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DOMESTIC VIOLENCE: RESEARCH IN REVIEW

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Highlights

- ✓ The purpose of this research was to examine the extent to which local level domestic violence serious incident/fatality reviews exist in New York State.
- ✓ Findings indicate that domestic violence serious incident/fatality reviews are relatively rare events in New York State.
- ✓ Professionals from counties with reviews have found reviews very helpful in improving their community's response to domestic violence.
- ✓ Many professionals from counties without reviews have expressed their desire to learn about and initiate reviews with the hope of improving their community's response to domestic violence.
- ✓ Models of serious incident/fatality review are discussed, as well as future initiatives that might involve a larger, comprehensive, domestic violence accountability assessment structure for every community in New York State.

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Target Audience:

Law enforcement officers, district attorneys, domestic violence advocates, public policy professionals, county domestic violence task forces and all agencies associated with a community's response to domestic violence.

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Domestic Violence Serious Incident/ Fatality Reviews in New York State

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In 1997, the Commission on Domestic Violence Fatalities, convened by Governor George E. Pataki, published a review of several domestic violence homicides that occurred in New York State (NYS).(1) In that report, the Commission recommended that, while a state Fatality Review Board should not be established, "the findings and recommendations of the Commission…should be considered and implemented on appropriate state and local levels." The Commission also recommended that the need for a State Fatality Review Board be "reconsidered in light of the experience with this local review process."

Despite these recommendations, in the past ten years since the Commission's report, local level domestic violence fatality incident review boards have been relatively rare in New York State. This is not surprising since fatality reviews can be quite resource intensive, especially for small communities. The purpose of this research is to examine the extent to which domestic violence serious incident or fatality reviews exist in New York State, how they are structured, how they exist in relation to other related task-forces, and for communities without reviews, the extent to which local domestic violence professionals desire one.

A domestic violence fatality review is basically a process that engages domestic violence-related professionals in the review of a domestic violence incident that resulted in a homicide or suicide. The main purpose of a fatality review is to identify gaps in service delivery and to determine how the system can be improved, possibly preventing future deaths.(2) Fatality reviews afford local communities an opportunity to discuss how public service systems can improve their response to domestic violence, and increase their attention to victim safety.

Methodology

A brief survey was sent to every district attorney's office, police department and major domestic violence service provider in New York State in the Spring/ Summer of 2006 (refer to *Appendix A*). These professionals are most often the main players in a community's response to domestic violence, and as such, are important "informants" about domestic violence-related practices and viable strategies for improvement. Efforts were made to ensure representation from every county in New York State, especially from service providers and district attorney's offices, two main response systems to domestic violence. Therefore, selective follow-up (by telephone) was done for counties that did not respond within the desired time frame.

The survey included several questions about the existence and structure of a domestic violence serious incident or fatality review, and questions on other related task forces (e.g. child fatality reviews and domestic violence task forces). Our decision to include a question about participation on child fatality reviews was an attempt to understand where overlap between the two fields might occur, and

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also, to see if certain communities already have current structures operating for fatality review.

The survey focused on both serious incident *and* fatal incident reviews because some systems do not distinguish between the two, and we wanted to capture all domestic violence related-reviews. Furthermore, sometimes it may only be chance that distinguishes a serious incident from a fatality, and so, conceivably, serious incidents and fatalities may be more similar than not. We did not define "serious" or fatality "review" for respondents and instead, allowed them to apply their own definition.

A total of 207 responses were received, representing all 62 counties in New York State**.** While most of the respondents were from police departments, a higher proportion of responses were gathered from district attorney's offices and domestic violence service providers.[3] It should be noted that since most police department respondents were from smaller departments, police agency responses may not necessarily be representative of the experiences and beliefs of larger police departments in New York State. On a similar note, no responses were received from any New York State Police (NYSP) troops, which generally have different jurisdiction than other police departments.[4] Fortunately, for the large majority of the counties (85%), responses were received from a service provider and/or a district attorney, who usually are aware of domestic violence initiatives throughout the county. In most of the remaining counties, responses were received from a major (large city) police department.

In addition to the county level surveys, researchers met with police, district attorneys and service providers from a few Capital District jurisdictions to further discuss the issue of domestic violence serious incident/fatality reviews. These interviews helped to provide greater context to findings from the surveys.

Results

Tables 1 through 3, and *Figure 1* summarize survey results by county, and describe domestic violence serious incident/fatality reviews, domestic violence task forces and child fatality reviews in New York State.[5] Since respondents will naturally have different opinions about their community's response to domestic violence, *Tables 4 though 6*, and *Figures 1 and 2* present information on respondents' perceptions and visions for their community regarding domestic violence.

County-Level Summaries

Prevalence of Serious Incident and Fatality Reviews

When summarizing the data by county, *Table 1* indicates that only about one-third of the counties in New York State (N=21) have or had a domestic violence serious incident/fatality review (also refer to *Table 2 and Table 3*). The total number of counties with current reviews is only 16, or 26% of all New York State counties. Slightly more than 60% of the counties with current reviews examine domestic violence serious incidents *and* fatalities while 44% of the counties review fatalities only. The median number of agencies that participate on reviews is six. All county reviews involved a multi-agency effort that included at a minimum, participation from law enforcement and domestic violence service providers. One county had a review that involved only two agencies (the city police department and the main local domestic violence service provider). At least two counties had a multi-agency review effort, and simultaneously, another review effort by a single agency (*results not shown*).[6] Both of these single agency reviews were conducted by police departments.

Every review existed within a county that had an active domestic violence task force. However, while reviews always existed within counties that had active domestic violence task forces, reviews were not always *connected to* task forces. In some situations (as stated above), a single agency might conduct a "review" (however they defined "review"), or task force related agencies might conduct a review, while in other situations, the review emerged as an integral part of the domestic violence task force.

Of the 46 counties that did not have a current review, the large majority (76%) of the counties had at least one respondent who said that they would like a domestic violence serious incident/fatality review started in their community (refer to *Table 1).*

Training

Only 38% of the counties with past or current reviews, had one or more participants who received training on domestic violence serious incident/fatality reviews (refer to *Table 1).* All respondents from these counties said that the training was very useful. They said that the training helped the team identify what works and what does not work. Respondents also said that the training offered concrete recommendations on how to handle reviews, and it helped to introduce an expertise into the entire review process.

Written Protocols / Family Member Participation

Only about half of the counties had respondents who reported that their review had written protocols or policies that helped to guide reviews (refer to *Table 1).* About one-third of the reviews notified or interviewed family members of the victim. Only one review invited family members of the (deceased) victim to participate.

Although attachments were requested, very few respondents attached written policies or protocols associated with their review. So, it was not completely clear from the survey what processes the differing models of reviews were implementing. However, based on the narrative responses, most reviews appeared to involve examination of available data (e.g. aggregate data analysis) or sharing case record information, and rarely involved interviews with victims, witnesses or family members of the victim.

Factors for Case Selection

Each respondent was asked to report on what factors were used to determine which cases are selected for review (refer to *Table 1*). The most frequently occurring factor for case review was crime seriousness (e.g. level of injury, sexual abuse, strangulation case, or repeat incidents).

Table 1 County-level Summaries of the NYS Domestic Violence Serious Incident/ Fatality Review Survey

	#	%
Total counties represented by respondents (1) (N=62 NYS counties)	62	100.0%
Average # of responses per county	Avg	3
Counties that have or had a domestic violence serious incident/fatality review	21	33.9%
Counties with a current domestic violence serious incident/fataity review	16	25.8%
Counties with a current review that review fatal incidents only	6	37.5%
Of those without a current review,	46	
counties with one or more DV professionals who would like one	35	76.1%
Description of Old or Current Serious Incident or Fatality Reviews		
Counties with four or more agencies participating	14	66.7%
Number of participating agencies	Median	6.0
Counties with persons who received training	8	38.1%
Counties with written protocols or policies	11	52.4%
Reviews which notify family members	7	33.3%
Reviews which interview family members	6	28.6%
Reviews in which family members can participate	1	4.8%
Decision making factors		
Crime seriousness (e.g. including injury or repeat incidents)	9	42.9%
A vote is taken OR a designated person makes the decision	6	28.6%
All cases reviewed	5	23.8%
Dissemination of findings (# who answered question)		
Findings are shared at meetings, or with individual agencies	14	66.7%
Findings documented or otherwise turned into a report	5	23.8%
Findings shared with media	1	4.8%
Counties that had or have a domestic violence task force	58	93.5%
Counties with a current domestic violence task force	55	88.7%
Number of participating agencies	Median	6.0
Counties with professionals who expressed interest in LISTSERV	57	91.9%
Counties with child fatality reviews	31	50.0%
Number of participating agencies	Median	4.0
Domestic violece service provider participates on child fatality review	8	25.8%
Child fatality review is done within county with a Child Advocacy Center	6	19.4%

Note: The five counties of New York City are conducting a joint fatality review audit. They are each counted separately for purposes of the county-level summary analysis.

(1) A domestic violence service provider and/or a district attorney's office response was received from approximately 84% of the counties.

Table 2 Domestic Violence Task Force, Fatality or Serious Incident Review

	Has or Had DV Task Force	Has *Current* DV Task Force	Has or Had Review	Has *Current* Review	Fatal Review Only	No curret review, but interested in starting a review
Albany	1	1				1
Allegany	1	1				1
***Bronx**	1	1	1	1	1	NA
Broome	1	1	1	1		NA
Cattaraugus	1	1	1	1		NA
Cayuga	1	1				1
Chautauqua	1	1				1
Chemung	1	1				1
Chenango						1
Clinton	1	1				1
Columbia	1	1	1			1
Cortland	1					1
Delaware	1	1				
Dutchess	1	1	1	1		NA
Erie	1	1	1			1
Essex	1	1				1
Franklin	1	1				1
Fulton	1	1				1
Genesee	1	1				1
Greene	1	1				1
Hamilton						
Herkimer	1	1				
Jefferson	1	1				
***Kings**	1	1	1	1	1	NA
Lewis						1
Livingston	1	1				1
Madison	1	1				
Monroe	1	1	1	1	1	NA
Montgomery	1	1	1	1		NA
Nassau (1)	1	1	1			
***New York**	1	1	1	1	1	NA
Niagara	1	1	1	1		NA
Oneida	1	1				1
Onondaga	1	1	1		1	1
Ontario						1
Orange	1	1				1
Orleans	1	1				1
Oswego	1	1	1	1		NA
Otsego	1	1	1	1		NA
Putnam	1	1				1
***Queens**	1	1	1	1	1	NA
Rensselaer	1	1	1	1		NA
***Richmond**	1	1	1	1	1	NA
Rockland	1	1				1
Saratoga	1	1				
Schenectady	1	1				1
Schoharie	1	1				1
Schuyler	1	1				1
Seneca	1	1	1	1		NA
St. Lawrence	1	1				1
Steuben	1	1	1			
Suffolk	1	1				1
Sullivan	1					1
Tioga	1	1				
Tompkins	1	1				1
Ulster	1	1				
Warren	1	1				1
Washington	1	1				1
Wayne	1	1				1
Westchester	1	1				NA
Wyoming	1	1	1	1		NA
Yates	1					1
Total	58	55	21	16	7	35
% of state	93.5%	88.7%	33.9%	25.8%	11.3%	56.5%

(1) Although Nassau County no longer has a fatality review, and does not review serious incidents only, an interagency group does review all domestic violence incidents, not just serious or fatal incidents.

The second most frequently cited selection factor or approach was having a designated person or team vote on which cases to review. Respondents from five counties said that their teams examined all domestic incidents reported to the police. A respondent from one county said that their review team bases their case review decision on the victim's (or victim's family's) willingness to cooperate with the process.

Dissemination of Findings

The large majority (67%) of the counties with past or current reviews reported that the primary way findings and recommendations are disseminated is through their team's meetings, or in meetings or contact with individual agencies (refer to *Table 1*). Only 24% of the counties had respondents who said that their findings were documented or turned into a report. One respondent said that they disseminate their findings through release to the media.

Domestic Violence Task Force

The large majority of the counties (89%) had one or more respondents who said that their county currently has a domestic violence task force (refer to *Table 1*). Three counties reported that they had a task force, but no longer have one. Respondents from the remaining four non-task force counties reported that they never have had a domestic violence task force.

There was quite a wide range in the number of agencies that participated on a county domestic violence task force. While the median number of agencies on task forces was six, there were ten counties that had 40 or more agencies participating on their task force. Task forces most frequently included at least one police department (usually the largest city police department in a county, the county sheriff's office or representation from the NYSP), the district attorney's office, the main domestic violence service provider, the county probation department, and the county's department of social services and/or its child protective services unit. In some communities, task forces also had participation from representatives from the courts, legal aid, pa-

Table 3 Counties with Current Domestic Violence Serious Incident /Fatality Reviews

County	Level	Type	Policies	Who's Involved (# Agencies)	Criteria	Victim's Family Involved?	PROCESS	REPORT
Bronx	County/all NYC	Fatalities	Yes, local laws	Multiagency (6 or more)	All fatalities perpetrated by family or household members	No	Aggregate Data Review only	Forthcoming
Broome	County	Fatalities & Serious	No	Multiagency (6 or more)	Unknown	Unknown	Unknown	At meetings
Cattaraugus	County	Fatalities & Serious	Yes	Multiagency (6 or more)	Nature of case, injury level, case seriousness	Yes	Respond as needed when case meets criteria	Meetings, flyers, newspaper articles
Dutchess	County	All incidents	No	Multiagency (Less than 6)	Jurisdiction, intimate partner violence (IPV) or former IPV, level of injury	Yes	Domestic Abuse Response Team (DART) steering committee	Discussed at meetings
Kings	County/all NYC	Fatalities	Yes, local laws	Multiagency (6 or more)	All fatalities perpetrated by family or household members	No	Aggregate Data Review only	Forthcoming
Monroe	County	Fatalities	Yes	Multiagency (6 or more)	Closed cases – committee decides	No	Case record review; information transferred to a standardized questionnaire. Non-case specific recommendations shared with task force. Sometimes agency staff are interviewed.	Reviews confidential; general summary; affected agencies given specific recommendations.
Montgomery	County	Fatalities & Serious	Yes	Multiagency (6 or more)	Domestic violence representative reviews all cases and helps determine further review	Yes	Handled by responding agency; reviewed by service provider; some brought to task force for further review.	Discussed in meetings and placed in minutes
New York	County/all NYC	Fatalities	Yes, local laws	Multiagency (6 or more)	All fatalities perpetrated by family or household members	No	Aggregate Data Review only	Forthcoming
Niagara	County	Fatalities & Serious	No	Multiagency (6 or more)	Level of injury, history of violence, repeat offenders, violence escalation, victim reluctance to cooperate	No	DA's office or advocate initiates; informal gathering of involved agencies; examine prior history and incident	Discussed at meetings
Oswego	County	Fatalities & Serious	Unknown	Multiagency (6 or more)	Task force reviews all physical injury dv incidences	Unknown	A monthly review of all serious domestic violence cases at coalition meeting	Unknown
Otsego	County	Fatalities & Serious	No	Multiagency (Less than 6)	Review all dv serious incident cases	Unknown	Unknown	Unknown
Queens	County/all NYC	Fatalities	Yes, local laws	Multiagency (6 or more)	All fatalities perpetrated by family or household members	No	Aggregate Data Review only	Forthcoming
Rensselaer	Town/City	All incidents	Yes	Multiagency (Less than 6)	All cases reviewed and receive follow-up	Depends on the case	Reviewed by detectives; some cases discussed with advocates	Unknown
Richmond	County/all NYC	Fatalities	Yes, local laws	Multiagency (6 or more)	All fatalities perpetrated by family or household members	No	Aggregate Data Review only	Forthcoming
Seneca	County	Fatalities & Serious	No	Multiagency (Less than 6)	Serious injury, sexual abuse, fatalities	Yes	Victim asst coordinator contacts Sheriff dept to review case. Discussion among agencies.	Discussed at meetings
Wyoming	County	All incidents	No	Multiagency (Less than 6)	All ongoing dv cases reviewed	Unknown	Review of progress in cases by all agencies. Has DART program.	Unknown

Multiagency = means interdisciplinary, and includes law enforcement and service providers, at a minimum

role, hospitals, schools, other service provider agencies such as mental health, substance abuse or batterer programs, and members from faith communities. In at least four counties, the multidisciplinary task force focused on issues of both domestic violence and sexual assault; in two counties, domestic violence was a subcommittee of the child abuse coalition.

Desire for Participating on a LISTSERV

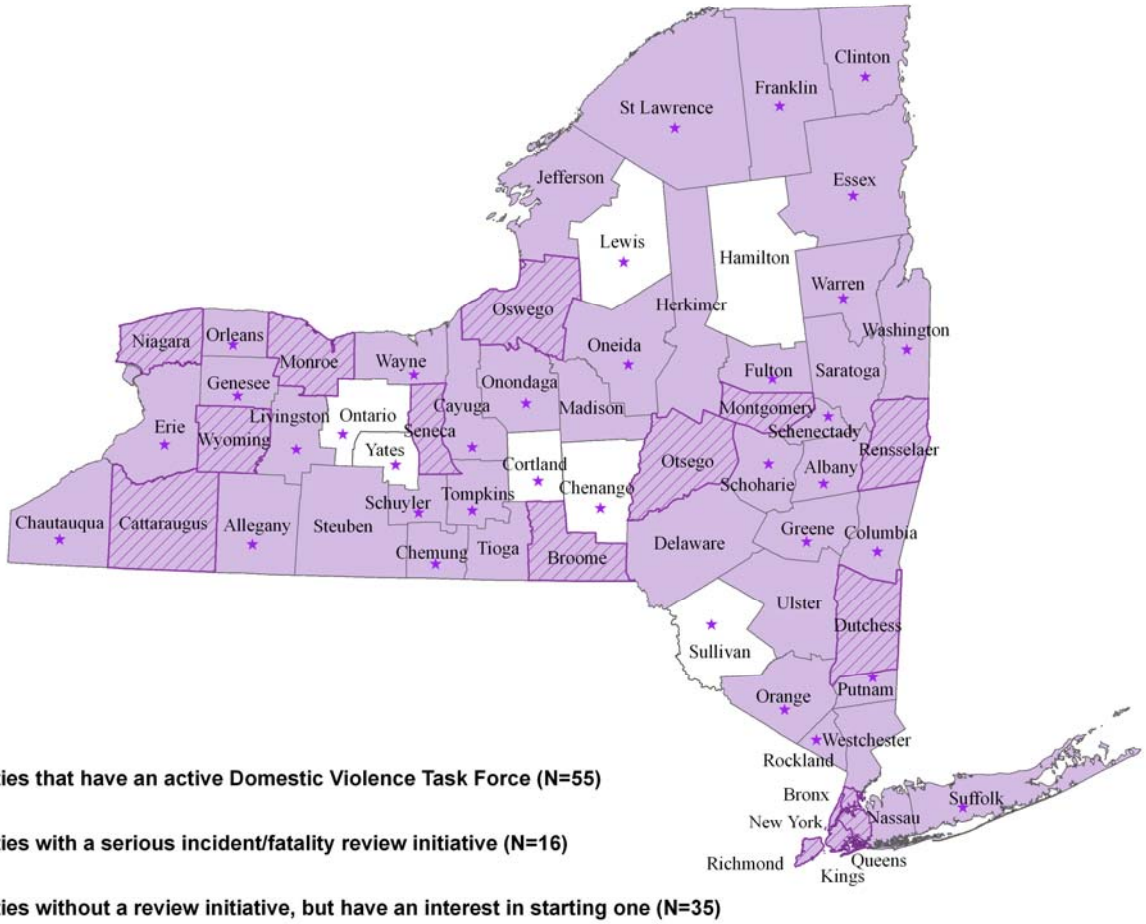
Almost all of the counties (92%) had one or more respondents who said that they were interested in being on a LISTSERV that would circulate information about domestic violence serious incident/fatality reviews (refer to *Table 1*). Respondents from communities with a domestic violence task force, and respondents with knowledge of a professional from their team who had engaged in a child fatality review, were significantly more likely to want to be a part of a serious incident/fatality review LISTSERV (results not shown). Also, respondents from domestic violence service provider agencies, and to some extent, from district attorney's offices, were more likely to want to be on a LISTSERV.

Child Fatality Review

To examine the extent of overlap between domestic violence related professionals and child welfare professionals at the local level, respondents were asked if any professional or team from their community ever engaged in child fatality reviews. *Table 1* indicates that half of the counties had at least one respondent who said they had knowledge of a professional or team in their community who had participated in a child fatality review. It should be noted that this statistic does not indicate the prevalence of such reviews on the county level because many child fatality reviews occur in county social services departments, and those agencies were not directly surveyed. This figure merely hints at the possible overlap between domestic violence service professionals and child welfare fatality review professionals at the county level.

The median number of agencies engaged in child fatality reviews was four.

Figure 1 - Domestic Violence Task Forces and Fatality Review Efforts in New York State By County



The types of agencies that participated on child fatality reviews were similar to the types of agencies that participated on domestic violence task forces: the district attorney's office and the local police department were almost always child fatality review participants. However, child fatality reviews were more likely to include participation by the local coroner or medical examiner, representation from local hospital(s), and of course, representation from Child Protective Service (CPS) or the Department of Social Services (DSS) which is statutorily required. Only about one-fourth of the child fatality reviews included participation by a domestic violence service provider. About one-fifth of the counties had participation (or facilitation) from the county's child advocacy center.[7] In fact, respondents from one county in particular, reported that although they did not have a domestic violence serious incident/fatality review, they were regularly engaged in child sexual assault and child fatality reviews through the county's child advocacy center.

Respondent-Level Summaries

Respondents with Current Domestic Violence Serious Incident/ Fatality Reviews

Helpfulness and Challenges of Implementing a Review

Table 4 presents statistics on respondents from communities with current serious incident/fatality reviews. Of those respondents who answered the follow-up questions on their community's review, the majority (67%) said that having a serious incident/fatality review has substantially helped to improve community safety. They reported that community safety has

Table 4 Respondents from Communities with Current Reviews

	#	% of Total
Total Surveys	207	
Respondents from communities who have or had reviews	33	15.9%
Respondents from communities who currently have reviews	24	11.6%
Of respondents from communities who currently have reviews:		
Ways review has been helpful *(# who answered question)*	12	50.0%
Improve community safety (e.g.handling of cases, services to victims)	8	*66.7%*
Increase awareness and education	4	*33.3%*
Biggest challenges with implementing a review *(# who answered question)*	11	45.8%
Administrative problems (e.g. meetings, organizing, personnel, support, apathy)	5	*45.5%*
Confidentiality issues	2	*18.2%*
Agency cooperation	1	*9.1%*
Victim cooperation	1	*9.1%*
What would be most helpful to improve your review? (# who answered question)	11	45.8%
Addressing administrative problems (e.g. training, organizing, support, legislation)	7	*63.6%*
Addressing confidentiality issues	1	*9.1%*

improved through better management of cases, improved services to victims, increased ability to identify lethality factors, and improved protocols and policies. Other respondents (33%) said that their review substantially increased education and awareness of domestic violence in their community.

Several respondents who answered the follow-up questions on domestic violence serious incident/fatality reviews reported that the biggest challenges their review team faced were the administrative challenges associated with trying to implement a review. These challenges included, for example, difficulties with arranging, organizing, and structuring meetings; obtaining the participation of personnel from various agencies, especially personnel with authority to make changes in their agency; maintaining enthusiasm and warding off apathy. A few respondents reported that their review team struggled with issues of confidentiality. One respondent said that securing interagency cooperation was a challenge; another said that obtaining victim cooperation was a challenge.

When asked what would be most helpful in improving their community's review of domestic violence serious incidents or fatalities, most respondents felt that administrative-type issues should be addressed (e.g. organization, training, legislation). One respondent said that addressing confidentiality issues would improve the effectiveness of their review.

Respondents Without Current Serious Incident/Fatality Reviews

Desire for a Review

Table 5 presents statistics on respondents who are from communities without current domestic violence serious incident/fatality reviews. Of those respondents from communities without current reviews, 43% stated that they would like their community to start a review; seven respondents (4%) were unsure about whether or not they would support a review. Respondents from communities with domestic violence task forces were significantly more likely to want a serious incident/fatality review than those without task forces (results not shown). Also, respondents from service

provider organizations and district attorney's offices were significantly more likely to want a review than respondents from police departments.[8]

The large majority of respondents (79%) who answered the follow-up questions on reasons for wanting a review believed that starting a review would improve their community's response to domestic violence (refer to *Table 5 and Figure 2*). They felt that establishing a review would increase awareness, help identify needed areas of improvement in terms of service development and delivery, identify safety concerns, and in doing so, possibly help prevent future domestic violence related homicides. About one-fifth of the respondents stated that they would like a review in their community because domestic violence is a serious issue, and/or because there is a large volume of domestic violence incidents in their community. Interestingly, several respondents stated that although there are very few serious or fatal domestic violence incidents, they felt it would still be very important to review them. A few respondents said that while the current process of addressing domestic violence incidents is adequate, that process should be expanded to include system service review of serious injury incidents. One respondent wrote that a review would help ensure that a "victim has not died in vain." Another respondent reported that a serious incident/fatality review would be especially useful for a class of cases that often tend to disappear from a community's safety audit radar screen: murder-suicides. When there is a domestic violence-related homicide, there is an extensive case investigation over the course of several months because prosecution is at hand. However, when there is a murder-suicide, there is no continued involvement by the law enforcement system once the perpetrator has been identified as the suicide victim. Thus, this respondent said that a review would be especially useful for these cases which do not benefit from the scrutiny of a prosecutorial investigation.

Four respondents commented that their county has a child fatality review board or another type of child abuse response team. They reported that their child fatality review initiative could serve as a good model for domestic violence fatality reviews, or that a domestic violence fatality review could be combined

Table 5 Respondents from Communities without Current Reviews

	#	%
Respondents who said there is no current fatality review	183	88.8%
Respondents who do not want to start a review	87	47.5%
Respondents who want to start a review	79	43.2%
Respondents who are unsure about starting a review	7	3.8%
Missing	9	4.9%
Reasons why a review should or should not be started in their county *(# of responses)*	161	88.0%
Of those who wanted to started a review, reasons why	75	*(% of responses)*
It will improve the community's response to domestic violence	59	78.7%
Domestic violence is very serious or there is a large volume here	16	21.3%
There are too few cases but it is still important to review them	9	12.0%
The current process is adequate	3	4.0%
Of those who did not want to start a review, reasons why not	81	*(% of responses)*
There are too few cases to warrant a review	49	60.5%
The current process is adequate	34	42.0%
It is a waste of time; it takes away from other DV cases	2	2.5%
The potential for breach of confidentiality causes too many problems	2	2.5%
What would be needed for an effective review? *(# of responses)*	88	48.1%
		(% of responses)
Interagency cooperation and access	31	35.2%
Resources: money and staff	29	33.0%
Training, information, education, guidelines, awareness	11	12.5%
Nothing; we already have the ability	9	10.2%
Regular, well run meetings	7	8.0%
Need more serious or fatal dv incidents	6	6.8%
Consent from the victim, address issues of confidentiaty	4	4.5%

Figure 2 Quotes from Respondents Who Want a Serious Incident/Fatality Review

Respondents from Police Departments

"Due to the statistics, prevention needs to be more of a priority. A pro-active approach is always best."
"This is the best way to track repeat offenders and increase the accountability of violent offenders. Money from the government would [be needed for an effective review] and a full-time officer. We have a program that provides follow-up to the victim. [It has] seen limited success. So much more could be done with additional resources and manpower. This department takes this issue very seriously and would like to improve our overall efforts in this area."
"A review of serious incidents will help locate potential problems and develop a game plan for future incidents."
"I think this would be a good educational tool to help prevent future fatalities or serious incidents."
"Although rare, a thorough review would be an excellent learning opportunity."
"[A serious incident/fatality review is needed because] in recent years I have seen a dramatic decrease in law enforcement's response to domestic incidents..."
"Due to the increase in the number of domestic violence investigations, their serious nature and their complexity, the establishment of a review team may be warranted."

Respondents from District Attorney Offices

"The only way to understand and stop domestic violence is to beware, educate and punish."
"Yes [a review is needed]. Domestic violence is escalating in our area and we need to be prepared to handle serious situations.
"[A review is needed] to determine if there was anything the criminal justice system could do to prevent the abuse."
"[There are] multiple reasons [why I believe our community should start a serious incident/fatality review]: (1) to identify safety concerns, (2) to stop the cycle, (3) [increase] agency cooperation, (4) better investigation/prosecution, and (5) increased public safety and health.

Respondents from Service Providers

"I am interested in starting a serious incident/fatality review, but first we are trying to enliven our task force."
"[To start an effective review] all agencies would need to be on-board with the idea and [we would need] expert guidance to make sure the review is done correctly."
"We've had a number of fatalities over the years and I think our community needs to learn something from them."
"[A review would help us] learn from the input of all agencies. [It] encourages communication between agencies [and] improves services to victims."
"[A review would] enhance services and address the issue [of domestic violence] in a coordinated manner; to get people to understand how serious a problem family violence is."
"Since our community is so small, it should be combined with child fatality reviews."
"The only means of effectively evaluating policies and procedures in the county is to review cases to determine where there is need for improvement."
"[A review will help us] learn from experience; find and close gaps; address factors correlated with fatality; not let victims die in vain."

with the child fatality review initiative.

Nearly two-thirds of the respondents (61%) who said that they did not favor a review in their community felt that there were too few domestic violence incidents to warrant a review (refer to *Table 5 and Figure 3*). However, a few of these respondents felt that such a review might be more appropriate for the county level. In fact, several respondents from counties without reviews said that they were first trying to establish or "breathe life into" their domestic violence task force before they initiated new projects.

Just over 40% of these respondents said that the current process of reviewing domestic violence incidents in their community was adequate. These processes appeared to revolve around four different categories of "review:" (1) sending all Domestic Incident Reports (DIRS)[9] or the equivalent of their information to domestic violence service providers; (2) forwarding cases to the State Police or county sheriff's office for review and investigation; (3) openly communicating about cases at meetings with the police and district attorney's office (and sometimes, with the domestic violence service provider); or (4) having a structured Domestic Abuse Response Team (DART) program in place.[10] Two respondents expressed their concern that focusing on a few serious incidents will take away from other incidents which comprise the majority of most law enforcement case loads. Additionally, two respondents expressed concerns that reviews might breach confidentiality, and subsequently, spiral into other problems.

Of those who said their community's review was discontinued, respondents gave several reasons for the discontinuation (results not shown). They stated that the review was too labor intensive, there was not enough information to conduct the review, there was substantial difficulty in getting information, there was a change in personnel that caused substantial continuity problems, or there was lack of funding. One respondent felt that even though their review was discontinued because the task force had disbanded, there were also concerns about the lack of objectivity, and there was a failure to focus on the issues at hand.

What is Needed for an Effective Review

Respondents who said they did not have a current review were asked what they felt would be needed to implement

Figure 3 Quotes from Respondents Who Do Not Want a Serious Incident/Fatality Review

Respondents from Police Departments

"Initially, our [committee] was created to …review domestic violence homicides and serious assaults, but it was revised to identify and address issues related to the criminal justice responses to family violence. [This way], we could work on issues without waiting for a serious incident to initiate the process."
"We don't need a fatality review because we already work closely with and information flows well between the district attorney, police, advocates, judicial branch etc."
"While our agency handles a large number of domestic related incidents, we have been fortunate not to have these incidents escalate into a serious incident or resulting fatality."
"The frequency of such incidents is minimal to non-existant."
"[We are] small enough, and enough agencies review domestic incidents to ensure thorough investigation. Various meetings [are] held on [the] same."
"[We do not need a review because of] the infrequency of occurrence in our jurisdiction. It would perhaps be more feasible on a county level."
"I would rather see money spent on officer training and community education programs dealing with domestic violence."
"Cases are handled by police and the district attorney's office. Further review is time consuming and offers little or no assistance to victims."
"No. Serious/fatal incidents would be investigated by Sheriff's Office or the state police."
"We don't have any incidents. The New York State Police do all our investigations."
"Law enforcement and the district attorney's office are very involved in all domestic violence cases. There are very few, if any fatalities involving domestic violence in our area and [we have a] very progressive arrest policy."
"We are an accredited NYS Accreditation Agency with a domestic violence policy in effect."
"It is the policy of our Department to exercise a "pro-arrest" policy with respect to domestic incidents in the belief that the arrest is an effective deterrent to future incidents of such violence."
"All domestic incidents reports are faxed daily to domestic violence coordinators with the DAs office and family court domestic violence part. The county also has a domestic violence task force. The review should be conducted on the county level."
"We have enough community groups doing enough public hand-wringing over various issues. I have never seen one of these groups actually accomplish anything. We waste enough time around here trying to "out sincere" each other."

Respondents from District Attorney Offices

"We do not have such incidents except on rare occasion. When we do have such an occurrence, we review with all appropriate agencies involved."
"The problem does not appear to be so severe …to justify creation of such a review."
"A serious incident/fatality review is not needed because the majority [of incidents] are not serious injury."
"This community is small enough and there are few enough homicides that we can gather any information we need."
"We have an active community response network that meets monthly and discusses important cases."
"A fatality review during the pendency of a criminal prosecution or appeal has the potential to impact a case in a negative manner by disclosing confidential information to unnecessary parties. Additionally, individuals who are not prosecutors may not understand the ramifications of taking notes, speaking to the press, etc."

Respondents from Service Providers

"It would break confidentiality. Not everyone on the task force needs to know. [We] would support it more if it were *not* attached to the task force."
"We have never had a domestic violence fatality."
"[A review would] divert from daily high incidents of domestic violence to focus on only a few of many."
"Currently, with the past history of reported serious incidents/fatalities being very low, we have not started a serious incident/fatality review team."

an effective review (refer to *Table 5*). The first most frequently occurring response referred to securing interagency cooperation and access. In listing issues related to cooperation, a few respondents indicated that creating a working environment with non-defensive attitudes and avoiding the finger-pointing, "blame-shame" game is critical. One respondent in particular, talked about how years ago, relationships between agencies on the interagency coalition were compromised, and unfortunately, some were severed, because of "blame-shame" reactions in the aftermath of a domestic violence homicide. The respondent also stated that the community has been trying to repair relationships ever since.

The second most frequently occurring response pertained to resources (money and staff). These respondents reported that additional funding and/or staffing would need to be dedicated to a serious incident/fatality review effort, since current systems were already strained.

The third most frequently cited factor for an effective review by respondents was training. This topic area includes training review participants, providing documentation, research and other information on conducting reviews, developing guidelines for reviews, and overall,

Table 6 NYS Survey on Domestic Violence Serious Incident/Fatality Reviews

	#	%
Total Respondents	207	100.0%
District Attorney Office	23	11.1%
Police Department	134	64.7%
Service Provider (or Coalition)	46	22.2%
Other	4	1.9%
Respondents reporting the existence of a Domestic Violence Task Force		
Respondents from counties that have or had a domestic violence task force	109	52.7%
Respondents with current task force	88	42.5%
Respondent perception of task force effectiveness (scale of 1 to 5, most effective)		
Average effectiveness rating (all respondents with past or current task forces)	---	3.39
Respondents from communities with current task forces		
Average effectiveness rating (with current review) (1)	---	4.00
Average effectiveness rating (without current review)	---	3.26
Reasons for effectiveness rating (for current task forces) *(# of responses)*	77	
Cooperation issues between agencies	34	44.2%
Resource issues (e.g. money, staff, turnover)	14	18.2%
Meeting issues (frequency, structure, agenda/focus)	12	15.6%
Training issues	11	14.3%
Problem-solving ability (or disability), good recommendations (productivity)	8	10.4%
In process of restructuring	3	3.9%
Just not effective in stopping domestic violence	2	2.6%
County is too small and rural to have effective task force	1	1.3%
Respondents who expressed interest in a LISTSERV	117	56.5%
Respondents who knew of community professionals who participated in local child fatality reviews	52	25.1%

(1) The difference in the average effectiveness score rating was statistically significant at the < p.01 level.

increasing education and awareness of all review team participants. In addition, several respondents said that having regular, well-run meetings is also important for having and sustaining effective reviews. Often, communities start initiatives, but find it difficult to sustain them because there are so many other initiatives that are competing for the time of domestic violence-related professionals. Only four respondents added that consent from the victim should be required for an effective review, or that another approach be implemented to address issues of confidentiality.

Interestingly, nine respondents said that nothing new would be needed to conduct an effective review in their community. Most of these respondents said that they were interested in starting a domestic violence serious incident/fatality review in their community, and most of them were already connected to a domestic violence task force.

Domestic Violence Task Force

Table 6 presents statistics on respondent answers to questions on their local domestic violence task force, their desire to participate on a LISTERV, and participation on child fatality reviews. About half of the respondents said that they have or had a domestic violence task force in their community; most of these task forces were currently active.

Using a Likert scale of 1 to 5, with "5" meaning "very effective" and "1" meaning "not very effective," respondents were asked to rate their task force's effectiveness. The average task force effectiveness score was 3.39. While task force effectiveness ratings did not differ significantly by agency type (i.e. district attorney's office, police or service provider), respondents from counties *with* on-going reviews were significantly more likely to rate their task force as more highly effective than counties *without* active reviews. [(11)] It should be noted that while the average task force effectiveness score fell in the middle of the scale, several respondents, representing 16 of the 55 counties with task forces (29%), scored their task forces as very low (1 or 2) on the effectiveness scale.

To further understand why respon-

dents rated their task force a certain way, we asked them to explain the reasons for their scoring (refer to *Table 6*). The highest proportion of explanations given for task force effectiveness involved cooperation issues between the agencies. Respondents who reported that cooperation was good said that agencies working together were able to develop stronger ties with local service providers and work toward the common goal of addressing issues of service delivery. They also reported that the cooperative, collaborative nature of the meetings encouraged both traditional and non-traditional partners to participate, and helped participants to effectively articulate policy and protocol problem areas without having discussions degenerate into staff disagreements or agency defensiveness. One respondent said that cooperation would be improved if the staff were more knowledgeable and if there was more support from the community.

The next most frequently occurring group of reasons given for task force effectiveness pertained to resource issues (e.g. money, obtaining staff, and staff turnover). Several respondents reported that their initiatives are often resource-dependent, especially since there are several other community initiatives that are simultaneously competing for the time and talent of local domestic violence related professionals (i.e. police, district attorney, service providers). Thus, these respondents described the effectiveness of their task force as often hanging on the availability of resources.

Next, several respondents reported that basic meeting issues interfered with the effectiveness of their task force. These issues included basic organizational issues such as meeting frequency and the structure of the meeting. These respondents reported that often, it seemed difficult to develop the proper focus for the task force meetings, and that it was sometimes difficult to keep the team focused on the issues at hand.

Training issues (good or bad) were also cited as reasons for task force effectiveness. Respondents who had positive comments about their task force's training initiatives said that their task force was very good at providing sound domestic violence training, and/or other venues of information sharing (e.g. pamphlets, video).

Several respondents commented on the problem-solving ability of their task force. Respondents who reported good problem-solving abilities said that their task force was effective in exchanging ideas, and identifying and solving issues. Some of these respondents said that their task force was very proactive, or progressive which helped them to address problem areas. They also stated that because of the good problem-solving ability of their task force, they were ultimately able to develop sound recommendations that could positively impact and change responding systems in the community.

A few respondents said that they were in the process of restructuring their task forces, and so it was difficult to see their task forces as effective yet. A few respondents said that although their task force was fairly effective, it was still not effective enough to stop domestic violence. One respondent said that their county was too small and rural for their task force to be effective.

Desire for Participating on a LISTSERV

Slightly more than half of all survey respondents expressed an interest in being on a LISTSERV about domestic violence serious incident/fatality reviews (refer to *Table 6*). Respondents from communities with a domestic violence task force, and respondents with knowledge of a professional from their team who had engaged in a child fatality review, were significantly more likely to want to be on a LISTSERV (results not shown). Also, respondents from domestic violence service provider agencies or district attorney's offices were more likely to want to participate on a LISTSERV.

Child Fatality Review

Only 25% of the respondents participated in or knew of a member from their review team or community who had participated in a child fatality review (refer to *Table 6*). These respondents most frequently were from police departments or district attorney offices.

Summary and Discussion

Despite the Governor's Commission's recommendations nearly ten years ago that domestic violence fatality reviews be established in New York State at the local level, this research has found that *the large majority of the counties in New York State (74%) do not have an active domestic violence serious incident/fatality review*. Several obstacles have interfered with the establishment of these reviews: lack of interagency cooperation, lack of administrative support and organization, lack of funds, lack of training, and a few have struggled with concerns about confidentiality.

On the other hand, while most counties in New York State do not have active reviews, about one-fourth of the counties do have active reviews. Furthermore, respondents from counties with reviews stated that reviews have been very useful in identifying areas that need improvement, increasing education and awareness in the community, improving victim services, and in general, improving public safety. These benefits remained even though review efforts sometimes struggled with administrative problems such as staff turn-over, or organizational and resource issues. These experiences of New York State domestic violence-related professionals mirror those of participants of fatality review teams across the country.[12]

Another important finding from this research is that there are a variety of serious incident/fatality review models or processes currently operating in New York State. Some reviews were being overseen by the county's task force; others were somewhat disconnected from the task force or were being overseen by a single agency. Some had written policies or were based on local laws; most were not. Some included family members or witnesses, but most did not. Some reviews involved detailed case file analyses, and the sharing of information between agencies, while others only examined aggregate data. Some communities only reviewed fatal incidents, but most reviewed all serious injury incidents. A few reviews published their recommendations in a report, but most did not. Again, these findings mirror the various types of reviews that have developed nationally.[13]

However, given these variations, there is very little research strongly supporting one approach over another in terms of which review is most effective or comprehensive.

Differences in models of review raise two other important issues revealed by findings from this study. The first issue relates to a community's theoretical view about the importance of serious incident/ fatality reviews. Although only reported by a few respondents, one concern was that reviews might "take away from" the equally important, larger volume of domestic violence cases that occur in a community. In response to this issue, some counties have chosen to either review no cases or to review all cases. However, while seemingly achieving equity, it is unclear whether this "all or nothing" approach is more beneficial to a community in terms of identifying system gaps and developing recommendations for improvement.

A second issue related to models of review pertains to a community's ability to distinguish between "*case response review*" and "*service system review*." Many respondents reported that their agency has a proactive domestic violence policy or that all cases are "reviewed" (and therefore, no serious incident review initiative is needed). These respondents may have been actually referring to individual case management response initiatives, instead of a fatality review initiative that focuses on identifying and addressing system gaps. Distinguishing between these two types of reviews may be an important area to include in training programs geared towards domestic violence related professionals.

This study also found that respondents from counties with reviews seemed to indicate a sort of synergy in review counties versus non-review counties. For example, respondents from counties *with* serious incident or fatality reviews tended to rate their task forces as more effective than counties without reviews, and respondents from these communities were generally more likely to be interested in being part of an informational LISTSERV on reviews. These counties seemed to reveal contagious enthusiasm and activity that was reciprocated by the interdisciplinary agencies involved on their task force.[14] This finding raises an important consideration about fatality reviews. While the nascent state of research has not indicated either the effectiveness or ineffectiveness of reviews in terms of preventing serious incidents or improving system response to domestic violence, reviews do seem to sustain community energies dedicated to domestic violence, and energize communities to enhance their response to domestic violence.

Survey responses also suggest that domestic violence task forces, whether or not they were rated effective, appear to be the perceived building block or stepping stone to serious incident/fatality reviews. For example, of respondents in counties without reviews, those *with* an active task force were significantly more likely to want a serious incident or fatality review than respondents from counties without task forces. Secondly, several of the respondents from counties without reviews said they were first trying to establish or "breathe life into" their domestic violence task force before they initiated new projects. Clearly, even beyond important theoretical reasons, a perceived critical ingredient to the formation and sustainability of any model of serious incident or fatality review is a connection to an active domestic violence task force.

This finding raises an important reminder and challenge to state policy makers: "Given the importance of the local domestic violence task force in a community's response to domestic violence and its potential to serve as a foundation for incident/fatality reviews, what can the State and counties do to breathe life into these task forces?" This survey found that in 2006, although the large majority of New York State counties did have an active domestic violence task force, several of the respondents from counties with a task force said that they were still struggling with increasing the effectiveness of their task force. While counties in New York State have made substantial progress since the passage of the mandatory arrest policy in 1994,[15] maintaining the momentum of these sweeping changes, and dedicating time and resources to a community's continued response to domestic violence remains an important task at hand. This task becomes even more difficult given today's environment of dwindling federal funds.[16]

Future Initiatives

The findings from this research provide a basis from which New York State policy makers can explore new initiatives. Three main policy questions emerge from these findings. The first question state policy makers must address is, "*Should New York State increase its commitment to the development of domestic violence serious incident/ fatality reviews?*"

Although few reviews have developed since the Commission's report ten years ago, law enforcement professionals and domestic violence service providers currently engaged in reviews in New York State report that reviews have substantial value for their community. Furthermore, the large majority of counties without reviews in New York State have one or more domestic violence-related professionals who have expressed their desire to bring review initiatives to their community. Advocates across the country are also identifying reviews as critically important ventures for a community's response to domestic violence,[17] and in fact, the United States Department of Justice funds the National Domestic Violence Fatality Review Initiative (NDVFRI) which provides training and technical assistance to domestic violence fatality reviews nation-wide.[18] There is also precedent for fatality reviews in New York State, since several other state agencies are currently engaged in similar review processes,[19] although they are applied to different populations. At the same time, the development of reviews in local communities in New York State must be thoughtfully and strategically implemented, given their potential, (as we have seen from a few respondents in this study), to compromise rapport between agencies which many communities have taken years to build.

Should New York State choose to increase its commitment to building domestic violence review initiatives, the second question that state policy makers must address is, "*Which process or model of serious incident/fatality review should be recommended for coun-*

ties in New York State?" This is a much more difficult question to answer. Because of the dearth of research on the various models of domestic violence serious incident/fatality review that are being implemented across the country, little is known about the effectiveness of various structures of review or how to sustain them. While not supporting one particular model of fatality review, the NDVFRI offers advice on important tools for fatality reviews which include for example, beginning with multi-agency membership, adopting a "no blame, no shame" ethos, outlining the decision making criteria for case selection and review, developing confidentiality agreements addressing disclosure of information between the agencies, and developing guidelines for interviews with family members of the victim should a fatality review team choose to include them in the review process.[20] Many domestic violence fatality review teams conceive fatality reviews as intensive, case file analysis.[21] However, one issue raised in this study that needs to be addressed is the fact that many local communities are already hard pressed for time and resources. Therefore, when determining a best model for serious incident/fatality review in New York State, policy makers must take into consideration that most communities are beginning from a place with limited resources.

For this reason, county or state-level policy makers should consider the various models of review and determine which current models or new alternative models might offer the best hope for a comprehensive and efficient review process in a community. Clearly, implementing a review after a case is closed requires additional time and energy from a team, and diving back into a case, pouring through many case file records is also a time and resource-laden activity. Perhaps, a potential alternative model for serious incident/fatality review should include a protocol that is already a part of the natural rhythm of the criminal justice process. Consider the fact that counties spend tens of thousands of dollars in the investigation and prosecution of felony cases. Countless hours are spent with victims and/or their families and witnesses. If the professionals involved with these investigations were trained and given the tools to gather important review-related information on system response, that information could be reported back to local task forces, and perhaps, communities would not have to initiate a secondary serious incident/review process (post-prosecution). For example, if the district attorney's office (or police department) had a guideline or checklist of safety audit[22]/system service questions that could (respectfully) be asked of the victim and/or the victim's family (or gleaned from case file review) during the course of the investigation, then the information gleaned from these interviews could be shared with the county task force on a routine basis.[23,24]

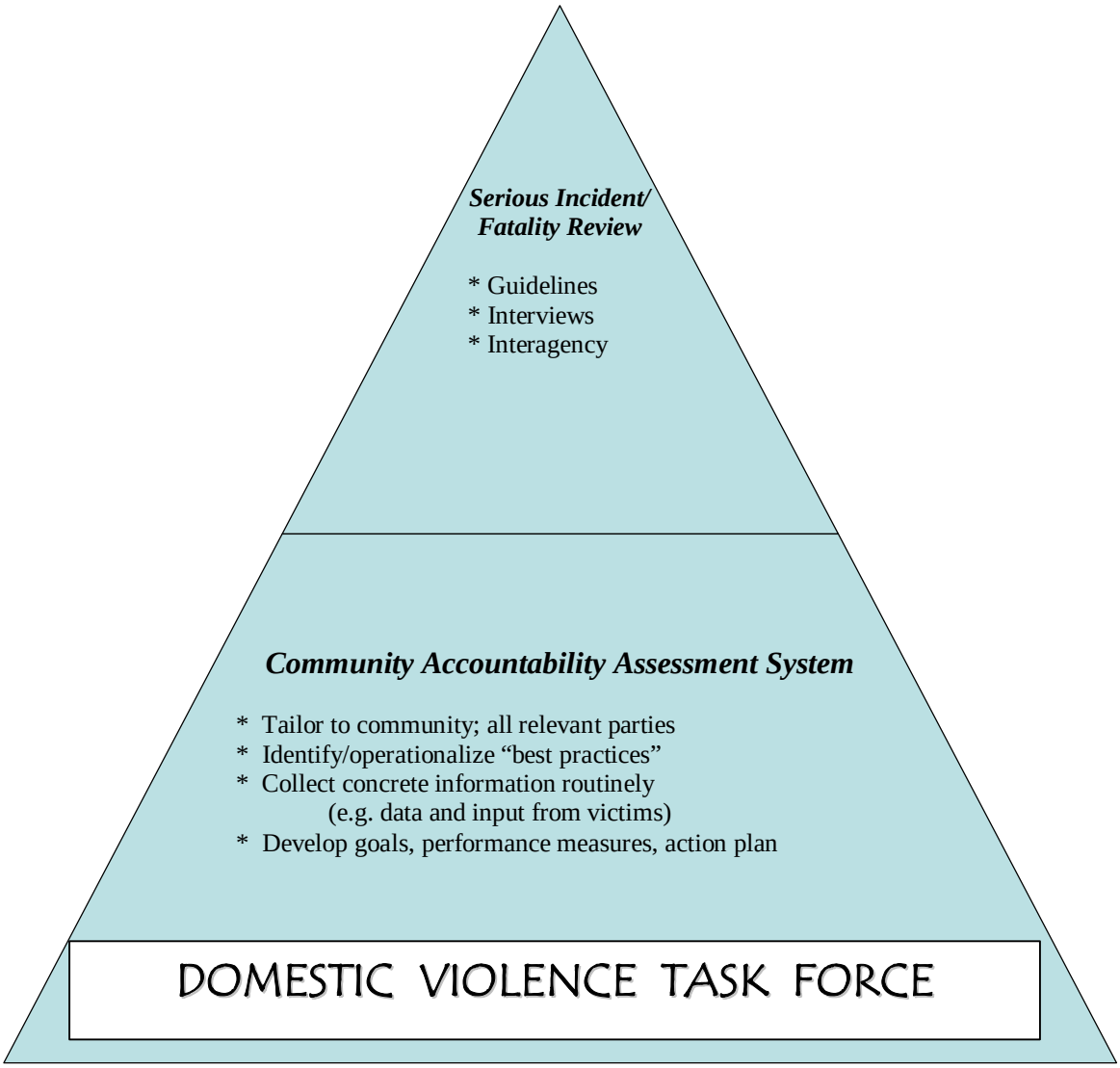
By integrating the system audit into the routine work of prosecutors and others serving the needs of victims of domestic violence, rich and detailed information on system response could be collected without expending a great deal of extra resources. Such integrated reviews, at a minimum might seek to address the following questions: *"What experiences did this victim have with agencies in the community? In what ways were these agencies helpful? In what ways were these agencies not helpful? What were the biggest obstacles this victim faced in escaping the violence? Can any of these obstacles be tackled by existent service systems, or is it possible that new service systems should be created (for the benefit of future victims)? Which priority areas can best be addressed by the task force?* Since our research found that few review participants had received training, structured protocols might help to ensure that reviews are equally comprehensive in every county. In fact, if all domestic violence-related agencies regularly monitored the community's response to domestic violence as a part of the natural rhythm of their work with victims, each agency might be more likely to develop an institutional mindset of system accountability.

Naturally, an integrated approach to serious case review would require a huge paradigm shift at the local level. However, it could probably be accomplished with few additional resources, since it involves information gathering at a stage when information is already being gathered by a responding system (e.g. criminal justice system, medical examiner review). Furthermore, an integrated approach might yield some additional benefits. First, it would be feasible for smaller communities whose professionals may often feel that reviews are not necessary because there are too few cases, or who forward most or all of their domestic violence cases to the county sheriff's department or to the State Police. These communities may be more likely to initiate a well-planned review process if a second (post-case) initiative was not required, and professionals from these communities may even decide that a guidelines approach could be applied to a broader category of cases, since serious injury cases are so much less prevalent in their community. Second, because larger communities have such higher volume, they may find that instituting a parallel review process to the prosecutorial investigative process (or to the social service process) may be less onerous than initiating a secondary review process after a case is closed.

Finally, any approach to serious incident/fatality review would benefit from including a blend of quantitative data (sometimes referred to as aggregate data), as well as qualitative data (e.g. interviews). Quantitative data has a wealth of information to offer communities. Consider for example the following pieces of "performance indicator" information: the length of time it takes for police to respond to a domestic call; the rate by which domestic violence offenders are arrested and removed from the scene; the dispositional outcome of a case; the rate by which stay away orders are secured for victims; and the availability of shelter or financial assistance. Those in the field know that any one of these events could possibly make or break a victim's ability to escape the violence. However, each community's ability to collect, aggregate and decipher performance indicator information will vary. Nevertheless, the quantitative data can be useful for the bigger picture on service system response, and quantitative data can help contextualize the few serious or fatal incidents that might be "investigated" in a community's review process.[25] Certainly, state policy makers and local domestic violence professionals may want to dialogue further on how access to important performance indicator information could be facilitated.

While discussing models of serious incident/fatality review is worthwhile, there is however, a bigger question that underlies the dialogue on domestic violence serious incident/fatality reviews:

Figure 4 Diagram of a Comprehensive Community-Wide Accountability Assessment Structure



"What is the best approach that communities can apply to monitor and maximize their response to domestic violence?" That is to say, what is the ultimate accountability assessment structure that communities can implement? After all, this is the main reason why fatality reviews have been developed, and certainly, every community needs some sort of accountability structure. However, while serious incident/fatality reviews are one type of accountability system (and are generally liked by those involved), they have several drawbacks. First, serious incident/fatality reviews are reactive, not proactive because they identify problems after they occur, which may lead to defensiveness by service providers. Second, serious incident/fatality reviews may miss common problems that occur in cases that do not result in serious injury or death. Third, serious incident/fatality reviews may provide a distorted picture of why fatalities occur. That is to say, only reviewing serious injury or fatal incidents may lead to identification of system gaps that are important to identify, but (a) could be identified without waiting for someone to die and without going through the expense of a fatality review and (b) may be causally unrelated to the death. For example, a suspect may be a repeat offender and a court may have failed to issue an order of protection; however, in the end analysis, these failures may not have mattered in terms of their ability to prevent injury. Therefore, if the only

value of a fatality review is to identify system problems, then other mechanisms of review may work just as well. Serious incident/fatality reviews are only superior if they provide unique information that will actually reduce fatalities, and/or if they are able to identify system gaps that would otherwise not have been identified.

To address these concerns, it seems reasonable to suggest that a starting point for communities is to begin with a larger plan for a community-wide *accountability assessment structure.* There are several critical features of such a structure (refer to the visual presented in *Figure 4*). First, an accountability assessment structure should be tailored to the community, bringing all relevant parties together. In essence, the foundation of such a structure should be the community's domestic violence task force. Second, these parties must identify and operationalize measurements of "best practices." Third, the team must be able to develop clear goals, performance measures, time tables and an action plan.[26] Fourth, an accountability assessment structure should collect concrete information to inform decision making, ensuring that the most critical measures are routinely available in an automated fashion so that they can be produced for the assessment team on a routine basis. This information should include whenever possible, input from domestic violence victims. Finally, the accountability assessment structure could include a review of "failures," that is, cases that resulted in serious injury or death, to investigate whether something was missed. In this light, serious incident/fatality review initiatives could be viewed as the "tip of the iceberg," and/or could be used to collect more detailed information about service system response that could not be accessed at the broader level due to resource constraints.

Since 1989, available data indicates that there have been at least 1,470 domestic violence partner-related homicides in New York State.[27] Furthermore, nearly 80% of the identified partner-related homicide victims in New York State have been women. These statistics alone are persuasive enough to encourage New York State to more systematically consider the development of domestic violence serious incident/fatality reviews, and perhaps more importantly, how they fit in with a broader, community accountability assessment structure. At a minimum, this consideration should include ways the state can assist local community coordinated coalitions as they attempt to create, strengthen and sustain their task forces. This consideration should also include efforts to ensure that reviews do not unduly burden law enforcement, service and advocacy response systems, and that the review processes are intricately *connected to* coordinated initiatives at the local level. Finally, consideration of serious incident/fatality reviews must give precedence to respecting the privacy, confidentiality, and dignity of the victims and their families, most of whom will be grieving the loss of life or quality of life for many years.

Responding to domestic violence takes community collaboration, stamina and persistence. Law enforcement, advocacy and other service systems in New York State are ripe to address it. It is important that the state find ways to facilitate this continued dialogue.

ENDNOTES

(1) *"Commission on Domestic Violence Fatalities: Report to the Governor,"* by the Governor George E. Pataki Commission on Domestic Violence Fatalities, October 1997.

(2) See for example, "*Reviewing Domestic Violence Deaths*," by Neil Websdale, *National Institute of Justice Journal, Issue No. 250, November 2003, NCJ 196549.*

(3) Surveys were sent to 62 district attorney offices, 673 police departments and 102 domestic violence service providers. Responses were gathered from 45% of the domestic violence service providers, 37% of the district attorney offices and 20% of the police departments. In two of the counties, the main domestic violence service providers were located within the county department of social services.

(4) New York State has several categories of law enforcement officers. Three main categories are (1) city, town and village police; (2) the Sheriff's Office and (3) the New York State Police (NYSP). Each group has different jurisdictions and is overseen at different governmental levels. City, town and village police are overseen by local government and their jurisdiction is usually confined to the city/town/village limits (see *Criminal Procedure Law, Section 1.20(34).* The Sheriff's Office is a county level agency (except in New York City, which has one Sheriff for the five boroughs) (see *County Law, Article 17; Correction Law, Article 20; NYC Administrative Code, Title 7, Chapter 5).* Each Sheriff outside New York City serves as conservator of the peace within the county, maintains the county jail, and sometimes provides court security. The NYSP is operated by state government, and its patrols are generally restricted to areas outside city limits (see *Executive Law, section 223*).

(5) In our sample, when there was more than one respondent from a county, there was generally, congruity in the responses, for most of the questions. If there was not congruity, and at least one county-level respondent expressed a desire or need for a fatality review, then that is the response that was chosen to represent the county. The reason we chose this analytic approach is because we wanted to identify counties in which there was at least one key professional who expressed interest in starting a domestic violence serious incident/fatality review. Therefore, when interpreting the county-level tables, the reader should keep in mind that county-level summarized responses do not necessarily represent the opinions of all domestic violence service professionals in that particular county.

(6) For example, in 2005, New York City

passed a law to institute an aggregate data fatality review committee for all domestic homicides (*New York City Charter, Local Law, Int. No. 366-A*). This effort, facilitated by the New York City's Mayor's Office to Combat Domestic Violence, involves an examination of New York City domestic violence homicides. There is also a comparable effort to review domestic violence fatalities within the New York City Police Department (NYPD), as well as a follow-up program for a proportion of several precinct's domestic violence incidents (based on personal conversation with NYPD, May 2006). Rensselaer County also had two police departments which conducted "reviews;" only one of these departments was connected with the local domestic violence service provider.

(7) A child advocacy center is a community's multidisciplinary response to child victims of sexual assault or serious physical abuse. The goal of child advocacy centers is to improve the response and management of child abuse cases. (See *Social Services Law, section 423-a*, for more information.

(8) One issue possibly confounding the answers to this survey question is the fact that we did not define the purpose of a serious incident/fatality review (and intentionally so). For example, several professionals we interviewed stated that they did not think their county should have a review because there is no information they could glean from a review that could accurately predict which cases would end in homicide and which would not. However, when we explained that reviews are primarily done to determine the effectiveness of the system's response to domestic violence, they said in that light, a review might be very useful for their community. Thus, given this information, if we had outlined the purpose of serious incident/fatality reviews, it is possible that more respondents would have stated that they would be interested in having a review started in their community.

(9) Domestic Incident Reports (DIR) are standardized New York State forms that must be completed by police departments when responding to any alleged incident of domestic violence (see *Criminal Procedure Law, Section 140.10(5)).* While the practice of sharing information on DIRs with other non-law enforcement agencies is a practice that is not specifically addressed statutorily, many law enforcement agencies across the state do share DIR information with service providers. Some do so with verbal or written consent from the victim; others do not.

(10) DART programs traditionally, are multi-agency approaches designed to prioritize victims safety and offender accountability. The main goal of a DART program is to enhance a community's response to domestic violence. Usually, these programs are started with seed money and/or federal funding in local communities (see for example, "*The Clinton Domestic Abuse Reduction Team (DART): August 1999- Clinton County, NY,"* by Margaret Marcus Hal, 2000, Institute for Law and Justice, Alexandria, Virgina). Based on this research, three counties were found to have DART programs: Dutchess, Steuben and Wyoming. However, based on our field work and published reports (cited above), Clinton County also had a DART program at one time, and several other communities have started DART-like initiatives (e.g. New York City Police Department).

(11) Also, although the sub-sample size was too small to examine statistical significance, counties with defunct domestic violence serious incident/fatality reviews had a substantially lower task force effectiveness rating than counties with current reviews or than counties who had never attempted a review initiative.

(12) See for example, "*Reviewing Domestic Violence Fatalities: Summarizing National Developments,*" by Neil Websdale, Maureen Sheeran and Byron Johnson, *Reno, NV: National Council of Juvenile and Family Court Judges, October 1998.*

(13) Refer to a state matrix of reviews provided by the National Domestic Violence Fatality Review Initiative website, (www.ndvfri.org) or the article by Websdale (2003), cited in footnote #2.

(14) Similar findings have been reported elsewhere. For example, the National Domestic Violence Fatality Review Initiative (NDVFRI) website reports that communities have felt that reviews help to revitalize community coordination, and that participation on reviews provide a new focus for interagency liaison work and communication (www.ndvfri.org/questions/bgs.html 9-26-05).

(15) See the *Family Protection and Domestic Violence Intervention Act of 1994, Chapter 396 of the Laws of 1994.*

(16) Refer to the "*Fiscal Year 2007 Appropriations Fact Sheet on the Violence Against Women Act and Victims of Crime Act Fund,*" by the National Network to End Domestic Violence.

(17) See for example, the report by the Washington State Coalition Against Domestic Violence, *"Advocates and Fatality Reviews,"* by Margaret Hobart, June, 2004.

(18) Refer to the National Domestic Violence Fatality Review Initiative website, at www.ndvfri.org.

(19) New York State has at least three other examples of fatality reviews: child fatality reviews overseen by the New York State Office of Children and Family Services (OCFS), occupational fatality reviews overseen by the New York State Department of Health (DOH), and reviews of inmate deaths, investigated by the New York State Commission of Corrections (COC). Each of these initiatives differ in terms of the involvement they have from local agencies and state-level personnel. As such, these processes could be informative to the discussion on the development of domestic violence serious incident/fatality reviews in New York State. (For more information on investigations of child fatalities, see *sections 17(d) and 20(5) of the Social Services Law* for duties of OCFS. For information on the development of local and regional fatality review teams, see *section 422-b of the Social Services Law. section 17-191 of the New York City Administrative Code* outlines the responsibilities of the child fatality review advisory team

in New York City. For information on DOH fatality review initiatives, refer to the Census of Fatality Occupational Injury (CFOI) program, and the Fatal and Control Evaluation (FACE) program, via the agency's website www.health.state.ny.us/nysdoh/environ/cfoi/contents.htm). For information on COC's responsibilities for investigating inmate deaths, see *section 47 of the Corrections Law.)*

(20) Refer to the NDVFRI website (www.ndvfri.org).

(21) Refer to the published state reports on the NDVFRI website (www.ndvfri.org).

(22) A domestic violence safety audit is a tool for evaluating an agency's response to domestic violence. By investigating data sources, written policies or protocols, and conducting observations and interviews, a safety audit can assist jurisdictions with identifying victim safety and offender accountability concerns. For more information, refer to "*The Duluth Safety and Accountability Audit: A Guide to Assessing Institutional Responses to Domestic Violence*," by Ellen Pence and Kristine Lizdas, Minnesota Program Development, Inc. (MPDI), 1998. Following national trends, New York State has already been engaged in and supportive of communities conducting domestic violence safety audits (e.g. refer to "*Safety and Accountability Audit Report: Domestic Violence Case Information Sharing Between Law Enforcement and Prosecution,"* by the New York State Office for the Prevention of Domestic Violence, June 2004.

(23) Since this type of safety audit interview would be occurring during case prosecution, other issues that would have to be addressed are (1) whether or not the safety review information gleaned from interviews would be vulnerable to discovery, and (2) what consequences to the case would exist if the information was vulnerable to discovery. If it is determined that these consequences could possibly interfere with case prosecution or safety of the victim or witnesses, then serious incident/ fatality review interviews should of course, only be done after case closure.

(24) The idea of developing a guidelines approach is not completely new, as other state fatality review processes have attempted to develop some standardized approaches to collecting service system response information. However, these approaches usually involve a secondary fatality review process initiated by a fatality review team. (See for example, the "*Case Cover Sheet"* of the Maine Domestic Abuse Homicide Review Panel, published in "*Til Death Do Us Part: Domestic Violence Homicides in Maine*," January 2004, by the Maine Domestic Abuse Homicide Review Panel; or the Fresno County, California "Data Collection Form;" or the Contra Costa County Domestic Violence Death Review Team "Data Collection Form." State by state reviews are presented on the NDVFRI website (www.ndvfri.org))

(25) Contextualizing a case, or understanding how a case fits in with other cases in a community, is important on a number of levels. First, it could influence findings, recommendations and discussions with target agencies. For example, if a review team finds that an offender, who was on-scene when the officer arrived, was not arrested for a criminal act, and the victim was shortly thereafter murdered, a team might conclude that the police department is not arresting frequently when this may not necessarily be the case. It may be that the police department already has a very high arrest rate and a strong pro-arrest policy. It could be that the case did not rise to the level of a mandatory arrest incident, and the victim affirmatively expressed her desire for no arrest. By juxtaposing the quantitative data with the qualitative data, the fatality review team may be cued to delve more deeply into the case, to determine if there are other important recommendations that should be made.

(26) In fact, New York State has already provided communities with many ideas for clear goals and performance measures in the report, "*Model Domestic Violence Policy for Counties,"* by the New York State Office for the Prevention of Domestic Violence, January 1998.

(27) Supplementary Homicide Report (SHR) data analysis, by the NYS Division of Criminal Justice Services, Bureau of Justice Research and Innovation. However, victim-offender relationship information for New York City cases was missing approximately 70% of the time. Therefore, this figure is most likely an underestimate.

APPENDIX A

Domestic Violence Serious Incident and Fatality Review Survey

The NYS Division of Criminal Justice Services would like to learn more about how communities in New York State are organized in their response to domestic violence. This information will help us plan for new initiatives in the state, including policy and program development, funding opportunities, training initiatives and technical assistance. ***Would you please take a few minutes to answer the following questions and return the survey to the address below by April 21, 2006.*** If you would like more information about this inquiry, or if you would like to e-mail your responses, please use the following contact information:

Deborah J. Chard-Wierschem, Ph.D, Director, Domestic Violence Research Unit
Bureau of Justice Research and Innovation *(518) 457-0423*
NYS Division of Criminal Justice Services *dchard@dcjs.state.ny.us*
4 Tower Place, Stuyvesant Plaza
Albany, New York 12203

Your Name: _____ *Phone:* _____

Agency: _____ *E-Mail:* _____

Address: _____ *City/State/Zip:* _____

Your Job Title:
1. **Attorney**
2. **Law Enforcement**
3. **Advocate**
4. **Other:** _____

(1) **(a)** Has any domestic violence-related task force, committee, agency, or other group from your community *ever* engaged in a ***serious incident or fatality review of domestic violence incidents***?
1. Yes **2. No** *(IF NO: Skip to Q. (1)(d)*

(b) Is this domestic violence serious incident or fatality review initiative still on-going, and available for reviews?
1. Yes *(IF YES: Skip to Q. (1)(f))* **2. No**

(c) Please explain why your community's domestic violence serious incident/fatality review initiative is no longer on-going. _____

(SKIP TO QUESTION (1f))

(d) In your opinion, should your community start a serious incident / fatality review for incidents of domestic violence? **1. Yes** **2. No**

Why or Why not? _____

(e) What would be needed to start an effective serious incident/fatality review? _____

(SKIP TO QUESTION 12)

(1)(f) Please list the agency participants and facilitators of your community's domestic violence serious incident or fatality review (even if it is no longer on-going):

Agencies _____ _____ _____

_____ _____ _____

Facilitator(s)

Name: _____ Agency: _____
Phone: _____ Address: _____
E-Mail: _____ City/Zip: _____

Name: _____ Agency: _____
Phone: _____ Address: _____
E-Mail: _____ City/Zip: _____

(g) What is (or was) the name of your serious incident/fatality review effort? _____

(2) What does (or did) your domestic violence serious incident/fatality review team investigate?
1. **Fatal Incidents Only**
2. **Serious (non-fatal) Incidents**
3. **Both**

(3) **(a)** Did any of the participants on your domestic violence serious incident/fatality review initiative receive training? **1. Yes** **2. No** *(Skip to Q. 4)*

(b) What type of training? _____

(c) Was it useful? **1. Yes** **2. No** *Explain.* _____

(4) Are there (or were there) any ***written policies, protocols or guidelines*** (or guidance) for domestic violence serious incident/fatality reviews in your community? *(If available, please attach a copy.)*
1. Yes **2. No**

(5) Please briefly describe ***what factors determine (or determined) if a domestic violence serious incident or fatality review is (or was) conducted*** (e.g. level of injury, nature of relationship). Note which agency professional(s) make (or made) the decision to review a case. _____

(6) Please briefly describe the domestic violence serious incident/fatality review process in your community. _____

(7) **(a)** Are (or were) family members of a homicide victim notified about the fatality review process? **1. Yes** **2. No**

(b) Are (or were) family members of a homicide victim interviewed? **1. Yes** **2. No**

(c) Are (or were) family members of a homicide victim invited to otherwise participate in the fatality review process? **1. Yes** **2. No**

Please Explain. _____

(8) How are (or were) recommendations from your domestic violence serious incident/fatality review disseminated (e.g. discussed at meetings, published)? _____

(9) In what ways have domestic violence serious incident/fatality reviews in your community been *helpful*? _____

(10) What have been your community's biggest challenges with regards to implementing domestic violence serious incident/fatality reviews? _____

(11) What would be most helpful to your community for improving serious incident/fatality reviews? _____

(12) Would you be interested in being a part of a NYS local community listserv on domestic violence serious incident/fatality reviews if one were developed? **1. Yes** **2. No**

(13) **(a)** Has any professional or team from your community ever engaged in ***child fatality reviews***?
1. Yes **2. No** *(Skip to Q. 14a)*

(b) IF YES: What person(s) and/or agencies have been involved with ***child fatality reviews***?

_____ _____ _____

_____ _____ _____

(14) **(a)** Has your community ***ever*** had a ***domestic violence task force, coalition or response team*** in which professionals from different disciplines participate? *(If your community has (or had) more than one task force, to answer these questions, select the task force with the largest number of participating agencies, or the task force that might be identified as the main task force in the community. If possible, attach a list of the names of other task forces in your community.)*
1. Yes **2. No** *(Skip to END)*

(b) What is (or was) the name of your task force? _____

(c) Which agencies participate(d) on this task force?

_____ _____ _____

_____ _____ _____

(d) Is this domestic violence task force still on-going?
1. Yes **2. No**

IF NO, please explain why your task force is no longer on-going (*then SKIP to END*). _____

(e) Who facilitates your domestic violence task force meetings? (Please provide contact information if it is available.)

(1) Name: _____ Agency: _____
Phone: _____ Address: _____
E-Mail: _____ City/Zip: _____

(2) Name: _____ Agency: _____
Phone: _____ Address: _____
E-Mail: _____ City/Zip: _____

(f) On a scale of 1 to 5, how effective do you feel your current domestic violence task force is in addressing domestic violence in your community?

1	**2**	**3**	**4**	**5**
Not very effective		*Fairly Effective*		*Very Effective*

Please explain. _____

_____ *(Continue on separate sheet if necessary)*

Thank you so much for your time.

For more information on crime and criminal justice,

visit the

New York State Division of Criminal Justice Services website

at

criminaljustice.state.ny.us

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