Domestic Fatality Review Teams

A National Approach and Alternative to Review Homicide, Suicide and Suspicious Death Situations
Tennessee’s New Legislation

- Permissive in Nature
- Addresses liability, confidentiality, and discovery issues
- Identifies potential team members
- Provides guidelines for communication of results
What Are the Trends in Knoxville

- 33% of all KPD domestic cases are repeat offenders
- Violence escalates with each offense
- Repeat cases can result in homicide and suicide
- Aggravated assault accounts for 8-16% of all KPD domestic violence cases
Aggravated Assaults

Percentage of Total Incidents that are Aggravated Assaults

- Jan-Dec 97: 16%
- Jan-Dec 98: 11%
- Jan-Dec 99: 11%
- Jan-Dec 00: 8%
Domestic Homicide in the City of Knoxville

Domestic Homicides 98-00

- Jan-Dec 98: 6
- Jan-Dec 99: 3
- Jan-Dec 00: 5
Domestic Homicide in the City of Knoxville

DV Homicide Victims by Race 98-00

<table>
<thead>
<tr>
<th>Race</th>
<th>Number of Victims</th>
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</thead>
<tbody>
<tr>
<td>b/m</td>
<td>2</td>
</tr>
<tr>
<td>b/f</td>
<td>5</td>
</tr>
<tr>
<td>w/m</td>
<td>2</td>
</tr>
<tr>
<td>w/f</td>
<td>4</td>
</tr>
<tr>
<td>other</td>
<td>1</td>
</tr>
</tbody>
</table>

Number of Victims
Domestic Homicide in the City of Knoxville

Victims by Age

<table>
<thead>
<tr>
<th>Years of Age</th>
<th>Number of Victims</th>
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</thead>
<tbody>
<tr>
<td>0-18</td>
<td>3.0</td>
</tr>
<tr>
<td>19-25</td>
<td>1.5</td>
</tr>
<tr>
<td>26-35</td>
<td>3.0</td>
</tr>
<tr>
<td>36-45</td>
<td>3.0</td>
</tr>
<tr>
<td>46-55</td>
<td>2.0</td>
</tr>
<tr>
<td>55+</td>
<td>0.5</td>
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</tbody>
</table>
Domestic Homicide in the City of Knoxville

### Methods of Homicide

- **Shot**: 8 victims
- **Beaten**: 2 victims
- **Other**: 3 victims

<table>
<thead>
<tr>
<th>Method</th>
<th>Number of Victims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shot</td>
<td>8</td>
</tr>
<tr>
<td>Beaten</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
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Number of Victims
History of Fatality Review Panels

- Started with Child Abuse Review Teams in the 80’s to look at child deaths, using a multidisciplinary systematic approach.
- Team members are Law Enforcement, Child Protective Services, Coroner, Medical Experts, Attorney General, Health Department, Family Court, Other.
History of Fatality Review Panels

- Proved to be an effective tool to address areas that needed systematic change for the welfare of children.
- Communities worked together to address problems in the system and not just individual agencies.
Domestic Violence Review Teams

- Use of Death Review Teams in domestic violence situations began in the early 1990’s.
- Purpose was to identify areas where systematic change could ensure victim safety and hold offenders accountable.
Charan Investigation

Joseph Charan murdered his wife, Veena Charan, on January 15, 1990, and then took his own life. Veena had sought the support of several agencies for a period of 15 months prior to her demise. Veena had been separated from Joseph and was awarded the custody of their nine-year-old son. During the 15 months preceding her death she made numerous reports to police. Immediately prior to her death Joseph was arrested for felony wife beating and malicious mischief. As a result of the conviction for this offense, Joseph received a 12-month suspended jail sentence.
He was put on probation through the Adult Probation Department with the following conditions: 1. Domestic violence counseling; 2. Stay away order; and 3. 30 days jail, of which he was given four days, the remainder to be served in the Sheriff’s Work Alternative Program. Veena Charan obtained a restraining order through the civil courts. Mr. Charan violated the order on several occasions. He attempted to kidnap his son at the son’s school. It was at the school that Mr. Charan killed his wife in front of school teachers and school children, before committing suicide.
Charan Investigation

- Conducted by the Commission on the Status of Women, City of San Francisco, and the County of San Francisco.
- One of the most detailed fatality or death reviews ever conducted.
Charan Investigation

• Questions it sought to address
  – Do the departments of the City and County have policies and procedures relating to domestic violence? If so, what are they and how adequate are they?
  – Is there sufficient information-sharing among departments in these particular types of cases?
Charan Investigation

• Questions it sought to address
  – Are there sufficient data to evaluate the effectiveness of the system? If not, what additional data need to be collected? What changes, if any, to current procedures can be adopted to avert future tragedies?
Findings revealed four essential gaps in service delivery in the Charan case:

1. Communication and Coordination
   - Aside from communication between the San Francisco PD and the DA’s Office, there was little communication among the multiple agencies which had contact with Veena Charan. These agencies included municipal court, adult probation, family court services, social services.
1. Communication and Coordination
   - The commission called for centralization of information and better coordination of service delivery.
Charan Investigation

Findings revealed four essential gaps in service delivery in the Charan case:

2. Data Collection
   - The committee recognized the need for systematic information about domestic violence cases. The investigation notes, “Data on the number of DV cases handled by the departments ranged from very limited to not at all.” The committee deemed the data to be of central importance in the identification of the level of need for services and the subsequent delivery of those services.
Findings revealed four essential gaps in service delivery in the Charan case:

3. Access to Services
   - The committee pointed out that a lack of sensitivity to and an understanding of the multicultural issues in city departments increases the numbers of those suffering from domestic violence.
Findings revealed four essential gaps in service delivery in the Charan case:

4. Training
   - Translation services were lacking. Specifically, there was a lack of translators on the Superior Court, Civil Division, and a limited number in the Criminal Court Division. This created delays, misunderstandings of the agreements/court orders and proceedings. The investigation called for the development of DV advisory committees in each city department that worked with DV cases.
Charan Investigation

Other Excerpts

- The P.D. did not deem previous injuries Veena Charan and other family members received at the hands of Joseph to be serious. “Had the investigators looked at the pattern of violence used by Mr. Charan and presented that information to the DA’s Office, stronger measures and responses to the situation may have prevented escalating violence.”
Charan Investigation

Other Excerpts

- According to felony protocol of the DA’s Office, prior history was one of the factors taken into account regarding booking. If the DA’s office had access to the same information the commission did, the re-booking charges may have been different.

- Probation officers were not adequately trained in the dynamics of domestic violence.
Charan Investigation

Other Excerpts

- The commission called for greater DV training of the Municipal Court, Criminal Division. In particular, it stated a “need for training judges on interpretation of restraining orders.”

- Family Court refused to answer question of the commission based on confidentiality. The commission stated this is “indicative of the lack of the departments’ efforts to improve the City’s response to battered women and children.” Mediation was also criticized.
Conclusion

- Communities that have conducted Domestic Violence Fatality Reviews have benefited system wide
- DV Reviews can save lives in the future
- There must be a consensus to do the reviews
Immediate and Future Goal

• Agree to Agree
• Develop an article of agreement
• Develop the guidelines for the panel
• Identify the team members
• Identify cases to review
• Begin reviewing cases