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Reviewing Domestic Violence Deaths

by Neil Websdale

About the Author

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Every year in the United States, 1,000 to 1,600 women die at the hands of their male partners, often after a long, escalating pattern of battering.¹ The estimated number of deaths due to intimate partner violence does not include those women who kill themselves to exit violent relationships, or who die homeless on the streets avoiding batterers. (See “What Is the Actual Death Toll Due to Domestic Violence?”)

Increasingly, criminal justice professionals and other practitioners involved in domestic violence cases are using a tool that may help reduce the many deaths due to intimate partner homicide. It’s a fatality review.

Like the reviews conducted after an airplane crash, a fatality review helps determine what went wrong and what could have been done differently to prevent the tragedy. (See “Borrowing an Airline Industry Strategy—The Post Mortem,” page 28.)

What Are Fatality Reviews?

In a fatality review, community practitioners and service providers identify homicides and suicides resulting from

domestic violence, examine the events leading up to the death, identify gaps in service delivery, and improve preventive interventions.

The review team asks many questions: Did the victim approach a social service or law enforcement agency? If so, what services and interventions were provided? How might these have been provided more effectively? How might the victim have been better protected? In short, a fatality review identifies relevant social, economic, and policy realities that compromise the safety of battered women and their children.

Fatality reviews can reveal trends and may lead to changes to the system that could prevent future deaths. They may also enhance prevention and intervention programs aimed at reducing the death toll from acts of domestic violence.

Reviewing domestic violence deaths over time might identify broader issues with social policies, criminal justice intervention strategies, and political initiatives. Such reviews might also highlight success stories.

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WHAT IS THE ACTUAL DEATH TOLL DUE TO DOMESTIC VIOLENCE?

Even more deaths than those directly associated with an act of domestic violence can be traced to domestic violence if the women who die from conditions that are byproducts of domestic crimes are included in the count. For example, many female deaths are attributed to HIV, the consequences of homelessness, and prostitution. Because battered women are somewhat more vulnerable to HIV infection than other women,¹ some deaths of women currently attributed to HIV or its complications might be traced to a woman’s status as battered. The same could be said of women who die on the streets, where roughly half of homeless women report “fleeing abuse” as the primary reason for their homelessness.² Likewise, prostitutes typically experience extensive interpersonal abuse and sometimes even death at the hands of male intimates, family members, and clients.

1. Websdale, Neil, and Byron Johnson, “Battered Women’s Vulnerability to HIV Infection,” *Justice Professional* 10(4) (1997): 183–198.
2. Zorza, Joan, “Woman Battering: A Major Cause of Homelessness,” *Clearinghouse Review* 25(4) (1991).

BORROWING AN AIRLINE INDUSTRY STRATEGY—THE POST MORTEM

Commercial airline crashes draw a lot of attention and quickly become high-profile news, mostly because many deaths occur at once and the event increases general anxiety about flying. The airline industry responds by conducting reviews to find ways to prevent future crashes. Such investigations cost millions of dollars and use enormous amounts of technical expertise. The expensive, sophisticated, and systematic investigation of airline crashes has many benefits, not the least of which are the specific precautions that are subsequently introduced to prevent similar crashes from occurring.

In the United States, deaths traceable to domestic violence are more numerous than those stemming from airline crashes. This raises the question of why comparable amounts of time, money, and expertise are not applied to investigating the causes of domestic violence deaths. Most intimate partner homicides are stylized killings that exhibit common patterns and antecedents.¹ Although they share many of the characteristics of abuse cases that do not result in death, many of the cases that do end in death may be preventable. Nevertheless, most domestic violence homicides are not subject to any systematic review, and substantial resources are not spent trying to learn ways to better protect future victims of domestic violence.

Despite limited funding for in-depth local fatality reviews, some States and local jurisdictions are exploring the reasons for and causes of domestic violence-related deaths.² Approximately 27 States and the District of Columbia conduct or plan to conduct some form of domestic violence fatality review. In some regions, the reviews dovetail with or build upon existing coordinated community responses to domestic violence.

For example, without any funding or protective legislation, the Philadelphia Department of Public Health, with support from the district attorney's office, has been reviewing all deaths (not just domestic violence cases) of women ages 15 to 60.³ The Santa Clara County, CA, review team has examined domestic homicides since 1994. This team generates a wealth of information on what happened in the lives of both the perpetrators and their victims before the death. Fatality reviews are increasingly part of an expanding arsenal of multiagency, interdisciplinary strategies for addressing the effects of violence against women. Underpinning these strategies is a concern about the risks of harm faced by women and other family members and a desire to improve the accountability of individual service agencies and to enhance the effectiveness of interagency coordination efforts. If conducted thoroughly and thoughtfully, fatality reviews may yield a more comprehensive understanding of the causes of and prevention strategies for domestic homicide.

1. See Websdale, Neil, *Understanding Domestic Homicide*, Boston: Northeastern University Press, 1999; Dobash, Russell P., R. Emerson Dobash, Margo Wilson, and Martin Daly, "The Myth of Sexual Symmetry in Marital Violence," *Social Problems* 39(1) (1992): 71–91; Ewing, Charles Patrick, *Fatal Families: The Dynamics of Intrafamilial Homicide*, Thousand Oaks, CA: Sage Publications, 1997; Heide, Kathleen, *Why Kids Kill Parents: Child Abuse and Adolescent Homicide*, Thousand Oaks, CA: Sage Publications, 1995.
2. The following States have some form of domestic violence fatality review activity. The letter "L" in parentheses after a State means that State has passed fatality review legislation; the letters "EO" in parentheses denote the issuance of an Executive Order to formally initiate the process. Alaska, Arizona, California (L), Colorado, Delaware (L), District of Columbia (L), Florida (L), Illinois, Indiana (L), Iowa (L), Kentucky (L), Maine (L), Michigan (L), Minnesota (one county only, local legislation), Nevada (L), New Hampshire (EO), New Jersey (EO), New Mexico (EO), North Carolina, Ohio, Oklahoma (L), Pennsylvania, Rhode Island, Tennessee (L), Vermont (L), Virginia (L), Washington (L), West Virginia. The United States Department of Defense is considering adopting domestic violence fatality reviews throughout the four branches of the military.
3. This includes deaths classified as homicides, suicides, unintentional injury, undetermined cause, those with inadequate certificates, and peculiar circumstances (i.e., asthma, AIDS).

The Review Process Varies with Local Needs

Fatality reviews may vary with the locale. They can be formal or informal. Some review teams track basic demographic data. These teams may have fewer resources that might prevent in-depth analysis. However, other teams, even those with few resources, conduct very detailed reviews including a critical examination of interagency cooperation or lack thereof.

Reviews Lead to Tailored Services

Fatality reviews can uncover a region's special needs, such as a need for language services. For example, in Washington State, a report from a fatality review of a domestic homicide noted that "a law enforcement officer had to ask a 6-year-old child to translate for the family member...who had discovered the bodies of the two victims."² In another case, a hostage situation, "the young hostage had to provide translation while the murderer held a gun to her head."³ In addition to the potential trauma associated with having victims, family members, or bystanders translate in such circumstances, the use of untrained translators may impede case investigations of all domestic assaults.

The Washington State report recommended that "law enforcement, hospitals, domestic violence programs, and Temporary Aid to Needy Families offices...create collaborative relationships with grassroots organizations based in limited English-speaking communities."⁴ The report continued, "Law enforcement agencies should conduct investigations of domestic violence crimes with qualified interpreters."⁵

In African-American communities, particularly those in inner city public housing, the domestic homicide rate is almost six times higher than that of the white population. This overrepresentation appears to be largely a product of poverty.⁶

Reviews of domestic violence deaths in poor black neighborhoods reveal that African-American women display a deep suspicion of police, social services, shelters, housing agencies, and the courts. Community policing and its emphasis on greater and more varied forms of surveillance seems to make little difference to domestic violence in these acutely disadvantaged areas. Fatality reviews might offer one means of enhancing dialogue between inner-city minority citizens and political authorities. This dialogue might include discussion of the war on drugs, public housing rules,

WHAT DO FATALITY REVIEWS DO?¹

- Identify deaths—both homicides and suicides—caused by domestic violence.
- Examine the effects of all domestic violence interventions that took place before the victim's death.
- Consider changes in prevention and intervention systems to help prevent such deaths in the future.
- Develop recommendations for coordinated community prevention and intervention initiatives to reduce domestic violence.

1. Barbara Hart, Legal Committee, Domestic Violence Death Review, National Council of Juvenile and Family Court Judges, February 9, 1995 (unpublished).

The challenge is timeliness: the review must be recent enough that the findings—usually from public records—can inform and guide discussions about improving existing policies and procedures. Such reviews have produced a wealth of information about homicide-suicide deaths.

DOMESTIC VIOLENCE PROVOKES SUICIDES

A significant number of the 6,000 or so women who commit suicide in the United States each year likely do so because of being abused by an intimate male partner.¹ Evan Stark and Anne Flitcraft found that “among the medical histories of the 176 women who attempted suicide, 29.5 percent were battered” and “22.2 percent... had at least one documented incident of domestic abuse in their records.”²

1. During the 1990’s, approximately 30,000 people per year took their own lives. Of these, approximately 6,000 were female. Retrieved from the World Wide Web site <http://www.cdc.gov/ncipc/factsheets/suifacts.htm>, August 9, 2002.
2. Stark, Evan, and Anne Flitcraft, *Women at Risk: Domestic Violence and Women’s Health*, London: Sage Publications, 1996: 107.

welfare-to-work initiatives, the mass incarceration of black people, the ongoing loss of meaningful and relatively well-paid jobs from the inner city, and other policies that limit battered women’s ability to exit dangerous intimate relationships.

Removing Barriers to Review

Fatality reviews—like many processes that seek to save lives—raise liability issues and make some agencies nervous. Some States have reduced the concern associated with liability by enacting confidentiality laws to shield the deliberations and findings. These laws immunize teams from civil suits and disciplinary action.

In Florida, 16 review teams operate under immunity legislation that protects their deliberations. Florida’s fatality review process began after a statewide initiative recommended examining the particulars of all domestic homicides.⁷ Team deliberations “are not subject to discovery or introduction into evidence in any civil action or disciplinary proceeding by any department or employing agency... A person who has attended a meeting of a domestic violence fatality review team may not testify in any civil action or disciplinary proceeding as to any records or information produced or presented to the team during meetings or other activities authorized by this section.”⁸

The Florida statute stipulates that data collection procedures be consistent throughout the State. The data are used to write Florida’s annual report on domestic violence fatalities, which goes to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court.⁹

The downside of requiring that data be in a standardized format is that local review teams, typically underfunded and frequently staffed by volunteers, often do not willingly complete standard government forms. The upside is that such a system can generate comprehensive statewide data, which, when reviewed by key decisionmakers, can advance policy development.

In States without confidentiality protections, reviewing only closed cases (e.g., homicide-suicides) in which all the parties involved have died and where there are no pending civil or criminal legal proceedings, can reduce concerns about liability. The challenge is timeliness: the review must be recent enough that the findings—usually from public records—can inform and guide discussions about improving existing policies and procedures. Such reviews have produced a wealth of information about homicide-suicide deaths.

For example, in Washington State, reviewers noted the dangers that suicidal abusers pose and recommended that “officers...routinely ask victims about the abuser’s history of making homicidal or suicidal threats.” If such threats have been made, officers should “urge the victim to call a domestic violence program for help with safety planning.”¹⁰ The report also recommended expanding the contents of the Washington Association of Sheriffs and Police Chiefs Model Operating Procedures on screening for suicide and responding to suicidal abusers.¹¹

What the Future Holds

It is up to local jurisdictions and agencies to decide if they can assign resources to fatality reviews. Although the benefits of conducting such reviews have yet to be measured on a broad scale, preliminary results indicate that fatality reviews can have a positive effect in addressing domestic violence. Nevertheless, decisionmakers can weigh the time and money needed for the reviews against the time and money being spent on answering domestic violence calls and managing death scenes—not to mention the number of lives that could be saved by acting on the information that fatality reviews uncover.

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Notes

1. Fox, James Alan, and Marianne W. Zawitz, *Homicide Trends in the United States*, Washington, DC: U.S. Department of

Justice, Bureau of Justice Statistics, January 1999 (NCJ 173956).

2. Hobart, Margaret, *Honoring Their Lives, Learning From Their Deaths: Findings and Recommendations From the Washington State Domestic Violence Fatality Review*, Washington State Coalition Against Domestic Violence, 2000: 48.
3. *Ibid.*, 49.
4. *Ibid.*, 9.
5. *Ibid.*, 9.
6. See Centerwall, Brandon S., “Race, Socioeconomic Status, and Domestic Homicide, Atlanta, 1971–1972,” *American Journal of Public Health* 74 (1984): 813–815; and Centerwall, Brandon S., “Race, Socioeconomic Status, and Domestic Homicide,” *Journal of the American Medical Association* 273(22) (June 14, 1995): 1755–1758. For a recent analysis of the relationship between race, poverty, and domestic homicide, see Websdale, Neil, *Understanding Domestic Homicide*, Boston: Northeastern University Press, 1999: 204–236.
7. See Websdale, *Understanding Domestic Homicide*. For the most recent statement on the status of the Florida fatality review teams, see Websdale, Neil, and Byron Johnson, *Implementing and Monitoring New Fatality Review Teams*, Tallahassee: Florida Department of Children and Families, 2001.
8. Florida Statutes 741.316 s.6
9. Florida Statutes 741.316 s.3
10. Hobart, *Honoring Their Lives*: 12.
11. *Ibid.*, 11. The report recommends that law enforcement officers immediately call in mental health professionals when batterers threaten suicide (p. 35).