Homicide at Home

Washington State's Domestic Violence Fatality Review Project

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Executive Summary

Chapter One

> "He took it upon himself to become her judge, jury and executioner for a crime she didn't commit, for being a loving and caring mother, a concerned and responsible adult..."
>
> (family member of a victim of murder at sentencing hearing)

While crime rates across the country have dropped, the rate at which women are murdered by their male current or former intimate partners has been consistent since 1976. Washington State crime statistics indicate that, consistent with the rest of the nation, about 30% women murdered are killed by a current or former husband or boyfriend. Further, official crime statistics do not track the murders of friends, family members, or police officers, which occur as a result domestic violence. Tracking news reports in Washington State suggests that the number of these fatalities is significant.

In response to the recognition that no mechanism existed to systematically examine the circumstances leading up to domestic violence related fatalities, battered women's advocates in Washington urged the development of a Domestic Violence Fatality Review Project. Based on models for child fatality reviews, a domestic violence fatality review can be an important tool for identifying gaps in system response to domestic violence, identifying critical points for intervention and prevention, and providing a forum for increasing communication and collaboration amongst those involved in a coordinated community response to domestic violence.

Four major considerations shaped the development of the Washington State model: lack of access to confidential records, a reluctance to risk influencing active criminal or civil cases, a belief that locally based, interdisciplinary reviews would result in higher quality information, and agreement that state level coordination and dissemination of information would increase the impact of recommendations generated at the local level.

Given these goals and constraints, procedures, case information forms and policies were developed in consultation with an

> "[my husband] try looking for me, and call me back home, but I don't want to go back home, because he so crazy right now. Please, I want him to get away from me and the kids. I don't want to see him."
>
> (from the protection order of a woman who was later murdered by her abuser, along with her mother)

Advisory Committee. The project purpose emphasizes promoting cooperation and communication and identifying gaps in the system in order to increase victim safety and perpetrator accountability.

To test the model, three pilot regions were chosen to represent the diverse conditions within the state. Domestic Violence Fatality Review Teams were convened in each region, and at least two domestic violence fatality reviews took place in each region.

Most of people invited to serve on a panel did so willingly and enthusiastically. Reviews raised a number of issues, which had previously received little attention in state level policy discussions of domestic violence, but none-the-less affect many battered women's lives. With adequate preparation and strong facilitation, reviews were focused and generated high quality discussion. In most cases, relying exclusively on public records provided enough information for a productive Review. Participants consistently endorsed the value of the project, emphasizing the usefulness of an interdisciplinary discussion.

Locally based, state coordinated, multi-disciplinary reviews proved a useful tool for gaining insight into local and state systems for response to domestic violence, identifying gaps in the system, and increasing communication and collaboration amongst those involved in a coordinated community response to domestic violence.

Introduction

Chapter Two

Background

The Washington State Domestic Violence Fatality Review Project came about as a result of battered women's advocates' concern about the significant number of women murdered each year by current or former intimate partners. No mechanism existed in the state to systemically examine the circumstances of these murders. Advocates believed that careful examination of these deaths could yield important insights into the response to domestic violence, and a greater understanding of the lethal potential of domestic violence. They hoped domestic violence fatality reviews would serve as a powerful tool to catalyze knowledge and action from tragedy and to ensure that victims of domestic violence homicides are remembered.

Four major considerations shaped the development of the Washington State model: lack of access to confidential records, a reluctance to risk influencing active criminal or civil cases, a belief that locally based, interdisciplinary reviews would result in higher quality information, and agreement that state level coordination and dissemination of information would increase the impact of recommendations generated at the local level. Those involved with the Washington State Domestic Violence Fatality Review set out to create a model which would be as useful as possible, given these considerations.

Case by case review is a strength of the project – the pace is good and it allows for exploration of details

The Washington State Domestic Violence Fatality Review eventually defined its primary goals as promoting cooperation, communication and collaboration among agencies investigating and intervening in domestic violence; identifying patterns in domestic violence related fatalities; and formulating recommendations regarding the investigation, intervention and prevention of domestic violence.

> "I observed a picture of a female...the picture had several bullet holes in it...[the suspect] said he was upset at a girlfriend again..."
>
> (police report describing scene of the home of an abuser who murdered his girlfriend three years later)

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

The model described here does not assign blame for fatalities to individuals, agencies or institutions. The perpetrator of the homicide or suicide is always ultimately responsible for the fatality. It also does not seek to identify patterns of individual pathology on the part of the batterer or battered woman; nor does it provide a mechanism for identifying and reviewing all domestic violence related fatalities. Finally, it does not provide the information needed to create a lethality assessment.

This report seeks to distill the insights gained over eighteen months of organizing a state-wide Domestic Violence Fatality Review in Washington State. The author has sought to identify the key issues, challenges and questions Washington State faced in putting together a Domestic Violence Fatality Review, and to explain what choices Washington State made in response.

What is in this report

The report is divided into seven sections: an overview of domestic violence fatalities, a discussion of the role of domestic violence fatality reviews in a community response to domestic violence, a review of the key issues faced in initiating a domestic violence fatality review, a discussion of confidentiality and access to information, descriptions of setting up a review and the process of doing a review, and finally, findings from Washington State's project. The reader will also find an extensive set of attachments, which represent many of the forms and policies developed by the Washington State Domestic Violence Fatality Review Project.

Defining "Domestic Violence Fatality" and Understanding the Scope of the Problem

Chapter Three

How do law enforcement agencies identify domestic violence homicides?

Law enforcement agencies and FBI crime reports identify domestic violence homicides through the victim/offender relationship. "Domestic violence" crimes are those in which the relationship of the victim to the perpetrator is that of a family or household member, or someone whom the victim is dating or has dated. Some states, like Washington, include same gender relationships in their definition.

"Intimate partner homicides" form a significant subgroup of the larger category of "domestic violence homicides." These are the homicides in which the victim is the current or former wife, husband, boyfriend or girlfriend of the perpetrator. Homicides in which the victim was the child, parent, sibling, or any family relationship other than marriage are excluded from this category.

What do crime statistics tell us about the number of domestic violence fatalities?

The Bureau of Justice Statistics reports indicate that an average of 1,444 women were murdered each year from 1990 to 1996 by their current or former intimate partners. Annual reports of the Washington Association of Sheriffs and Police Chiefs (WASPC) indicate that between the years 1990 and 1996, an average of 26 women were killed by their intimate partners each year.

The majority of the victims in intimate partner homicides are women. The Department of Justice reports that three out of every four victims of intimate murder were female in 1996. Overall, a current or former intimate partner perpetrates 30 to 50% of

murders of women. An intimate partner commits about 5% of all murders of men. In Washington State, homicides committed by current or former intimate partners accounted for 29% of all murders of females and 3.6% of all murders of males between 1994 and 1997.

Evidence suggests that a history of violence and abuse against the female partner precede most homicides between intimate partners. A study of 1988 murder trials in large urban counties found that men's murders of their female intimate partners often occurred in the context of abuse and women's murders of their male partners often occurred in the context of self defense.

Recent evidence indicates that, like other violent crimes, overall rates of intimate partner homicide are falling. However this drop reflects a decrease in women's murders of their male intimates, but not the reverse. Nationally, men killed by a female intimate comprised 11.2% (1357 homicides) of all male homicide victims in 1976, but only 5.4% (516 homicides) in 1996. The rate of men's murders of their female intimates has not changed significantly since 1976, hovering around 30% (1326 homicides in 1996) of all murders of women.

What are the limitations of crime statistics?

I have found the Domestic Violence Fatality Review interesting and informative. So often one only knows a tiny part of the entire picture of the dynamics of domestic violence and its impact across community agencies

Crime statistics like those cited above are useful for sketching out the scope of the problem of domestic violence fatalities, but they also have limitations. An exclusive focus on official crime statistics results in an undercount of the lives lost due to domestic violence for five reasons:

1) In their drive to gain power and control over their intimate partners, abusers sometimes kill people other than their intimate partner. Methods for tracking crimes which focus exclusively on the victim/offender relationship as opposed to the circumstances surrounding the homicide do not reliably identify domestic violence related deaths of law enforcement officers, bystanders, advocates, or the battered woman's friends and family.

Further, while crime statistics do count the murders of children by parents or relatives as domestic violence, it is impossible to distinguish revenge oriented child "assassinations" (the calm, planned murder of children after a battered woman announces her intention to leave, for example) from other child homicides.

2) Crime statistics cannot identify non-homicide domestic violence related deaths. Suicides committed by battered women as a result of the despair and entrapment they experience are not reflected in crime statistics. In addition, murder/suicides attributable to domestic violence are also often obscured and not captured in official statistical counts.
3) Crime statistics are not updated when a murder is solved after the statistics are reported. Thus, a portion of the cases in which the victim/offender relationship was unknown at the time of reporting are later identified as domestic violence related but this is not reflected in the statistics.
4) Some jurisdictions do not submit statistics to crime reporting agencies.
5) Some domestic violence homicides are mistakenly classified as "accidental" and thus never make their way into crime statistics.

> "[the suspect] offered that he struck [the victim] multiple times in the face with an open hand."
>
> (police report, describing abuser's telling of events leading to the murder of his girlfriend)

How should we define domestic violence fatality?

Domestic violence fatalities are those fatalities, which arise from an abuser's efforts to seek power and control over their intimate partner. (Attachment 1)

The definition of domestic violence fatality used in Washington State's project is both wider and narrower than the one used by most criminal justice system reporting agencies.

It is wider, in that it takes into account that abusers sometimes kill non-family members. It is narrower in that the project definition excludes some cases in which family members and cohabitants kill one another but the deaths do not take place in the context of intimate partner abuse. Thus, some cases in which

siblings kill siblings or children kill parents, and some death by child abuse cases will be excluded.

Using this definition, domestic violence fatalities include:

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

> "The defendant admitted to Detective L that he had an argument with the victim [two days before the murder] and ended up striking her. Testimony will show that she went to the hospital with a reopened wound on her head on that date."
>
> (Prosecutor's trial memorandum)

How does using this broader definition change what we know about number the of domestic violence fatalities?

An examination of clippings from Washington State newspapers regarding domestic violence related deaths occurring in calendar year 1997 indicated a total number of more than twice as many domestic violence homicides as the intimate partner homicides reported by WASPC. While WASPC reported 22 intimate partner homicides (17 women and 5 men), utilization of the broader criteria which includes murders of friends, police officers and family by abusers, yielded a total of 44 domestic violence related homicides: a 100% increase.

Including the deaths of the 14 people who committed murder/suicides, and two abusers who were killed by police officers, the documented death toll in Washington State for 1997 was at least 60 people, 175% higher than official crime statistics indicate. However, even this must be considered an undercount, since it does not encompass domestic violence related suicides of women,

unsolved murders, and deaths, which were mistakenly classified as accidents.

In 1997, victims of domestic violence homicide in Washington State included:

- 23 women killed by current or former husbands/boyfriends (35% more than reported in the WASPC annual report – indicating that perhaps not all suspects were identified at the time statistics were gathered.)
- 6 instances in which the abuser killed his partner's mother.
- 6 children who were "assassinated" — killed in planned, calm murders (often combined with suicide) which took place in the context of abuse between the adult intimate partners.
- 5 men killed by current or former wives/girlfriends.
- 4 instances in which friends and relatives of the abused woman were murdered.
- 1 law enforcement officer who was shot by an abuser.

The death toll for 1997 also includes:

- 2 cases in which an abuser took actions during the course of police intervention, which forced the police to kill him.
- 14 suicides committed by the abuser after the murder of an intimate partner and/or child(ren).

Diverse panel members broadened the perspective outside individual employment areas. The Project is a natural way to bring multiple diverse agencies together to network and (hopefully) to develop a unified community response to domestic violence.

The Role of a Domestic Violence Fatality Review in a Coordinated Community Response to Domestic Violence

Chapter Four

What is a fatality review?

Domestic violence fatality reviews, like child fatality reviews and hospital mortality reviews, build on a public health model of identifying prevention and intervention strategies based on detailed examination of a relatively small number of fatalities.

The fatality review process assumes that the circumstances of untimely deaths are likely to be repeated and that detailed examination can lead to important insights regarding risks, intervention and prevention efforts. The process rests on the notion that in-depth analysis of small number of cases can provide a window into problems with system response, which may affect a large number of people.

What can be accomplished by a domestic violence fatality review?

While domestic violence fatality reviews may take varied forms and have slightly different primary goals, those who have taken part in them consistently mention several major areas of benefit. (Attachment 2)

Examinations of domestic violence fatalities conducted in other states suggest that the police, courts or social service systems are often involved with the domestic violence victim or perpetrator prior to intimate partner homicides. These systems analysis reviews have revealed missed opportunities for stronger, more effective interventions prior to the fatality.

As communities work to achieve a coordinated community response to domestic violence, systematic examination of the

circumstances leading up to domestic violence fatalities can be a means to learn more about how a community's justice and social service systems respond to domestic violence.

Reviews may also suggest avenues for prevention, such as arenas in which education and access to information should be increased. They can help communities identify training needs, gaps in system response to domestic violence, and areas in which practice does not conform to policy or policy could be improved.

> "Slain woman might have been stalked"
> (The Olympian 7/28/98)

When participation is interdisciplinary and locally based, domestic violence fatality reviews provide a forum for individuals from the organizations involved in a coordinated community response to come together. During the course of fatality reviews, panel members have the opportunity to educate one another, increase communication, problem solve, and identify needs and opportunities for collaboration.

Some domestic violence fatality reviews are investigative. They seek to identify domestic violence related deaths, which have previously gone uncounted, such as suicides and homicides mistakenly classified as accidents. Identifying these deaths can lead to recommendations for changes in investigations, autopsy procedures, and record keeping in order to more accurately reflect the toll of domestic violence.

Finally, domestic violence fatality reviews draw attention to the high cost of domestic violence in terms of human life, and they can help ensure that the pain and suffering which often precedes domestic violence fatalities are not easily forgotten or minimized. In this capacity, they contribute to public education and ensure that victim's lives are not invisible and forgotten.

Can Domestic Violence Fatality Review be used to develop lethality assessments to help focus criminal justice system efforts?

While Domestic Violence Fatality Review may prove useful in a variety of ways, assisting in the development of a lethality

> "Jolted awake by an intruder, a 16 year old boy called 911. While on the phone with a dispatcher, he overheard the fatal shooting of his mother and her male friend."
>
> (The News Tribune, 7/20/97)

assessment is not one of them. The Washington State Domestic Violence Fatality Review determined early in the project that while interest on the part of some law enforcement agencies and others existed in the development of a lethality assessment tool, the Project could not contribute to the development of such a tool.

Lethality assessments are often intended to inform the allocation of resources–more to the most dangerous cases, relatively less to the rest. These sorts of allocation priorities could impact victim safety and access to assistance, and thus must be considered very carefully. Domestic violence fatality reviews can highlight policies and practices which may be helpful to all battered women, but they are not a reliable tool for identifying who should and should not receive extra attention.

Domestic violence fatality reviews focus only on cases in which a death occurred, and yield no information about comparable situations in which no one died. Without this comparison, it is impossible to know whether or not individual variables/ characteristics occur primarily within the relationships, which end in death, or are also common in the many abusive relationships, which do not result in death. Thus, findings cannot be used to distinguish between abusers who may kill from those who never would.

For example, a fatality review team may note that death threats preceded domestic violence homicides quite frequently. But death threats may be quite common in abusive relationships. In this case, a high incidence of such threats in cases, which actually ended in murder, is not surprising, nor will it distinguish cases, which end with a fatality from all domestic violence cases. The conclusion from a domestic violence fatality review may be that all death threats must be taken seriously, not that some deserve particular focus and others do not.

Key Issues in Setting up a Domestic Violence Fatality Review

Chapter Five

Who should be involved in deciding whether or not to initiate a Domestic Violence Fatality Review?

The impetus for the Domestic Violence Fatality Review Project in Washington State came from domestic violence advocates within the Washington State Coalition Against Domestic Violence and the Department of Social and Health Services. The discussion was expanded in the context of state planning meetings for Violence Against Women Act (VAWA) grants, and eventually included leaders from law enforcement, prosecution, social services, and the State Office for Crime Victims Advocacy. With the agreement of this group, a proposal for to create a model for a statewide domestic violence fatality review project was funded by a grant from the VAWA Grants Office within the US Department of Justice.

As work on the Project began, it immediately became clear that many decisions needed to be made about the focus, structure and policies of a domestic violence fatality review. An Advisory Committee to the project was formed in order to bring a broad spectrum of expertise into this decision making process.

The Advisory Committee consisted of experts on domestic violence in various disciplines: law enforcement, judiciary, prosecution, community based advocacy, public health, research, legal advocacy, batterer's treatment, and probation. Committee members were also recruited with attention to gaining representation from tribal communities and both urban and rural counties.

The Advisory Committee met several times over the initial nine months of the project to think through the following issues: What

do we want to achieve with a domestic violence fatality review? What constraints does such a project face? Who should participate in domestic violence fatality reviews? Should reviews be locally based or occur at the state level? What information should be gathered, and what should be done with it? What procedures and policies are needed?

Project Mission

What do we want to achieve with a Domestic Violence Fatality Review?

Enthusiasm for the idea of a Domestic Violence Fatality Review Project was considerable among the Advisory Committee members. Many on the committee saw the benefits that the Project might bring. However, the Advisory Committee also pointed out that important constraints also existed which would affect what the Project could achieve. It became clear that the mission of the Domestic Violence Fatality Review Project would be a compromise between what it was possible to do and what it was most desirable to do.

The Advisory Committee agreed that it would be desirable to obtain as much information as possible about all domestic violence fatalities in the state. Maximum information would yield the most informed recommendations and paint the most accurate picture of the lethal nature of domestic violence.

A judge noted the Domestic Violence Fatality Review Project had been "very valuable to me. Important to have third party reaction to proceedings to reevaluate the decisions made."

What are the constraints?

However, several critical constraints were noted early on: resources, access to information, and the reluctance to risk affecting the outcome of criminal or civil cases. Each of these is discussed in some detail below. Given these constraints, the Advisory Committee created a mission statement, which reflected the worthwhile goals, which were attainable.

The mission of the Washington State Domestic Violence Fatality Review emphasizes careful analysis of the community response

to domestic violence and increasing communication and coordination.

The Mission of the Washington State Domestic Violence Fatality Review Project

Through the process of conducting a formal review of selected fatalities in which domestic violence is considered a significant factor, the Washington State Domestic Violence Fatality Review Project will:

1) Increase safety for victims and accountability for perpetrators of domestic violence by:
   - Promoting cooperation and communication among agencies investigating and intervening in domestic violence.
   - Identifying gaps in services and accountability structures and formulating recommendations for policies, service and resources to fill those gaps.
2) Identify and describe patterns in domestic violence related fatalities by:
   - Documenting information from domestic violence fatality reviews conducted throughout the state and publishing periodic reports based on the aggregated findings of reviews.
3) Formulate recommendations for collaboration on domestic violence investigation, intervention and prevention.

> "A 34 year old transient was charged with second degree murder yesterday in the fatal beating of his girlfriend in a camp under Interstate 5 at the Swift-Albro exit."
>
> (Seattle Post Intelligencer 7/3/97)

Participants, responsibilities and statewide structure

Who should participate in fatality reviews?

The mission of the Washington State Project reflects the preference of the Advisory Committee for state level coordination of locally based review panels made up of agencies concerned with victim safety and batterer accountability.

> "In the course of the argument, I pointed the gun at her in order to scare her..."
>
> (written plea statement by man who killed his girlfriend on her birthday.)

Should locally based reviews be coordinated at the state level?

Three models were identified for involvement in domestic violence fatality review panels: Experts, Involved Agencies, and Advocates. (Attachment 3)

Members of the Advisory Committee expressed a strong preference for the locally based Involved Agencies model. However, advocates from some communities warned that the knowledge base in their communities was not adequate to formulate recommendations, which would help and not harm battered women. In response to these concerns, the Project went forward with the emphasis on local involvement, but also held open the possibility of a state level expert Board meeting once or twice a year to review findings and recommendations made at the local level. An alternative to a state level Board would be a greater investment of project staff time in research and analysis of findings and recommendations.

How can the benefits of locally based reviews be maximized and the limitations minimized?

Emphasis on local reviews with state level coordination represented a departure from the original vision of the project, which was for a single state level review board composed of experts in the field. It is also distinct from a model like that in California, where legislation has placed the responsibility for initiating and funding locally based reviews at the local level, and provided minimal coordination at the state level.

What are the advantages of locally based reviews coordinated at the state level?

The locally based/state coordinated approach has several advantages:

- Local investment in the process and the recommendations which come out of it.

- Reviews sensitive to specific characteristics of communities.
- Opportunity to build expertise and leadership at the local level.
- Better access to detailed information about how the justice and social service systems work in particular communities.
- Consistent procedures and information gathering throughout the state.
- Combined information from all reviews is an efficient way to paint a comprehensive picture for greater impact and identification of statewide trends than would be possible with multiple local level reports.
- The possibility of state level meetings of experts provides a point of involvement for experts, stakeholders, and state level organizations, which does not exist at the local level.

> "Man killed after taking family hostage. A marriage not yet 3 months old ended tragically when [the man] took a shot at his wife and a ... Sheriff's deputy shot him dead."
>
> (The Spokesman Review 7/26/97)

What should the geographic scope be of the locally based Domestic Violence Fatality Review Panels?

Following upon the agreement for locally based panels, the Project had to decide on the geographic scope of local reviews. Washington has several sizable cities, but the majority of its 39 counties are rural.

How can we capture the multiple jurisdictions a woman may have moved between?

Review panels in rural areas will be composed of two or three counties for the following reasons:

- Battered women may move between towns and counties while trying to escape domestic violence. For this reason, they may have contacts with the justice system in several jurisdictions. Multi-county reviews can provide a greater chance of capturing all institutional contacts, and flexibility exists to invite representatives from other jurisdictions if the history of domestic violence included contacts with those jurisdictions.
- Multi-county reviews provide the opportunities for panel members to learn from people in neighboring counties and thus avoid insularity.

"[the defense attorney] contended that [the defendant] was mentally ill when he put his wife into a choke hold... Less than three weeks before her death, [the murder victim] suffered severe neck injuries..."
(The News Tribune 5/22/97)

- Some counties already work together quite closely. Multi-county reviews can take advantage of these pre-existing relationships.
- Multi-county reviews reduce the total number of review panels, making better use of resources.

In densely populated urban counties, how can we balance the need for broad representation with the need to keep the panel size manageable?

Review panels in urban areas will encompass only one county. This is because the number of domestic violence fatalities in the urban counties is relatively high. Combining counties would result in an unrealistic workload for the review panel.

In addition, urban counties encompass numerous municipal jurisdictions and many social service agencies. Organizers face balancing broad representation with limiting the size of the panel so that it does not become unwieldy. When panels swell to more than 20 people, the review can easily lose its focus and clarity. Limiting the geographic scope to one county can help mitigate this problem.

This Project has considered several alternatives for structuring the Domestic Violence Fatality Review in the most densely populated urban county in Washington:

- A panel composed of experts from within the county, as opposed to seeking representation from all the municipal jurisdictions and social service agencies in that county.
- Creating a large pool of panel members from jurisdictions and agencies throughout the county, but having only those most closely connected to the case attend each review.
- Splitting the county into several sub-regions and creating domestic violence fatality review panels within these regions.

Local domestic violence fatality review panels, state review board, and the state office

Local Domestic Violence Fatality Review Panels

The Advisory Committee to this project thought that the following list represented the core disciplines which should be represented on local panels: (Attachment 4)

Who should be represented?

- Domestic violence victim services programs
- Law enforcement
- Judiciary
- Batterer's intervention programs
- Probation
- Prosecutors
- Victim witness advocates
- Domestic violence court advocates
- Animal cruelty investigators
- Child protective services
- Medical examiner/coroner
- In areas with significant sub-communities (i.e., immigrant groups, non-English speaking groups, people of color, etc.) representatives from agencies trusted within those communities should also be invited

> "[the Chief of Police] said officers are trained to defuse domestic violence situations by separating the combatants, giving them a chance to cool off. 'It usually works,' he said"
>
> (Chief of police quoted in relation to a decision not to arrest a man who had threatened his wife with an assault rifle, and later killed a police officer. The News Tribune, 9/3/97)

What mix of people will maximize information about system response?

In Washington, each agency sending a representative signed an inter-agency agreement, which affirms the importance of representation from each of these disciplines. Additionally, spirit of flexibility was maintained from review to review, holding open the possibility of inviting representatives from specific agencies involved with the family prior to the fatality, or people with specific expertise, which may bear on the issues, discussed. For example, if the events leading up to a fatality included a difficult

custody battle, the panel may want to locate a local expert on custody decisions and domestic violence.

What role do battered women's advocates play on local panels?

Even when confidentiality requirements prohibit them from disclosing specific interactions with a particular battered woman, the presence of battered women's advocates on the panel is of critical importance. Of all the varied panel members, advocates are the most likely to have had contact with battered women over an extended period of time. Unlike the relatively short, goal directed interactions law enforcement officers, prosecutors and medical professionals may have with battered women, advocates' interactions are often less structured and leave more room for open-ended discussion. For this reason, advocates often possess detailed knowledge of the challenges women face as they seek safety and cope with abuse. This insight is valuable, even when (for confidentiality reasons) the advocate must speak in general terms and not about specific women.

Who should be on the panel to ensure that discussions do not become victim blaming or reinforce complacency?

I believe the review of (a specific case) was helpful in learning what measures were tried and how the courts failed to defuse an ongoing domestic violence problem.

Generally, domestic violence fatality reviews will be most effective when the review panel includes individuals who:

- Can speak in detail about the day to day struggles battered women face.
- Can help the panel see how a battered woman might have thought about her options and perceived institutions.
- Can envision the possibility of change.
- Know the "best practice" for various disciplines.
- Can resist the pull of the status quo and hopelessness.

Knowledgeable panel members and strong panel facilitation can ensure that the review does not become a forum for:

- Victim blaming ("if she had only done X, we could have helped her, or it wouldn't have happened").

- Building agreement that the death was inevitable ("you just can't help that sort of person").
- Complacency ("no one could have been expected to do more, there was nothing more that could have been done").
- Simplistic thinking which blames racial or cultural differences for the death instead of examining the role institutional racism or lack of culturally relevant resources might have played ("it's a tradition for those people to handle conflict this way; they won't come get help from us").
- Overly individualized analysis, which does not reflect on how a particular fatality might indicate systemic problems or gaps ("this was a fluke").

> "I always feared he would kill her because of so many things and so many signs."
>
> (victim impact statement from the friend of a woman murdered by her boyfriend)

Local Review Panel responsibilities

The following responsibilities were identified for the local review panels:

- Assist in identification of deaths.
- Identify which deaths to review.
- Assist in gathering public records regarding cases to be reviewed and forward to project staff.
- Each member to review their own agency records.
- Participate in reviews.
- Identify local/regional issues, make recommendations.
- Send representative(s) to the Domestic Violence Fatality Review Board.

State Domestic Violence Fatality Review Board – why have a state level board?

This Project has anticipated the formation of a state level Domestic Violence Fatality Review Board. A state level board provides a point of contact with the Project for experts and stakeholders within state level institutions and organizations which does not exist at the local level. Those involved with the project believed that broad involvement is a good way to build broad investment in the outcomes of a project. (Attachment 5)

> "She was my only mother, my life, and all I lived for was to get a high school diploma to please her..."
>
> (victim impact statement from son of a woman murdered by her boyfriend)

What are the Board's responsibilities?

The State Domestic Violence Fatality Review Board's responsibilities would be to:

- Review the issues and recommendations raised in the local domestic violence fatality reviews in order to identify common themes as well as state level policy and training issues.
- Assist with developing and refining recommendations, ensuring that characterizations of present policy are accurate, and proposals for changes are well thought out, and that the recommendations do not create new burdens or barriers for battered women.
- Serve as a resource bank of experts for local review panels.
- Consult on the content of the annual report.

Who would serve on the State Domestic Violence Fatality Review Board?

The Washington State Domestic Violence Fatality Review Project did not convene a State Domestic Violence Fatality Review Board as part of this grant. **However, we anticipate its membership to be composed of:**

- Representatives from local review panels.
- Recognized experts in varied disciplines.
- Liaisons and those with domestic violence expertise from state agencies such as the Attorney General, Department of Health, Department of Social and Health Services, Governor's Office.
- Representatives from state level organizations such as the Washington State Coalition Against Domestic Violence, the Washington Association Of Sheriffs And Police Chiefs, and the Washington Association of Prosecuting Attorneys.
- Researchers.

Are there alternatives to a state level board?

With a statewide project fully implemented, local review panels will generate a great deal of information, issues, and

recommendations. One option is to simply document all of these without an effort to evaluate, refine or prioritize, and present it in an annual report. However, this may not be the most effective means of making recommendations public.

If there is a desire to research, refine, and prioritize recommendations, then some resource must be brought to bear on this set of tasks. An alternative to the State Review Board model would be to provide sufficient staff resources to accomplish this work.

State Domestic Violence Fatality Review Office

A State Domestic Violence Fatality Review Office facilitates the work of local domestic violence fatality review panels and the state level Board. It ensures consistency across local panels, and in the initial stages of the project, initiates the formation of review panels in each region.

State office responsibilities.

Tasks for a State Office are:

- Identify domestic violence related deaths using news service and existing databases.
- Convene, facilitate and document local domestic violence fatality reviews.
- Recruit local domestic violence fatality review panel members.
- Coordinate information gathering on cases.
- Summarize public records, issues and recommendations raised during local reviews.
- Create and maintain a database to record information obtained through reviews.
- Convene and document State Domestic Violence Fatality Review Board meetings.
- Issue annual report.
- Locate financial resources for the Project.

What skills should project staff possess?

Project staff should have a detailed understanding of domestic violence, battered women's experiences, and the public policy response to domestic violence. They also need to be able to understand the constraints present in institutions and still think critically about their possibilities. Familiarity with research methods, statistics and database management are helpful. Staff should also have strong skills in meeting facilitation, oral and written communication, and project management.

Siting the project

Where should the Domestic Violence Fatality Review Project be sited?

Those involved with writing the VAWA grant to initiate the Washington State Domestic Violence Fatality Review had to decide where to site the project. They chose the Washington State Department of Social and Health Services (DSHS) for two reasons: In conjunction with the Department of Health, the Children's Administration of DSHS has conducted child fatality reviews on children who were involved in the child protection system. Second, while state funding for domestic violence shelter programs is administered through DSHS, the agency was likely to be seen as a neutral state level facilitator of the Domestic Violence Fatality Review Project.

Possible sites for domestic violence fatality reviews are state domestic violence coalitions, Departments of Health, Departments of Social Services, public policy institutes situated in university departments of public health, social work or public administration, the Attorney General's office, or the Governor's office.

Ideally, the site of a domestic violence fatality review project would meet the following criteria:

What makes some sites better than others?

- The mission of the parent agency connects to the goals of a fatality review project, and resources and expertise useful to the project exist within the agency.
- Leadership of the agency will be invested in the success of the project.
- The agency has a fund of expertise in at least some of the following: domestic violence prevention, systems analysis, collaborative policy evaluation and analysis.
- The agency is seen as neutral enough to ensure multidisciplinary participation.
- The agency has expertise in working with the media and releasing reports, which may be controversial or provocative.

The Domestic Violence Fatality Reviews have allowed us to talk about a number of issues from many points of view as well as from many different disciplines. Very informative and a great learning tool for all of us. I find them to be very valuable...

Access to Information, Confidentiality and Documentation

Chapter Six

What information should we seek out for reviews?

Questions concerning information were central to the planning process in Washington State. It quickly became clear that any discussion of information was inevitably shaped by three concerns:

- The ability to obtain an adequate amount of information to do a fatality review.
- Constraints on access to information.
- Ensuring that the information was used responsibly and productively.

A strength of the project is the fact that we are all willing to work together to find out more about each others' contributions to stopping domestic violence. It is wonderful that we all share so many different parts of the pie and we are willing to come together and discuss what our particular pie slices and expertise are. As we work together more, we have become a better whole and we all learn how to do things better.

Who should decide what review panels focus on?

A subcommittee of the Project Advisory Committee took on the task of identifying what information was necessary to conduct reviews consistent with the Project's mission statement. The subcommittee approached this task by setting aside concerns about access to information in order to freely identify all the kinds of information which might be helpful to a fatality review panel in understanding the circumstances leading up the fatality.

Augmenting the Advisory Committee subcommittee, a group of domestic violence victim advocates met to discuss how review panels could identify the issues advocates saw affecting battered women's ability to access help or seek safety, and the community's ability to hold batterers accountable.

The Case Information Form

Out of these efforts, an extensive, three part Case Information Form was developed to guide reviews. (Attachments 6A-C) It was clear that in many cases review panels would not have perfect

access to information, and would not be able to answer all questions on this form. However it was agreed that it might be as useful for panels to be aware of what they did not know as to identify what they did know.

The Case Information Form focuses on two areas: Information about the individuals involved, and information about the context in which previous domestic violence and the fatality occurred.

> "Over the past five months he threatened my life about murder-suicide. He said he would kill me and himself."
>
> (from the protection order of a woman who was later murdered by her ex boyfriend while she was 7-1/2 months pregnant. He then killed himself.)

What should we know about the individuals involved in the fatality?

While the greatest proportion of domestic violence homicide victims are the current or former intimate partner of the perpetrator, victims can also include bystanders, law enforcement officers, friends, children, the domestic violence victim's relatives or new romantic interest. Based on the understanding that a domestic violence fatality results from a perpetrator's efforts to gain power and control over an intimate partner, the Case Information Form focuses on the history and circumstances of the domestic violence victim and the domestic violence perpetrator.

Why ask about race, income, educational level, etc?

Information requested in the Case Information Form about the domestic violence victim and the domestic violence perpetrator fall into four major categories. These are history of domestic violence, past and pending civil or criminal actions, prior points of intervention, and socio-economic indicators such as race, age, level of education, and income. Social and economic factors are highlighted in order to further understanding of the potential barriers to seeking/receiving help, obstacles to effective intervention, accessibility of helping resources, and constraints on the domestic violence victim's options.

Could this information be misused?

In response to concerns of the Advisory Committee members

and battered women's advocates that collected information could be used to reinforce negative stereotypes, a policy statement regarding the use of data collected was developed. (Attachment 7)

What do we need to know about the context?

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 system response, the panel must gain a sense of the context in which the abuse took place.

The Case Information Form directs attention to the justice system's responses to prior domestic violence and the availability of community resources. Perhaps most importantly, it directs attention to the training, policies, and practices of the agencies, which came into contact with either the domestic violence victim or perpetrator.

Obtaining information about the community context and how the systems function encourages the panel to evaluate the victim's resources for gaining safety or leaving. The process asks panels to carefully consider the readiness of various community resources to recognize and respond appropriately to domestic violence.

Confidentiality and constraints on access to information

Concerns about confidentiality impacted decisions as to the nature of information gathered by the project. Unlike California, Nevada and Delaware, Washington State does not have a statute in place which gives permission for system actors to reveal confidential information during a domestic violence fatality review.

What kind of information is accessible?

Panel participants are neither asked nor expected to compromise legal or professional confidentiality requirements. Instead, the

project identified several categories of information relevant to the review process which do not compromise individual or professional confidentiality restrictions:

- *Public records related to all the parties involved in the domestic violence fatality*

  Public records include protection orders, divorce documents, police incident reports and investigative notes, prosecutor's charging papers for homicides and previous assaults, victim impact statements, sentencing information, and trial transcripts if available.

- *Knowledge of institutions' policies and practices*

  Panel participants can often provide insight into how particular agencies and institutions function, including their training in domestic violence, how they receive and make referrals and how they prioritize cases. This information, while not specific to individuals involved in fatalities, can be of enormous importance in understanding the circumstances leading up to domestic violence fatalities, including what was likely to happen when the particular agency/institution came in contact with the abuser or the victim.

- *Local knowledge of community resources*

  Gaining a full understanding of a case often involves examining what resources were available to the abused woman when/if she had attempted to stay safe from the abuser, and what resources were available to the system as it worked to hold the abuser accountable.

- *Knowledge of best practice regarding domestic violence within various disciplines*

  Bringing this information into the review process provides a standard against which to compare existing resources, policy and practice.

These are good learning sessions for all of us.

What is public record?

One of the Advisory Committee's tasks was a comprehensive review of the state and federal statutes and administrative codes

"Killing came just hours before man was to appear on assault charges"
(The News Tribune, 4/10/98)

relating to public records and release of information. (Attachment 8) This review revealed that some documents were unequivocally public record (civil and criminal filings, for example), and some could be released based on a discretionary decision (law enforcement incident reports) or in the context of research. Reviewing confidentiality requirements in detail proved useful for obtaining the fullest possible access to information.

How can access to information be expanded?

While public records can often provide a great deal of information, some gaps will persist. Generally, information about medical visits, information about contacts with domestic violence programs, batterer's treatment, contacts and content of discussions with probation, and child protective services cannot be obtained.

To augment public information, the following options have been considered:

Release of information to be distributed to battered women through domestic violence programs

What other avenues exist for obtaining information?

In conjunction with the Washington State Coalition Against Domestic Violence, the project developed a release of information for victims using domestic violence services and a model policy for its use in domestic violence programs. This release allows the domestic violence program to share information about her in the event of her death, and also provides the opportunity for her to direct the release of other information as well. (Attachment 9)

Interviews with family, friends and neighbors.

Interviews with friends, neighbors and family members can be an invaluable source of information about events and concerns, which are undocumented in the official record. In many cases, family members also have the power to direct the release of otherwise confidential records.

Interviews should be done by someone with crisis intervention and/or grief counseling training, and resources for support and information should be offered during the interview.

Should legislation to open access to information be considered?

As mentioned, some states have passed legislation to establish Domestic Violence Fatality Reviews. Legislation typically covers two key areas: permission for system actors to share confidential information in the context of the review, release of liability for individuals participating in the reviews, and protection of the review process from discovery in legal proceedings. (Attachment 10)

The following should be considered in any decision making process regarding legislation:

- Should domestic violence fatality review panels have the power to demand information? Or should it simply be an option for agencies to reveal information at their discretion?
- What problems might be associated with opening otherwise confidential records in fatality reviews? Is there any concern about creating a precedent for domestic violence programs to reveal information about the victims who have used the program? Could legislation undermine or erode current confidentiality or privileged communication protections for domestic violence advocates?
- Is it desirable to limit what sorts of information should be shared during a domestic violence fatality review? For example, is it preferable to specify that a domestic violence program could indicate if someone used the program, for what services and when, but no further specifics?
- Is it possible to ensure that fatality reviews don't become forums to brush problems under the rug and remove cases from public scrutiny? Should legislation spell out what should be released to the public from reviews?

The Nuts and Bolts of Setting Up a Domestic Violence Fatality Review Project

Chapter Seven

What steps need to be taken?

The Washington State Domestic Violence Fatality Review Project evolved over almost two years of research, meeting with the Advisory Committee, multiple drafts of forms and procedures, recruiting pilot review panels, and implementing several local fatality review panels. What follows is a brief timeline of the steps taken in setting up the Washington State Domestic Violence Fatality Review Project.

Month	Activities
1-3	Research existing models for child and domestic violence fatality reviews; interview people who have reviewed fatality review panels; review literature on domestic violence fatalities
2-3	Recruit and convene an Advisory Committee
4-9	Work with the Advisory Committee and its subcommittees to: • Refine a project mission statement • Identify core constituencies for local domestic violence fatality review panels • Research confidentiality and release of information codes • Create a proposed structure and procedures for the Project • Create the Case Information Form
10	With Advisory Committee, identify three pilot regions for testing the model developed

Month	Activities
11-13	Identify local review panel participants, travel to pilot regions to meet with and orient participants
14	Hold initial meetings for pilot local review panels. Agenda for this meeting: everyone to meet, review purpose and policies, identify and prioritize fatalities for review, plan for initial review
15-16	Prepare for initial reviews
16	Hold domestic violence fatality reviews in each pilot region and choose next fatality for review
17	Follow up on initial reviews
	Revise policies and procedures
18-19	Prepare for next set of reviews
19	Hold second domestic violence fatality review in each pilot region
20	Follow up from reviews
Anticipated	Recruit and convene additional local review panels throughout the state
Anticipated	Convene State Domestic Violence Fatality Review Board to create recommendations and consult on the Annual Report

Why Pilot Projects?

Three pilot regions were chosen for the initial implementation of the Domestic Violence Fatality Review panels. It was hoped that experience in pilot regions would allow the Project to quickly identify the strengths and problems of the model, which had been developed in consultation with the Advisory Committee.

The pilot regions were chosen to represent the diverse conditions within the state. They varied in their population density, access

The analysis of an old case in comparison to how the system has adapted was constructive. It certainly points to the need for continuing victim/community education and clearly additional training for defense attorneys, judges and guardians ad litem.

to major population areas, and presence of immigrant communities, tribal lands and military bases. (Attachment 11)

> "A... man used his computer at work to search the Internet for advice on killing his wife in the weeks before he reported her missing, prosecutors said yesterday...[the defendant] had been searching the Internet for topics such as 'kill+spouse'"
> (South County Journal 9/5/98)

Gaining commitment and cooperation at the local level

The model created in Washington relies heavily on local panel members' commitment and cooperation. Local domestic violence fatality review panel members have primary responsibility for obtaining public records and forwarding these to the state office. They must also review their own confidential records, and attend reviews.

What concerns did local participants have about the Project?

Some local review panel members perceived risks involved with participation in the Domestic Violence Fatality Review Project. Common worst fears included having mistakes exposed, and being made the scapegoat for the fatality. Some expressed concern that challenging others on the review panel could add tension to working relationships.

Meeting people on their own turf

Potential participants took in information more fully and felt more free to ask questions and discuss concerns when they were approached in their own office and could take part in a one to one conversation. Project staff traveled to rural towns and tribal headquarters to meet with potential participants to discuss the project. In some cases, staff met with small groups of two to four people who had close working relationships. (The prosecutor and victim advocate, for example.)

Tying the Project to local concerns and goals

Potential participants were often asked what they thought their community might find useful in a detailed review of domestic violence fatalities. Whenever possible, points of overlap between their vision and the project mission were emphasized. Most

participants (especially law enforcement and victim services) appreciated knowing that the reviews would emphasize the inability of any single agency to solve the problem of domestic violence alone and the need for a coordinated response.

Emphasizing learning, not blaming

The mission statement for the Washington Domestic Violence Fatality Review Project clearly focuses on learning and collaboration over blaming. While recruiting panel members, this focus was repeatedly emphasized. The fear that blame would be assigned for deaths was explicitly discussed and rejected in meetings with potential participants.

Group Agreement

In response to concerns about the tone of the domestic violence fatality reviews, a Group Agreement was created. All participants were asked to agree to the Group Agreement, and given the opportunity to add or dispute any point within it. (Attachment 12)

Confidentiality Agreements

The Advisory Committee and panel members thought that the conversation that takes place during the course of the review should remain confidential. Panel members need to feel they can speak freely during the review without concern as to whether their comments will be repeated out of context. In response to this concern, three separate confidentiality agreements were drafted: (Attachments 13 A-C)

1) Individual review panel member.
2) Inter-agency agreements for each agency represented on the review panel.
3) An agreement to be signed at each meeting.

Quarterly Meetings

Anticipating the formation of multiple review panels combined with limited staff resources, quarterly Domestic Violence Fatality

Review meetings were proposed to potential participants. Panel members generally seemed to agree that quarterly meetings were manageable, and were able to set aside an entire afternoon for a meeting once a quarter. Clearly, quarterly meetings limit the number of reviews, which may be accomplished, but the trade off is a time commitment, which even the resource scarce agencies were willing to accommodate.

Off setting transportation costs

In the pilot region that encompassed three rural counties, some panel members had to travel over 100 miles to participate in meetings. The Washington State Domestic Violence Fatality Review Project had budgeted to reimburse participants for mileage.

What resources are needed to set up a Domestic Violence Fatality Review Project?

What kind of staff time is necessary?

The Washington State Domestic Violence Fatality Review began with half time staff for project development and pilot implementation. This is significantly more than many fatality reviews, and was sufficient during start up phases. However, it is not enough to sustain a statewide review effort as set forth in this model.

The opportunity to bring together all the players in a total system is definitely a good thing, and fosters a different level of understanding and cooperation.

The model presumes the bulk of preparation and follow up work will be done by the state office staff as opposed to local panel members. This was because (at least initially) local participants were interested in participating but were not invested enough in the project to make commitments beyond attending meetings and looking up records; in rural areas and tribal communities, local agencies did not have the extra resources to take on additional tasks, and in some cases, the panel members could not agree on one agency or individual for leadership.

Given these realities, it is estimated that each fatality reviewed consumes about 20 staff hours:

Month	Activities
1	Track down records, follow up with panel members regarding forwarding of public documents
6	Reading, sorting records and creating a chronological summary for the review panel
1	Assembling mailings prior to each review
8	Travel
4	Synthesizing information from review, preparing and mailing out summaries
20	**Hours total**

This Project anticipates forming a total of 14 review panels. Once panels are formed throughout the state, if each panel conducted an average of 4 reviews per year for a total of 56 reviews, this alone comes to about 1120 hours, or 28 weeks of full time work. Of course, as participants and staff gain experience in conducting reviews, it is possible that the process will become more efficient and each review will take less time.

Domestic violence fatality review projects may want to consider budgeting for additional staff and paid, graduate level interns from public health, public administration or social work departments. (Attachment 14)

Collaboration with academic researchers

Collaboration with university researchers may bring more resources into a domestic violence fatality review project. Researchers in a variety of disciplines may be interested in collaborating with a domestic violence fatality review project.

In evaluating the value of collaboration, it may be useful to ask the following questions:

What is this particular researcher's agenda for participation? Is it one, which those involved with the review project support? What skills and resources can the researcher bring into the Project? (possibilities are statistical analysis, database set up, graduate student interns, physical space for meetings, information about studies and scholarship related to questions raised in the reviews.)

What does it take to keep everything organized?

Tools for Organization

To maintain efficiency, a statewide domestic violence fatality review project have adequate resources to stay organized. Project staff must keep track of a large number of people and a great deal of information.

For example, in Washington State:

14 review panels x 20 panel members = 280 people

8 reviews per year x 14 panels = 112 reviews

112 reviews x (1 prep mailing + 1 follow up mailing) = 224 mailings

112 reviews x 5 sources of public information = 560 sources of records

A flexible, customizable database for tracking addresses and contacts with review panel members and for generating mailings is very helpful and can increase the efficiency of the project.

A database for tracking progress towards reviews as well as the information obtained in them is also desirable.

The Process for Domestic Violence Fatality Review

Chapter Eight

> "A man accused of killing his girlfriend told investigators he didn't mean to kill her when he aimed a gun at her head and pulled the trigger."
> (The News Tribune, 10/27/98)

How do we identify domestic violence fatalities?

Identifying the names of the victims and perpetrators involved in domestic violence fatalities proved challenging. While death records are public information, County Coroners are under no obligation to assemble and release information about particular kinds of deaths. The Washington Association of Sheriffs and Police Chiefs (WASPC) release fairly detailed information about domestic violence homicides, but this information does not include names. And, as already noted, many deaths that met the Project's criteria would not be included in the WASPC listing.

Several strategies for identifying domestic violence fatalities were pursued:

- Law enforcement and prosecutor's assistance was requested to correlate names with WASPC data, which included the month of the homicide, the county, age and race of the victim and perpetrator, victim/offender relationship and weapon. This turned out to be relatively simple and very effective in rural areas that did not have large numbers of fatalities. It was less effective in the urban pilot region, for which there were at least 10 domestic violence fatalities a year.
- A data sharing agreement was made with the State office of vital statistics to obtain all recorded death information from 1990 to 1996, in order to correlate names with the information provided by WASPC.
- Use of the newspaper clipping service.

Using news accounts of domestic violence fatalities

The Domestic Violence Fatality Review Project hired a newspaper

clipping service to clip articles fitting the following criteria from all newspapers in Washington state:

1) Homicides (and attempted homicides) in which the victim's current or former intimate partner (boyfriend, girlfriend, husband, wife, lover) is the suspect. (include gay and lesbian relationships).
2) Suicides and murder/suicides.
3) Any homicide, which mentions domestic violence, spouse abuse, or involves a family relationship.
4) Homicides in which a current or former intimate partner kills their ex's new love interest, friend, or family member.
5) Reports of missing adult women and unsolved murders of adult women.

Information from articles was entered into a spreadsheet. The spreadsheet tracked names and ages of those involved, victim/offender relationship, charges filed and outcome, circumstances of the death, mention of prior domestic violence and address information. (Attachment 15)

News accounts of fatalities proved very useful for identifying domestic violence related fatalities that would not be captured in official crime statistics relying on the victim/offender relationship.

After a year of collecting news reports, it became possible to correlate names with WASPC's reports of domestic violence homicides. This comparison provided some perspective on WASPC statistics, and made clear the substantial number of domestic violence related fatalities which domestic violence crime statistics do not capture.

Finally, the newspaper database also served as a powerful educational tool. Information from the news database merged easily into a document which summarized reported fatalities by county or chronologically. (Attachment 16)

Which cases should (and should not) be examined?

The project defined "domestic violence related fatality" as any

fatality which occurs as a result of the efforts of an abuser to obtain power and control over their intimate partner. However, this criteria did not clearly identify a method for selecting specific cases for review.

The following criteria were developed for case selection: the perpetrator was already identified by the criminal justice system; the case was closed with no appeal pending; and the fatality was as recent as possible, given the other constraints. Another way to approach selection would be to focus on types of cases: homicide suicides or those involving teens, for example.

This Project's criteria rules out unsolved homicides, deaths which were classified as accidental and thus never triggered a criminal investigation, and cases in which prosecution, a civil suit, or an appeal was pending.

Four factors influenced this narrowing of the universe of cases for review:

1) The practical difficulties of sorting through large numbers of deaths (particularly in the urban counties) in order to identify those which might be domestic violence related, but not recognized as such by the justice system.
2) A reluctance on the part of panel members to risk jeopardizing or influencing an active criminal prosecution or civil action.
3) Lack of access to the confidential records that would be necessary to identify previously unidentified domestic violence fatalities. (i.e., deaths classified as "accidents" and some suicides)
4) A conviction that much could be learned through analysis of the many known domestic violence related homicides.

Using this criteria clearly limits the ability to review all domestic violence related deaths in a particular year. However, given the constraints posed by lack of access to confidential information and lack of protection of the review process itself from discovery, this narrowing of the universe of cases to be reviewed was seen as necessary.

It is extremely important to step back and take an objective look at what led up to these homicides, discussing them with people from other disciplines, to determine what could have been done, and what can be done in the future, to stop the violence from escalating, and break the cycle. These reviews so far have been very valuable in accomplishing that.

> "Two...children were shot in their beds early the morning of April 5. [The abuser's] wife had told him that week she wanted a divorce, and he kept her up all night at gun point, threatening to take her life and his own. When she escaped...he shot the two children..."
>
> (Peninsula Daily News 5/28/97)

What kind of preparation is necessary for the fatality review?

Advisory Committee members and review panel members expressed a desire to receive a summary of the public information available about the fatality prior to the review. Some domestic violence fatality reviews operate differently, with each member of the panel being responsible for bringing information from their agency to the table, and sharing it during the course of discussion. After considering this option, it was felt that the ability to review and reflect would enable a more effective review.

For each review, civil and criminal public records are obtained by panel participants and forwarded to project staff at least one month prior to the scheduled review.

In Washington, the individual law enforcement officers on the review panels are not empowered to release incident reports. Therefore, Project staff makes official requests to law enforcement agencies for release of incident reports, dispatch records and investigative notes regarding homicide investigations and prior incidents.

Information from public records are then condensed into a chronological summary. A list of questions for discussion is also generated. (Attachments 17 A and B) The summary and questions is mailed to each panel member. In some cases, additional materials are also enclosed, such as news articles and protection order narratives.

What happens during a review?

Conducting the domestic violence fatality review

Reviews were scheduled three to four hours on a quarterly basis. Depending on the complexity of a case and the amount of discussion, this allowed time to review one or two cases.

The process begins with introductions of everyone present and a review of the confidentiality agreements and group agreement. From there, the committee examines the chronology of events

leading up to the fatality, and asks questions. Project staff facilitates the meeting and keeps notes regarding unanswered questions and policy related issues. Staff also ensures that the questions contained in the case information form are posed.

Review panels in Washington's pilot regions have not gone through the Case Information Form question by question. However, this may be an option when review panels have a difficult time staying focused or tend to lapse into victim blaming.

Review of the case ends with review of issues raised, recommendations for change and unanswered questions. The meeting ends with planning for the next review. Cases are selected and responsibilities for obtaining public records are assigned. A meeting date is set.

What happens after the review of a case?

After the review, project staff writes up a summary of the issues raised during the course of the review. (Attachment 17 C) This is sent to panel members for correction, elaboration or clarification. The "issues summary" does not contain policy recommendations. Specific recommendations are avoided in this document because of the desire to have recommendations discussed thoroughly before they are put forth in writing by the Project, to avoid recommendations focusing on individual cases, agencies or communities and, instead, to have recommendations be part of the state level review in the annual report.

The Project anticipates convening a state level Domestic Violence Fatality Review Board, which will review the issues and summaries generated in the local review panels. This group of experts will work to refine recommendations as well as identify patterns and needs across the state.

How will information from reviews be documented?

Documentation should relate to the project purpose. In Washington, this means a focus on system response, the availability of resources, and possible barriers to intervention.

The names of individuals who had contact with either the victim or perpetrator (i.e., law enforcement officer, CPS worker) are not documented, as the focus is on systems, not individuals. While the review panel may examine in detail perceived flaws or shortcomings in response, no agency or individual is held responsible for the fatality in the documentation of the review.

What will go in the annual report?

The Case Information Form and a summary of issues raised during review comprise the documentation from individual reviews. Neither of these is intended for public distribution in and of themselves. Rather, these function as sources of information for the Annual Report.

It is anticipated that the Washington State Annual Report will be disseminated to member programs of the Washington State Coalition Against Domestic Violence, judges, policy makers, educators and state level agencies and organizations such as the Washington Association of Sheriffs and Police Chiefs and the Washington Association of Prosecuting Attorneys. It will include

- Summary of known crime statistics regarding domestic violence fatalities.
- Summary and analysis of the information gathered in local domestic violence fatality reviews.
- Overview of the issues and problems noted in reviews without identifying failings or strengths of particular agencies or communities.
- Recommendations for change.

Findings from the Washington State Domestic Violence Fatality Review Project

Chapter Nine

Response from participants and others

Panel members and others throughout the state found the project valuable and participated enthusiastically. Almost everyone asked to serve on the Advisory Committee or a local Domestic Violence Fatality Review panel said yes.

Participants on the pilot review panels consistently endorsed the value of the project, and wanted to continue to hold domestic violence fatality reviews. (Attachment 18) Local review panel members appreciated being able to participate in a process which they found valuable but did not require extensive preparation time on their part. In spite of the enthusiasm of the panel members, consistent attendance proved hard to maintain, particularly for those involved with trials (judges, prosecutors and court advocates.)

Advocates found the information developed through the project valuable for public education.

Quality of Discussion

Issues which had previously received little attention in state level policy discussions but which assuredly affect many battered women's lives were raised in the reviews.

Some examples of these included: the problem outstanding criminal warrants pose for battered women as they seek help from the justice system; lack of education and resources about suicide and how to respond to suicide threats, especially when they come from a batterer; the way in which a custody battle can become a forum for an abuser's power and control tactics.

The strength of the project lies in reviewing all possible factors: previous acts of violence and threats, proximity of abuser, effectiveness of protection/no contact orders, resources available to victims, their awareness of them, and knowledge of how to access them, missed opportunities to intervene, support systems available to all parties, access to weapons/laws regarding same, diverse cultural norms, etc. Diversity of backgrounds in the group is a big strength, as is intensive review of just one or two cases in each meeting.

> "...the Court finds that...[the father] has never once admitted any responsibility for the troubled marriage, the resulting separation, the alienation of the children, the frustration of counseling, or the violations of both the spirit and the content of the court orders in this matter... He refuses to accept any counseling that defines him as part of the problem..."
>
> (from a judicial decision affirming the father's primary custody of the children. He murdered his ex-wife the following year.)

Reviews required strong facilitation, as some teams had a tendency to wander. Reviews worked best when three to five key questions/issues focused the group.

Two reviews were conducted without distribution of a summary of public record information ahead of time to the group. While some valuable information was obtained, these reviews did not have the clarity and focus of those reviews in which materials were made in advance. Panel members clearly preferred entering the review with a chronology of events and the chance to prepare questions.

Relying on local panel members to obtain records

Relying on local review panel members to obtain public records and forward these to project staff had mixed success. Responsibilities for obtaining records must be clearly allocated, and some follow up may be necessary. Especially in rural areas, local panel participants may not have time to review long and complex records to decide which parts should be copied. In one case, which involved an extensive custody battle, project staff traveled to the location to review and copy records rather than rely on local participants.

Conclusion

Chapter Ten

During the grant period (March 1997 to December 1998), 43 women were killed by their current or former intimate partners in Washington State. In an addition, 13 friend or family members of battered women were killed. Finally, 7 children were killed by their fathers in the context of domestic violence between their parents.

The detailed domestic violence fatality reviews conducted in the pilot regions reinforced for all participants the importance of coordinated response to this problem. It is only through a coordinated community response to domestic violence that communities can reduce the number of domestic violence fatalities. The model described in this report can play an important role in creating and maintaining that response. As one panel member noted: “The project is a natural way to bring multiple and diverse agencies together to network and to (hopefully) develop a unified community response to domestic violence.”

Endnotes

Chapter Eleven

[1] RCW 10.99.020 and RCW 26.50.010.

[2] Bureau of Justice Statistics, "Violence by Intimates" March 1998 (NCJ-167237).

[3] Id.

[4] Washington Association of Sheriffs and Police Chiefs Annual Reports 1994-1997.

[5] Bureau of Justice Statistics "Spouse Murder Defendants in Large Urban Counties" (NCJ-153256).

[6] Supra note 2.

[7] For more information on child fatality reviews, see A Nation's Shame: Fatal Child Abuse and Neglect in the United States, A report of the U.S. Advisory Board on Child Abuse and Neglect, (US Government Printing Office) 1995. Copies may be obtained by calling 800/394-3366.

[8] See, for example, San Francisco's Response to Domestic Violence: The Charan Investigation 1991, report by the Commission on the Status of Women City and County of San Francisco, and A Study of Domestic Violence and the Justice System in Manitoba, by Honorable Mr. Justice Perry W. Schulman, Commissioner of the Commission of Inquiry in the deaths of Rhonda Lavoie and Roy Lavoie, June 1997.

[9] Judges can play an important role in the review process, and reviews are beneficial for judges. Judges responded to requests for their participation in a variety of ways. Some were quite interested in serving on panels. Others were unsure whether or not participation would violate judicial ethics regarding impartiality. If possible, obtain a statement from the state judicial ethics board condoning involvement.

[10] The release of information was discussed in Coalition membership meetings several times over a one-year period. In addition, several shelters discussed the possibility of such a release with battered women in support groups. Participants expressed an openness to the release. Most were not surprised at the thought that their abuser may kill them, as many already feared for their lives. Some expressed that they liked the idea of the release because they did not want their abuser protected in any way. They saw the domestic violence fatality review as one more forum in which the abuser's acts would be discussed and named as unacceptable.

[11] In a personal communication, Marie DiSantis wrote about her experience with interviews as part of a domestic violence fatality review in California: "My opinion is that people are overall very grateful for the opportunity to talk because most everyone else is trying to avoid the subject right at the time friends and family are most acutely reliving the events that led to the murder...I am always amazed how much people want to talk. I'm also always impressed with the amount of information we gain from these interviews. In domestic violence homicides, different from most other homicides, friends and family have usually been intimate witness to the situation over very long periods of time. They generally know a lot. We also give people the option of keeping their name out of any final report. Often they begin taking that option and then later on give us permission to put their name in."

[12] The Project has not yet pursued this option because other methods resulted in the identification of more deaths than could be reviewed during the grant period in each pilot region.

[13] Those interested in such a model may be interested in the domestic violence fatality review process in Philadelphia which seeks to do just this.

[14] The Advisory Committee members expressed concern that identifying particular agencies in public documentation of the

reviews may result in liability for those agencies. In addition, it was felt that many issues identified in local review panels may be common throughout the state, and it was unnecessary to draw attention to a particular community in order for the information to have value. Thus, the annual report might say something like, “review panels noticed that battered women who had outstanding warrants seemed to avoid contact with the police, and were often arrested when they did attempt to enlist the assistance of police” or, “Panels in rural counties consistently noted problems with access to legal advocacy as a difficulty victims faced.”

Attachments

Washington State Domestic Violence Fatality Review Project

Definition of Domestic Violence Fatality

A domestic violence fatality is a fatality that occurs as a result of the efforts of an abuser to obtain power and control over an intimate partner. This includes:

- All homicides in which the victim was a current or former intimate partner of the perpetrator.
- Homicides occurring in conjunction with an attempted or completed homicide of the perpetrator's current or former intimate partner. (For example, situations in which someone kills their current/former intimate partner's friend, family, child, legal advocate….).
- Homicides occurring as an extension of or response to ongoing abuse between intimate partners. (For example, when an ex spouse kills the children in order to exact revenge on a partner).
- Suicides that appear to be a response to abuse (as determined by information indicating prior domestic violence or knowledge from a particular committee member/agency about the circumstances leading to the suicide).

Criteria for Review

The Domestic Violence Fatality Review Project seeks to identify as accurately as possible all fatalities that occur as a result of domestic violence. Domestic Violence Fatality Review Panels will conduct detailed reviews of selected domestic violence related fatalities. Because of constraints on confidentiality and access to information, fatalities to be reviewed must conform to the following criteria:

- All civil and criminal actions related to the death are closed with no appeal pending.
- In cases of homicides, the perpetrator has been identified by the criminal justice system.
- The fatality is as recent as possible, given the first two criteria.

Eventually, the Project hopes to be able to review fatalities which fall outside these limits, including unsolved homicides of women known to have histories of abuse and cases which may not be classified as homicides by the police/prosecutors or coroners/medical examiners, but members of the committee suspect may be domestic violence related. The legal and confidential issues related to review of these sorts of fatalities remain unresolved at present.

Attachment 1

Investigative versus Systems Analysis Models for Domestic Violence Fatality Reviews

	Investigative Fatality Review	Systems Analysis Fatality Review
Priority	Identify DV fatalities which have not previously been identified as DV related by police, prosecutors and coroners	Identify how accountability systems and helping systems were or were not effective for batterers and DV victims involved in DV related fatalities
Goals for reviews	Understand how or why deaths were not classified as DV related Work toward more accurate identification of DV related deaths	Understand how CJS and social service policies and practices did or did not achieve goals of identifying and ending domestic violence
Potential Outcomes	Improved protocols for coroners and others investigating deaths More accurate counts of how many people die each year in DV related fatalities Increased public awareness	Policy initiatives, better practice, identification of systems gaps, training needs, increased public awareness
Numbers	Greater emphasis on ensuring the *entire* pool of DV related deaths are identified Any discussion of trends must be careful to acknowledge the limits of the data	Greater emphasis on what can be learned from the deaths which are identified versus identifying every DV related death Any discussion of trends must be careful to acknowledge the limits of the data
Identifying DV related deaths	Will require a great deal of "footwork": obtaining a list of "unexpected deaths" from Coroner / ME, then panel participants check against records	Identifying every single DV related death is not necessary to achieve systems analysis goals Relying on newspaper coverage and knowledge of participants on review panel will result in the identification of a significant number of DV related fatalities

Attachment 2

Washington State Domestic Violence Fatality Review Project

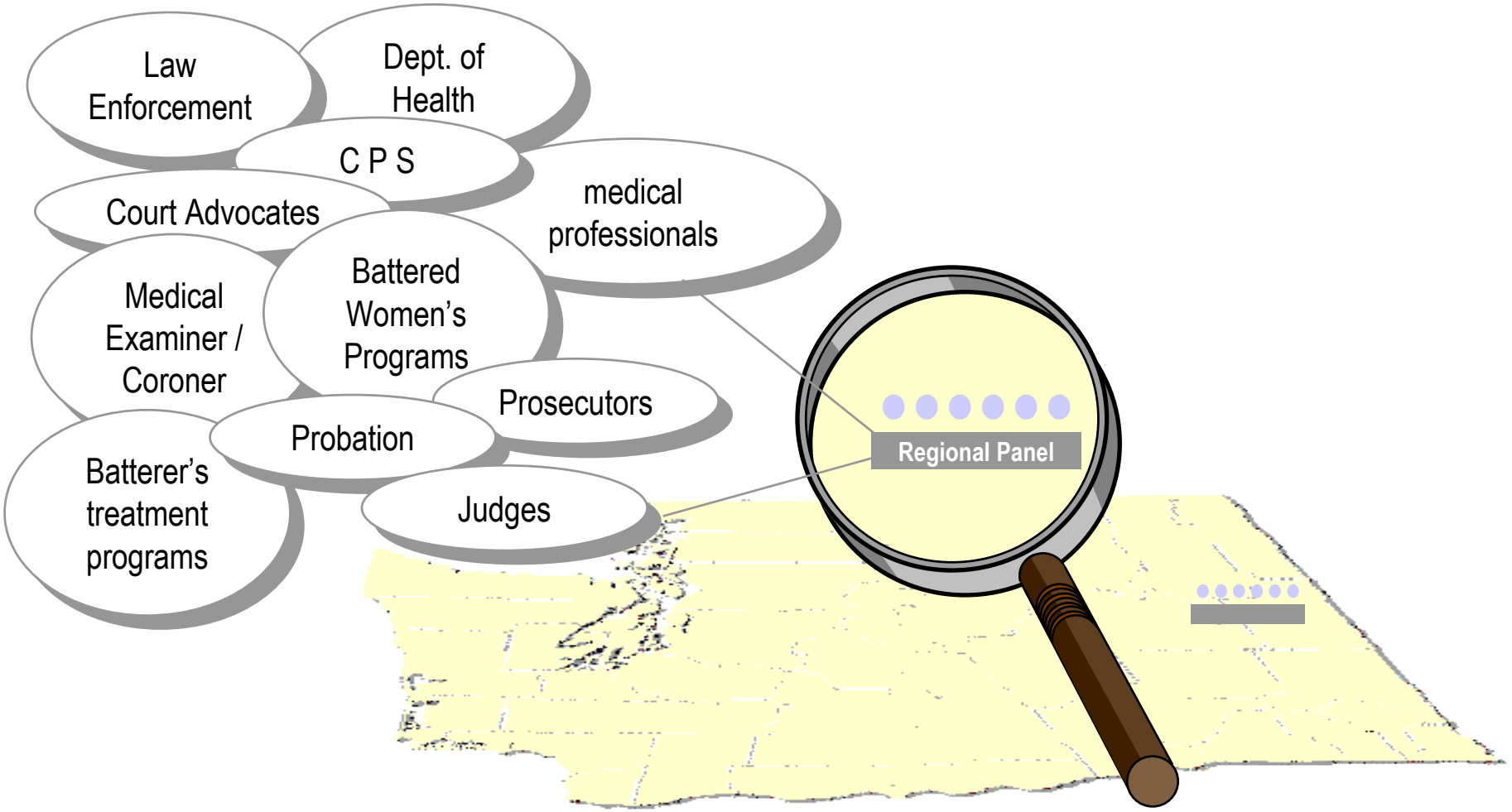
Three Models for Fatality Review Panel Participants

	Experts	Involved Agencies	Advocates
Brief description	Subject matter experts are identified within each discipline to participate in the review	Representatives of the agencies / organizations / institutions in the region participate in the review	Participants identify primarily as battered women's advocates (but may work in a variety of disciplines)
Contact with case	Experts may not have had any contact with particular cases	Goal is to involve agencies who had contact with particular cases	Advocates may have had contact with the case but not necessarily
Information obtained	Experts receive information/records regarding the case	Agency representatives bring information they have on the case; public record information may be distributed to all participants; family and friends may be interviewed	Advocates seek out all available public records regarding the case, and may interview family, neighbors and friends for additional information
Standard against which information is measured	Information is compared against "the state of the discipline" as understood by domestic violence experts in each discipline	Information is compared against the "state of the discipline" as it is understood by participants (who may not be experts)	Information is compared against the "state of the discipline" and explicitly feminist visions for women's empowerment
How does the review impact practice	Generate recommendations for change on several levels: agency, system, regional, state are made and distributed to individual agencies, perhaps to regional and state coalitions Periodic report by state coordinating body can become a tool for policy makers, advocates and educators	Panel participants will undoubtedly be affected by their experience on the panel Group discussion may lead to recommendations for change on several levels: agency, system, regional, state Individual representatives to the panel may be stimulated to rethink practice issues and policies in their own agencies, whether or not the panel identifies a need for change in their agency's practices Periodic report by state coordinating body can become a tool for policy makers, advocates and educators	Results of reviews can be publicized and used in education of the general public and systems players Advocacy centered review panels may put pressure on agencies to explain or improve their policies and practice Recommendations for change and exposure of problems may address local, county and statewide issues Periodic report by state coordinating body can become a tool for policy makers, advocates and educators

Attachment 3

Advantages	Reviews may go more quickly because of shared understandings about domestic violence and optimum response to it Workgroup can be small, increasing efficiency Relationships may be easier to build because of common investment in DV, and the depersonalized nature of examining other people's work and decisions	Direct participation leads to direct emotional/intellectual impact on people involved with DV victims A broader range of people receive information, the review process creates an environment in which people can build expertise Higher quality information about agency interactions, policies, because people bring verbal as well as written information with them, insider's view of how agency works and why, etc.	Small workable group of people with a shared understanding of domestic violence may facilitate efficient and incisive reviews Discussion is likely to be forward looking and change/prevention oriented, likely to avoid victim blaming and the pull of complacency Advocates' familiarity with the day to day struggles battered women face adds dimension to the review May be the best solution in areas in which local players are unfamiliar with domestic violence, victim blaming, or hostile to change
Dis-advantages	Difficult access to information, low quality information. When DCFS child fatality reviews take this form, CPS turns over an agency file that contains quite a bit of info. Doubtful that multiple agencies involved with adult DV victims and perpetrators will consent to turn over their records for other people to discuss. No analogous agency to CPS exists for these sorts of reviews Potentially contributes little to community in terms of building expertise or insight in people who do not already have it	Possibly too many people at the table, too cumbersome Challenges gaining local commitment and consistency in attending reviews Risk that voices of battered women's advocates and DV experts may be unproductively diluted, resulting in victim blaming or proposed "solutions" which do not take in battered women's realities If local expertise regarding the state of the discipline is weak this can interfere with identifying problems and proposing recommendations	A limited number of people in a narrow range of disciplines have the opportunity to engage in the process and thereby learn from it Results of advocates' reviews may be dismissed by agencies that were not included, and/or may be perceived to be antagonistic Potentially contributes little to community in terms of building expertise or insight in people who do not already have it

Key Participants in Regional Domestic Violence Fatality Review Panels



Attachment 4

Washington State Domestic Violence Fatality Review

Flow of information

protocols
technical assistance
deaths for review
summary reports
forms

common issues and concerns

data on fatalities from reviews

assist in identifying deaths for review

State DV Fatality Review Office

State DV Fatality Review Board

Regional / County Review Panel

Responsibilities and tasks

identify deaths
recruit panel members
locate financial resources
convene, facilitate and document meetings
issue annual report

identify statewide trends and policy issues, advise on annual report

assist in recruitment of panel members
identify which deaths to review
conduct and document review
identify regional issues

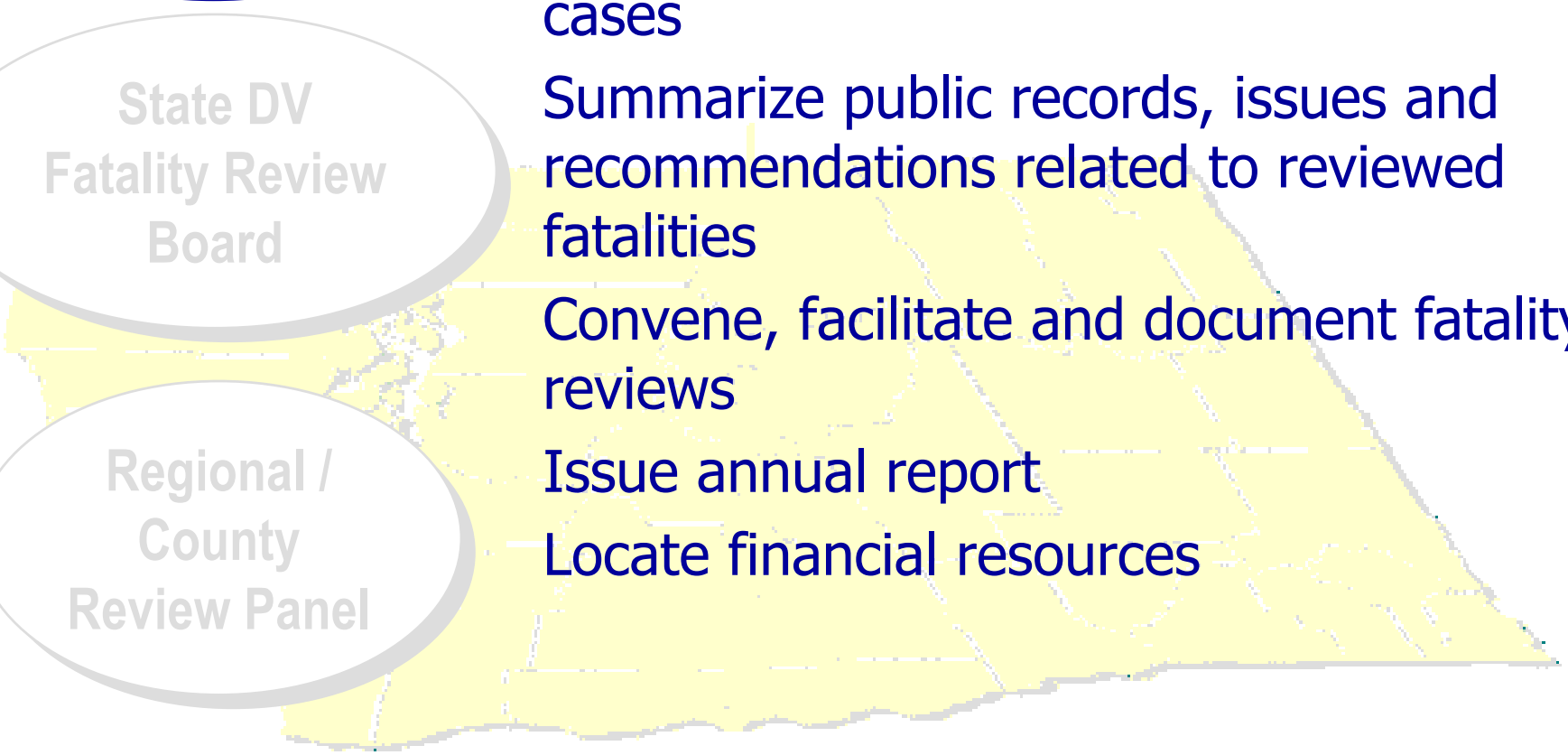
Attachment 5

Washington State Domestic Violence Fatality Review

State DV Fatality Review Office

State DV Fatality Review Board

Regional / County Review Panel



Tasks:

- Identify domestic violence related deaths
- Recruit review panels and state board
- Coordinate information gathering on cases
- Summarize public records, issues and recommendations related to reviewed fatalities
- Convene, facilitate and document fatality reviews
- Issue annual report
- Locate financial resources

Washington State Domestic Violence Fatality Review

State DV Fatality Review Office

State DV Fatality Review Board

Regional / County Review Panel

Membership:

Regionally diverse

Review panel representatives

Recognized experts in varied disciplines

Representatives from other state agencies ie, department of health, washington association of police chiefs and sheriffs

Washington state coalition against DV

County level domestic violence policy

Activist lawyers

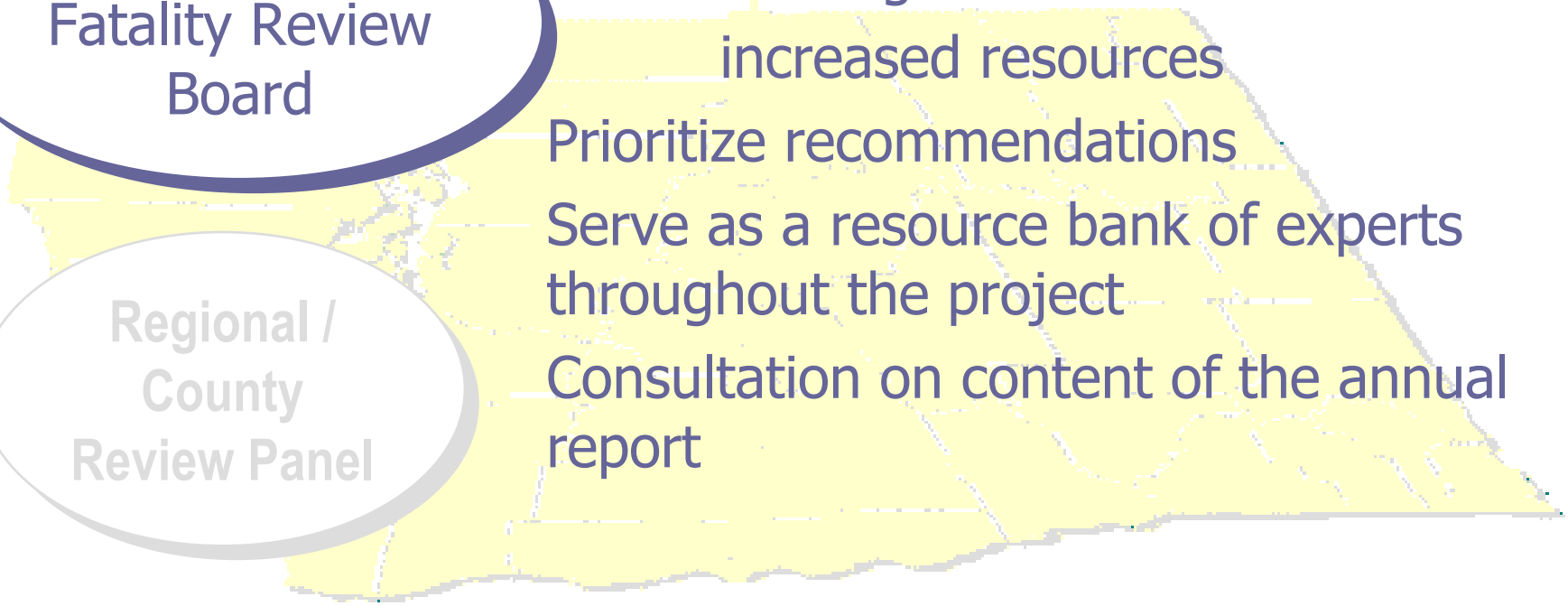
Academics

Washington State Domestic Violence Fatality Review

State DV Fatality Review Office

State DV Fatality Review Board

Regional / County Review Panel



Tasks:

Develop recommendations in response to issues raised in local reviews

- new or refined law
- changes in practice
- training
- increased resources

Prioritize recommendations

Serve as a resource bank of experts throughout the project

Consultation on content of the annual report

Washington State Domestic Violence Fatality Review

State DV Fatality Review Office

State DV Fatality Review Board

Regional / County Review Panel

Membership:

- Battered women's program(s)
- Court advocate
- Law enforcement
- Medical professionals
- Judges
- Victim witness
- Child protective services
- Probation
- Prosecutor
- Batterer's treatment
- Medical examiner/coroner
- Culturally specific programs
- Animal cruelty investigators

Washington State Domestic Violence Fatality Review

State DV Fatality Review Office

State DV Fatality Review Board

Regional / County Review Panel

Tasks:

- Assist in recruitment of panel members
- Assist in identification of deaths
- Identify which deaths to review
- Gather public records and forward to project staff
- Each member reviews their agency records
- Participate in review
- Identify local/regional issues, make recommendations
- Send representative(s) to State DV Fatality Review Board

Washington State Domestic Violence Fatality Review

State DV Fatality Review Office

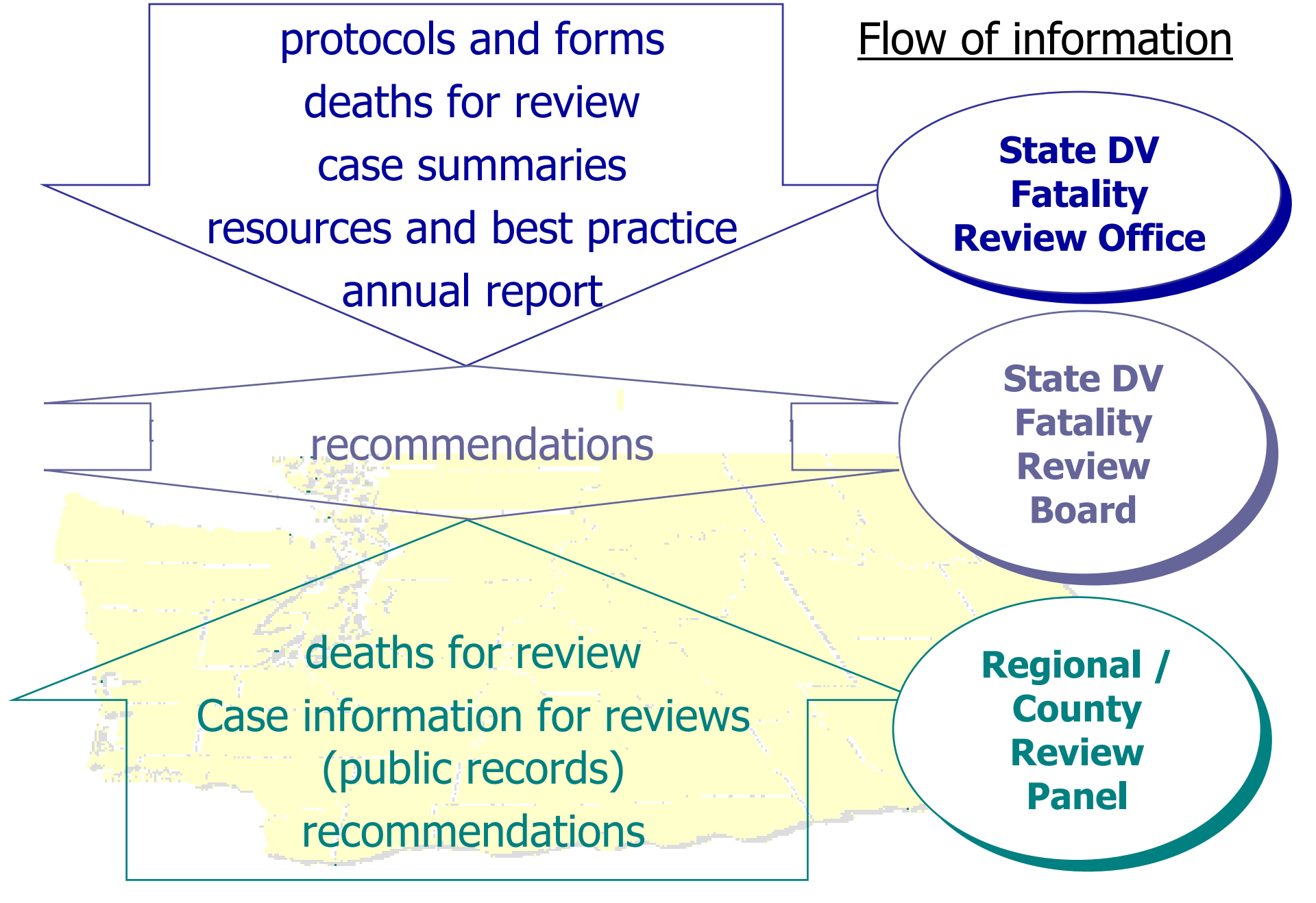
State DV Fatality Review Board

Regional / County Review Panel

Burden on local level is light, for the following reasons:

- Lack of local leadership which everyone would endorse
- Lack of resources in rural areas (no agency is well funded enough to devote staff time)
- Investment in the project must be developed

Washington State Domestic Violence Fatality Review



Washington State Domestic Violence Fatality Review Project

Case Information Form

definition of terms:

decedent(s): person(s) whose death is under review. If there are multiple decedents, please fill out a separate decedent information sheet for each person.

domestic violence perpetrator: person who is identified as the primary abuser in the relationship. This is the person who held the balance of power in the relationship over time, perhaps had a record of assaulting the dv victim, and who otherwise made threats or acted in ways consistent with common definitions of domestic violence. This person may be either the decedent, the person directly responsible for another's death, or play another role.

domestic violence victim: person who is identified as the victim of ongoing domestic violence prior to the death under review. This is the person who held the balance of fear in the relationship over time, perhaps had a record of seeking help to end the abuse, and who otherwise had experiences consistent with being abused. This person may be the decedent or the perpetrator of homicide or play another role.

Contents of the Case Information Form

Attachment 6

Washington State Domestic Violence Fatality Review

This face sheet to be stored separately from rest of data

Case #

date review initiated: county/tribe/region of review:

date review completed:

Identifying Information:

For cases of homicide, or when a death occurs in the course of self defense:

name of person directly responsible for the fatality:	Gender	relationship to decedent(s)	If deceased, date of death	Date of Birth
Aliases/AKAs				
Did this person commit suicide following a completed or attempted homicide?	☐ yes ☐ no ☐ unknown			

Decedents:

decedent(s) name	Gender	relationship to perpetrator of homicide	date of death	Date of Birth
Aliases/AKAs				

Please note: none of the information on this page except for the case number will be entered into a permanent database. This information, which connects a set of names to a case number, will be kept long enough to ensure that fatalities are not reviewed more than once by different regions, and then destroyed. Thus, all documentation of the case in the records of the Domestic Violence Fatality Review Project will be designated by case # and not names.

Date of review:

Domestic Violence Fatality Review Case #_____

Short narrative overview:

A. Type of Incident

☐homicide ☐ suicide ☐multiple homicide ☐was a suicide involved as well? ☐suspicious accident

Check all that apply:

deceased	**person(s) who are the direct cause of death**
☐domestic violence perpetrator	☐domestic violence perpetrator
☐domestic violence victim	☐domestic violence victim
☐children of dv victim	☐child of dv victim and / or perpetrator
☐children of dv victim and perpetrator	☐person hired by or acting on behalf of: domestic violence perpetrator
☐children of dv perpetrator, but not the dv victim's	☐person hired by or acting on behalf of: domestic violence victim
☐other family of dv victim	☐law enforcement
☐other family of dv perpetrator	☐other (specify):
☐friends of dv victim	
☐new intimate partner of dv victim	
☐advocates/lawyers for dv victim	
☐co workers of dv victim	
☐police officer	
☐bystanders	
☐other (specify):	

B. Demographic information:

Identification of dv victim and dv perpetrator

Has the panel identified a domestic violence victim and a domestic violence perpetrator? ☐yes ☐no

If yes, what did the panel base this identification on?

☐Filings for any of the civil orders for protection
☐testimony from friends and family
☐perpetrator treatment records
☐histories of arrest and prosecution for dv
☐histories of seeking help from programs for victims of dv

Race

Please note that racial identifications can be complicated by citizen/immigrant status as well as assimilation/acculturation. Panel members should take care to consider race in relation to immigration/citizen status.

Domestic violence victim's racial identification		Domestic violence perpetrator's racial identification
	white / non Hispanic	
	African/African American	
tribe:	Native American	*tribe:*
	Hispanic / Latino	
specify:	Asian	*specify:*
specify:	mixed race	*specify:*
specify:	other	*specify:*

Gender

Domestic violence victim's gender		Domestic violence perpetrator's gender
	man	
	woman	
specify:	other	*specify:*

Age

Domestic violence victim's date of birth		Domestic violence perpetrator's date of birth

Education

Domestic violence victim's educational attainment		Domestic violence perpetrator's educational attainment
	no high school	
	some high school	
	high school degree	
	GED	
	some college	
	AA degree	
	BA	
	M.A.	
	Ph.D.	
	J.D.	
	other license/certificate	
	Unknown	

Economic status

Domestic violence victim's estimated income: $		Domestic violence perpetrator's estimated income: $
source of income:		source of income:
	employed	
	on SSI / SSD	
	receiving food stamps	
	unemployment	
	On AFDC	
	on TANF	
	minimum wage job	
	spousal support	
	family	
	no income	
	Other	
	unknown	

Law Enforcement / Military

Was either the domestic violence victim or the domestic violence perpetrator employed by the law enforcement or the military?

☐no ☐ yes. If yes, specify below:

domestic violence victim		domestic violence perpetrator
	employed in law enforcement	
	specify position	
	employed in military	
	specify position	

Please specify the country if the law enforcement or military experience was for an institution other than the US:

Sex Industry

Is there any evidence that the domestic violence victim was involved in the sex industry? ☐ yes ☐no ☐unknown

Is there any evidence that the domestic violence perpetrator encouraged or coerced the domestic violence victim to participate in the sex industry? ☐ yes ☐no ☐unknown

C. Immigrant / Refugee / Citizenship status

Please check all that apply:

domestic violence victim's status		domestic violence perpetrator's status
	citizen of the United States	
	documented immigrant/refugee	
	undocumented immigrant / refugee	
	in the process of attaining documented legal status	
sponsored by: ☐ domestic violence perpetrator ☐ employer ☐ filing individually based on status as a battered woman ☐ other *specify:*	sponsor	sponsored by: ☐ domestic violence victim ☐ employer ☐ other *specify:*

If the domestic violence victim was an immigrant or refugee, is there any evidence that the domestic violence perpetrator held the domestic violence victim's passport or other important legal documentation? ☐ yes ☐ no ☐ unknown

D. Relationship Information

Domestic violence perpetrator's relationship to domestic violence victim at time fatality occurred:

(check one in each column)

legal status of relationship	living together status	emotional status	children
☐ no legally recognizable relationship / never married	☐ living together since:	☐ relationship current at time of death	☐ had children in common
☐ married date	☐ previously lived together, not living together at time of death	☐ in process of breaking up/victim had stated intention of leaving	☐ no children, in common or otherwise
☐ separated date	☐ always maintained separate dwellings	☐ broken up/ separated/divorced at time of death date of separation:	☐ children in the household, but not in common
☐ divorced date		☐ dating history existed, but indicators of a serious reciprocal relationship not present	☐ pregnant at time of fatality how many months?
☐ registered as domestic partners			☐ were children living with someone other than parent? specify ☐ Fostercare ☐ relatives

E. Family Information

number of children living in the domestic violence victim's home age and gender of each:

(if different) number of children living in the domestic violence perpetrator's home ages genders

legal relationships to children:

children living with domestic violence victim		children living with domestic violence perpetrator (if different)
	parent	
	stepparent	
	relative	
	guardian	
	no legally recognized relationship	
	other	

Number of others living in domestic violence victim's home:

relationship(s) ☐parent ☐sibling ☐cousin ☐friend ☐acquaintance ☐husband/boyfriend/partner (different than abuser) ☐ other

Was the domestic violence victim pregnant? ☐ Yes ☐ No ☐ Unknown

If yes, was the domestic violence perpetrator the father? ☐ Yes ☐ No ☐ Unknown

F. Information about the circumstances of death

Where the death occurred

check an appropriate range for the population of the city and county in which the death occurred:

county population ☐under 15,000 ☐15,000-40,000 ☐40,001-70,000 ☐70,001-400,000 ☐400,001 and up

Did the death take place on: ☐ a reservation or tribal land? *specify* ☐military land? *specify*

Nature of the location where the death or the injurie(s) which resulted in the death occurred:

☐domestic violence victim's home ☐domestic violence perpetrator's home ☐street/parking lot
☐home of friend/family ☐public building *specify* ☐ Unknown
☐hospital ☐public land/park/forest *specify* ☐ other
☐domestic violence victim's workplace ☐domestic violence perpetrator's workplace

If death or the injurie(s) which resulted in death occurred at a home, where?

☐kitchen ☐bathroom ☐bedroom
☐living room ☐yard ☐garage
☐basement ☐barn or other outbuilding ☐other (please specify):

Medical Care

Did the death occur under medical care? ☐ yes ☐no if yes, specify (hospital, trauma center, private doctor)

Did the decedent receive any medical attention for the fatal injurie(s) prior to death?

Who provided medical intervention:

☐Emergency Medical Team ☐Fire department personnel ☐police ☐Ambulance personnel
☐local hospital emergency room personnel ☐regional trauma center emergency room personnel ☐other_____

What sort of medical intervention took place?

Did the decedent have to be transported to a regional trauma center (i.e., Harborview)? By what means? How long did this take?

Access to / use of firearms

If a gun was used, was it available in the home? ☐ Yes ☐ No ☐ Unknown

was it available in the car? ☐ Yes ☐ No ☐ Unknown

Who owned the gun? ☐domestic violence perpetrator ☐domestic violence victim ☐ other (specify)

When was it purchased? Date:

Was it acquired legally? ☐ yes ☐no ☐unknown

Were all required registrations in place? ☐ yes ☐no ☐unknown

Was the gun stolen? ☐ yes ☐no ☐unknown

If yes, when was it stolen? (date) from where was it stolen?

Did the dv victim or prosecutor ever request on a court order that guns be surrendered or destroyed? ☐ yes ☐no ☐unknown

Did a court ever order that the guns be surrendered or destroyed? ☐ yes ☐no ☐unknown

Were they? ☐ yes ☐no ☐unknown

Did law enforcement ever have the legal authority to remove guns from the home? ☐ yes ☐no ☐unknown

If the dv victim and perpetrator lived together, did the dv victim ever request directly to the police that guns be removed from the home?
☐ yes ☐no ☐unknown

Were they removed? ☐ yes ☐no ☐unknown date of removal:

Were they returned? ☐ yes ☐no ☐unknown date of return:

Federal prohibitions on gun ownership/possession

Had the person in possession of the gun ever been convicted of a domestic violence misdemeanor or felony?

☐ yes ☐no ☐unknown

Had the person in possession of the gun ever been a respondent to a domestic violence protection order (not NCO or RO)?

☐ yes ☐no ☐unknown

Did the domestic violence perpetrator own large guns not covered by laws limiting offender's right to own guns?

☐ yes ☐no ☐unknown

Motor vehicle involved:

If Motor vehicle incident/crash, check all that apply

domestic violence victim		domestic violence perpetrator
	Driver	
	passenger	

	pedestrian	

Who investigated the scene of the accident:

☐ specialized auto accident unit within the local jurisdiction

☐ specialized auto accident unit from State Patrol

☐ non specialized unit

Was there any history reported to any agency of "crazy driving" as an abusive tactic?

☐ *Yes* ☐ *No* ☐ Unknown

Who was present at the scene of the fatal attack / fatality / accident?

	Who was present? (on same property, in same house, nearby…) check as many as apply	Did they witness the fatal attack / fatality / accident?		
		Yes	no	unknown
Children (list by age / gender)				
other family				
friends				
acquaintances				
strangers/bystanders				
new intimate partner				
coworkers				
helping professionals/advocate				
Emergency Medical Tech				
Fire Dept Personnel				
Ambulance personnel				
other				

Did anyone hear excited utterances before the death occurred? ☐ yes ☐ no ☐ unknown

If yes, were the excited utterances documented? ☐ yes ☐ no ☐ unknown

G. Prior Threats To Kill / Knowledge Of Level Of Dangerousness

Do any law enforcement reports, charging papers or protection order narratives include descriptions of the following (if yes, indicate dates if possible):

	law enforcement reports	charging papers	protection order narratives	reported in counseling / advocacy	Reported to / witnessed by family / friends
threats to kill dv victim					
threats to kill children ,family members or friends					
suicide threats					
suicide attempts					
choking					
knife brandished					
knife used					
gun brandished					
gun used					
blunt object brandished					
blunt object used					
suspected or charged in death of former intimate partner					
former intimate partner died in an accident					

H. Criminal Justice System response to the fatality

Law Enforcement

What agency(s) responded to the fatality (or incident which resulted in a fatality)?

Did law enforcement arrive ☐before or ☐after the fatality occurred?

What sort of call were law enforcement responding to:

☐domestic violence ☐barricaded ☐possible suicide ☐possible DOA ☐suspicious circumstances

☐shots fired ☐other (specify)

If the situation was a barricade or hostage situation, were negotiators brought in? ☐ yes ☐ no ☐ unknown

Were police forced to defend themselves or otherwise act with deadly force? (blue suicide/suicide by police) ☐ yes ☐ no

Was there enough information to immediately identify a suspect?

If no, how long did it take to identify a suspect? date suspect identified:

Was an arrest made at the scene of the fatality/fatal injury/attack?

Was there a tentative identification of a suspect or identification of a person of interest? ☐ yes ☐ no ☐ unknown

How much time elapsed between the fatality and arrest of suspect? date of arrest:

Did law enforcement investigations identify enough information to charge the suspect? ☐ yes ☐ no ☐ unknown

Prosecution and Courts

Were criminal charges filed related to the fatality? ☐ Yes ☐ No ☐ Unknown

If No, were charges not filed because:

☐ it was a suicide/homicide ☐ it was a suicide (no homicide involved)

☐ it was ruled self defense

☐ No for other reasons, please explain:

Against whom were charges filed? ☐ domestic violence perpetrator ☐ domestic violence victim ☐ other(s)

the original charges	plead down to:
1.	1.
2.	2.
3.	3.
4.	4.

What amount was bail set at?

Did the suspect make bail?

Was the suspect offered a plea bargain?

What factors informed the decision to offer a plea bargain:

If defendant did not plea, was the case tried before a jury?

trial date length of trial

Sentencing date:

Disposition: ☐ acquitted ☐ probation # years/months: ☐ prison # years/months:

☐jail # years/months ☐treatment ☐credit for time served (months/days)

☐suspended?

If on probation, what were the conditions of release?

Were any court orders issued? (i.e., a No Contact Order)

Were parental rights severed? ☐yes ☐no ☐unknown

I. Status of Children after the fatality

Had CPS/CFS been involved with the family prior to the fatality? ☐ yes ☐no ☐unknown

Were children placed immediately after the fatality? ☐ yes ☐no ☐unknown

Where were children placed?

☐Foster care ☐group home ☐relatives of the domestic violence perpetrator

☐relatives of the domestic violence victim ☐other (specify)

If children were placed in foster care, was a relative ever identified for permanent placement? ☐ yes ☐no ☐unknown

How long did it take to identify a relative for placement?

Were the policies of the Indian Child Welfare Act followed?

Was the children's tribal status assessed?

If the children were members of a tribe, was the tribe contacted?

What factors influenced the placement decision?

Were children expected to testify at a trial?

What counseling / support did children receive after the fatality?

J. Criminal Justice System involvement prior to the fatality

(please fill out a Criminal Justice System prior to the fatality form for each contact)

Pending criminal actions at time of the fatality

	court date		court date
protection order violation		stalking	
no contact order in place		sexual abuse of domestic violence victim	
no contact order violation		sexual abuse of children	
assault		other	

Were domestic violence related charges ever dismissed against this domestic violence perpetrator with this dv victim?

☐ yes ☐no ☐unknown

How many times? Official reason for dismissal

Does the domestic violence perpetrator have a prior history of domestic violence towards other victims?

☐ Yes ☐ No ☐ Unknown How many?

Was there ever any indication that the domestic violence perpetrator pressured the domestic violence victim to refuse cooperation with the prosecution, or to change the story from the initial statements? ☐ Yes ☐ No ☐ Unknown

K. Batterer's Treatment/Perpetrator's Intervention Programs

How many times had the domestic violence perpetrator been ordered to batterer's treatment? to anger management?

Was the domestic violence perpetrator ordered to batterer's treatment by more than one jurisdiction?

How many times had the domestic violence perpetrator successfully completed batterer's treatment? Or anger management?

If the domestic violence perpetrator was in batterer's treatment, was there ever any talk of homicide or suicide?

☐ Yes ☐ No ☐ Unknown If yes, explain:

If yes, what actions were taken with reference to victim safety?

☐ victim contacted and warned ☐ dv perpetrator expelled from program ☐ law enforcement notified ☐ other

L. Civil Actions

Past, disputed and pending Civil Actions:

	in place (date)	disputed	pending action/decisions (date)
divorce			
parenting plan			
primary physical custody			
visitation			
parenting evaluation			
child support collection			
civil orders			
Temporary protection order			
Permanent protection order			
restraining order			
anti harassment order			
Tribal Peacemaker Circle or other traditional dispute resolution order			
other			

Custody

What were the custody arrangements? (check all that apply)

domestic violence victim		domestic violence perpetrator
	had sole legal physical custody	
	joint custody	
	unsupervised visitation	
	supervised visitation	
	overnight visits	

	no visitation	

Threats regarding the children:

Is there any indication that the following threats were ever made (indicate person threatening, nature of threat/action)

domestic violence perpetrator			domestic violence victim	
threatened to	actually did		threatened to	actually did
		take the children to a location unknown by the other for reasons other then their own or the parent's safety (please make a distinction between seeking safe shelter and 'kidnapping')		
		harm the children		
		kill the children		
	for how long?	otherwise deny the other person contact to the children		for how long?
Specify relationship		harm family members, new love interests, or friends	Specify relationship	

Guardian ad Litems	Yes	No	Unknown
Had a guardian ad litem or Court Appointed Special Advocate been appointed?			
Had this person received training in identifying and responding to domestic violence?			

Parenting Evaluations

Had a parenting evaluation taken place?			
Did the evaluator identify domestic violence?			
Were considerations for the domestic violence victim and children's safety built into the recommended plan?			

Visitation

Had the victim indicated fear of or reluctance for an arrangement including unsupervised visitation?			
Do affordable supervised visitation centers exist in the domestic violence victim's or the domestic violence perpetrator's community?			

M. CPS/CFS involvement prior to the fatality

According to CPS/CFS, were there any founded or unfounded (in CPS/CFS terms) allegations of child abuse filed against the domestic violence victim? ☐ Yes ☐ No ☐ Unknown

date	allegation	child involved	did CPS/CFS find the allegation to be founded or unfounded ?	consequences / follow up

According to CPS/CFS were there any founded or unfounded (in CPS/CFS terms) allegations of child abuse filed against the domestic violence perpetrator? ☐ Yes ☐ No ☐ Unknown

date	allegation	child involved	did CPS/CFS find the allegation to be founded or unfounded ?	consequences / follow up

According to CPS/CFS, had either the victim or perpetrator of domestic violence received services as victims of abuse when they were children? If yes, check off boxes below:

Domestic violence victim		Domestic violence perpetrator
	Unfounded reports filed	
	Founded reports filed (specify year and nature of report)	
	Was removed from home	
If yes, specify years in foster care:	Placed in foster care?	If yes, specify years in foster care:

	yes	no	unknown
Had the CPS/CFS worker received training regarding the identification of domestic violence and its role in child abuse?			
Did the CPS/CFS worker screen for domestic violence?			
Was domestic violence identified as an issue by the CPS/CFS worker?			
Was the dv victim given referrals to a dv program or legal advocacy by the CPS/CFS worker?			
Did domestic violence victim safety figure into the CPS/CFS plan for the family? (specify)			

N. Domestic Violence Perpetrator History Of Violence Towards Others

Is there any evidence that the domestic violence perpetrator was violent towards other people? (i.e., bar brawls, complaints filed by people other than the domestic violence victim, previous intimate partners, fighting with police…)

date	source of this information	type of incident	Relationship to the victim	was an agency involved? If so, specify	outcome

Is there any evidence that the domestic violence perpetrator was violent or abusive towards animals?

date	source of this information	type of incident	was an agency involved? If so, specify	outcome

O. School, Workplace and Public Assistance Response

Was the domestic violence victim was in school? ☐*yes* ☐*no*

If yes, specify type of campus: ☐ high school ☐community college ☐private 4-year institution ☐public university

	yes (specify)	no	unknown
Had the domestic violence perpetrator harassed, threatened or assaulted the victim at school or on the way to school?			
Were school officials notified of the existence of domestic violence?			
Were any provisions for the domestic violence victim's safety on campus implemented?			
Does the school have a policy for responding to domestic violence?			
Does the school have on campus resources for victims of domestic violence?			

Did the domestic violence victim hold a job prior to the fatality ? ☐*yes* ☐*no* *if yes, please answer the following:*

	yes (specify)	no	unknown
Had the domestic violence perpetrator harassed, threatened or assaulted the victim at the workplace or on the way to work?			
Were supervisors aware of the existence of domestic violence?			
Were any provisions for the domestic violence victim's safety in the workplace implemented?			
Does the workplace have a policy for responding to domestic violence?			
Does the workplace provide any resources for victims of domestic violence?			

Was the domestic violence victim on any form of public assistance prior to the fatality? ☐yes ☐no If yes, answer the following:

	Yes (specify	No	Unknown
What training had the case worker had regarding domestic violence?			
Did the caseworker screen for domestic violence?			
If the domestic violence victim was on TANF, had she qualified for the domestic violence exceptions?			

P. Medical

	yes	no	unknown
Had the victim suffered prior injuries as a result of domestic violence?			
Do hospital records make any note that injuries were domestic violence related?			
Do hospital records note having provided referrals/resources for domestic violence?			
If the domestic violence victim was pregnant in the 5 years prior to the fatality:			
Had the domestic violence victim received prenatal care?			

If yes, starting what month of pregnancy?			
Did the prenatal care provider routinely screen for domestic violence?			
Was abuse identified during the course of prenatal care?			

Summary of history of visits for injuries, accidents and trauma to hospital/medical by domestic violence victim

Date of visit	chief complaint	admit/discharge	disposition	domestic violence discussed?

Summary of history of visits to hospital/medical by children in the home for injuries, accidents and trauma

Date of visit	chief complaint	admit/discharge	disposition	any suspicion of abuse?

Q. Access To Helping / Accountability Resources

Did the domestic violence victim have access to a working telephone? ☐ yes ☐ no ☐ unknown

If yes, where? ☐ In the domestic violence victim's home ☐ At the domestic violence victim's place of work ☐ At friend/family/neighbor's ☐ Other (specify)

How far did the domestic violence victim have to travel to access community resources in person?

Did the domestic violence victim have access to transportation? ☐ yes ☐ no ☐ unknown

If yes, specify: ☐ own car ☐ borrowed car ☐ public transportation ☐ other (specify)

To the panel's knowledge, were any of the following agencies involved with the domestic violence victim or the domestic violence perpetrator in the past 5 years prior to the fatality? Check all that apply and list specific names:

dv victim	dv perpetrator	Organization
		law enforcement
		city prosecutor
		county prosecutor
		court/judges (specify) ☐ superior ☐ district ☐ municipal
		family court

dv victim	dv perpetrator	Organization
		domestic violence victim shelter/safehouse
		religious community / church / temple / mosque
		community based legal advocacy
		court based legal advocacy
		Protection order advocacy program

dv victim	dv perpetrator	Organization
		municipal court
		probation
		parole officer
		anger management program
		batterer's intervention program
		substance abuse program
		mental health provider
		health care provider
		supervised visitation/drop off center
		regional trauma center
		local hospital
		Fire department
		ambulance services

dv victim	dv perpetrator	Organization
		immigrant advocacy organization
		animal control/humane society
		Dept. of Child and Family Services (CPS, FRS)
		culturally specific organization
		TANF office
		TANF employment program
		homeless shelter
		sexual assault program
		other domestic violence victim services (i.e., support group, one to one counseling….)
		other social services agency: specify
		private/HMO Dr.
		emergency medical technician
		daycare

R. Communication, Translation And Accessibility

Disability

domestic violence victim		domestic violence perpetrator
	Physical disability (specify)	
	was the disability work related?	
	What sorts of accommodations were required for accessibility?	
	Cognitive disability (specify)	
	was the disability work related?	
	What sorts of accommodations were required for accessibility?	

Communication and access to information

domestic violence victim		domestic violence perpetrator
	spoke English as a 2nd language	
1 2 3 4 5 (none) (excellent spoken English)	Degree of fluency in spoken English	1 2 3 4 5 (none) (excellent spoken English)

domestic violence victim				domestic violence perpetrator		
1 2 3 4 5 (could not read) (reads at 8th grade level+)			Degree of fluency in written English	1 2 3 4 5 (could not read) (reads at 8th grade level+)		
			specify 1st or primary language			
1 2 3 4 5 (could not read) (reads at 8th grade level+)			Degree of literacy in written 1st language	1 2 3 4 5 (could not read) (reads at 8th grade level+)		
			could speak/vocalize enough English to do the following without a translator / signer?			
yes	no	unknown	give a statement to law enforcement	yes	no	unknown
yes	no	unknown	understand spoken instructions or questions from law enforcement	yes	no	unknown
yes	no	unknown	receive meaningful counseling/advocacy in spoken English	yes	no	unknown

Translation

If the domestic violence victim possessed a limited capacity in spoken English, who provided translation in the following circumstances?

	With law enforcement	for protection orders	in criminal hearings	In probation meetings
no one				
children				
neighbor				
relative				
domestic violence perpetrator				
professional translator				
bilingual law enforcement officer or court personnel				
language bank				

Access to community resources for the domestic violence victim

service	exists in community in domestic violence victim's primary language?	domestic violence victim accessed in primary language	is there affordable translation available to make accessible?	domestic violence victim accessed via translation	accessible to a person with the domestic violence victim's physical or cognitive disabilities?
community based legal advocacy					
victim's shelter					

service	exists in community in domestic violence victim's primary language?	domestic violence victim accessed in primary language	is there affordable translation available to make accessible?	domestic violence victim accessed via translation	accessible to a person with the domestic violence victim's physical or cognitive disabilities?
support groups					
mental health					
substance abuse					
homeless shelter					
criminal proceedings					
civil proceedings					
court based legal advocacy					
supervised visitation/drop off					
police department domestic violence unit					
specialized dv prosecutor's unit					
immigrant women's advocacy organization					
police DV unit					
prosecutor DV unit					
probation ☐specialized DV unit ☐municipal ☐state					
immigrant advocacy organization					

Access to community resources for the domestic violence perpetrator

service	exists in community in domestic violence perpetrator's primary language?	domestic violence perpetrator obtained service in primary language	translation available to make accessible?	domestic violence perpetrator obtained service via translation	accessible to a person with the domestic violence perpetrator's physical or cognitive disabilities?
batterer's treatment					
mental health					

substance abuse					
probation officer ☐ muni ☐ state					
criminal proceedings					
civil proceedings					
defense attorney					

S. Substance Abuse / Mental Health

domestic violence victim		domestic violence perpetrator
☐ no ☐Drugs ☐alcohol drug, if known	affected by drugs or alcohol at the time of the fatality?	☐no ☐Drugs ☐alcohol drug, if known
has a history of substance abuse indicated by enrollment in substance abuse treatment (specify program) ☐police reports ☐convictions self identification other:		has a history of substance abuse indicated by enrollment in substance abuse treatment (specify program) ☐police reports ☐convictions self identification other:
had history of mental illness indicated by (specify clinic, program or doctor) crisis mental health response inpatient treatment outpatient treatment prescriptions for :		had history of mental illness indicated by (specify clinic, program or doctor) crisis mental health response inpatient treatment outpatient treatment prescriptions for :

Substance abuse providers	Yes	No	Unknown
Did the substance abuse provider have a dv assessment tool in place?			
Do the substance abuse counselors receive training regarding domestic violence?			

Mental health providers

Did mental health programs have a dv assessment tool in place?			
Did mental health providers have training regarding domestic violence?			

T. Domestic Violence Victim's Efforts To Leave / End The Violence

If the victim was living with the domestic violence perpetrator at the time of death, had she/he attempted to move out and/or leave the relationship at a prior time? ☐ Yes ☐ No ☐ Unknown If yes, how many times?

Housing

Is there any evidence that the domestic violence victim sought shelter (please check):

type of program:	sought out and succeeded in obtaining shelter	sought out and did not succeed in obtaining shelter	unknown
domestic violence shelter	for how long?	Reason, if known:	
homeless shelter	for how long?	Reason, if known:	
transitional/long term shelter	for how long?	Reason, if known:	
subsidized housing	for how long?	Reason, if known:	

What is the average number of requests for shelter turned down by the domestic violence shelters in the area?

Were waiting lists for subsidized housing open in the domestic violence victim's area in the year prior to fatality?

How long would a domestic violence victim expect to wait for an opening in subsidized housing?

Was there an unusually low vacancy rate in the domestic violence victim's area, making rents high?

☐ yes ☐ no ☐ unknown

What does the panel estimate rent would cost for the domestic violence victim (and her children)?

Making ends meet

What percentage of the dv victim's income would have to go to rent?

What percentage of the total income would have to go to child care?

Is there any indication (for example, statements to friends, relatives, attorneys or advocates) that the domestic violence victim could not afford to leave the domestic violence perpetrator and still provide housing, clothing and food for the children?

☐ yes ☐ no ☐ unknown

Are there any indications that the domestic violence perpetrator prevented the domestic violence victim from succeeding in work environments? ☐ yes ☐ no ☐ unknown

Other barriers

If it seems the domestic violence victim was seeking to escape the relationship, what other barriers to leaving were identified by the review panel?

U. Domestic Violence Fatality Review Panel summary

Based on the information available to the Domestic Violence Fatality Review Panel, does the Panel agree that this is a domestic violence related death? ☐ Yes ☐ No

If not, please note why:

What prevention activities would the committee like to propose? (please elaborate)

- ☐ increase existing services for domestic violence victims
- ☐ create new services for domestic violence victims
- ☐ increase services for domestic violence perpetrators
- ☐ create new services for domestic violence perpetrators
- ☐ Legislation change
- ☐ community safety project
- ☐ public forum
- ☐ education activities in schools
- ☐ education through media
- ☐ changes in government agency practice
- ☐ changes in non profit agency practice
- ☐ changes in other agency/organization practice (specify)
- ☐ new programs
- ☐ increased coordination / cooperation / communication between ____ and ____
- ☐ increased training for _____ on _____
- ☐ changes in TANF policy/implementation

What if any, recommendations would this panel make as a result of case review?

V. Which agencies were present and participated in the review?

	shelter/safehouse		batterer's intervention program
	law enforcement		other social services agency: specify
	city prosecutor		court advocate
	county prosecutor		animal control/humane society
	family court		Dept. of Child & Family Services (CPS/CFS, FRS)
	municipal court		TANF case worker
	mental health provider		Probation ☐ municipal ☐ state
	court based legal advocate		parole
	community based legal advocate		court/judges
	health care providers		other
	Health department program (specify)		

Washington State Domestic Violence Fatality Review Project

This form to be filled out for each contact with the criminal justice system prior to the fatality.

Criminal Justice System Involvement prior to the fatality

This is _____ of _____ total Criminal Justice System contact forms

Is there any indication that the domestic violence perpetrator and the domestic violence victim may have had contact with multiple law enforcement agencies and multiple jurisdictions? (ie, did they move from another county/city?) ☐ yes ☐no ☐unknown

Was the panel able to obtain information from all agencies which were suspected or known to have contact with the domestic violence victim and domestic violence perpetrator? ☐ yes ☐no ☐unknown

Police

Date police contacted: time of initial contact:

police contacted via ☐911 ☐non emergency line ☐other (specify)

Who contacted the police?

☐domestic violence victim ☐domestic violence perpetrator ☐child ☐neighbor ☐other

Were officers dispatched? ☐ yes ☐no ☐unknown

If not, why not?

If yes, to what sort of call were officers dispatched?

☐Domestic disturbance ☐suspicious circumstances ☐other

Who was present when police arrived? Check all that apply:

☐domestic violence victim ☐domestic violence perpetrator ☐children

☐other family member(s) ☐other acquaintance(s) ☐neighbors

Did officers take a report? ☐ yes ☐no ☐unknown

If no, why not?

Did the suspect have a gun? ☐yes ☐no ☐unknown

If yes, did the officers confiscate the weapon(s)? ☐yes ☐no ☐unknown

Did officers arrest a suspect? ☐ yes ☐no ☐unknown

If no, why not? ☐probable cause not established ☐suspect not present ☐other (specify)

Were both the domestic violence victim and the domestic violence perpetrator arrested? (mutual arrest)

☐ yes ☐no ☐unknown

If the suspect was not present, did the officers make an effort to locate the suspect? ☐ yes ☐no ☐unknown

What injuries (if any) did the domestic violence victim report?

☐No injuries ☐other (specify

What injuries (if any) did the domestic violence perpetrator report?

☐No injuries ☐other (specify

Did any one require medical attention? (check all that apply)

	medical attention:

	needed	offered	refused	dispensed on site	transported to hospital
domestic violence victim					
domestic violence perpetrator					
child(ren)					
other family member(s)					
other acquaintance(s)					
other					

Did law enforcement give domestic violence victim information about resources?

☐pamphlet or other written material ☐verbal information ☐ unknown

Was there any follow up investigation?

Did the department possess adequate equipment/resources to investigate the case?

Did law enforcement return to take pictures of bruises? Or other injuries?

Did law enforcement forward the case to the prosecutor? ☐ yes ☐no ☐unknown

If no, why not?

If yes, date case forwarded:

Arraignment

If the domestic violence perpetrator was taken into custody, how long were they held before released?

Were they released on bail?☐ yes ☐no ☐unknown If yes, in what amount?

Were they released prior to arraignment? ☐ yes ☐no ☐unknown

Were any conditions attached to the domestic violence perpetrator's release?

Was a no contact order issued as a condition of release?

Was a no contact order issued at arraignment? ☐ yes ☐no ☐unknown

Was the no contact order dropped at some point?

Who initiated dropping this order? ☐Prosecutor ☐dv perpetrator ☐dv victim

What factors influenced the decisions about bail amounts, release and conditions for release?

Prosecution:

Date prosecutor received case:

Did the prosecutor's office attempt to contact the domestic violence victim? ☐ yes ☐no ☐unknown

How? ☐Letter ☐phone call ☐domestic violence victim initiated contact ☐other:

Did the prosecutor's office succeed in contacting the victim

If yes, who did the victim talk to? ☐advocate ☐prosecutor

Did the prosecutor file charges? ☐ yes ☐ no ☐ unknown

If no, what factors influenced the decision not to file charges?

charges filed	defendant plead to
1.	1.
2.	2.
3.	3.

Did the prosecutor accept a plea bargain and / or dismiss some charges?

What factors influenced the decision to accept a plea / or dismiss charges?

If the case went to trial:

date of trial:

sentencing date:

Did any new assaults/violations of protection orders or calls to law enforcement for assistance occur between the initial contact on these charges and the trial date? ☐ yes ☐ no ☐ unknown

If so, please reference dates of these contacts and ensure separate contact with CJS sheets are filled out.

Outcome:

charges	disposition	Sentence/conditions (specify length)	
1.	☐ acquitted ☐ dropped/dismissed ☐ guilty ☐ deferred sentence ☐ stipulated order of continuance	☐ probation ☐ jail time: ☐ batterer's treatment ☐ substance abuse treatment ☐ other	☐ time served ☐ prison time
2.	☐ acquitted ☐ dropped/dismissed ☐ guilty ☐ deferred sentence ☐ stipulated order of continuance	☐ probation ☐ jail time: ☐ batterer's treatment ☐ substance abuse treatment ☐ other	☐ time served ☐ prison time
3.	☐ acquitted ☐ dropped/dismissed ☐ guilty ☐ deferred sentence ☐ stipulated order of continuance	☐ probation ☐ jail time: ☐ batterer's treatment ☐ substance abuse treatment ☐ other	☐ time served ☐ prison time

The prosecutor asked for (check all that apply)		The court ordered (check all that apply)	Program successfully completed? (date of completion if yes)
	batterer's treatment		
	batterer's evaluation		
	anger management		
	substance abuse treatment		
	restitution		
	victim's education or counseling		
	court costs	specify amount	
	other(specify)		

Was the victim asked to testify? ☐ yes ☐ no ☐ unknown

Did the victim ☐ not testify ☐ recant her original statements ☐ testify to the crime

Did the victim have contact with a court advocate? ☐ yes ☐ no ☐ unknown

Courts and monitoring of court orders:

Court orders were issued in ☐ district court ☐ municipal court ☐ superior court ☐ no court

What mechanisms exist for timely monitoring of treatment enrollment and completion in the jurisdictions in which it was ordered?

Did municipal court have a probation department? ☐ yes ☐ no ☐ unknown

If yes:

Did probation officers have specialized training in domestic violence? ☐ yes ☐ no ☐ unknown

Is it common practice for probation officers to contact victims? ☐ yes ☐ no ☐ unknown

Was the victim contacted in this case? ☐ yes ☐ no ☐ unknown

Did the district court have a probation department? If yes:

Did probation officers have specialized training in domestic violence? ☐ yes ☐ no ☐ unknown

Is it common practice for probation officers to contact victims? ☐ yes ☐ no ☐ unknown

Was the victim contacted in this case? ☐ yes ☐ no ☐ unknown

If conditions of court orders were violated, what consequences were imposed?

Date condition	condition ordered	date consequences imposed for failure to comply to condition	what were the consequences?

Washington State Domestic Violence Fatality Review

Official Records of Death and Cause of Death (to be filled out for each decedent, using additional forms if necessary)

DV Fatality Review Case #_____

This form is # of total related to this case

☐ Decedent is one of total homicides and suicides

☐ Decedent committed suicide

Deceased (check one)		**person(s) who are the direct cause of death**
☐ DV perpetrator	☐ law enforcement officer	☐ DV perpetrator
☐ DV victim	☐ bystanders	☐ DV victim
☐ children of DV victim	☐ other (specify):	☐ child of DV victim and / or perpetrator
☐ children of DV victim and perpetrator	☐ other family of DV victim	☐ person hired by or acting on behalf of: DV perpetrator
☐ children of DV perpetrator, but not the DV victim's	☐ other family of DV perpetrator	☐ person hired by or acting on behalf of: DV victim
☐ other family of DV victim	☐ friends of DV victim	☐ law enforcement
specify:		
☐ other family of DV perpetrator	☐ new intimate partner of DV victim	☐ other (specify):
☐ friends of DV victim	☐ advocates/lawyers for DV victim	
☐ new intimate partner of DV victim	☐ co workers of DV victim	
☐ advocates/lawyers for DV victim	☐ law enforcement officer	
☐ co workers of DV victim	☐ bystanders	
	☐ other (specify):	

Relationship of victim of homicide to perpetrator:

Autopsy and official record of death

Was an autopsy performed? ☐ Yes ☐ No ☐ Unknown

if yes, by who? ☐ Medical Examiner ☐ Pathologist contracted by a Coroner ☐ other

Category of death listed on death certificate:

☐ natural ☐ accident ☐ suicide ☐ homicide ☐ undetermined

What is the official cause of death?

Was blood alcohol level determined?

☐ Yes ☐ No ☐ Unknown Results?

Were tests conducted to determine the presence of drugs?

☐ yes ☐ no ☐ unknown Results?

How the death occurred

Agent of injury:

☐ blunt weapon *specify:*	☐ rifle	automatic ☐	☐ suffocation/strangulation
☐ motor vehicle	☐ handgun	automatic ☐	☐ poisoning
☐ burns	☐ fire		☐ striking
☐ hanging	☐ hatchet/ax		☐ other *specify:*
☐ knife			
specify: ☐ kitchen ☐ hunting ☐ other			

If homicide:

Did the fatal assault include a sexual assault? ☐ yes ☐ no ☐ unknown

Did the decedent die ☐ in the midst of an attack or ☐ some time later as a result of injuries arising from that attack?

If decedent died sometime later as the result of an attack, what sorts of injuries were sustained?

How much time had passed between the attack and receipt of medical care?

Who provided medical care / first aid after the attack? Check all that apply:

☐ fire department ☐ emergency medical technicians ☐ hospital emergency room ☐ police

How much time passed between the attack and the death?

Where did the decedent die? ☐ At the scene of the attack ☐ in hospital ☐ in transport to hospital ☐ other (specify)

Did any other medical factors contribute to the fatality? ☐ yes ☐ no ☐ Unknown

if yes, check all that apply:

☐ infection ☐ post-surgical ☐ other medical problems

were these the result of DV? ☐ yes ☐ no ☐ unknown

☐ congenital medical condition ☐ cancer ☐ prior injuries

were these the result of DV? ☐ yes ☐ no ☐ unknown

Policy on the collection and recording of information from Domestic Violence Fatality Reviews

Two ways to gather information on domestic violence fatalities

The Washington State Domestic Violence Fatality Review Project will engage in two primary methods of information gathering:

1. county/regional reviews of specific fatalities (these are detailed, multidisciplinary examinations of the circumstances leading up to a particular fatality)
2. analysis of existing publicly available databases (i.e., Washington Association of Sheriffs and Police Chiefs)

Purpose of gathering information

Each of these methods of gathering information may contribute to achieving the project purpose which is to

- identify trends and patterns in domestic violence related fatalities
- increase safety for victims and accountability for perpetrators
- formulate recommendations for collaboration on domestic violence investigation, intervention and prevention

County / regional reviews of specific fatalities

County/regional reviews of specific fatalities allow for detailed discussion of individual cases (making use of *public records* for information). Interdisciplinary groups thinking through circumstances of these cases can identify training and resource needs as well as gaps in local systems. Discussion will also increase understanding of the complex nature of domestic violence, the challenges battered women face in escaping violence, and the policies and constraints each institution/organization works within in responding to domestic violence.

Some information obtained in these reviews will be entered into a database in order to facilitate identification of common themes between cases, and avoid reviewing the same fatality twice. Common themes identified in these detailed reviews can raise issues for discussion regarding policy and practice around the state and will help focus analysis of existing databases.

Attachment 7

Analysis of existing data bases	Existing databases (vital statistics, Uniform Crime Report compilations by the Washington Association of Sheriffs and Police Chiefs) can be used to identify quantitative information regarding domestic violence. For example, these sources of information can help identify how many deaths are currently identified as domestic violence related. We may be able to track what percentage of women murdered by current and former partners had obtained restraining orders against their partners, or had sustained traumatic injury in the years preceding the fatality. Such information may guide inquiry in the future and form the basis of policy proposals, educational information and training materials.
In the future…	Examining existent databases in order to track domestic violence related fatalities might lead to the formulation of recommendations regarding the compilation of such information.
Protection of confidentiality	The database created from the information gathered in county/regional fatality reviews will *not* include the name of the victim or perpetrator or the county in which the death took place. Such identifying information will be stored separately and destroyed regularly.
Reports	Domestic Violence Fatality Review Project Annual Reports will include two kinds of information: 1. quantitative information from publicly available databases such as WASPC, (how many women and men died, numbers of homicide/suicides, how many children died, etc.) 2. identification of common themes from county/regional reviews (for example, a commonly felt need for increased training for a particular profession) Reports will *not* focus on particular fatalities, but will instead seek to identify trends, patterns and general recommendations. If a particular case is specifically referenced, identifying information will not exceed information available in public records or in newspaper coverage of the fatality.
Collaboration	Domestic Violence Fatality Review Project reports may contain interpretations of data and information obtained from reviews as well as recommendations and policy suggestions. These will be formulated in collaboration with county/regional review panels, domestic violence experts in the law enforcement, prosecution, batterer's treatment, probation, judicial, child protective and medical professions, community based battered women's advocates, and the Washington State Coalition Against Domestic Violence.

How demographic information will be used

Particulars such as race, income level, educational attainment and language ability will be gathered during fatality reviews in order to further understanding of the following:

- potential barriers to seeking/receiving help
- obstacles to effective intervention and accountability
- accessibility of helping resources
- constraints domestic violence victim's options

As in all aspects of the review, the focus is on understanding system response to domestic violence victims and perpetrators, and identifying ways to increase victim safety and perpetrator accountability.

Avoiding misuse of information

All evidence indicates that the capacity for violence resides in every human population. In interpreting information from reviews, care will be taken to avoid drawing inferences about the inherent characteristics of particular populations.

Except in cases of self-defense, no person deserves to be abused or die at the hands of another. Interpretation of information from reviews should not imply that victims of domestic violence are responsible for or deserved their victimization or death.

The case information form

The case information form was created in collaboration with an Advisory Committee consisting of judges, prosecutors, law enforcement officers, medical personnel, probation officers, battered women's advocates, child welfare workers, and the Washington State Coalition Against Domestic Violence.

The form contains many questions regarding the abuse and the context in which it took place. It reflects the many factors experts on the Advisory Committee believed may affect a domestic violence victim's ability to obtain safety, and a community's ability to hold an abuser accountable for violence.

In many cases, the panel will not be able to answer all the questions posed in the form. However, it is important to resist equating *available* information with *relevant* information. Reflecting on what we <u>do not</u> know about the circumstances leading up to a fatality may be as important as reflecting on what we <u>do</u> know.

Washington State Domestic Violence Fatality Review

Confidentiality and Access to Information Overview, 2000
Margaret Hobart, (206) 389-2515 ext. 102

	Relevant codes	*Public Record?*	*Additional notes*
Law enforcement			
911 tape and Computer Assisted Dispatch records	RCW 9.73.030-090	yes and no	911 tapes are public record if they are admitted into evidence in the course of prosecution. Tapes not admitted into a record of court proceedings are not public record. If tapes are not made into public record via court proceedings, then to obtain release, the consent of the party taped is required (or, if that person is a deceased, the consent of a family member.) 911 operators also often function as dispatchers and decision-makers. They enter a great deal of info into the Computer Assisted Dispatch system (CAD) which may also be saved and requested. Each 911 center has a policy for destruction of tapes and CAD databases, usually every 90 days, unless otherwise requested by police or prosecutor.
police incident report	RCW 10.97	yes, with some limitations for open cases under active investigation	Closed cases: releasable, but criminal justice agency must include in any released information the dispositions of all charges and arrests. Records which include non conviction data may be disseminated to individuals and agencies for the express purpose of research, evaluative, or statistical activities. Open cases: the state Supreme Court clarified 11/26/97 in *David Newman v King County* that when a criminal case is still open and investigation active, RCW 42.17.310 (1) (d) allows for a law enforcement agency to refuse to disclose the (otherwise) public documents contained therein when " disclosure would render law enforcement efforts ineffective or violates personal privacy interests."

Attachment 8

	Relevant codes	*Public Record?*	*Additional notes*
disposition of charges	RCW 10.97	yes	10.97.45 (1) conviction records may be disseminated without restriction 10.97.46 (4) Criminal history record information that includes non-conviction data may be disseminated to individuals and agencies for the express purpose of research, evaluative or statistical activities pursuant to an agreement with a criminal justice agency. Such agreement must authorize the access to non conviction data, limit the use of that information which identifies specific individuals to research, evaluative or statistical purpose, and contain provisions giving notice to the person or organization to which the records are disseminated that the use of information obtained and further dissemination of such information are subject to the provisions of this chapter and applicable federal statutes and regulations, which shall be cited with express reference to the penalties provided for a violation thereof. 10.97.120 Violation of the provisions of 10.97 constitute a misdemeanor
detective follow up	RCW 10.97		Much of this may be releasable based on the Domestic Violence Fatality Review Project being evaluative and/or research, as noted in RCW 10.97.46
Prosecutor	RCW 10.97		Prosecutor records are also covered by RCW 10.97, please see above under police
prosecutor notes		no	Attorney work products are protected from discovery (but does not necessarily mean that attorneys or agencies are prohibited from discussing them)
Certification of Probable Cause		yes	These are public record. These are usually based on initial police work. They may contain inaccuracies, and will vary in degree of detail. Cases that are very circumstantial may include more detail in order to build a case. These are in the court clerk's office, looked up by cause number (which can be obtained if one knows the name of the person charged.)

	Relevant codes	*Public Record?*	*Additional notes*
Judiciary			
trial and sentencing documents	10.97 and Washington Court Rules	yes	Washington Court Rules, rule #9, Disclosure of Records: a) Unless the trial judge rules otherwise in a particular case, the following are considered public records and may be viewed and copied by the public: 1) court pleadings; 2) dockets 3) tape recordings of court proceedings 4) search warrants, affidavits and inventories, after execution and return of the warrant. b) Private records: the following are considered exempt from disclosure unless they have been admitted into evidence, incorporated into a court pleading, or are the subject of a stipulation on the record which places them into public records: 1) witness statements and police reports 2) pre-sentence reports and reports related to compliance with conditions of sentence 3) copies of driving records or criminal history records subject to RCW 10.97 4) correspondence received by the court regarding sentencing and compliance with the terms of probation
other			Code of Judicial Conduct, adopted by the Supreme Court October 9, 1995 notes in Canon 4: Judges May engage in Activities to Improve the Law, the legal system and the administration of justice… A) They may speak, write, lecture, teach and participate in other activities concerning the law, the legal system and the administration of justice. C) Judges may serve as members, officers or directors of an organization or governmental agency devoted to the improvement of the law, the legal system or the administration of justice…As judicial officers and persons specially learned in the law, judges are in a unique position to contribute tot he improvement of the law, the legal system and the administration of justice, including revision of substantive and procedural law and improvement of criminal and juvenile justice…

	Relevant codes	*Public Record?*	*Additional notes*
Probation			
records of meetings		no	These are not public records according to Washington Court Rule #9, section (b) (2): reports related to compliance with conditions of sentence.
disposition social file PSI's and compliance reports treatment reports	10.97 Federal regulations 42 CFR	yes no no no	
Medical			
hospital records private Dr. DOH records HMO records	70.02.140 privacy of deceased patient 7.70.065- who can waive privacy rights for deceased	no	Privacy of deceased patient, info cannot be given out w/out release from appropriate person specified in 7.70.065 Who can waive privacy rights for deceased are the same as the person(s) who could give informed consent for health care. These are (in order of priority) appointed guardian, individual to whom deceased gave durable power of attorney that encompasses the authority to make health care decisions, deceased's spouse, children of the deceased who are at least 18 years of age, parents, and adult brothers and sisters of the deceased

	Relevant codes	*Public Record?*	*Additional notes*
Coroner / Medical Examiner/			
death certificate	70.58.104	yes	RCW 70.58.104 notes that the state registrar of vital statistics may authorize by regulation the disclosure of information contained in vital records for research purposes. (pending approval of research project based on scientific merits) Local registrars may, upon request, furnish certified copies of birth, death, and fetal death, subject to all provisions of state law applicable to the state registrar.
autopsy information	68.50.105	no	Confidential, but the following persons may obtain this information: personal representative of the decedent; family members, attending physician, prosecuting attorney and law enforcement and public health officials
death scene investigation			may be part of criminal justice records, if a criminal case ensued.
DV Programs			
Shelters and battered women's programs	state and federal contracts speak to confidentiality	no public records	VOCA requirements state that "Except as otherwise provided by Federal law, no recipient of moneys under VOCA shall use or reveal any research or statistical information furnished under this program by any person and identifiable to any specific private person for any purpose other than the purpose for which such information was obtained in accordance with VOCA. Such information, and any copy of such information, shall be immune from the legal process and shall not, without the consent of the person furnishing the information, be admitted as evidence or used for any purpose in any action, suit, or other judicial, legislative, or administrative proceeding. See Section 1407(d) of VOCA codified at 42 U.S.C. 10604. This provision is intended, among other things, to ensure the confidentiality of information provided by crime victims to counselors working for victim services programs receiving VOCA funds. …. This confidentiality provision should not be interpreted to thwart the legitimate informational needs of public agencies. For example, this provision does not prohibit a domestic violence shelter from acknowledging, in response to an inquiry by a law enforcement agency conducting a missing person investigation, that the person is safe in the shelter. (From the Federal Register, Vol. 60, No. 208, Friday, October 27, 1995 Notices p 55060)

	Relevant codes	*Public Record?*	*Additional notes*
			Additionally, states receiving federal funding must provide "documentation that procedures have been developed and implemented, including copies of the policies and procedure, to ensure the confidentiality of records pertaining to any individual who is provided prevention or treatment services by any program assisted under the Act." 42 USC 10402(a)(2)(E)
batterer's treatment	RCW 18.19.020 relating to Counselors RCW 26.50.150 relating to DV Perpetrator Treatment WAC 388.60 relating to DV Perpetrator Treatment	no	RCW 26.50.150 notes that perpetrators must sign a the following releases: a) a release for program to inform the victim and the victim's community and legal advocates that the perpetrator is in treatment… and to provide information, for safety purposes, to the victim and victim's community and legal advocates b) a release to prior and current treatment agencies to provide information on the perpetrator to the program c) a release for the program to provide information on the perpetrator to relevant legal entities including: Lawyers, courts, parole, probation, child protective services, and child welfare services
Mental Health			
community clinic, private practitioner	RCW 18.19.020 relating to counselors	no	Counselors include marriage and family therapists, mental health counselors, social workers, hypnotherapists who are certified as defined in RCW 18.19.020. RCW 18.19.180 notes that "an individual registered or certified under this chapter shall not disclose…any information acquired from persons consulting the individual in a professional capacity when the information was necessary to enable the individual to render professional services to those persons, except with written consent or, in the case of death or disability, the person's personal representative…

	Relevant codes	*Public Record?*	*Additional notes*
substance abuse	42 CFR part 2	no	Federal legislation and regulations from Health and Human Services "prohibit disclosure without the patient's consent. Even when the patient has consented, the program may disclose information only after it has made an independent determination that disclosure is in the patient's best interest" (from: Protecting Confidentiality of Victim/Counselor Communications, Susan Rausch, National Center on Women and Family Law, 1993 p 242)
DCFS			
CPS case records FRS case records	74.04.060 74.13.500- disclosure of child welfare records in case of child death 74.13.505- what will be disclosed	no	Records may be revealed "for purposes directly connected with the administration of the programs of DCFS. Further, provisions for confidentiality do not apply to duly designated representatives of approved private welfare agencies, public officials… and advisory committees when performing duties directly connected with the administration of this title." (1) Consistent with the provisions of chapter 42.17 RCW and applicable federal law, the secretary, or the secretary's designee, shall disclose information regarding the abuse or neglect of a child, the investigation of the abuse or neglect, and any services related to the abuse or neglect of a child if any one of the factors is present….(d) the child named in the report has died and the child's death resulted from abuse or neglect or the child was in the care of, or receiving services from the department at the time of death or within 12 months before death. For the purposes of RCW 74.13.500, the following information shall be disclosable: (1) the name of the abused or neglected child, (2) the determination made by the department of the referrals, if any, for abuse or neglect, (3) Identification of child protective or other services provided or actions, if any, taken regarding the child named in the report and his or her family as a result of any such report or reports. These records include but are not limited to administrative reports of fatality, fatality review reports, case files, inspection reports, and reports relating to social work practice and issues; and (4) any actions taken by the department in response to reports of abuse or neglect of the child.

Washington State Domestic Violence Fatality Review Project

Permission For Release Of Information In The Event Of My Death

Battering can result in death. Over a third of women who are murdered in Washington State are killed by their current or former intimate partners. This is over 30 women per year. Abusers sometimes kill family members and children as part of their efforts to gain power and control over their intimate partners.

The Washington State Domestic Violence Fatality Review Project has been established to review cases in which domestic violence results in death. The purpose of the Domestic Violence Fatality Review Project is to:

1) Increase safety for victims and accountability for perpetrators of domestic violence by:
   a) promoting cooperation and communication among agencies investigating and intervening in domestic violence.
   b) identifying gaps in services and accountability structures and formulating recommendations for policies, services and resources to fill those gaps.
2) Identify and describe trends and patterns in domestic violence related fatalities by:
   a) documenting trends and patterns in periodic reports which present the aggregated findings of the of domestic violence fatality reviews conducted throughout the state.
3) Formulate recommendations for collaboration on domestic violence investigation, intervention and prevention.

Attachment 9

Washington State Domestic Violence Fatality Review

I understand the purpose of the Washington State Domestic Violence Fatality Review Project.

I also understand that release of records to the Domestic Violence Fatality Review Project is completely optional. Refusing to release information to the Domestic Violence Fatality Review Project will not affect my ability to receive services and advocacy from (Agency)

Initial one:

——— In the event of my death, I do not wish to have any information about me released to the Domestic Violence Fatality Review Project.

——— In the event of my death, the individuals and agencies checked off below are authorized to release all documented information and confidential communications I had with the individual or agency to the Washington State Domestic Violence Fatality Review Project. I also understand that all this information will remain confidential within the confines of the Review Project. I can change my mind and revoke this release anytime by submitting a request in writing to (agency).

I do not intend the limited waiver of my rights described above to operate as a general waiver of confidentiality with respect to any person or entity other than the Domestic Violence Fatality Review Project.

initial		Contact name and/or organization name
_____	domestic violence agency (information about me)	_____
_____	domestic violence agency (information about my children)	_____
_____	my court advocate	_____
_____	my doctor or health care provider	_____
_____	the hospital(s) I use	_____
_____		_____
_____	my counselor	_____
_____	my abuser's probation officer	_____
_____	my substance abuse program	_____
_____	my abuser's batterer's treatment program	_____
_____	my religious counselor	_____
_____	my attorney	_____
_____	Other (may include family/friends)	_____
_____		_____

My abuser(s) full name(s) is/are (include any aliases)

_____

_____

_____ _____

Signature Date

_____

Printed Name

_____ _____

Witness Date

_____

Printed Name

Washington State Domestic Violence Fatality Review

Proposed policy regarding

confidentiality in the event of a client's death

and the Domestic Violence Fatality Review Project:

Each person receiving services from the agency will be informed of her rights with regard to confidentiality and the limits of confidentiality, and that the agency's confidentiality policy remains in effect in the event of her death.

1. *In the Event of My Death Release*

A. Advocates will discuss the possible lethal nature of domestic violence with each client and her wishes regarding confidentiality and sharing of records in the event of her death.

1) This discussion should include clarification that the program will not reveal that she had used the program services if she is murdered unless required to do so by law or directed to do so by the client.

2) Each client will be informed that she can specify whether or not she would like her records released to the Domestic Violence Fatality Review by signing the "Permission For Release Of Information In The Event Of My Death" release. No one should be pressured to agree to release her records.

3) While releases of information for the purposes of advocacy and coordinated service delivery should "expire" in a set period of time, the "In the Event of My Death" releases should not include an "expiration date." However, clients should be informed of their right to revoke this release by a written request to the agency.

4) Agency will keep the "In The Event Of My Death" release with the client's file.

2. *When a client dies*

A. An agency may find out about the death of a client several ways:

1) Staff and volunteers may hear about the death from the client's children, friends or family.

2) They read/hear about it in the news.

3) The domestic violence fatality review project may periodically send out lists of women involved in domestic violence fatalities and ask programs to search records to see if the program served any of these women.

4) Program staff may participate in a domestic violence fatality review panel and find out about the death through this participation.

B. When the program realizes that a client the program has served has died, a designated member of the staff will search out that client's file in order to find out if she had signed a "In The Event Of My Death" release. If the client had signed an "In The Event Of My Death" release, the program will follow the requests set forth in that release.

C. If the client requested that records be made available to the Domestic Violence Fatality Review Project, the program will keep a copy of the release information and send the original release to the Domestic Violence Fatality Review Project. (Do not send the client file.)

3. Participation in the Washington State Domestic Violence Fatality Review Panel

A. Programs will be asked to send representatives to the Washington State Domestic Violence Fatality Review Panel.

1) Representatives from Program will not disclose specific information about a client (including that she sought services) without release of information.

2) Like all members of the Domestic Violence Fatality Review Panel, the program representative will search program records for any history of service to the person involved in the domestic violence fatality at least two months prior to the review.

3) In the event that the program has provided services to someone discussed in the course of a fatality review, the program staff will review program records.

a) If no release of information exists for the Domestic Violence Fatality Review Project:

(i) The program representative to the Domestic Violence Fatality Review Panel will not reveal to the review panel that Program provided services to the client.

(ii) Program staff sitting on the review panel will participate as an advocate for battered women and expert on battering and community resources. This would include offering general information about common struggles and difficulties victims face without compromising the confidentiality of a particular client.

b) If a release exists:

(i) The program representative will review the Case Information Form and fill in any information possible based on the case file.

(ii) The program representative will reveal any relevant information from the client's file during the course of the review.

4. *A note about records destruction*

   A. Most programs are required by contract or statute to keep records for a specified length of time. Some programs then destroy rather than archive records. Programs with a destruction policy may want to consider the following proposal:

      1) (Agency) will keep the client's records for no less than (the contract/statute specified #) years have passed since the last time the client sought services from the program.

         a) If the woman had specified that she wished to have information released to the Domestic Violence Fatality Review Project, the program will preserve only the name of the client and the time period she used services (i.e., Mary Smith, in shelter 12/1/95-2/1/96 or Jane Doe, support groups 7/12/98 to 12/30/98) and the "In The Event Of My Death" release of information.

Nevada

Senate Bill No. 402 Senator Titus

CHAPTER 678

AN ACT relating to the criminal justice system; revising certain provisions concerning admitting a person to bail; revising certain provisions relating to conditions of probation;

authorizing the state board of parole commissioners to impose certain conditions of parole; revising certain provisions relating to residential confinement; increasing the fee that

parolees and probationers must pay to defray the cost of supervision; imposing such a fee on certain offenders in residential confinement; providing for the formation of

multidisciplinary teams to review and investigate the death of a victim of domestic violence; providing penalties; and providing other matters properly relating thereto.

[Approved July 17, 1997]

Sec. 11. Chapter 217 of NRS is hereby amended by adding thereto a new section to read as follows:

1. A court or an agency of a local government may organize or sponsor one or more multidisciplinary teams to review the death of the victim of a crime that constitutes domestic violence pursuant to NRS 33.018.
2. If a multidisciplinary team is organized or sponsored pursuant to subsection 1, the court or agency shall review the death of a victim upon receiving a written request from a person related to the victim within the third degree of consanguinity, if the request is received by the court or agency within 1 year after the date of death of the victim.
3. Members of a team that is organized or sponsored pursuant to subsection 1 serve at the pleasure of the court or agency that organizes or sponsors the team and must include, without limitation, representatives of organizations concerned with law enforcement, issues related to physical or mental health, or the prevention of domestic violence and assistance to victims of domestic violence.
4. Each organization represented on such a team may share with other members of the team information in its possession concerning the victim who is the subject of the review or any person who was in contact with the victim and any other information deemed by the organization to be pertinent to the review. Any information shared by an organization with other members of a team is confidential.
5. A team organized pursuant to this section may, upon request, provide a report concerning its review to a person related to the victim within the third degree of consanguinity.
6. Before establishing a team to review the death of a victim pursuant to this section, a court or an agency shall adopt a written protocol describing its objectives and the structure of the team.

Attachment 10

7. A team organized pursuant to this section may, if appropriate, meet with a multidisciplinary team to review the death of a child organized pursuant to NRS 432B.405.
8. Each member of a team organized pursuant to this section is immune from civil or criminal liability for an activity related to the review of the death of a victim.
9. The results of the review of the death of a victim pursuant to this section are not admissible in any civil action or proceeding.

California Code Regarding Domestic Violence Death Review Teams

11163.3.

(a) A county may establish an interagency domestic violence death review team to assist local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. Interagency domestic violence death review teams have been used successfully to ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives to reduce and eradicate the incidence of domestic violence.

(b) For purposes of this section, "abuse" has the meaning set forth in Section 6203 of the Family Code and "domestic violence" has the meaning set forth in Section 6211 of the Family Code.

(c) A county may develop a protocol that may be used as a guideline to assist coroners and other persons who perform autopsies on domestic violence victims in the identification of domestic violence, in the determination of whether domestic violence contributed to death or whether domestic violence had occurred prior to death**,** but was not the actual cause of death, and in the proper written reporting procedures for domestic violence, including the designation of the cause and mode of death.

(d) County domestic violence death review teams shall be comprised of, but not limited to, the following:

(1) Experts in the field of forensic pathology.
(2) Medical personnel with expertise in domestic violence abuse.
(3) Coroners and medical examiners.
(4) Criminologists.
(5) District attorneys and city attorneys.
(6) Domestic violence shelter service staff and battered women's advocates.
(7) Law enforcement personnel.
(8) Representatives of local agencies that are involved with domestic violence abuse reporting.
(9) County health department staff who deal with domestic violence victims' health issues.
(10) Representatives of local child abuse agencies.
(11) Local professional associations of persons described in paragraphs (1) to (10), inclusive.

(e) An oral or written communication or a document shared within or produced by a domestic violence death review team related to a domestic violence death review is confidential and not subject to disclosure or discoverable by a third party. An oral or written communication or a document provided by a third party to a domestic violence death review team, or between a third party and a domestic violence death review team, is confidential and not subject to disclosure or discoverable by a third party. Notwithstanding the foregoing, recommendations of a domestic violence death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the domestic violence death review team.

11163.4.

Subject to available funding, the Attorney General, working with the state domestic violence coalition, shall develop a protocol for the development and implementation of interagency domestic violence death review teams for use by counties, which shall include relevant procedures for both urban and rural counties. The protocol shall be designed to facilitate communication among persons who perform autopsies and the various persons and agencies involved in domestic violence cases so that incidents of domestic violence and deaths related to domestic violence are recognized and surviving non offending family and household members and domestic partners receive the appropriate services.

11163.5.

(a) The purpose of this section is to coordinate and integrate state and local efforts to address fatal domestic violence, and to create a body of information to prevent domestic violence deaths.

(b) (1) The Department of Justice is hereby authorized to carry out the purpose of this section with the cooperation of the State Department of Social Services, the State Department of Health Services, the California State Coroner's Association, the County Welfare Directors Association, and the state domestic violence coalition.

(2) The Department of Justice, after consulting with the agencies and organizations specified in paragraph (1), may consult with other representatives of other agencies and private organizations to accomplish the purpose of this section.

(c) To accomplish the purpose of this section, the Department of Justice and agencies and organizations involved may engage in the following activities:
   (1) Collect, analyze, and interpret state and local data on domestic violence death in an annual report to be available upon request. The report may contain, but need not be limited to, information provided by state agencies and the county domestic violence death review teams for the preceding year.
   (2) Develop a state and local data base on domestic violence deaths.
      (A) The state data may include the Department of Justice statistics, the State Department of Health Services Vital Statistics, and information obtained by other relevant state agencies.
      (B) The Department of Justice, in consultation with the agencies and organizations specified in paragraph (1) of subdivision (b), may develop a model minimal local data set and request data from local teams for inclusion in the annual report.
   (3) Distribute a copy of the report to public officials in the state who deal with domestic violence issues and to those agencies responsible for domestic violence death review investigation in each county.

(d) The Department of Justice may direct the creation of a statewide domestic violence death review team directory, which shall contain the names of the members of the agencies and private organizations participating under this section, the members of local domestic violence death review teams, and the local liaisons to those teams. The department may maintain and update the directory annually.

(e) The agencies or private organizations participating under this section shall participate without reimbursement from the state. Costs incurred by participants for travel or per diem shall be borne by the participant agency or organization. Any reports prepared by the Department of Justice pursuant to this section shall be in consultation with the state domestic violence coalition.

State of Washington 56th Legislature 2000 Regular Session

By House Committee on Appropriations (originally sponsored by Representatives Tokuda, D. Sommers, Kagi, Boldt, Kenney, Dickerson, Ogden, Veloria, Haigh, Santos, Romero, O'Brien, Edwards, Constantine, Rockefeller, Miloscia and McIntire)

Read first time 02/07/2000. Referred to Committee on .

AN ACT Relating to domestic violence fatality reviews; adding a new chapter to Title 43 RCW; and creating new sections.

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

{+ NEW SECTION. +} Sec. 1. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Department" means the department of social and health services.

(2) "Domestic violence fatality" means a homicide or suicide under any of the following circumstances:

(a) The alleged perpetrator and victim resided together at any time;

(b) The alleged perpetrator and victim have a child in common;

(c) The alleged perpetrator and victim were married, divorced, separated, or had a dating relationship;

(d) The alleged perpetrator had been stalking the victim;

(e) The homicide victim lived in the same household, was present at the workplace of, was in proximity of, or was related by blood or affinity to a victim who experienced or was threatened with domestic abuse by the alleged perpetrator; or

(f) The victim or perpetrator was a child of a person in a relationship that is described within this subsection.

This subsection should be interpreted broadly to give the domestic violence fatality review panels discretion to review fatalities that have occurred directly to domestic relationships.

{+ NEW SECTION. +} Sec. 2. (1) Subject to the availability of state funds, the department shall contract with an entity with expertise in domestic violence policy and education and with a state-wide perspective to coordinate review of domestic violence fatalities. The coordinating entity shall be authorized to:

(a) Convene regional review panels;

(b) Gather information for use of regional review panels;

(c) Provide training and technical assistance to regional review panels;

(d) Compile information and issue biennial reports with recommendations; and

(e) Establish a protocol that may be used as a guideline for identifying domestic violence related fatalities, forming review panels, convening reviews, and selecting which cases to review. The coordinating entity may also establish protocols for data collection and preservation of confidentiality.

(2)(a) The coordinating entity may convene a regional domestic violence fatality review panel to review any domestic violence fatality.

(b) Private citizens may request a review of a particular death by submitting a written request to the coordinating entity within two years of the death. Of these, the appropriate regional review panel may review those cases which fit the criteria set forth in the protocol for the project.

{+ NEW SECTION. +} Sec. 3. (1) Regional domestic violence fatality review panels shall include but not be limited to:

(a) Medical personnel with expertise in domestic violence abuse;

(b) Coroners or medical examiners or others experienced in the field of forensic pathology, if available;

(c) County prosecuting attorneys and municipal attorneys;

(d) Domestic violence shelter service staff and domestic violence victims' advocates;

(e) Law enforcement personnel;

(f) Local health department staff;

(g) Child protective services workers;

(h) Community corrections professionals;

(i) Perpetrator treatment program provider; and

(j) Judges, court administrators, and/or their representatives.

(2) Regional domestic violence fatality review panels may also invite other relevant persons to serve on an ad hoc basis and participate as full members of the review team for a particular review. These persons may include, but are not limited to:

(a) Individuals with particular expertise helpful to the regional review panel;

(b) Representatives of organizations or agencies that had contact with or provided services to the homicide victim or to the alleged perpetrator.

(3) The regional review panels shall make periodic reports to the coordinating entity and shall make a final report to the coordinating entity with regard to every fatality that is reviewed.

{+ NEW SECTION. +} Sec. 4. (1) An oral or written communication or a document shared within or produced by a regional domestic violence fatality review panel related to a domestic violence fatality review is confidential and not subject to disclosure or discoverable by a third party. An oral or written communication or a document provided by a third party to a regional domestic violence fatality review panel, or between a third party and a regional domestic violence fatality review panel is confidential and not subject to disclosure or discovery by a third party. Notwithstanding the foregoing, recommendations from the regional domestic violence fatality review panel and the coordinating entity generally may be disclosed minus personal identifiers.

(2) The regional review panels, only to the extent otherwise permitted by law or court rule, shall have access to information and records regarding the domestic violence victims and perpetrators under review held by domestic violence perpetrators' treatment providers; dental care providers; hospitals, medical providers, and pathologists; coroners and medical examiners; mental health providers; lawyers; the state and local governments; the courts; and employers. The coordinating entity and the regional review panels shall maintain the confidentiality of such information to the extent required by any applicable law.

(3) The regional review panels shall review, only to the extent otherwise permitted by law or court rule when determined to be relevant and necessary to an investigation, guardian ad litem reports, parenting evaluations, and victim impact statements; probation information; mental health evaluations done for court;

presentence interviews and reports, and any recommendations made regarding bail and release on own recognizance; child protection services, welfare, and other information held by the department; any law enforcement incident documentation, such as incident reports, dispatch records, victim, witness, and suspect statements, and any supplemental reports, probable cause statements, and 911 call taker's reports; corrections and postsentence supervision reports; and any other information determined to be relevant to the review. The coordinating entity and the regional review panels shall maintain the confidentiality of such information to the extent required by any applicable law.

{+ NEW SECTION. +} Sec. 5. If acting in good faith, without malice, and within the parameters of this chapter and the protocols established, representatives of the coordinating entity and the regional domestic violence fatality review panels are immune from civil liability for an activity related to reviews of particular fatalities.

{+ NEW SECTION. +} Sec. 6. Within available funds, data regarding each domestic violence fatality review shall be collected on standard forms created by the coordinating entity. Data collected on reviewed fatalities shall be compiled and analyzed for the purposes of identifying points at which the system response to domestic violence could be improved and identifying patterns in domestic violence fatalities.

{+ NEW SECTION. +} Sec. 7. (1) A biennial state-wide report shall be issued by the coordinating entity in December of even-numbered years containing recommendations on policy changes that would improve program performance, and issues identified through the work of the regional panels. Copies of this report shall be distributed to the governor, the house of representatives children and family services and criminal justice and corrections committees, and the senate human services and corrections and judiciary committees and to those agencies involved in the regional domestic violence fatality review panels.

(2) The annual report in December 2010 shall contain a recommendation as to whether or not the domestic violence review process provided for in this chapter

should continue or be terminated by the legislature.

{+ NEW SECTION. +} Sec. 8. Sections 1 through 7 of this act constitute a new chapter in Title 43 RCW.

{+ NEW SECTION. +} Sec. 9. If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state.

*{+ NEW SECTION. +} Sec. 10. If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 30, 2000, in the omnibus appropriations act, this act is null and void.

*Sec. 10 was vetoed. See message at end of chapter.

Passed the House March 7, 2000.

Passed the Senate March 2, 2000.

Approved by the Governor March 22, 2000, with the exception of certain items that were vetoed.

Filed in Office of Secretary of State March 22, 2000.

Note: Governor's explanation of partial veto is as follows:

"I am returning herewith, without my approval as to section 10, Engrossed Second Substitute House Bill No. 2588 entitled:

"AN ACT Relating to domestic violence fatality reviews;"

This bill establishes a statewide domestic violence fatality review program, to coordinate multi-disciplinary local reviews of deaths involving domestic violence.

The bill specifically provides that the program can operate only if funds are available to the Department of Social and Health Services for this purpose. Section 10 would have made the bill "null and void" unless specific funding for its purpose, referencing the bill, is provided in the supplemental budget.

As I act on this bill, the Legislature has not yet adopted a supplemental budget. I expect that budget, when adopted, will include funding to implement the fatality review program the bill establishes. However, some versions of the budget legislation do not reference this bill specifically, even though they include the necessary funding. To avoid the possibility of nullifying this important legislation through inadvertent failure to refer to it in the supplemental budget, I have vetoed section 10.

For these reasons, I have vetoed section 10 of Engrossed Second Substitute House Bill No. 2588.

With the exception of section 10, Engrossed Second Substitute House Bill No. 2588 is approved."

Pilot Regions

Attachment 11

Washington State Domestic Violence Fatality Review Project

Group Agreement and Working Assumptions for Domestic Violence Fatality Reviews:

Domestic Violence Fatality Review Panel members should agree to each of the following:

1. Honor all signed confidentiality agreements.
2. Keep in mind each participant brings important knowledge and expertise to the panel, and each participant can learn from others on the panel.
3. Maintain professionalism: Focus discussion on issues of policy, practice and accurate information about domestic violence, not on personalities or individuals. Avoid taking discussion personally.
4. Assume that every person on the Domestic Violence Fatality Review panel has a sincere interest in:
    - increasing domestic violence victim safety and domestic violence perpetrator accountability
    - improving collaboration amongst agencies coming into contact with domestic violence victims, domestic violence perpetrators and their children
    - accurately identifying trends and patterns in domestic violence fatalities.
5. Keep in mind that the purpose of the Domestic Violence Fatality Review process is *not* to assign blame for the fatality. The purpose of reviews is to improve understanding of the circumstances leading up to the fatality in order to gain the knowledge necessary to track trends, improve safety and accountability and create recommendations for collaboration, training and policy change. No person in any agency represented on the review panel should be held responsible for a person's death.
6. Some reviews will include a critical examination of how agency/institution practices, policies and procedures figured into the circumstances leading up to a fatality. Such examination will take place in order to consider recommendations for changes which will increase domestic violence victim safety and domestic violence perpetrator accountability in the future, and not for the purpose of assigning blame. In some cases, the panel may come to the conclusion that an agency's policies were not adequate or were not adequately followed. In these cases, the panel may ask that agency to review its mechanisms for ensuring the consistent realization of its policies or to review its policies.
7. Avoid victim blaming. No person deserves or wants to be abused or die at the hands of another. Interpretation of data from reviews should not imply that victims of domestic violence are responsible for or deserved their victimization or death.

Attachment 12

Washington State Domestic Violence Fatality Review Project

Agency Representative Agreement to Confidentiality

*Name and title:*_____

designated representative to the Spokane Domestic Violence Fatality Review Panel for

organization: _____

Through the process of conducting a formal review of selected fatalities in which domestic violence is considered a significant factor, the Washington State Domestic Violence Fatality Review Project will:

1. Identify and describe trends and patterns in domestic violence related fatalities by:
    a) documenting trends and patterns in periodic reports which present the aggregated findings of the of domestic violence fatality reviews conducted throughout the state.
2. Increase safety for victims and accountability for perpetrators of domestic violence by:
    a) promoting cooperation and communication among agencies investigating and intervening in domestic violence.
    b) identifying gaps in services and accountability structures and formulating recommendations for policies, services and resources to fill those gaps.
3. Formulate recommendations for collaboration on domestic violence investigation, intervention and prevention.

The effectiveness of the **Spokane** Domestic Violence Fatality Review Panel's work is conditioned upon the confidentiality of the review process and the information shared within it. I, the undersigned, as a representative of «Organization» therefore agree to maintain the confidentiality of information obtained through the review process and not use any material or information obtained for any reason other than that which it was intended.

I will not take any case identifying material from a meeting other than that which originated in the agency I represent. Thus I will not make copies or otherwise document/record material made available in these reviews, including electronically. I will return all material shared by others at the end of each meeting.

I agree not to release confidential information about individual cases outside of committee meetings, and instead discuss the findings of the Domestic Violence Fatality Review Panel in terms of trends and aggregate findings. I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigation materials and information may result in civil or criminal liability, and exclusion from the Domestic Violence Fatality Review Panel.

I agree to refrain from representing the views of Domestic Violence Fatality Review Panel to the media. I also agree to immediately notify the State coordinating body of the Domestic Violence Fatality Review Project if I am subpoenaed for information obtained via the review process.

I hereby agree to keep confidential all case related information discussed at the **Spokane** Domestic Violence Fatality Review Panel and all related subcommittee meetings. I also agree to abide by confidentiality procedures established by and for this committee.

_____ _____

Signature Date

Attachment 13

Washington State Domestic Violence Fatality Review Project

Interagency Confidentiality and Cooperation Agreement

to be signed by a representative of each agency agreeing to participate in DV Fatality Review Panel

organization: _____ (referred to as «Organization» below)

represented by: _____

This cooperative agreement is made this day of , 199 between «Organization» and The Washington Domestic Violence Fatality Review Project and all the agencies and individuals who serve on the **Spokane** Domestic Violence Fatality Review Panel.

On behalf of «Organization», I indicate our support of the objectives of the Washington Domestic Violence Fatality Review Project:

Through the process of conducting a formal review of selected fatalities in which domestic violence is considered a significant factor, the Washington State Domestic Violence Fatality Review Project will:

1. Identify and describe trends and patterns in domestic violence related fatalities by:
    a) documenting trends and patterns in periodic reports which present the aggregated findings of the of domestic violence fatality reviews conducted throughout the state.
2. Increase safety for victims and accountability for perpetrators of domestic violence by:
    a) promoting cooperation and communication among agencies investigating and intervening in domestic violence.
    b) identifying gaps in services and accountability structures and formulating recommendations for policies, services and resources to fill those gaps.
3. Formulate recommendations for collaboration on domestic violence investigation, intervention and prevention.

«Organization» agrees that membership of each regional Domestic Violence Fatality Review Panel should be comprised of (but not limited to) the following disciplines: domestic violence victim advocates, law enforcement; judiciary; medical; public health; social services; law enforcement; coroners/medical examiners; prosecution; probation; child protective services, batterer's treatment...

«Organization» agrees to participate in the **Spokane** Domestic Violence Fatality Review Panel subject to the renewal of this Interagency Agreement on biennial basis. This participation will include providing an ongoing primary representative and alternate representative to participate on a regular basis as a member of the Review Panel and providing the necessary information to support the Domestic Violence Fatality Review Project's operations.

I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigation materials and information may result in civil or criminal liability.

Because the review process may involve case specific sharing of information and confidentiality is inherent in many of the involved reports, each member and the Domestic Violence Fatality Review Panel will take clear measures to understand the limits of what they may reveal in their capacity as an agency representative. All members of the regional Panels will sign a confidentiality statement that prohibits any unauthorized dissemination of information related to the review process. No material may be used for reasons other than that which was intended.

«Organization»agrees that no one associated with this agency will represent the views of the Domestic Violence Fatality Review Panel to the media.

«Organization»agrees to immediately notify the state office of the Domestic Violence Fatality Review Project if the agency or any individual connected with it is subpoenaed for information obtained via the review process.

In my capacity as its authoritative representative, I commit «Organization»'s participation, support and assistance to the Washington State Domestic Violence Fatality Review Project.

This agreement will be in effect as of the date below. I can request a revision or review of this agreement within thirty (30) days of written notice. Notice of revision or termination of this Agreement will be sent to all members of the **Spokane** Domestic Violence Fatality Review Panel.

Signature

Date

title

Washington State Domestic Violence Fatality Review Project

Agreement to Maintain Confidentiality

to be signed by each person in attendance at each Domestic Violence Fatality Review Panel meeting

By signing this form, I do hereby acknowledge and agree to the following:

I agree to serve as a member of the (Region) Domestic Violence Fatality Review Panel, under the auspices of the Washington Domestic Violence Fatality Review Project. I acknowledge that the effectiveness of the fatality review process is dependent on the quality of trust and honesty panel members bring to it. Thus I agree that I will not use any material or information obtained during the Domestic Violence Fatality Review Panel for any reason other than that which it was intended.

I further agree to safeguard the records, reports, investigation material, information I receive from unauthorized disclosure. I will not take any case identifying material from a meeting other than that which originated in the agency I represent. Thus I will not make copies or otherwise document/record material made available in these reviews, including electronically. I will return all material shared by others at the end of each meeting.

I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigation materials and information may result in civil or criminal liability and exclusion from the Domestic Violence Fatality Review Panel.

I agree to refrain from representing the views of Domestic Violence Fatality Review Panel to the media.

Printed Name	Signature	Date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Washington State Domestic Violence Fatality Review

Internship Opportunity

Responsibilities:

Work with a multi-disciplinary regionally based Domestic Violence Fatality Review Panel to gather all available information about parties involved in domestic violence related fatalities targeted for review; synthesize available information into a case summary for members of review panels

Identify issues raised in the course of reviews which reflect on the following: inadequate policy; gaps between policy and practice; training needs for particular groups; institutional norms which need to be changed; system gaps

Research policy alternatives for addressing issues raised in the course of reviews. Evaluate these alternatives with sensitivity to local/regional needs and context.

Assist in preparation of an annual report for the Domestic Violence Fatality Review Project which will document findings and include policy recommendations. This report will be disseminated throughout the state to policy makers, battered women's advocates and educators

Analyze information from existing databases and research regarding domestic violence related fatalities

Other responsibilities as assigned

Qualifications:

Enrollment in a public policy, policy administration, public health or social work graduate program

Knowledge of the dynamics of woman battering and domestic violence, and of public policy regarding violence against women

Ability to write clearly and concisely

Excellent organizational skills; ability to complete tasks in a timely manner

Flexibility

Experience as an advocate for battered women an asset

Hours and Stipend: $10 per hour, 10 to 20 hours a week. A two quarter commitment is preferable

Attachment 14

Washington State Domestic Violence Fatality Review

Fields in the Newspaper Summary

The information listed below is pulled from news reports of domestic violence related fatalities and recorded in a spreadsheet or database which then can be merged into a document listing domestic violence fatalities covered by newspapers.

	field	notes
1.	type of incident	4-5 word summary for quick reference, i.e., man kills woman, woman kills man, friends/family killed…
2.	dv victim first name	
3.	dv victim last name	
4.	dv victim's gender	
5.	age	
6.	domestic violence victim's race	tracked in order to be mindful of the barriers institutional racism may pose, not to pathologize any particular group
7.	victim year of birth	helpful for looking up public records
8.	dv perp first name	
9.	dv perp last name	
10.	dv perp's gender	
11.	age	
12.	domestic violence perpetrator's race	tracked in order to be mindful of the barriers institutional racism may pose, not to pathologize any particular group
13.	perpetrator year of birth	helpful for looking up public records
14.	date of homicide or suicide	
15.	city where fatality occurred	
16.	county where fatality occurred	
17.	names of homicide victims	homicide victim may not be the domestic violence victim
18.	names of suicides	
19.	relationship of victims of homicide to perpetrator of homicide	
20.	weapon used	
21.	children	ages, how many, were they present, whose were they?

Attachment 15

	field	notes
22.	leaving / separated / divorced?	
23.	prior dv/court	prior protection orders, arrests, other trouble
24.	pending criminal/civil action at time of murder	
25.	summary of the events	
26.	charges	charges and plea bargains, dates of arraignment, trial starting, trial ending, sentencing
27.	outcome	sentence
28.	officials involved	useful for when case is reviewed
29.	prior suicide attempt?	had the batterer threatened or attempted suicide, as reported by friends, family, neighbors, the domestic violence victim?
30.	murder / suicide by batterer?	
31.	apparent suicide of woman?	
32.	welfare notes	the newspaper rarely mentions any information which speaks directly to economic barriers, but to the extent possible, we wanted to track the degree to which welfare reform changes affected women.
33.	address info	This is useful for emergency medical response personnel on the panel
34.	notable (good/bad) quotes	useful for work with the media
35.	domestic violence expert quoted?	

Washington State Domestic Violence Fatality Review

Newspaper summary for King County 3-97 to 10-98

Domestic violence related fatalities in King County which occurring between 3/97 and 10/98 and reported in Washington newspapers. Please note that this is not a complete listing of all domestic violence fatalities, but only those covered in Washington newspapers.

5/27/97 Jensen and 7/4/97 Dittrick — family/friends killed — Seattle, King County

Domestic violence victim:	Julie Jenson (?)	Year of birth:
Domestic violence perpetrator:	Gary Ackerly	Year of birth: 1969
Name(s) of deceased:	Arlene Jensen born (1944) and Stephanie Dittrick (born 1968)	
Relationship of deceased to perpetrator of homicide:	Jensen was his girlfriend's mother and Dittrick was his friend	
Children:	he had two children by Jensen's daughter, Julie	

Prior domestic violence: None mentioned in article, but charging papers indicate he had threatened Jensen in late 1996. He was concerned that she would report him to CPS for child abuse (or already had)

Summary: It seems Ackley thought Jensen would report him to CPS for child abuse. He blamed her for problems in his relationship. Friends/family testified in trial that he had threatened to kill her. It seems he killed her in April/May. He had a key to Jensen's house and let himself in, attacked her there and dumped her body in a marsh in Woodinville. Prosecutors think he later admitted the killing to his childhood friend, Stephanie Dittrick (her mother recalls a conversation in which Stephanie indicated Ackley might be involved in Jensen's death.) He apparently then killed Stephanie after a July 4th party, presumably because she knew about the murder of Jensen. Dittrick was last seen leaving on a camping trip with him and her body was later found near her tent and clothes. Dittrick's body was found near Miller River road. near the car she and Ackley had left the party in. Evidence collection was compromised since it took several weeks to locate Dittrick and Jensen's bodies, which were partially decomposed. Julie Jenson, daughter of Arlene and in a 11 year relationship with Ackley, is standing beside him, claiming she believes he is innocent until proven guilty.

Charges and outcome: first degree murder for Jensen's death and one count of aggravated first degree murder for Dittrick's death. If convicted, he would face life in prison. Trial begins week of 6/22/98. Mistrial declared 6/24/98 because the prosecutor repeatedly pointed out that Ackley would not testify, an infringement of his 5th amendment rights.

5/17/97 — man kills woman and himself — Hazel Dell, King County

Domestic violence victim:	Rae Custer	Year of birth: 1916
Domestic violence perpetrator:	George Custer	Year of birth: 1914
Name(s) of deceased:	Rae Custer	
Relationship of deceased to perpetrator of homicide:	wife	
Children:	None mentioned in article	

Prior domestic violence: none mentioned in article

Attachment 16

Summary: may not be DV. Man shot wife and self, told 911 dispatcher they were both ill. Married 48 yrs

Charges and outcome: murder/suicide no criminal case

6/3/97	man kills woman	Seattle, King County	
	Domestic violence victim:	Mary Ginger	Year of birth: 1954
	Domestic violence perpetrator:	Robert Smith	Year of birth: 1963
	Name(s) of deceased:	Mary Ginger	
	Relationship of deceased to perpetrator of homicide:	girlfriend	

Prior domestic violence: none mentioned in article, although it seems likely

Summary: man and woman were homeless, camped under Swift-Alfbor off ramp off the I-5. She died after three days in Harborview from a head injury. Article mentions that he attacked her after accusing her of being unfaithful. A friend found her unconscious the next day.

Charges and outcome: man held in jail as of 7/3/97

6/16/97	murder/suicide man kills entire family	Bellevue, King County	
	Domestic violence victim:	Arlene Lau	Year of birth: 1948
	Domestic violence perpetrator:	Sam Lau	Year of birth: 1942
	Name(s) of deceased:	Arlene Lau, Sammy Lau, 21 and Terence Lau, 17	
	Relationship of deceased to perpetrator of homicide:	wife and children	
	Children:	Sammy 21 and Terence 17	

Prior domestic violence: none mentioned in article

Summary: Wealthy business man shot and killed his family, they all died of wounds to the abdomen, he then turned the gun on himself and died fo a single shot. He left a note identifying himself as responsible. He had bought the gun just a few days prior. Expressed in letter worry about legal troubles, but two pending lawsuits did not seem likely to devastate business according to lawyers. Both sons were extremely successful in school and vol work .

Charges and outcome: murders/suicide no case

8/25/97	man kills child and self	Bellevue, King County	
	Domestic violence victim:	Evelyn McLemore, dv victim, mother of Aubrey	Year of birth: 1964
	Domestic violence perpetrator:	David Kouchalakos	Year of birth: 1945
	Name(s) of deceased:	Aubrey, 8 years old	
	Relationship of deceased to perpetrator of homicide:	child	
	Children:	Aubrey, 8	

Prior domestic violence: Couple were engaged in an acrimonious child custody dispute, required police standby on exchange of child 11/96 and 7/96

Summary: Bodies of father and daughter found in his home 9/6/97. He had picked up his daughter for a three day visit 8/25. When the child was not not returned, mom called and went to the house and found it dark on 8/28. She reported child missing to Seattle PD 8/29, but no action was taken. Finally called Bellevue PD, who came and saw dead dogs thru window, entered house and found bodies. Neighbors had been worried but did not call police. They describe man as private, abrasive. He was on SSI b/c vietnam vet with PTSD. Divorce papers had said, "not uncommonly you read about seeminly quiet and innocuous men with few social ties who suddenly go berserk and murder their families " As usual, a neighbor on hand to say how much he "doted on" his child.

Charges and outcome: no case, murder suicide

8/27/97 man kills woman SeaTac, King County

Domestic violence victim:	Tina Olsen	Year of birth: 1965
Domestic violence perpetrator:	Pedro Torres-Vasquez	Year of birth: 1950
Name(s) of deceased:	Tina Olsen	
Relationship of deceased to perpetrator of homicide:	girlfriend	
Children:	she had 4 in foster care	

Prior domestic violence: Police had responded to domestic violence calls at least three times to the motel room where they were living, including on 8/22/97. Reports documented injuries including a lump on the head.

Summary: Tina Olsen had lived in the Seaview Motel with her boyfriend. Neighbors reported a lot of fighting, he had been arrested for DV 5 days before she was found dead. She had moved out of the motel (which was closed by court order) into her parents house. Her stepfather found her body in the living room, lying face down. She had died of head trauma, having suffered about 13 blows to the head with a sharp instrument. Police tracked ex boyfriend down to his mother's house in West Seattle, where they also found a large blood stained knife. He had shown a knife to friends, previously, saying he would kill his ex girlfriend for turning him in to police for drug possession.

Charges and outcome: He was arrested 8/29/97, and was held in lieu of $750,000 bail as of 9/5/97, Charged with first degree murder. Closing arguments took place 7/23/98. A mistrial was declared 7/27/98 when jurors failed to reach a verdict. Apparenlty 11 jurors voted to convict, and one wanted to acquit.

8/28/97 batterer shoots officer Auburn, King County

Domestic violence victim:	Samoun Srip (she survived, but batterer killed a police officer)	Year of birth: 1997
Domestic violence perpetrator:	Sap Kray	Year of birth:
Name(s) of deceased:	Tacoma PD officer Bill Lowrey, 39	
Relationship of deceased to perpetrator of homicide:	intervening police officer	

Prior domestic violence: none mentioned in the article

Summary: Kray and Srip were separated. He showed up at Emerald Downs, where she does night cleaning, with an assault rifle. He left once, returned in a couple hours and Auburn police were called. He threatened to shoot anyone who approached, displayed the assault rifle and refused to cooperate with officers. He did not point the weapon at anyone, and officers allowed him to leave. Auburn Police chief Purdy characterized this as "a nonincident until the incident in Tacoma." Purdy also noted that offers are trained to defuse dv situations by separating "the combatents" so that "cool down" -- says "it usually works." After the "non incident" Kray went to his wife's home. Police were called and a standoff ensued. Kray shot Lowrey after being shot himself.

Charges and outcome: Cty Prosecutor announced 4/21 that they will not seek the death penalty, but will charge with aggravated 1st degree murder. Among the mitigating factors in this decision: his emotinal distress b/c of "difficulties with his wife"

12/4/97	man kills woman	Seattle, King County	
	Domestic violence victim:	Nina Flunker Del Toro	Year of birth: 1997
	Domestic violence perpetrator:	Humberto Maya-Martinez	Year of birth: 1956
	Name(s) of deceased:	Nina Flunker Del Toro	
	Relationship of deceased to perpetrator of homicide:	girlfriend	
	Children:	4 your old son witnessed	

Prior domestic violence: none mentioned in article

Summary: Maya-Martinez is charged with stabbing Del Toro to death in front of her 4 year old son. Prosecutors said that he had lived with Del Toro, her husband and son for a time, but had been asked to leave. Not sure of the relationships between these 3 adults.

Charges and outcome: charged with first degree murder, held on $750,000 cash only bail as of 12/9/97

12/21/97	man kills woman	Seattle, King County	
	Domestic violence victim:	Pacita Marcelo	Year of birth: 1997
	Domestic violence perpetrator:	John Marcelo	Year of birth: 1941
	Name(s) of deceased:	Patricia Marcelo	
	Relationship of deceased to perpetrator of homicide:	girlfriend	
	Children:		

Prior domestic violence: none mentioned

Summary: Prosecutors allege that he struck her on the head with a bowl and stick during an argument and she died late that night. He was held on $250,000 bail

Charges and outcome: charged 12/24/97 with 2nd degree murder

1/2/98 bodies found	murder suicide	Seattle, King County	
	Domestic violence victim:	Dorothy Ure	Year of birth: 1932
	Domestic violence perpetrator:	Joseph Ure	Year of birth: 1921

Name(s) of deceased: Dorothy Ure

Relationship of deceased to perpetrator of homicide: wife

Prior domestic violence: none mentioned

Summary: Bodies were found by police after family members called and requested a well being check. Initially reported as a murder/suicide, but then King Cty Med Examiner's office has listed both as "apparent homicide" ME's office later ruled it homicide suicide. Looks like he shot his wife as she was sleeping, then himself. He is known to have suffered debilitating back pain and to have threatened suicide in the past

Charges and outcome:

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body found 1/24/98 — man kills woman — Skyway, King County

Domestic violence victim: unnamed — Year of birth: 1998

Domestic violence perpetrator: unnamed — Year of birth: 1972

Name(s) of deceased: unnamed woman

Relationship of deceased to perpetrator of homicide: frequent guest

Prior domestic violence: King Cty Sheriff's spokesperson Joanne Elledge said police had responded to the address before for "noise complaints."

Summary: 19 year old man had not seen woman who was a friend of his housemate for a couple days, so went to look for her. Found her body in a backyard shed. 26 year old identified as a suspect and arrested near Bonney Lake at a friend's house.

Charges and outcome: will be charged with first degree murder

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1/23/98 — family/friends killed — Auburn, King County

Domestic violence victim: Tina McPherson — Year of birth: 1998

Domestic violence perpetrator: Eric Deloy Westman — Year of birth: 1962

Name(s) of deceased: David Kenneth Stone

Relationship of deceased to perpetrator of homicide: ex girlfriend's new boyfriend

Prior domestic violence: none mentioned

Summary: Westman and McPherson (both postal workers) had dated for about two years when she broke off the relationship and began dating Stone. Westman had threatened to hurt Stone and prosecutors argued during trial that Westman had staled and harassed Stone for about a month before killing him. He showed up at Stone's apartment 1/23/98 and shot him in the head and chest. McPherson showed up a short time later and found him unconcious, tried to revive him as a 911 operator coached her over the phone.

Charges and outcome: first degree murder convicted of first degree murder 6/9/98. Sentencing range is 25-30 years. Sentencing date is in July.

4/15/98 may not be dv Seattle, King County

Domestic violence victim: Oum Duang Cheth Year of birth: 1961

Domestic violence perpetrator: An Kim Tiv Year of birth: 1952

Name(s) of deceased: Oum Duang Cheth

Relationship of deceased to perpetrator of homicide: acquaintance, he was not her husband.

Children: 5 children were present, 10 and 11 year old girls seriously injured. 13 yr old girl and brothers 14 and 16 escaped

Prior domestic violence: none mentioned

Summary: Man showed up at Cheth's apartment, came in and started shooting. Killed her first and seriously wounded 10 and 11 yr old girls. 3 other children jumped out of a 2nd storey windo to escape. Police report said the man was upset because she had "mocked" him earlier. Neighbors described the family as good, quiet and studious. Info on acquaintance is not clear

Charges and outcome: he killed himself, so no case

5/26/98 man kills woman Seattle, King County

Domestic violence victim: Lita Ariola Olson Year of birth: 1959

Domestic violence perpetrator: Ex-husband is a suspect Year of birth: 1998

Name(s) of deceased: Lita Ariola Olson

Relationship of deceased to perpetrator of homicide: Ex-wife

Children: teen son and 6 year old daughter

Prior domestic violence:

Summary: On May 26, at about 7:40 pm Lita's son forced his way into the home when his mother did not answer the door. He discovered her dead in her bedroom. Seattle PI reports "neighbors learned of the woman's death when they heard the boy's mournful wail when he found his mother's body..." The six year old daughter was with a babysitter at the time. Lita had been shot multiple times in the chest. Efforts to locate her former husband (who shared the house) began immediately.

Charges and outcome:

5/30/98 may not be DV Seattle, King County

Domestic violence victim: Geraldine Hendrickson Year of birth: 1965

Domestic violence perpetrator: unknown Year of birth: 1998

Name(s) of deceased: Geraldine Hendrickson

Relationship of deceased to perpetrator of homicide: unknown

Children:

Prior domestic violence: Geraldine had been convicted of manslaughter in the death of her boyfriend in 1996 but had been given a short sentence. Her defense was battered women's syndrome. Once out of jail, she had lived in Wyoming and more recently in Seattle.

Summary: Medics were called to her apartment in Friday May 29, and found Geraldine unconcious in her apartment. She died at Harborview the next day. ME said the cause of death was "homicidal violence" but are not releasing details as of 5/31/98. No suspect identified in newspapers as of 5/31/98.

Charges and outcome:

7/18/98 man kills ex girlfriend's friend Westwood, King County

Domestic violence victim:	unnamed woman	Year of birth: 1998
Domestic violence perpetrator:	Anthony Deshon Anderson	Year of birth: 1978
Name(s) of deceased:	Matthew Lozeau	
Relationship of deceased to perpetrator of homicide:	friend of perps ex girlfriend	

Prior domestic violence: none mentioned

Summary: Anthony Anderson arrived at his ex-girlfriend's house around 2:30 am . He knocked on the door and Lozeau came out to talk to him. Lozeau told him to leave, he and the woman were trying to sleep, and to come back the next day. Anderson wouldn't leave, and he and Lozeau went in the backyard to talk. Soon Anderson's female friend joined them, as did the ex-girlfriend. Anderson and Lozeau got in a fight. Lozeau pinned Anderson to the ground. When Lozeau let Anderson up and stepped away from him, Anderson pulled out a revolver and shot Lozeau in the head. He then approached his ex-girlfriend, who fled to call police. An autopsy by the King Cty medical examiner found Lozeau was shot mutliple times, while prosecutor summary mentions only one shot from a .45 caliber gun.

Charges and outcome:

7/3/98 new husband kills ex husband North Bend, King County

Domestic violence victim:	Violet Stout	Year of birth:
Domestic violence perpetrator:	William E. Anderson Jr.	Year of birth: 1949
Name(s) of deceased:	William E. Anderson, Jr.	
Relationship of deceased to perpetrator of homicide:	ex husband of perpetrator's wife	
Children:	11 year old	

Prior domestic violence: Violet Stout reported that two years prior, Anderson had thrown her new husband, Gordon Stout, into a window.

Summary: Man was at his ex-wife's house to visit his daughter. According to Ms. Stout, he began goading her husband Gordan Stout, to pick a fight. Gordan Stout went into a bedroom, and Anderson began threatening his ex-wife and daughter. He had been drinking. Mr. Stout returned with a gun. Details leading up to actual gunshot are lacking, but Mr. Stout shot Anderson in the head, apparently in front of his daughter. After the shooting Ms. Stout took the gun and threw it in the Snoqualmie River. She later led divers to the location and the gun was recovered. Gordan Stout turned himself in.

Charges and outcome: In charging papers, King County prosecutors deny the story of self defense and argue that Stout was "fed up" with Anderson.

7/17/98 murder suicide Seattle, King County

Domestic violence victim: Kimberly Young Year of birth: 1957

Domestic violence perpetrator: Dominic Zegretti Year of birth: 1956

Name(s) of deceased: Kimberly Young

Relationship of deceased to perpetrator of homicide: unclear. Not his wife

Prior domestic violence: none mentioned

Summary: Bodies were found at the Gasworks Park parking lot around 6:30 am in a red Honda Civic. Zegretti had apparently fired several shots, blowing out the back window of the car. Young was in the drivers' seat. She had been shot in the chest. She was dead at the scene. Zegretti died of a self inflicted head wound at Harborview at 8am. He was married, Kimberly Young was not his wife. Seattle Times reporters tracked down a neighbor who commented on what a "great guy" Zegretti was. Zegretti worked at the University of Washington in the campus mail dept.

Charges and outcome:

7/20/98 murder suicide DesMoines, King County

Domestic violence victim: unnamed Year of birth: 1963

Domestic violence perpetrator: unnamed Year of birth: 1964

Name(s) of deceased: unnamed

Relationship of deceased to perpetrator of homicide: girlfriend

Children: 16 year old daughter found them

Prior domestic violence: none mentioned

Summary: 16 year old daughter came home around 7pm and found her mother and her mother's boyfriend dead. She called 911.. There was no evidence of forced entry. Medical examniner ruled it murder/suicide. Neighbors described a quiet family notable in that they did not seem to speak to each other, much less to anyone else.

Charges and outcome:

8/7/98 man kills woman Renton, King County

Domestic violence victim: Carolyn Durall Year of birth: 1963

Domestic violence perpetrator: Robert Durall Year of birth: 1958

Name(s) of deceased: Carolyn Durall

Relationship of deceased to perpetrator of homicide: wife

Children: three children, ages 9, 7 and 4

Prior domestic violence: none mentioned

Summary: Carolyn Durall left work 8/6/98 telling coworkers she intended to ask of ra divorce. Her husband reported her missing 8/7/98, along with their van. Witnesses noticed the van parked 8/6 to 8/9 about 2 miles from the Durall home, and report it. King Cty police phone Durall 8/10/98 to tell him where the van is located. The van is later seen on I-405, near Southcenter. 8/11/98, police interview Robert Durall. 8/13/98, police request access to the house to look at Carolyn's belongings. He denies their entrance. 8/19/98, Carolyn's coworkers, who have mounted a search campaign, find the van in a hotel parking lot near Sea-Tac airport. 8/21/98, police get a search warrant for the Durall residence, and find blood. 8/22/98, Durall is arrested. 8/26, Durall is charged with 2nd degree murder, pleads not guilty 8/31, and is held on $1 million bail. This charge is changed to first degree murder when it is found Durall used his work computer to search the internet on topis such as "kill-spouse," "accidental death," "smothering," "poisons," "homicides," and "murder." Bail upped to $5 million. 9/8/98 Robert Durall lead police to Carolyn's body, in a ravine 10 miles west of Snoqualmie summit. An autopsy revealed she died of blunt force trauma to her head. As she left work 8/6, Carolyn had directed coworkers to a drawer in her desk, telling them to look there "if anything happens to me." The drawer contained a letter detailing her fears of Durall and his jealousy. Robert Durall worked for King County Housing Authority. Carolyn worked for Morgan Stanley Dean Witter in Bellevue.

Charges and outcome: First degree murder

Washington State Domestic Violence Fatality Review Project

Case Summary

Domestic Violence Fatality Review Panel

Debby murdered by Brad who then committed suicide 4/7/97

For review June 30, 1998

Background:

Debby (white female, DOB 6/8/74) had grown up in Smalltown, attending school there until she dropped out in the 10th grade. She had not finished her GED, and was unemployed at the time of her death. She had worked various jobs, including at a warehouse, kennel and florist. She had dated Brad on and off since (?) but had told police she broke up with him around November 96. At the time of her death, she was 7 months pregnant with a child by him. She had married Tim after dating him on and off for 6 years on 2/14/97.

Brad, (white male, DOB 1/28/65) also grew up in Smalltown. In a letter to the editor of the Newspaper, retired Smalltown teacher described him as a "well behaved, good student" when he was in her class and "troubled" but not "bad." Brad had been arrested a couple of times for firing a weapon inside his home, according to Smalltown Police Chief Ron Emmons.

Prior Violence:

Debby had apparently told her family about her fears regarding Brad. She had also spoken with the Smalltown Chief of Police about her concerns.

Summary of events:

Date	Institution	Event
1989	Smalltown PD	Brad is arrested for Reckless Endangerment (for firing a weapon in the city limits) is mentioned in a 94 arrest report for the same crime. I did not receive a copy of the 89 report
7/93		Sandra discovers that her son, Tim is growing marijuana in their backyard. She calls the police to report both Debby and Tim on this charge. Tim denies that Debby was involved, and admits he grew the plants for his own use.
7/26/93	County Superior Court	Sandra, Tim's mother, obtains a temporary order of protection against Tim and Debby, excluding them from her residence at 20502 Patterson Road East and restraining them from the usuals. She describes Debby threatening her "You will be sorry, cunt. I am going to get you. I am going to kill you, bitch." The order was served the same day by PCSD.
8/9/93	Superior Court	Sandra failed to appear at the hearing for the permanent order, so the order was dismissed.
12/8/94	Smalltown PD	Reckless Endangerment/Discharging firearm: This report mentions a 1989 case in which Brad was arrested for discharging a firearm in the city limits. This time, numerous neighbors reported hearing a series of

Date	Institution	Event
		shots (six neighbors made written statements.) Police entered Brad's home with the permission of his father. Brad had shot at a framed picture of a girlfriend. Brad's explanation is that he was "upset at his girlfriend again but it was a different one than the last time." Police identified the smell of "intoxicants" on Brad. He was arrested and taken to local jail. Smalltown Police took possession of two rifles (an SKS 7.62 and Jennings J-22 LR), a 12 gauge shot gun, and quite a bit of ammunition. Brad had 45 days to respond to this seizure by requesting a hearing for the return of the property.
8/30/96	Smalltown PD	Welfare check: Brad's supervisor at Milgard asked that a wellness check be done on Brad. Police report states: "I spoke to the complainant who said he was concerned as Brad has been talking about suicide intensely for about three weeks. He (Brad was offered help through work but declined. He has been showing signs of unstableness and has said when he goes he's going to take out a bunch of employees with him. " When police arrived at Brad's house, he appeared normal. He was preparing a car for a drag race, did not appear intoxicated or affected by drugs. He denied knowing why anyone would request a wellness check on him. He was living with a girlfriend at the time and said things were okay with her.
Approx 10/96		Debby becomes pregnant with a baby by Brad
2/14/97		Marriage of Debby to Tim
3/3/97	County Sheriff	County Sheriff involved: Brad showed up at Debby's sister's house, where Debby was visiting. He came in uninvited and insisted on looking at Debby's abdomen. He ripped a phone from the wall as they attempted to call the police and made threats.
	Smalltown Police	Debby has a conversation with Smalltown Police Chief Ron Emmons. He advises her to get a protection order.
3/4/97	Superior Court Commissioner	Temporary Order for Protection Filed for and obtained by Debby and Tim against Brad. In her narrative, Debby wrote that "<u>over the last 5 months he on several occasions threatened my life about murder suicide. He said he would kill me and then kill himself</u>." She also notes "Brad's past history of alcohol abuse and mental health problems" Her address at this time is listed as 19000 Peterson Road in Smalltown
3/6/97	Smalltown PD	Service of order of protection filed by Debby

Date	Institution	Event
3/7/97	Superior Court Commissioner	Temporary Order for Protection filed for and obtained by Brad against Debby. In his petition, he claims that she assaulted him by throwing a glass of milk in his face and hitting him with the glass. The order is served on 3/12/98 by County Sheriff.
3/18/97	Superior Court Commissioner	Permanent Order for Protection granted to Debby and Tim against Brad. Brad was present at the hearing and testified, as did Debby and Tim. The final order excludes Brad from her address and restrains him from the usuals, but does not specifically restrain him from her school or place of employment. Permanent Order of Protection denied to Brad against Debby
4/7/97	Smalltown PD County Sheriff Harborview Children's Hospital	Day of Murder/Suicide: 8:30pm Debby is talking with a friend at the Jackpot Food Mart on Washington Street in Smalltown 8:30pm Brad spots Debby and pulls into the parking lot. went inside the store and asked the clerk to call 911. Brad walked in and told the clerk to put the phone down, and demanded to see if she was still pregnant. When she turned away, he shot her in the back of her head with a .45 caliber semiautomatic pistol. Brad then left the scene and went to his parents' home, where he told them that he had killed Debby and intended to kill himself. He then went to his house (a mobile home). He was behind the mobile home when Smalltown police arrived. He shot himself in full view of one of the officers, after being told several times to put the weapon down. County Sheriff are called in to assist in the investigation. Binoculars are found in Brad's car, indicating that he might have been watching Debby prior to killing her. Debby is transported to Harborview Hospital by helicopter. Her baby was delivered by cesarean section as she died, and taken to Children's Hospital and Medical Center in Seattle. Seven weeks premature, he weighs just 4 pounds and did not have fully developed lungs. He is named Jeffrey Kaylyn .
		Brad's parents told Sheriff's investigators that they were not surprised that he killed himself since he had been suicidal on and off for years, but were surprised that he took another person with him. Debby's parents indicated to Sheriffs investigators and to newspapers that they were aware of Brad's threats against her.

Date	Institution	Event
4/9/97	County Prosecutor	Brad is scheduled to be arraigned on 4th degree assault and interfering with reporting domestic violence.
4/18/97	Children's Hospital	Baby Jeffrey dies from a lung and blood infection.
7/13/97	Superior Court	Tim files a wrongful death complaint against the estate of Brad.
	Superior Court	10/13, 10/31, 11/7, 11/10, 11/12 - several motions and responses filed back and forth regarding the question of whether Tim as an individual can bring this action, or whether he must bring it as a representative of Debby's estate.
11/14/97	Superior Court	Tim 's claims against Brad's estate are dismissed without prejudice when the court finds that "there is no genuine issues of material fact, and that the defendant, the Estate of Brad, is entitled to summary judgement as a matter of law."
3/11/98	Superior Court	Brad's estate is finally settled. (The estate included two bikes, several undrivable cars, car tires, miscellaneous car parts, two functional late model cars, and one newer car. It also included $1100 credit card debt. Attorney's fees were $5,250)

Public Records available in this case: County Sheriff's reports – including their investigation following the murder/suicide, Smalltown Police Department incident reports, protection orders filed by all the parties, motions filed in civil court regarding Tim's complaint of wrongful death, motions and orders regarding the estates of Debby and Brad.

Washington State Domestic Violence Fatality Review Project

Questions about the murder of Debby

Brad had a history of suicidal thoughts and threats which was well known to his parents and Debby (and perhaps others as well). It is not clear if he ever actually attempted suicide.

- What services were available for a suicidal person like Brad? What was close by and accessible? How would people like his parents or Brad himself find out about services?
- Should Brad have been involuntarily committed for his suicidal ideation at some point?
- Under what circumstances (if any) can a gun be removed from a person who is suicidal by authorities?
- What would you have counseled Brad's parents to do if the had told you about his suicidal thoughts?

Debby told several people, including her parents and the Chief of Police, about her fears regarding Brad's threats to kill her and himself. She specifically relates his threats to do this on her protection order narrative.

- What options could have been presented to her besides the protective order by friends, family, judges and law enforcement personnel?
- How often do women mention murder/suicide threats on protection orders?

Debby was 7 months pregnant at the time of her death

- Did Debby receive prenatal care? Was dv identified during these visits?

About the law enforcement response:

- How did Brad have time to stop by his parents' house before going to his house to kill himself? This seems kind of amazing, even though Smalltown is small.

Washington State Domestic Violence Fatality Review

Summary of issues relating to

Debby's murder by Brad

and his subsequent suicide

Unresolved questions:

A newspaper article mentioned that Brad had been in trouble with police before because of shots being fired in his house. What were the circumstances in these events? Was this suicidal acting out? Was someone else in the house? Was he trying to control, intimidate or scare anyone? What sort of danger/mental health assessment was done, if any? What other sorts of contacts did Brad have with law enforcement?

Debby had filed for and received a Protection Order. Would this have entitled her to ask that Brad's guns be removed?

Brad's suicidal thoughts and acts:

Brad had a long history of suicidal threats and actions. When interviewed, his parents said they weren't surprised he committed suicide, since he had threatened it so often. They described him as having struggled with depression for 10 years. His current girlfriend had seen him put a gun in his mouth. Friends/family had heard him threaten to shoot himself at least two times.

According to her protection order narrative, he had threatened Debby with murder/suicide.

Brad had weapons in his home. While his parents knew of his suicidal thoughts, it would have been difficult for them to have these guns removed without Brad's consent. Law enforcement will remove guns from the home of the person making the request, but not from someone else's home. Even then, they can't keep the guns very long if the owner asks to retrieve them.

The Review Panel was unable to ascertain if Brad had ever been hospitalized or received treatment for his suicidal thoughts.

The review panel talked at length about the degree to which information on how to respond to threats of suicide is available or not. General consensus was that the information was not that accessible to the public. Many people are very ignorant about how to respond/assess suicidal threats. Some panel members mentioned the need for the public to be educated in risk reduction strategies, such as removing weapons from the home.

Accurate risk assessment and availability of information to Debby

Debby spoke to several people about the threats Brad had made prior to her murder. She spelled out his threats in her protection order narrative; spoke to Smalltown law enforcement; and presumably told her friends and family. It is also likely that she spoke to a domestic violence advocate while filing for her restraining order.

The panel had no way of knowing what kind of advice or guidance Debby received, but agreed that training on domestic violence for all criminal justice system and social service system personnel should include the understanding that risk is increased when the abuser is actively suicidal, and the role of suicide threats in domestic violence. (the person may sincerely be suicidal, but this works as a control strategy as well.)

The panel was curious about what sort of victim info pamphlet the police department handed out, and if Smalltown had considered taking advantage of STOP grant monies.

Some people in smaller towns are hesitant to seek help in the nearby city. There is a domestic violence advocate at a Family Support Center, this is relatively close to Smalltown.

Debby was 7 months pregnant at the time of her death. She may have encountered include prenatal care providers and possibly public assistance case managers (i.e., TANF, WIC). Did anyone screen for domestic violence and do safety planning?

<u>Danger for women not living with their abuser</u>

Debby was not living with Brad, and in that sense did not conform to stereotypic notions of the "battered woman." The panel wondered if any potential interventions were short circuited because of an illusion the situation was less dangerous because she was not living with the abuser. Because she was married and living with her husband, she probably would not have wanted to go to shelter. However, it was virtually impossible for her to be safe in Smalltown, as it is very small and run ins with Brad would be just about inevitable.

<u>Economics:</u>

Even if Debby had wanted to get out of town, it may have been difficult. She did not finish high school, was unemployed and expecting a child. The financial logistics of relocating would be just about unattainable for a person in this position. Access to subsidized housing is limited and most housing programs have considerable waits.

<u>Brad told his parents he wanted Debby to have an abortion</u>

Brad's explanation to his parents for his behavior toward Debby was that he had given her money toward and abortion and wanted her to end the pregnancy. He was furious she had not done so. (Thus his efforts to examine her abdomen.) His parents explained that he thought Debby was using drugs and would not be a good mother. He may have been fearful of the economic consequences of Debby bearing his child.

None of this can be confirmed. A couple panel members pointed out that an abuser may come up with explanations to rationalize their behavior. This may be just that. Even if it were true, it would indicate his desire for control. Her refusal to end the pregnancy and her recent marriage might have signified a loss of control for Brad.

Washington State Domestic Violence Fatality Review

Domestic Violence Fatality Review panel members in pilot regions were asked to comment on the Project. The following is a selection of their comments.

"Case by case review is a strength of the project – the pace is good and it allows for exploration of details."

"I have found the Domestic Violence Fatality Review interesting and informative. So often one only knows a tiny part of the entire picture of the dynamics of domestic violence and its impact across community agencies."

"Diverse panel members broadened perspective outside individual employment areas. The Project is a natural way to bring multiple diverse agencies together to network and (hopefully) to develop unified community response to domestic violence."

A judge noted the Domestic Violence Fatality Review Project had been "very valuable to me. Important to have third party reaction to proceedings to reevaluate the decisions made."

"I believe the review of (a specific case) was helpful in learning what measures were tried and how the courts failed to defuse an ongoing domestic violence problem."

"The Domestic Violence Fatality Reviews have allowed us to talk about a number of issues from many points of view as well as from many different disciplines. Very informative and a great learning tool for all of us. I find them to be very valuable…."

"A strength of the project is the fact that we are all willing to work together to find out more about each others' contributions to stopping domestic violence. It is wonderful that we all share so many different parts of the pie and we are willing to come together and discuss what our particular pie slices and expertise are. As we work together more, we have become a better whole and we all learn how to do things better."

"These are good learning sessions for all of us."

"The analysis of an old case in comparison to how the system has adapted was constructive. It certainly points to the need for continuing victim/community education and clearly additional training for defense attorneys, judges and guardians ad litem."

"The opportunity to bring together all the players in a total system is definitely a good thing, and fosters a different level of understanding and cooperation."

"It is extremely important to step back and take an objective look at what led up to these homicides, discussing them with people from other disciplines, to determine what could have been done, and what can be done in the future, to stop the violence from escalating, and break the cycle. These reviews so far have been very valuable in accomplishing that."

"The strength of the project lies in reviewing all possible factors: previous acts of violence and threats, proximity of abuser, effectiveness of protection/no contact orders, resources available to victims, their awareness of them, and knowledge of how to access them, missed opportunities to intervene, support systems available to all parties, access to weapons/laws regarding same, diverse cultural norms, etc. Diversity of backgrounds in the group is a big strength, as is intensive review of just one or two cases in each meeting."

Attachment 18