for their partners which influence how battered women perceive their choices. Even when advocates have not had contact with the specific victim or cannot reveal those contacts, their specialized knowledge can help place the specific facts of the case being examined in context of typical community response to domestic violence. Review panels may face two important challenges to ensuring strong advocacy voices: tension over advocates' limited ability to reveal confidential information, and dilution of advocates' voices.

Unless state-level legislation explicitly allows them to reveal information that is otherwise confidential, advocates on review panels are generally reluctant to reveal confidential information in the context of a fatality review. In some places, this has led to tension between advocates on panels and representatives of agencies whose interventions are available as public records or who make a decision to go outside of their legislated confidentiality requirements and then expect everyone else at the table to do so as well. While revelations of confidential material can be very interesting and even helpful to the review process, we have found that it is not viable to expect professionals (including advocates) to routinely reveal more than the law permits. States, counties and even municipal jurisdictions vary in their legal "cultures." In some places, professionals freely reveal confidential information. In others, they simply will not come to the table if they are pressured to reveal information that the law forbids them from revealing. However, if a review is structured to focus on *community and system response to domestic violence* (more on this in "Focus of Fatality Reviews" section), these limits do not have to debilitate the panel.

Like everyone else at the table, advocates can and should critique their own agency's capacity to respond to people with similar circumstances as the domestic violence victim, and those critiques should be as fearless and pointed as we hope every participant's critiques will be. For example, if the victim was an African American woman whom police noted smelled like alcohol when they responded to a DV call, the advocate could analyze her program's response to women in similar positions. What percentage of shelter residents are African American? Do they stay more or fewer than the average number of nights? How many women requesting shelter are turned away each month, compared to those who are admitted? When African American women come to shelter, do they encounter African American staff members? What policies does the shelter have around alcohol? Would having had a drink in the last week or day disqualify a woman from shelter? What if she had a problem with alcohol abuse? What sort of response would she encounter from the shelter staff in regard to this problem? Was shelter a viable option for her?

Reporting to the panel on a series of questions like this allows the group to think through the availability and viability of the victim accessing services from the advocate's organization without compromising confidentiality. Similarly, if the panel knows that the victim had very limited English capacity and that the advocacy program does not have any bilingual phone screeners or a policy for obtaining instantaneous translation over the phone, then it is not necessary to know whether or not that particular victim called the program to know that the program would not have been well positioned to serve her. When panels can have discussions on this level, it helps identify actual needs in the community, and dispel feelings that advocates are there to critique others but not to critically examine their own institutions.

Advocates' voices can easily get diluted within fatality review panels. When review panels rely on a "one of each" model (one prosecutor, one judge, one police officer, one advocate, etc.), panels end up heavily populated by criminal justice professionals and other social service providers, with a lone advocacy voice. The tasks of providing basic domestic violence education to review panel members who may be ignorant about the many ways that batterers seek to control and intimidate their partners, calling attention to points at which victim safety was compromised, and providing perspective on communities' typical responses to domestic violence often falls to the advocates on the review panel. If only one review panel member is an advocate, it can be difficult for that person to fulfill all these functions as well as participate in the review. Advocates on some panels have found it challenging to be the only person to

repeatedly speak up and identify problems or issues that may be "invisible" to others on the review panel. These strains can be minimized by ensuring the participation of multiple advocates on the panel. For example, the Hennepin County (Minnesota) Domestic Violence Fatality Review protocols require that three advocates sit on the panel. Other panels in urban areas invite an advocate from each domestic violence program in their area, which results in several advocates at the table. Including advocates from various parts of the system (police, prosecutor and court advocates, where they exist) can also be helpful.

Because a great deal of documentation exists in the criminal justice system, it is easy for reviews to become focused on criminal and civil interventions. However, many domestic violence homicide victims have not accessed the criminal justice system, or did not until late into the pattern of abuse. Advocates can help fill in the blanks regarding the various other routes women may have taken in their search for support and safety, and how they may have perceived system interventions. Even when they may not be able to discuss what a specific woman did, advocates should draw on their broader experience to discuss what they generally see women doing in similar situations, how the battered women they work with who have circumstances similar to the victim think about their options, encounter problems or seek help. Additionally, advocates can speak to how they see various parts of the community response working for (or failing) battered women similar to the victim in the case before the panel. For example, perhaps the victim in the case obtained a protection order, but never followed up for the permanent order. The panel may wonder why she failed to do so. If the advocate knows that generally battered women find the judge who hears civil cases harsh and intimidating, she should bring this important information forward as a possible explanation.

The tone and approach advocates bring to their participation and facilitation can influence the larger team's tone. Like all members of the review panels, advocates should come to the table with the intent to uncover as clearly as possible the points at which interventions were squandered or failed, the gaps between policy and practice, between need and available funding, including those of domestic violence advocacy programs. Identifying problems in clear and non-defensive ways is important in helping the fatality review team understand both technically detailed and experientially complex facts.

Addressing Disparities in Response and Involvement from Marginalized Communities

Racism, sexism, anti-immigrant sentiment, the assumption that everyone speaks and reads English well, and obliviousness to the way poverty magnifies every other challenge a person

may face can all manifest in the rules, protocols and norms of organizations and institutions. Institutional bias may play a considerable role in the multiple system failures victims of domestic violence homicide faced prior to their deaths. Fatality reviews provide an important opportunity to evaluate the community's ability, willingness and readiness to respond to women who are marginalized by poverty, race, language ability, disability or immigrant status. Every part of the community response to domestic violence (including advocacy programs and shelters) should be scrutinized along these lines by the DVFR panel. Frank discussion of how ignorance and bias affected community response can be challenging, but to avoid it is to lose the opportunity to uncover important information and look toward desperately needed reforms.

In Washington, we have found that identifying leaders and gatekeepers in immigrant communities and communities of color and recruiting them to join the review process has enriched our discussions. These representatives can help panels identify a full picture of barriers the victim faced and explain the "messages" both the victim and the perpetrator took away from interactions with the criminal justice or helping systems. This, combined with a willingness to engage and a facilitator willing to raise the issue of institutionalized bias in responses to domestic violence, has resulted in very useful discussions. Careful attention to participation by advocates and leaders from marginalized communities can enrich immeasurably reviews of the deaths of immigrant women, women of color, and other victims from marginalized populations.

Focus of Fatality Reviews

Beyond Counting Cases: Examining the Context of Domestic Violence Fatalities

Information on the individuals involved is not enough to understand the circumstances leading up to the fatality. Domestic violence fatalities occur in the context of a community and its response to domestic violence. To identify strengths, gaps and problems in the community response, the panel must gain a sense of the broad context in which the abuse took place.

This includes:

- availability of services
- availability of shelter space/shelter turnaway rates
- distances to service providers and transportation options
- availability of services in the victim's native language

- public education campaigns and efforts to inform domestic violence victims of their rights, options and available services
- the number of domestic violence-related calls received by police yearly
- arrest rates for men versus women
- number of domestic violence cases filed by the prosecutor yearly, and percentage of dismissals, acquittals, deferred sentences and convictions

Fatality review panels can also benefit from some basic information about their state and local communities, including:

- race breakdowns
- income distribution
- percentage of people living in poverty
- percentage of people in prison or jail and their race/gender breakdown
- amount of TANF cash grants
- housing costs/vacancy rates

Obtaining information about the community context encourages the panel to evaluate the woman's resources for gaining safety or leaving, and the likelihood of her abuser being held accountable for his behavior. Data collection forms should direct review panels to assess the community's readiness and ability to respond to battered women and perpetrators who share the homicide victim's characteristics. Review panels should collect information which will support efforts to create system change and accountability.

Both discussions during reviews and data collection should draw attention to the multiplicity of barriers battered women face, and the dearth of viable choices many encounter when facing violence. Data collection should also evaluate the readiness (or lack of readiness) and effectiveness of community institutions responding to domestic violence. Even when a panel is unsure if a victim sought support services from a particular shelter, program or institution, it can evaluate what quality of response she might have received if she did. For example, if no services exist in the victim's language in the community, and no information is available in her language regarding her rights or services, this is an important finding, regardless of what we do or do not know about where the victim sought help.

Analysis of the Community's Response to Domestic Violence

Effective fatality reviews balance the "no shame, no blame" approach with discussions which encourage institutional accountability and institutional change. The fatality review process should engage the panel in a rigorous examination of the gaps between policy and practice and the institutional reasons for those gaps. For example, rather than blaming a poor law enforcement intervention on the individual officer involved, the panel can find out:

- what the written and (perhaps most importantly) de facto policies are for handling domestic violence cases in the department
- what training officers have received
- how officers are held accountable (or not) for following domestic violence policies
- who monitors how consistently or how well the department's domestic violence policy is followed
- what the consequences are for failing to follow department domestic violence policies or rewards for implementing them well

In other words, what is the institutional support for individual accountability to a policy?

To analyze institutional responses and community context, fatality review panels might consider asking the following questions about each organization/institution the victim or perpetrator had contact with (or could have benefited from contact with):

- How would the victim/perpetrator have found out about services?
- Who in the various systems involved informed the victim of available services?
- How was the victim made aware that services were accessible/free/available (particularly if she had limited English skills)?
- Was the agency accessible to the victim (in terms of language, physical ability, literacy, geography or any other challenge the victim may have had)?
- How prepared were involved agencies to identify domestic violence and respond meaningfully?
- What training has the staff of the agency had regarding recognizing domestic violence and intervening?
- Were appropriate protocols in place to effectively respond to domestic violence cases?

- How up-to-date were resources and referrals?
- What kind of a working relationship/collaboration with the local domestic violence advocacy organization did involved agencies have?
- Are agency forms effective at directing professionals' attention to domestic violence and helping them take appropriate steps when it is identified?
- Are professionals within the agency able and willing to assist battered women in risk assessment and safety planning?
- Does the organization have a protocol in place for making meaningful referrals to battered women's organizations and do professionals within the organization consistently make these referrals?

For organizations dealing exclusively with the perpetrator, a similar list of questions can be asked, including:

- What protocols did the agency have for assessing danger to the victim?
- What protocols did the agency have which were aimed at increasing victim safety?
- Are the victim safety protocols consistently and effectively implemented?
- How does the agency assess its obligation to warn the victim of the danger of imminent harm?
- What policies are in place to ensure that victims are informed about the abuser's enrollment, compliance and completion of the program?
- Does the program provide victims with accurate information about the efficacy of the treatment? (Also, how is "success" defined?)
- What is the frequency, timeliness and quality of communication with the courts and probation?

If it is the sense of the panel that the response of a particular agency was weak, inadequate or lacked enough focus to identify the danger involved and offer meaningful assistance or intervention, it can be useful to consider the following:

- What pressures does this institution/agency work under in terms of funding, performance, public scrutiny? How does intervening in domestic violence cases relate to those pressures?

- Is a vigorous response to domestic violence consistent or at odds with this agency's other goals? If there is a disjuncture, how can this be minimized?
- Is this agency's response tied to a lack of resources or a need to "ration" intervention? What are the priorities for scarce resources within this agency/institution and why? Can this be changed to increase victim safety and perpetrator accountability?
- Is responsiveness to domestic violence valued within this institution? What are the institutional incentives and disincentives for a strong individual response to domestic violence/victim safety/perpetrator accountability?
- What would help shift institutional priorities to better attention to victim safety and perpetrator accountability?

Products of Domestic Violence Fatality Reviews

Review panels should make lasting contributions. Participants on review panels may feel that the experience is important and one from which they learn. This is valuable, but not enough to declare success. Personal attitude change in the absence of institutionalized change is transient and we should not be satisfied with projects that take up time, resources and energy but do not result in useful reports, strong recommendations and changes in policy and practice.

In effective DVFRs, the process for analyzing findings and formulating recommendations ensures that recommendations are strongly worded, specific, on target, well-informed and will not backfire on battered women. Reports should paint a compelling picture of the gaps the panel has identified, set forth a clear agenda for what needs to be changed and inspire action.

The process for writing reports should result in focused and challenging recommendations. Most team members should feel ownership over most of the recommendations. No one process for achieving this will be right for every DVFR project. While some projects have made a consensus model work, it is not always the most effective way to interpret findings and create recommendations. The risk with consensus processes is that strong recommendations may be lost because of one or two people's objections, even though the rest of the group supports them. Other models exist for reports which are both effective and "owned" by panel members. In Washington, while members of review panels and advisory groups have extensive input into the project's findings and recommendations, the state domestic violence coalition alone ultimately takes responsibility for the recommendations. This arrangement is particularly

helpful to judges who interpret state judicial canons as forbidding participation in recommendation-making bodies. Since panels per se do not create the recommendations, but instead are conceived of as "fact-finding" bodies, judges can participate in them freely. This structure allows us to convene expert advisory groups who can examine DVFR findings and think broadly about all the possibilities for solutions and carefully evaluate any ideas the panel did propose about changes. Alternative models might require consensus from a statewide advisory committee, a small subgroup of experts on a particular topic, or agreement of 75% of panel members.

Effective fatality review projects are not (just) homicide prevention projects. A focus solely on homicide prevention can result in energy devoted to identifying women at risk for lethal violence (and while some risk assessment tools exist, all are flawed to some degree) versus generally improving response. The aim of a DVFR is to improve community response for all battered women. Focus on individual cases provides a window into the community's response to domestic violence. Panels should remember that the victim's experience is shared by many women in her community. The missteps and barriers that she encountered are encountered by battered women every day; they just haven't been killed (yet). Therefore, reports should urge readers to think broadly about improving response for all battered women, not just potential homicide victims.

Some advocates have worried that DVFRs may absorb a lot of time and energy, but that recommendations will not be implemented. In order to make lasting contributions, fatality reviews should result in concrete changes in policy, practice, protocols and forms. This means that the process itself should include mechanisms for creating change and following through on recommendations. For example, agencies may agree to respond to any recommendations regarding their discipline within a set period of time; the panel may ask for and report on responses (as in New Hampshire), the committee may agree to examine a finite number of cases and then commit an equal period of time to focused organizing for change. Meetings may alternate between reviews and policy strategy sessions focused on implementing recommendations. Finally, doing a domestic violence fatality review should not be an end in itself; review teams should make a decision about how long they will do fatality reviews, and at what point looking at more cases no longer makes sense (and energy should be turned to other forms of action).

Conclusion

Domestic violence fatality reviews can be a powerful tool for catalyzing change. However, participants, organizers and advocates involved in these projects must guard against them becoming routinized meetings which reflect, rather than challenge, problems in community response to domestic violence. When advocates are able to offer a strong, clear vision of the potential of fatality reviews, they can provide important leadership, guidance and inspiration to their collaborators on review teams. We hope this paper is some assistance in informing that vision.