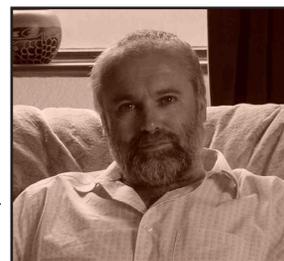


Q&A About Domestic Violence Fatality Review

This Q&A was conducted with Neil Websdale, Ph.D. (pictured right), Director of the National Domestic Violence Fatality Review Initiative.



Q: What is domestic violence fatality review?

A: Domestic violence fatality review involves an analysis of a death caused by, related to, or somehow traceable to domestic violence. The review creates a greater understanding of the tragedy and ideally leads to the implementation of preventive interventions. Teams review many different types of cases, including serious (non-fatal) incidents, intimate partner homicides, homicide suicides, familicides (perpetrator kills former or current spouse one or more of their children and often commits suicide), suicides (especially those of battered women who exit violent, tyrannical and controlling relationships), cases where bystanders die (e.g. police officers, workplace colleagues), cases where one sexual competitor (usually a previously abusive man) kills another and indirect deaths where decedents die from causes traceable to domestic violence, including the deaths of homeless women, HIV-infected women, and drug addicts.

Q: Why is fatality review a useful tool for communities?

A: Comprehensive fatality review allows us to make sense of the death(s) by recreating the experiences of the victims, perpetrators and other parties involved in the case, exploring the compromises and challenges parties faced in accessing services, making decisions and exploring strategies. The review prioritizes the experiences of victims, giving us new ways of improving services, plugging gaps, increasing communications between those agencies typically

involved and increasing the links between services and community members. Fatality review also provides opportunities for learning how we might better serve families that lost loved ones. It sharpens our understanding, allowing us to think about the relationships between coordinated community responses to domestic violence, safety audits, safety planning, and risk assessment and management.

Q: What are the steps in reviewing domestic violence fatalities?

A: Teams gather available information by a variety of means, including the use of Freedom of Information Law (FOIL) requests, through the public record. In a limited number of cases the testimony of family members, workplace peers, neighbors, friends, and others augments this information. Members discuss confidential information in different ways, some having a facilitator, others not, some being tied to a prescriptive process defined by state statute, others not. Although the depth of review varies, most teams follow similar and interrelated steps. One common step involves constructing a timeline of important events in the case, capturing how the case changed over time and how the nature of violence, tyranny, threats, and attempts to control perhaps intensified toward the death. Teams note the warning signs that might have suggested the case was moving toward a lethal outcome. Efforts are also made to identify the parts played by various agencies and community members and the level of coordination between these entities. Finally, teams suggest a number of recommendations based on the outcomes of their review(s), the goal being to make realistic recommen-

dations that can be effectively implemented and that contribute to more effective coordinated community responses to domestic violence.

Q: How can communities structure fatality review when there is not state legislation in place?

A: State statutes enabling entities to review cases of domestic violence related deaths provide a variety of guidelines, assurances, prescriptions, and protections for teams and their members. Most teams work within the frameworks of these statutes. Reviews have taken place without statutory guidelines and protections but they are tricky. It is entirely feasible for a group of professionals to conduct thorough reviews using only public record materials, perhaps utilizing the insights of family members if the group chooses. It is also possible for surviving family members to convene reviews in combination with other supportive and interested parties, gathering information through the public record or making requests for information under the Freedom of Information Act. It is also possible for family members to access personal information, documents and records although it is important to know the difference between public, private, and confidential data. Teams may consider obtaining waivers of confidentiality from surviving family members if appropriate.

For more information on domestic violence fatality review: www.ndvfri.org/ To access the 2008 New York City Fatality Review Report: www.nyc.gov/html/ocdv/downloads/pdf/FRC_2008.pdf