

POST-HOMICIDE DATA COLLECTION AND DEATH REVIEW

In 1990, Veena Charan was shot to death by her estranged husband, Joseph Charan, as she was dropping her son off at school. Joseph committed suicide at the scene. Prior to her murder, Veena had obtained a restraining order and contacted numerous agencies, including the San Francisco Police Department and the San Francisco County District Attorney's Office, about abuse and threats by Joseph. The agencies contacted by Veena were not only aware of Joseph's threats, they were also aware that he owned a gun. Moreover, Joseph was on probation for domestic violence against Veena at the time he committed the murder.

The San Francisco Commission on the Status of Women launched an investigation to determine whether systemic failures in the way city and county agencies responded to Veena's case contributed to her risk of murder. The investigation revealed, among other problems, a lack of effective communication and information-sharing among agencies that had contact with Veena, a need for improved data collection systems for domestic violence cases, and a need for increased training on domestic violence for law enforcement officers, probation officers, and civil and criminal court judges.. A report issued by the Commission concerning its investigation of Veena's murder made over 100 recommendations for improving San Francisco's response to domestic violence.

Ten years later in San Francisco, Claire Joyce Tempongko was stabbed to death by her ex-boyfriend, Tari Ramirez, while her two children watched. Like Veena, Claire had secured restraining orders and called the police numerous times during the year prior to her murder in order to protect herself and her children from Tari. Like Joseph Charan, Tari was on probation when he killed Claire. At the time of Claire's murder, less than half of the recommendations promulgated by the Charan investigation had been implemented and there were no formalized procedures for ensuring that implemented changes were being

Understanding the circumstances of past domestic violence deaths can save the lives of women currently at risk of intimate partner murder.

consistently and effectively applied by local agencies. Given the disturbing similarities between Veena and Claire's cases, Claire's murder resulted in another city-wide investigation into local agency responses to domestic violence.¹

Understanding the circumstances of past domestic violence deaths can save the lives of women currently at risk of intimate partner murder. A meaningful analysis of individual murders can uncover systemic gaps in services and legal protections, and provide government agencies and practitioners with valuable strategies for increasing victim safety and ultimately reducing the incidence of domestic violence murder in their communities.² The two primary ways that government agencies and the domestic violence community attempt to analyze and "learn" from domestic violence murders is through data collection and the establishment of local death review teams.

DATA COLLECTION

Comprehensive data collection is critical to understanding and preventing intimate partner murder.³ Data sets can be used to identify common trends and circumstances among intimate murders, such as the extent to which prior cases have involved a history of violence in the relationship, attempts by the victim to seek help from legal and community agencies for abuse, or evidence of suicidal tendencies and other mental health issues among victims and perpetrators.⁴ Based upon this information, practitioners can assess whether there are certain “risk factors” for domestic violence homicide. Evidence of “risk factors” can lead to legislative and policy reforms that improve system responses and save women’s lives.⁵

Despite these benefits, one of the most challenging aspects of collecting data on domestic violence homicide is that intimate murder, by its very nature, is resistant to statistical analysis.⁶ The dynamics of intimate partner violence and murder are often so complex that standardized data collection, while good for tracking general trends, may be insufficient to support a comprehensive examination of intimate murder in the context in which this violence occurs.⁷ The “cold hard facts” can often seem far removed from victims’ actual experiences as they fail to capture unquantifiable, yet still significant, factors such as victims’ perceptions and fears and unique social, cultural and economic dynamics or pressures that contributed to the murder.⁸ Accordingly, advocates, researchers and government agencies have struggled to find the right balance of data collection and analytical techniques that provide a meaningful analysis of these cases.

Data sets can be used to identify “risk factors” for domestic violence homicide and to support legislative and policy reforms that improve system responses to domestic violence.

HOW FAR HAVE WE COME?

National Data Collection

The U.S. Department of Justice (USDOJ) has collected national data on crimes through its Uniform Crime Reporting Program (UCRP) since 1930.⁹ Data collected by the UCRP comes from monthly crime reports sent by state and local law enforcement agencies to the Federal Bureau of Investigation (FBI). Currently, law enforcement agencies participating in the UCRP represent approximately 93 percent of the nation's total population.¹⁰

The USDOJ has collected and analyzed data on intimate partner murder, specifically, since 1976.¹¹ Federal data on intimate partner murder includes information about the age, race, and sex of victims and offenders, the victim-offender relationship (e.g., current or former spouse, boyfriend, or girlfriend) and the type of weapon used in the murder.¹²

Although the federal government has been collecting intimate partner homicide data for almost thirty years, for much of this period the data was incomplete¹³ and was not being analyzed or disseminated in a way that provided meaningful information and guidance to the public and government agencies. Consequently, in 1994, the Violence Against Women Act (VAWA) required the U.S. Attorney General to investigate how federal and state agencies were collecting data on domestic violence crimes, including domestic violence homicide, and make recommendations to Congress for improving and centralizing data collection efforts.¹⁴ In addition, VAWA provided six million dollars in grants to state and local governments to improve data collection relating to domestic violence and stalking.¹⁵

The USDOJ's Bureau of Justice Statistics (BJS)¹⁶ and National Institute of Justice (NIJ)¹⁷ were charged with the responsibility for investigating national data

collection practices as mandated by VAWA.¹⁸ Forty-seven states and territories, including California, participated in a study conducted by the BJS and NIJ and the results were issued in a 1996 report entitled, *Domestic and Sexual Violence Data Collection: A Report to Congress Under the Violence Against Women Act*.¹⁹

The study found that, although the federal and a majority of state governments were collecting data on domestic violence offenses, definitions of “intimate partner violence” and established data reporting systems differed so widely among states that aggregate data was hard to accurately and completely analyze on a national level.²⁰ These reporting problems were exacerbated by the fact that over 25 percent (12 of 47) of the surveyed states and territories were not collecting any information on domestic violence or domestic violence homicide at the time of the study.²¹

The BJS/NIJ study also raised concerns that existing federal and state data collection systems were insufficient for tracking the level of detailed information needed to engage in a meaningful analysis of domestic violence crimes.²² During this time, the UCRP was a summary-based reporting system that only tracked aggregate data concerning specified crimes.²³ Crime data collected under the UCRP would reflect, for example, the total number of homicides that occurred in given time period and, depending on the data collection practices of individual states and localities, the total number of homicides that were domestic violence-related.²⁴ The BJS/NIJ researchers noted that the lack of detail inherent in aggregate data made summary-based reporting more suitable for tracking general crime trends rather than analyzing commonalities among domestic violence crimes or informing policy in this area.²⁵

Although the federal government decided in the mid-1980s to change the UCRP from a “summary-based” to an “incident-based” reporting system called the National Incident-Based Reporting System (NIBRS), the study found that many states were slow to follow this transition.^{26, 27} The incident-based

reporting system requires agencies to collect information on 53 different data elements for every crime incident handled by state and local law enforcement agencies.²⁸ The victim-offender relationship, substance abuse by the offender, and circumstance of the murder (i.e. "lover's triangle," "brawl due to influence of alcohol," etc.) are some of the data elements tracked under the NIBRS with regard to homicide crimes.²⁹ Moreover, the NIBRS links initial incident reports to subsequent criminal arrests, thereby indicating the proportion of domestic violence offenses that result in arrest.³⁰

While the BJS/NIJ researchers touted the benefits of switching to a national, uniform incident-based data collection system, they noted that the attainment of this goal would require a substantial commitment of federal resources.³¹ Given that the criminal justice system is not the only government system that has regular contact with domestic violence victims and offenders, the study also recommended that data collection be expanded to include domestic violence-related data from health and social services agencies.³²

In addition to the data collected through the UCRP, the BJS collects national data on intimate partner violence through its National Crime Victimization Survey (NCVS). The NCVS was established in 1973 to supplement FBI crime data.³³ NCVS data is gathered through surveys conducted twice a year among a nationally representative sample of households.³⁴ Approximately 150,000 individuals ages 12 and over are surveyed annually.³⁵ The NCVS's interview-based method allows for the collection of detailed information on criminal victimization, as well as the collection of data on crimes that were not reported to law enforcement. This method, however, does not allow for the collection of data on homicide crimes, as the victims in such cases cannot be interviewed.

The BJS uses the data collected through the NCVS to produce national estimates on the incidence of, and trends associated with, criminal victimization in our country. In the early 1990s, the BJS completed a substantial redesign of

the NCVS in order to increase the accuracy of its data and broaden the scope of the survey.³⁶ One of the primary objectives of the redesign was to enhance the NCVS's capacity to collect meaningful information about the nature and consequences of violence against women, including intimate partner violence.³⁷ The BJS began releasing and analyzing data on intimate partner violence collected through the redesigned survey in 1993.

Federal data has provided criminal justice and community agencies with valuable information and insight on intimate partner violence and intimate partner murder. The BJS has published numerous reports analyzing federal data on intimate partner violence obtained through FBI crime reports and the NCVS. In 2000, the BJS released *Intimate Partner Violence, Special Report*. The report found that the percentage of female murder victims who were killed by an intimate partner during the period 1976 through 1998 remained fairly constant at 30 percent.³⁸ African American men experienced the greatest decrease in intimate partner murder, dropping 74 percent during this same period, with an overall decrease of 60 percent in the number of male victims of intimate partner murder.³⁹ Caucasian females were the only category of victims for whom there had not been any substantial decrease in intimate partner murder since 1976.⁴⁰ The report also found that several common factors were associated with higher rates of intimate violence.⁴¹ Among female victims, these factors included being African-American, young, divorced or separated, earning lower incomes, living in rental housing and living in an urban area.⁴²

The BJS report, *Intimate Partner Violence and Age of Victim, 1993-99*, highlighted further trends in intimate partner violence regarding the age of the victim.⁴³ Younger women generally experienced higher rates of domestic violence in comparison with older women during the period 1993 through 1999, with women ages 16 to 24 being the most vulnerable to nonfatal intimate partner violence.⁴⁴ Women ages 35 to 49, however, were found to be the most vulnerable to intimate murder.⁴⁵ In fact, the report noted that women in

Federal data has provided criminal justice and community agencies with valuable information and insight on intimate partner violence and intimate partner murder.

this age group experienced the smallest percentage decline in intimate partner murder, as compared to other age groups, and that they actually experienced an increase in intimate partner murder between 1997 and 1999.⁴⁶

Federal data has also been used by private organizations to advance policy regarding intimate partner violence. The Violence Policy Center has produced a series of reports entitled, *When Men Murder Women*, based on federal homicide data.⁴⁷ These reports summarize national data on female homicide victims, including examining the age and race of victims, the victim-offender relationship, the type of weapon used, and the circumstances of the homicide (i.e., victim killed during the course of an argument).⁴⁸ The purpose of these reports is to highlight the importance of reducing access to firearms among individuals involved in intimate partner violence. In fact, the Violence Policy Center noted that guns were the most common weapon used by men to murder women in 2001, and that having a gun in the home significantly increases a woman's risk of intimate partner murder, even when the woman bought the gun for her own protection.⁴⁹

The Violence Policy Center also ranks each state according to its rate of intimate partner femicide. California ranked twenty-second in the nation with regard to the number of females murdered by male intimate partners, with a homicide rate of 1.42 per 100,000 people.⁵⁰ The national average for 2001 was 1.35 per 100,000.⁵¹ State comparisons are helpful in placing California's intimate partner murder rate into a national context.

In addition to data collection, the federal government, through the NIJ and other federal agencies, also provides grants to private researchers to conduct targeted studies on risk factors and dynamics of intimate homicide that are difficult to capture and assess through hard data alone.⁵² For example, one new approach among federally-funded researchers to studying intimate murder is to survey women who were victims of "attempted" murder by their intimate partner.^{53, 54} Focusing on attempted murder cases allows researchers to have

the benefit of interviewing the actual victim of domestic violence to gain a more accurate and complete understanding of the history and escalation of violence in the relationship, the victim's state of mind, and other relevant factors that may only be known to the victim.⁵⁵

One study surveyed thirty (30) victims of attempted intimate murder to determine whether they shared similar characteristics or experiences that could provide guidance to practitioners in identifying and assisting women at risk of lethal domestic violence.⁵⁶ Interviews were conducted with victims covering topics such as the nature of the victim's intimate relationship with the perpetrator, the victim's perceptions of danger, and the victim's interactions with criminal justice and community agencies.⁵⁷

The study's findings highlight the importance of conducting more targeted, in-depth examinations of actual and attempted intimate murder cases, as opposed to mere data collection. For instance, researchers found that, although the vast majority (28 of 30) of victims had experienced past physical abuse and/or highly controlling behavior by the perpetrator, many women reported being more concerned about problems other than abuse at the time they were attacked, such as infidelity and alcohol or drug abuse by the perpetrator.⁵⁸ Almost half of the victims did not suspect that their lives were in danger.⁵⁹ Moreover, researchers found that, while the majority of victims were attacked when they were trying to leave the relationship, most of these women decided to end the relationship for reasons other than abuse.⁶⁰

Based on these findings, the researchers concluded that clinicians and practitioners should be vigilant in advising all victims of domestic violence about their risk of intimate murder, instead of waiting until the victim expresses fear for her life or safety before counseling her on these matters.⁶¹ Researchers further concluded that clinicians and practitioners should never force victims of intimate violence or abuse to leave the relationship before dealing with the possible safety issues that the victim may face in doing so.⁶² Such studies demonstrate

California law authorizes and encourages the coordination of state and local data to create a “body of information to prevent domestic violence deaths.”

the value of using targeted, federally-funded studies to supplement and inform current federal data collection information and techniques.⁶³

California Data Collection

Although the California Department of Justice (CADOJ) has collected crime information from local governments and agencies since 1955, the department did not begin collecting data on intimate partner murder until 1979.⁶⁴ The CADOJ collects data on intimate partner murder under the purview of general homicide data collection. State homicide data collection tracks, among other factors, the relationship between the victim and the perpetrator of the murder and whether domestic violence was a precipitating event to the murder. In addition, the CADOJ tracks the race of the victim and perpetrator, as well as the location of the murder and the weapon used.⁶⁵ Moreover, since as early as 1981, CADOJ has also tracked homosexual intimate partner murders, which is a progressive category of analysis for the nation.⁶⁶

Aside from collecting data, the CADOJ does not engage in extensive analysis of its homicide data to identify statewide trends in intimate partner murder. Total numbers of intimate partner murders, including breakdowns by gender and race, are included in annual homicide reports issued by the CADOJ.⁶⁷ Thus, although an increase or decrease in rates of intimate partner murder may be tracked each year, the CADOJ’s analysis of intimate partner murder rarely extends beyond this level.⁶⁸

In 1995, the California Legislature attempted to rectify this deficiency by enacting Penal Code Section 11163.5 which encourages the coordination of state and local data to create a “body of information to prevent domestic violence deaths.”⁶⁹ Section 11163.5 authorizes, but does not mandate, the California Department of Justice to: (1) produce an annual report on domestic

violence homicides based on state and local data collected, analyzed and interpreted, (2) develop a state and local database of domestic violence deaths, and (3) distribute the report on domestic violence homicides to public officials and county agencies that respond to domestic violence or investigate domestic violence deaths.⁷⁰ The structure of Section 11163.5 mirrors earlier child death review team and data collection legislation.⁷¹ It was introduced with the purpose of setting up review strategies almost identical to child death cases.⁷² However, the provisions of Section 11163.5 have not been implemented, likely due to a lack of funding.

In addition, in 1996 the state legislature created a pilot data collection program by designating the San Diego Association of Governments (SANDAG) as a clearinghouse for criminal justice data on domestic violence in San Diego County.⁷³ In establishing this regional clearinghouse, the legislature found that there was a serious dearth of data on the characteristics of, and commonalities among, domestic violence victims who seek services from community and government agencies.⁷⁴ The legislature further found that tracking such information was necessary to developing a victim profile that would allow community and government agencies to learn how they can better prevent and intervene in domestic violence situations.⁷⁵ SANDAG developed a standard intake form for San Diego County shelters, which tracked detailed information about the victim.⁷⁶ In addition, San Diego County added a supplemental data collection form to their standard police report to gather more detailed information on domestic violence crimes.⁷⁷ In 2000, SANDAG issued a report on the information on domestic violence and domestic violence victims that it had collected through San Diego's enhanced data collection procedures.⁷⁸

The data collected by local domestic violence shelters resulted included the following findings:⁷⁹

- Almost 70 percent of the domestic violence shelter clients were women of color;

- More than half of the shelter clients had been staying at a place other than their own residence prior to seeking shelter;
- Seventy-four (74) percent of the clients came with their children to the shelter;
- Sixty-six (66) percent of the clients reported they sustained some type of injury in the most recent incident of domestic abuse;
- Forty (40) percent of the clients reported having obtained restraining orders against their current partner;
- Seventy-three (73) percent of clients reported having police come to their household as a result of domestic violence;
- Fifty-five (55) percent of victims reported that their batterers had been previously charged with domestic violence;
- Thirty-nine (39) percent of the clients had previously received services related to domestic abuse; and
- About 50 percent of the clients, and over 80 percent of their batterers, had witnessed abuse while growing up.

The data collected from supplemental law enforcement police reports included the following findings:⁸⁰

- Victims of a domestic violence incident were predominantly female (82 percent) and Caucasian (55 percent);
- The most frequent type of weapon used against victims were the suspect's hands (88 percent; knives and firearms were used in less than 3 percent of the cases);
- There were children present in over 50 percent of the incidents and, in 58 percent of these cases, the children present actually witnessed the abuse;
- In 80 percent of the incidents, there was a history of prior abuse by the suspect against the victim and about 40 percent of the suspects had been previously arrested;

- A high proportion of incidents involved injury to the victim and substance abuse on the part of the suspect at the time of the incident;
- Thirty-one (31) percent of the suspects were arrested at the scene of the incident;
- Over 75 percent of arrests were for felony charges, with the most common charge being the infliction of corporal injury on a spouse/cohabitant;
- The primary reasons arrests did not take place were: the suspect was not present at the scene, the victim did not want the suspect to be arrested, there was no visible injury to the victim, and officers determined the incident to be mutually combative; and
- Over 50 percent of the cases that were referred to the prosecutor by law enforcement were rejected.

SANDAG's findings revealed critical information about the nature and dynamics of domestic violence among victims and perpetrators who come into contact with law enforcement and victims who are forced to seek shelter from abuse. Although the SANDAG study focused on domestic violence generally, not intimate partner murder, the data collected and the development of an effective data collection protocol is instructive for intimate partner murder analysis.

WHERE ARE WE NOW?

National Data Collection

Nationally, many states and local agencies have not yet converted to an incident-based data collection and reporting system that complies with the NIBRS. As of 2004, approximately 5,300 law enforcement agencies contributed incident-based NIBRS data to the FBI.⁸¹ These agencies represent 20 percent of

Nationally, many states and local agencies have not yet converted to an incident-based data collection and reporting system that complies with the National Incident Based Reporting System.

Discrepancies between federal agency definitions of “intimate partner” may cause federal data on intimate partner violence and intimate murder to be inconsistent and significantly understated.

the U.S. population and 16 percent of the crime statistics collected through the UCRP. Consequently, the collection and tracking of comprehensive, incident-based federal data on intimate partner murder remains an elusive goal.

In addition, discrepancies between the FBI and BJS’s definition of “intimate partner” for purposes of federal data collection may cause federal statistics on intimate violence and intimate murder to be inconsistent and significantly understated. In conducting the NCVS, the BJS defines “intimate partner” as including current and former spouses, current and former boyfriends/girlfriends, and same sex relationships.⁸²

The FBI’s NIBRS, on the other hand, tracks the following categories of “intimate partners”: spouse, common law spouse, ex-spouse, boyfriend/girlfriend, and homosexual relationship. Although the FBI purports to include former boyfriends/girlfriends in its definition of “intimate partner,” it does not include a separate category for these relationships in its data collection and reporting system.⁸³ Rather, the FBI includes former boyfriends/girlfriends in its general “boyfriend/girlfriend” category.

If there is no separate category for former boyfriends/girlfriends, law enforcement agencies participating in the UCRP that report intimate partner murders or crimes could misreport on the front-end, by not considering former boyfriend/girlfriend relationships to qualify as “intimate partner” relationships. Such discrepancies are particularly significant with regard to FBI data on intimate murder, as the NCVS does not have the capability to track data on homicide crimes. Researchers have estimated that excluding former boyfriends/girlfriends from intimate murder data collection practices may result in federal statistics being understated by as much as 11 percent.⁸⁴

California Data Collection

Statewide data collection and analysis has also failed to result in reliable and comprehensive information on intimate partner murder due to systemic problems, which include a lack of funding and ineffective inter-agency communication and collaboration. CWLC's interviews with advocates and practitioners revealed the following challenges and shortcomings with respect to state data collection practices:

The range of data collected by state and local agencies is insufficient to allow for a meaningful analysis of intimate partner murder in our state.

The CADOJ database is constructed from "summary-based" county criminal reports sent on a monthly basis to the Criminal Justice Statistics Center by local law enforcement agencies.⁸⁵ The Attorney General's office has been working to move California toward "incident-based" reporting for criminal databases, which would allow more details and circumstances of crimes to be analyzed.⁸⁶ A pilot program for incident-based reporting was launched in a few counties.⁸⁷ Unfortunately, the last incident-based report was received in June 2004.⁸⁸ The pilot program contained 53 data fields, including a flag for "domestic violence related" incident.⁸⁹ The state has not been able to implement incident-based reporting on a state level or even maintain the pilot program due to a lack of funding, although some local agencies have converted to such a system.⁹⁰

Moreover, as mentioned above, the collection of comprehensive data on domestic violence homicides authorized by Penal Code Section 11163.5 has not become a reality, likely due to a lack of funding. As a result, little progress has been made toward creating a centralized, statewide domestic violence homicide database.⁹¹ Intimate murder data continues to be entered into the state's general homicide database⁹² and California has not published

Statewide data collection efforts have failed to result in reliable and comprehensive information on intimate partner murder.

Variations in data collection and reporting systems, technologies and resources at the local level make it difficult to gather uniform and accurate intimate partner murder data on a statewide basis.

a formal report specifically analyzing its domestic violence homicide data to date.⁹³ However, the Attorney General's office recently affirmed the importance of collecting comprehensive criminal justice data on domestic violence incidents and recommended that the CADOJ develop a web-based system that allows local criminal justice agencies to report extensive data on domestic violence cases to the state.⁹⁴

Finally, the subtle complexities of intimate partner murder, such as the history of domestic violence, previous criminal activity, and mental health of the perpetrator or victim, are not quantified in state homicide reports nor collected by the statistics department.⁹⁵ More specialized information is needed to capture trends in intimate partner murder and learn from these crimes. Although many agencies, including social service agencies and shelters, collect data on cases involving domestic violence, this information is rarely shared among agencies and this data is not being collected and analyzed in any meaningful way on a statewide basis.

California's data on intimate partner homicide is inaccurate and subject to underreporting

Several problems were identified as contributing to inaccuracies and underreporting in state data on intimate murder:

- LACK OF UNIFORM DATA COLLECTION STANDARDS AND ACCOUNTABILITY AMONG LOCAL AGENCIES

There are 58 counties and over 500 law enforcement agencies in California, many of which have divergent data collection and reporting practices.⁹⁶ Variations in data collection and reporting systems, technologies and resources at these local levels, make it difficult to gather uniform and accurate intimate partner murder data on a statewide basis.

Moreover, there is evidence that some local agencies may be reporting inaccurate numbers to the state. CADOJ statistics show, for example, that there was only one intimate murder in Ventura County in 1999 and that this case involved the murder of a woman by her boyfriend.⁹⁷ CWLC's search of local news stories, however, identified at least three intimate murders in Ventura County that year.⁹⁸ One murder was a highly publicized case of a woman who shot her husband and dismembered his body, yet CADOJ statistics show no record of any husband murders in Ventura County in 1999.⁹⁹

One reason for the transmission of inaccurate data is that a murder may not be fully resolved and classified as an "intimate murder" until the completion of a lengthy investigation and/or criminal trial. Criminal investigations and trials can take over a year to complete, causing the crime to be omitted from reported intimate murder data in the year in which the crime occurred. Another reason for inaccuracies at the local level, however, is that some agencies are simply failing to fulfill their reporting requirements to the state.

- NEED FOR GREATER INTER-AGENCY COLLABORATION AND SPECIALIZED TRAINING ON IDENTIFYING INTIMATE MURDER

California's homicide database tracks cases where domestic violence was a precipitating event to the murder. For a murder to be included in this category, however, it must have been properly investigated and identified by a local law enforcement agency as involving domestic violence. Whether a domestic violence murder is missed or mislabeled, therefore, greatly depends on the training, resources, and priorities of local law enforcement agencies.

Indeed, intimate murder is not always easy to identify and corroborate. In order to properly classify intimate murders, or confirm suspicions that what appears to be an "accidental" death is actually an intimate murder, it is often critical that investigators know how to detect the warning signs of intimate murder and establish effective collaborations with medical, social services and community agencies that had prior involvement with the victim or perpetrator.

The accuracy of statewide intimate partner murder data depends greatly on the training, resources and priorities of local law enforcement agencies and coroner departments.

One type of murder that was repeatedly cited by practitioners as being easily mislabeled by investigators is strangulation murder cases. A 1996 San Diego study uncovered significant findings regarding the use of strangulation in domestic violence cases. The study examined 100 cases over a five-year period in which a woman reported being choked or strangled by her intimate partner.

Findings included the following:

- Ninety (90) percent of the women surveyed reported prior abuse by the partner who strangled them;¹⁰⁰
- In most cases, strangulation of the victim produced no visible injuries or only produced minor injuries, such as red marks;¹⁰¹
- Because strangulation often produced no immediate, visible signs of serious injury, police tended to treat such cases as a minor incidents and failed to arrest or prosecute the suspect;¹⁰² and
- Even when strangulation resulted in serious injury, police reports generally lacked relevant details about the incident, including victims' symptoms and complaints of injury, and many police photos were blurry and unusable as evidence of the injury.¹⁰³

Moreover, the study noted that victims of strangulation murders, in general, are predominantly female¹⁰⁴ and that strangulation was one of the most lethal forms of domestic violence. In fact, the study noted that strangulation was commonly used as a form of domestic violence precisely because it is a way of silencing and causing serious injury to the victim, while leaving no marks.¹⁰⁵

The study proposed a comprehensive training curriculum for law enforcement, coroners and prosecutors.¹⁰⁶ The training was aimed at improving how these agencies identify strangulation, collect and document useful evidence of strangulation, and work together to prosecute strangulation and strangulation murder cases.¹⁰⁷

Several practitioners interviewed by CWLC also emphasized the important role that county coroner's offices play in identifying and collecting data on

intimate partner murder and the need for better collaboration among these offices and law enforcement investigators. The coroner is responsible for inquiring into and determining the circumstance, manner, and cause of all violent, sudden, or unusual deaths.¹⁰⁸ A coroner's ability to accurately identify signs of intimate murder, particularly where someone has died under suspicious circumstances, has an important impact on intimate murder data collection.

In fact, in our 100-Case Survey, several murders were thought to be accidents at the scene, only to have coroner's offices uncover more suspicious, but less conspicuous, causes of death such as strangulation or bludgeoning. In the case of Kristine Fitzhugh, Kristine was found dead at the bottom of the stairs. Her husband, Kenneth, insisted that she must have fallen down the stairs, by slipping on some plastic while wearing "slippery" shoes.

Law enforcement investigators labeled the scene an accidental death and did not investigate further. However, the coroner discovered signs of strangulation and determined that her cause of death was a blow to the head, unrelated to falling down the stairs. The death was then labeled a homicide to be criminally investigated, and Kenneth was ultimately found guilty of murder.¹⁰⁹ In Kristine Fitzhugh's case, the coroner's report was the first indication of intimate partner murder. This case underscores how critical it is that law enforcement and coroners have the appropriate tools, training and collaboration needed to properly identify cases of intimate partner murder.

- LACK OF CONCRETE DATA ON DOMESTIC VIOLENCE-RELATED DEATHS

Another problem that contributes to under-representative data on domestic violence-related deaths, is the failure to identify and track deaths that are caused by domestic violence, but are not the result of a domestic violence murder. One example that surfaced in a roundtable discussion conducted by CWLC involved a case where a woman, who was part of a battered women's support group, was killed in a car accident when the car that she and her batterer were driving in went off the side of the road and crashed.¹¹⁰ This woman described to

In order to gain a complete picture of domestic violence fatalities, it is critical that state and local data collection systems track domestic violence-related fatalities in addition to domestic violence homicide statistics.

her group, on numerous occasions, how her batterer would lock her in his car and beat her as he drove around town.¹¹¹ Members of her support group were convinced that her death was caused by the batterer losing control of the car on such an occasion.¹¹²

Another example involves domestic violence against elderly women. Studies show that abused and neglected elders have significantly higher mortality rates than their non-abused peers, even after controlling for other health factors such as chronic diseases.¹¹³ Elderly women who die prematurely due to health problems that are caused or exacerbated by ongoing domestic violence are not reflected in existing data on domestic violence fatalities. Similarly, battered women's suicides resulting from ongoing abuse are typically not considered, or labeled as, domestic violence related deaths.¹¹⁴

- LACK OF CONCRETE DATA ON THE NUMBER OF COLLATERAL VICTIMS OF INTIMATE PARTNER MURDER

In 1 out of every 5 cases surveyed in our 100-Case Survey, a person other than the intended victim was either injured or killed at the time that the murder took place. A total of 27 people were killed in addition to the 100 intended intimate murder victims. Victims included children, friends, relatives, neighbors, current intimate partners of the victim, and co-workers. It is critical to find ways to identify and track these types of domestic violence-related deaths in order to gain a true picture of domestic violence fatalities in our state.

WHERE DO WE GO FROM HERE?

- **Local, state and federal definitions of “intimate partner” should be standardized and clearly articulated to advocates, researchers and law enforcement.** Unifying and expanding definitions of “intimate partner” will allow intimate violence and intimate murder to be accurately counted. Current and former spouses, current and former dating partners and same-sex relationships must be included in the definition of “intimate partner” at all levels of data collection and entry.

- **More state and federal funding should be committed to helping agencies convert to incident-based data collection and reporting systems.** Incident-based reporting is a move in the right direction because it tracks more meaningful details and paints a more complete picture of intimate murder. Law enforcement agencies in California and across the nation would like to implement effective incident-based data collection and reporting systems, but lack the funding and resources to do so.

- **Existing incident-based reporting standards should be expanded to include other significant factors relating to intimate partner murder.** Current models of incident-based reporting still fail to capture important data on intimate partner murders (i.e. perpetrator’s prior history of abuse, prior convictions, prior arrests, etc.). Instead, detailed information gathering and analysis on intimate murder is primarily occurring locally through private research and the work of county domestic violence death review teams (see Domestic Violence Death Review section below). Further investigation and research is needed to identify additional relevant factors that could be tracked through incident-based reporting on intimate murder and to determine the feasibility of imposing expanded reporting requirements on local agencies.

- **State funding and resources should be directed toward establishing a separate, statewide data collection and analysis program on domestic violence deaths, as authorized by Penal Code Section 11163.5.** The full implementation of Penal Code Section 11163.5 should be made a higher priority. Given the preventable nature of intimate murder, it is vital that state and local agencies engage in a more detailed level of data collection and analysis than that which is currently performed for stranger murder or other violent crime.

- **Law enforcement investigators and coroners should receive specialized training on identifying and documenting data on intimate murder.** Properly determining a person’s cause of death is central to collecting accurate data on intimate murder. As the primary agencies responsible for making these

determinations, law enforcement and coroners must have the tools and training needed to effectively investigate and identify cases of intimate murder.

- **State and local agencies should explore ways to identify and collect data on non-homicide, domestic violence-related deaths.** In order to gain a true picture of domestic violence fatalities in our state, domestic violence-related deaths, such as battered women suicides, collateral deaths and premature deaths due to domestic violence injuries and stress, should be included in state and local data collection efforts. Identifying and collecting data on such cases, however, is extremely challenging and would require strong commitments and collaborations among various agencies that respond to domestic violence in the community. For counties with active domestic violence death review teams, analysis and tracking of these cases may be performed within the review team setting. However, data collection and analysis of these cases should be standardized and centralized on a statewide basis.

- **State and local agencies should explore ways to require data collection and reporting on domestic violence from health and social services agencies.** Preventing intimate murder requires gaining a better understanding of domestic violence generally, including victims and perpetrators' interactions with agencies outside of the criminal justice system. Many public health, social services and shelter agencies engage in some level of data collection and documentation on cases involving domestic violence. However, this information is rarely shared among agencies and it is not being tracked or analyzed in any meaningful way on a statewide basis. Further, investigation is needed to identify information that can be tracked by these agencies on a statewide basis and to determine the feasibility of imposing data collection and reporting requirements on these agencies.

DOMESTIC VIOLENCE DEATH REVIEW

The demand for more detailed data collection and analysis of intimate partner murder led to the establishment of domestic violence death reviews in California and across the nation. Although domestic violence death reviews are performed after an intimate murder has already occurred, the underlying goal of “death review” is to prevent future homicides from occurring and ultimately reduce the incidence of these murders in the community.

To this end, general objectives of domestic violence death reviews include: (1) collecting detailed information about the history and circumstances of particular intimate murder cases; (2) identifying agency or systemic failures that may have contributed to a victim’s risk of murder; (3) making recommendations for improving agency responses to domestic violence; (4) building interagency collaboration and communication about intimate violence and murder; and (5) increasing public and agency understanding about domestic violence generally.¹¹⁵

The establishment of domestic violence death reviews represents a shift in focus among government and community agencies from protecting individual victims and holding their perpetrators accountable, toward addressing and improving broader systemic responses to domestic violence.¹¹⁶ Two types of domestic violence death reviews have developed in California: government-sponsored death review teams and independent death reviews.

HOW FAR HAVE WE COME?

Government-Sponsored Domestic Violence Death Reviews Teams

Government-sponsored domestic violence death review teams (“DVDRTs”) are typically formed on a county-wide basis and are composed of members from

The underlying goal of domestic violence death review is to prevent future homicides from occurring and ultimately reduce the incidence of these murders in the community.

various government and community agencies that play a role in responding to domestic violence in that community. Team members may include prosecutors, coroners, law enforcement officers, probation and parole officers, mental health and health care professionals, child protective service workers, victims' advocates, batterer's treatment counselors and representatives from community agencies who deal with a significant population of domestic violence victims, such as victim-witness assistance and immigration agencies.¹¹⁷

The multi-agency review process of DVDRTs allows for a comprehensive examination of intimate murders. DVDRT meetings provide a confidential forum for each agency involved in a particular intimate murder to come forward with relevant information that can assist the team in tracking exactly what happened in that case and how different agencies could have better protected the safety of the victim.¹¹⁸ Indeed, central to the mission of most DVDRTs is the creation of a safe and collaborative environment that promotes systemic change and improvement, rather than imposing blame on individual agencies for perceived failures or mistakes in responding to domestic violence.¹¹⁹

The first DVDRTs in the U.S. were established in the early 1990s.¹²⁰ DVDRTs were largely modeled after child abuse fatality review teams, which originated in the late 1970s and were considered successful in improving systemic responses to child abuse and neglect.¹²¹ Consequently, DVDRTs share many common characteristics with child abuse fatality review teams, such as interagency collaboration and an underlying conviction that intimate partner murders, like child abuse deaths, are often preventable.

The Charan Investigation, mentioned in the case study at the start of the section, was the first government-sponsored domestic violence death review in the nation.¹²² The investigation was conducted in response to the 1990 murder-suicide of Veena Charan and her estranged husband, Joseph Charan. In this case, Veena did everything she could to protect herself from her abusive husband. She separated from Joseph and obtained custody of their then 9 year-

old son. She obtained a civil restraining order against Joseph. Moreover, during the 15 months prior to her murder, Veena made numerous calls to police to report domestic violence by Joseph against herself and other family members, but these reports were not taken seriously by police.

Although Joseph was eventually arrested and convicted of domestic violence, investigators failed to provide the prosecutor with complete information about Joseph's past history of abuse against Veena. As a result of the conviction, Joseph was placed on probation, the terms of which included participation in domestic violence counseling and the Sheriff's Work Alternative Program. On January 15, 1990, less than two weeks after he was placed on probation, Joseph showed up at his son's school and shot and killed Veena before killing himself.

The Charan Investigation was conducted by the San Francisco Commission on the Status of Women at the request of the San Francisco Domestic Violence Consortium.¹²³ In 1991, the Commission issued a report stating its findings and recommendations from the investigation of the Charan case. The Commission found that Veena's murder highlighted systemic problems with the way that San Francisco's civil and criminal justice agencies responded to domestic violence, and that future domestic violence murders could be prevented if significant changes were made.¹²⁴ In fact, the Commission noted that, if Veena's domestic violence complaints had been taken seriously by law enforcement and information about her case had been effectively communicated between law enforcement, prosecutors and the probation department, stronger criminal justice measures could have been taken against Joseph to prevent the escalation of violence that led to Veena's murder.¹²⁵

In particular, the Commission's investigation revealed four significant gaps in services: (1) a lack of effective communication and coordination between the various city agencies that deal with domestic violence cases (i.e., police department, municipal court, adult probation); (2) a lack of systematic

California law authorizes and encourages the establishment of county domestic violence death review teams.

data collection and centralized information about domestic violence cases; (3) barriers to accessing services, including insensitivity among city agencies to cultural and gay/lesbian issues; and (4) insufficient training on multicultural awareness issues.¹²⁶ The Commission made over 100 recommendations for improving agency response to domestic violence in San Francisco and then worked with local agencies to implement their recommendations.¹²⁷ Changes included the establishment of an inter-agency council to coordinate domestic violence services throughout the city and the establishment of specialized domestic violence units within local police, district attorney and probation departments.¹²⁸

A few years later, in October 1994, Santa Clara County established one of the first on-going, multi-agency DVDRTs, which has served as a model for teams across the nation.¹²⁹ The Santa Clara Domestic Violence Death Review Committee was established as a sub-committee of the Santa Clara Domestic Violence Council.¹³⁰ Since 1997, the Committee has issued annual reports summarizing data on domestic violence murders occurring in the county each year, analyzing trends and significant issues concerning these murders, and making recommendations for improving local responses to domestic violence.

Growth and Standardization of County Domestic Violence Death Reviews

In 1995, California enacted legislation authorizing the establishment of domestic violence death review teams in all California counties (“1995 Authorizing Legislation”).¹³¹ Although state law does not require every county to have a review team, it encourages the formation of such teams and sets forth general principles and standards for their operation.¹³²

Penal Code Section 11163.3 describes the general objectives of county DVDRTs to include the following: (1) identifying and reviewing domestic violence

deaths, including homicides and suicides; (2) facilitating communication among agencies involved in domestic violence cases; and (3) reviewing agency involvement in domestic violence incidents to develop recommendations aimed at reducing the incidence of domestic violence in the community.¹³³

Section 11163.3 also lists categories of professionals who should be included on county DVDRTs, including forensic pathology experts, coroners, prosecutors, law enforcement personnel, medical professionals, battered women's advocates, and representatives from child abuse agencies.¹³⁴ Moreover, Section 11163.3 authorizes counties to develop protocols and written reporting procedures to assist coroners and others who perform autopsies in identifying whether a person had been a victim of domestic violence prior to death and whether domestic violence was the actual cause of death for a victim.¹³⁵

The number of county DVDRTs in California grew with the passage of the 1995 Authorizing Legislation. Currently, there are at least twenty-four (24) counties in California that have on-going, formalized DVDRTs.¹³⁶ The growth of DVDRTs led to a growing need among counties for guidance on how to effectively carry out the objectives articulated in Penal Code Section 11163.3. Areas of particular concern included general protocol development, data collection, and confidentiality issues among team members.

GENERAL PROTOCOL DEVELOPMENT

The 1995 Authorizing Legislation required the California Attorney General's Office to create a statewide protocol to assist counties with developing and implementing DVDRTs.¹³⁷ Shortly after the 1995 legislation was enacted, the Attorney General's Office and Department of Health Services began gathering information for the statewide protocol by conducting focus groups with professionals involved in domestic violence prevention and response, and meeting with existing domestic violence death review teams.¹³⁸ In addition, in

The growing number of DV-DRTs in California has led to a growing need among counties for guidance on how to effectively carry out team objectives.

1998, the Attorney General's Office established a Domestic Violence Death Review Protocol Advisory Committee ("Protocol Advisory Committee") to assist the office with defining the statewide protocol.¹³⁹

Published in 2000, the statewide protocol provides guidance to counties in the following areas: team goals, team membership, case review, confidentiality, data collection and policy recommendation development.¹⁴⁰ The protocol outlines state law standards in each of these areas and supplements these standards with recommended practices developed by the Protocol Advisory Committee. With regard to team membership, for example, the protocol states that, in addition to the list of core team members set forth in Penal Code Section 11163.3 (i.e., forensic pathology experts, coroners, prosecutors, law enforcement personnel, etc.), Protocol Advisory Committee members recommended having professionals such as probation officers, judges, and rape crisis advocates on county DVDRTs.¹⁴¹ The statewide protocol also includes an appendix of important resources for teams, such as sample confidentiality agreements and data collection forms.¹⁴²

The statewide protocol is not mandatory, but rather, is intended as a guide for existing and future DVDRTs.¹⁴³ County review teams are free to develop their own mission statements, protocols, and forms in conformance with state law. This flexible structure has the benefit of allowing counties to tailor their review team in a way that best meets their community's needs. However, divergence in strategies and procedures among teams may make it difficult to gather uniform, statewide data on domestic violence deaths.

In addition to developing the statewide protocol, in 2002, the Attorney General's Office held two regional conferences for California DVDRTs.¹⁴⁴ These conferences provided a valuable opportunity for teams to share information about strategies for conducting death reviews, important trends and risk factors identified through local death reviews, and recommendations for preventing future domestic violence deaths.¹⁴⁵ However, due to budget restraints, the Attorney

General's Office has no current plans to hold additional regional conferences in the future.¹⁴⁶ The office does hope to produce an on-line newsletter for teams, as well as a team listserv, both of which will better enable teams to share information and resources.¹⁴⁷

The National Domestic Violence Fatality Review Initiative (NDVFRI) has also served as an important resource for DVDRTs.¹⁴⁸ The NDFVRI is funded by a grant from the U.S. Department of Justice's Office on Violence Against Women.¹⁴⁹ NDFVRI provides technical assistance, training and resources for DVDRTs throughout the country. In addition, each year, the NDFVRI holds a national Domestic Violence Fatality Review Conference to help foster the growth and development of local teams. The California Attorney General's Office encourages county teams to attend these annual conferences.¹⁵⁰

DATA COLLECTION

Another purpose of the 1995 Authorizing Legislation was to create a "body of information to prevent domestic violence deaths."¹⁵¹ Section 11163.5, which was enacted as part of the 1995 legislation, authorizes the California Department of Justice ("CADOJ") to issue an annual report analyzing state and local data on domestic violence deaths, including the data collected by local DVDRTs.¹⁵² To this end, Section 11163.5 authorizes the CADOJ to establish minimum data collection standards for DVDRTs in order to better assess the data collected by local teams on a statewide basis.¹⁵³

Although more than 10 years have passed since the enactment of Penal Code Section 11163.5, the state has not been successful in creating a statewide "body of information" on domestic violence deaths. Moreover, the CADOJ has yet to issue a report analyzing state and local data on domestic violence deaths. The delay in achieving these goals may be attributed, in part, to the difficulty of standardizing and coordinating state and local data collection efforts. Indeed,

Although DVDRTs track and analyze critical data on local domestic violence deaths, there are currently no minimum, statewide data collection standards for local teams.

although the CADOJ intends to develop a standardized data collection form for county DVDRTs,¹⁵⁴ there are currently no minimum data collection standards for local teams.

In 1999, Penal Code Section 11163.6 was enacted to ensure more consistent and uniform data collection by county death review teams. Section 11163.6 promotes standardized data collection by defining what qualifies as a “domestic violence death” for purposes of conducting local domestic violence death reviews.¹⁵⁵ Pursuant to Section 11163.6, county review teams may, but are not required to, consider the following deaths in conducting their reviews:

- Deceased was murdered by an intimate partner;¹⁵⁶
- Deceased committed suicide and was a victim of domestic violence committed by an intimate partner;
- Deceased committed suicide after murdering an intimate partner;
- Deceased murdered an intimate partner and was then killed in connection with the domestic violence incident;
- Deceased was the child of the victim and/or perpetrator of a domestic violence homicide;
- Deceased was an intimate partner of the domestic violence perpetrator’s intimate partner;
- Deceased was a law enforcement officer, emergency medical personnel, or other agency representative responding to a domestic violence incident;
- Deceased was a family member of the domestic violence perpetrator, other than those identified above;
- Deceased murdered a family member, other than those identified above; and
- Deceased is someone who is not included in one of the above categories, but whose murder was related to domestic violence.

Section 11163.6 allows a wide range of murders and suicides to be reviewed by county DVDRTs. However, because Section 11163.6 does not require that local teams use its expansive definition of “domestic violence death,” these provisions, while instructive, do not guarantee that teams are utilizing uniform definitions in selecting and reviewing cases.

CONFIDENTIALITY ISSUES

Confidentiality is critical for the effective operation of county DVDRTs. Without a safe and confidential environment, team members may be reluctant or unable to share their agency’s information about a particular case or speculate about how agency omissions and/or failures may have contributed to the victim’s risk of murder.¹⁵⁷ Even with a confidential environment, however, a team’s authority to gather and assess information about a case is not without its limits. Teams must balance their interest of conducting an effective and comprehensive case review with the community’s interest in ensuring that the team’s efforts do not unlawfully infringe on a person’s or agency’s privacy rights.

There are generally two levels of confidentiality when it comes to a team’s case review process: team confidentiality and member confidentiality.¹⁵⁸ Team confidentiality covers all communications and activities that occur during a team meeting.¹⁵⁹ Member confidentiality applies on an individual level, and requires that each team member keep specific case information confidential and not discuss this information with anyone outside the group, including others in their member agency.¹⁶⁰

The 1995 Authorizing Legislation addressed confidentiality issues for DVDRTs by enacting Penal Code Section 11163.3(e) which states that all communications and documents shared within, or produced by, a DVDRT relating to a case review are confidential and, therefore, are not subject to disclosure or discoverable by a third party.¹⁶¹ The same privilege applies to

DVDRTs must balance their interest of conducting effective and comprehensive case reviews with the community’s interest in ensuring that the team’s efforts do not unlawfully infringe on a person’s or agency’s privacy rights.

communications and documents shared between a third party and a DVDRT relating to a case review.¹⁶² In addition, recommendations developed by a DVDRT may be publicly disclosed only when a majority of death review team members agree on publishing the recommendations.¹⁶³

In 1999, Penal Code Section 11163.3 was amended to further clarify confidentiality rules concerning a DVDRT's case review process.¹⁶⁴ Penal Code Section 11163.3(f) specifically authorizes agencies that are members of a DVDRT to share information their agency has about a particular victim or case under review with other team members, even if the information is otherwise deemed to be confidential or privileged. For example, if a team member represents a battered women's shelter at which the victim subject to review had previously sought assistance for domestic violence, Section 11163.3(f) allows that team member to share his/her agency's records concerning the victim with the DVDRT, despite the fact that such records may be prohibited from disclosure under the domestic violence victim-counselor privilege (Evidence Code Sections 1037, et seq.). Section 11163.3(f) states that information disclosed by a member agency to the team under these circumstances is confidential.

Penal Code Section 11163.3 (g), which was also enacted in 1999, allows DVDRTs to make written requests to third party agencies for information relating to a case review, including that which is confidential or privileged under state law.¹⁶⁵ Pursuant to Section 11163.3(g), information requested by a team may include the following:

- Medical information;
- Mental health information;
- Information concerning a report or investigation of elder abuse, except for the identity of the person who made the report;
- Information concerning a report or investigation of child abuse, except for the identity of the person who made the report;

- Criminal history and criminal offender information;
- Information concerning mandated reports by health practitioners of injuries inflicted by a firearm or assaultive or abusive conduct, including information concerning whether a physician referred the injured party to local domestic violence services as recommended under state law;
- Information in juvenile court proceedings;
- Information maintained by the family court;
- Information provided to probation officers in the course of their duties, including, but not limited to, the duty to prepare reports; and
- In-home supportive services records, unless federal law prohibits the disclosure of such records.

The broad range of information that DVDRTs are authorized to request pursuant to Penal Code Section 11163.3(g) is among the most expansive in the nation.¹⁶⁶ However, DVDRTs cannot compel individuals or agencies to provide them with the information described above.

The California Attorney General's statewide protocol recommends having DVDRT members and guests sign a confidentiality agreement at the beginning of every meeting that sets forth the team's confidentiality rules.¹⁶⁷ The protocol further recommends that members and guests also be verbally reminded at the beginning of each meeting that information shared or discussed during the meeting cannot leave the room.¹⁶⁸

The only exception to the confidentiality agreement recognized by the statewide protocol involves the rare situation where a prosecutor learns new information during a team meeting that he/she is constitutionally mandated to disclose to the defense in a case where the perpetrator is awaiting trial or has already been convicted.¹⁶⁹ All other breaches of confidentiality should result, at a minimum,¹⁷⁰ in the offending member being removed from the team.¹⁷¹

Annual reports from DVDRTs summarize data on county domestic violence deaths, analyze trends or patterns illustrated by this data, and list the team's recommendations for improving local responses to domestic violence.

Key Findings From Domestic Violence Death Review Teams: Annual Reports

Annual reports are one of the most important products of DVDRTs. These reports summarize the data collected from the team's review of county domestic violence deaths during the prior year, analyze trends or patterns illustrated by this data, and list the team's recommendations for improving local responses to domestic violence. Included below is a summary of important highlights from some of the most recent annual reports issued by DVDRTs in California.

SANTA CLARA COUNTY DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE

The Domestic Violence Death Review Committee of the Santa Clara County Domestic Violence Council issues an annual report at the end of each calendar year. The Committee's most recent annual report reviews six (6) domestic violence deaths occurring in Santa Clara County in 2004.¹⁷²

Key Findings

Key findings included, but were not limited to, the following:

- Only six (6) domestic violence deaths (2 homicides, 1 homicide/suicide, 2 suicides after an attempted homicide) occurred in the county in 2004, which represented a dramatic decrease from the twenty-one (21) identified cases that occurred the year before. The Committee attributed this decrease to a number of factors, including increased reporting of domestic violence incidents, improved responses by law enforcement and prosecutors, increased community awareness of domestic violence, and member agency's application of what they learn from participating in the Committee to their every day work;
- People close to the victims and perpetrators of the murder knew that something was seriously wrong in the relationship, but did nothing to intervene;

- Perpetrators of fatal domestic violence shared common characteristics which included making prior threats of murder or suicide, exhibiting signs of anger or depression, perpetrating prior physical violence against the victim or a prior intimate partner, and engaging in highly controlling and obsessive behavior against the victim; and
- Domestic violence deaths occurred in nearly every jurisdiction in the county and involved different racial and socio-economic groups. Individuals from middle and upper-middle classes made up the majority of deaths.¹⁷³

Policy Recommendations

As a sub-committee of the Santa Clara Domestic Violence Council, the Committee makes its recommendations directly to the Council. Policy recommendations made by the Committee to the Santa Clara Domestic Violence Council included, but were not limited to, the following:

- Encourage community members to report domestic violence;
- Continue to educate the public about domestic violence issues, including ethnic minority and immigrant communities;
- Continue to encourage victims to obtain restraining orders;
- Promote legislation requiring all mental health professionals to have domestic violence education;
- Encourage local school districts to develop curriculum addressing domestic violence, dating violence and stalking; and
- Continue to educate the public about gun restrictions for domestic violence offenders.¹⁷⁴

SAN DIEGO COUNTY DOMESTIC VIOLENCE FATALITY REVIEW TEAM

The San Diego County Domestic Violence Fatality Review Team (“SDDVFRT”) was established in 1996 and issued its first report in 2001. The

SDDVFRT's most recent annual report reviews twenty-five (25) cases occurring in 2002 and 2003 and combines these findings with findings from previous SDDVFRT case reviews, analyzing a total of sixty-one (61) domestic violence fatalities occurring from 1997 to 2003.¹⁷⁵

Key Findings

Key findings included, but were not limited to the following:

- The SDDVFRT identified the following eight (8) major risk factors for domestic violence lethality (listed in order of importance): history of domestic violence, access to firearms, victim ended the relationship prior to death, alcohol and/or drug abuse in the relationship, mental health issues in the relationship, suicidal tendencies, death threats against victim by perpetrator, and victim obtained a restraining order prior to death;¹⁷⁶
- Firearms were used in 44 percent of fatalities, including suicides;¹⁷⁷
- In 43 percent of the cases, victims did not access any services or receive support from the criminal justice system prior to their death;¹⁷⁸ and
- A total of 52 children were impacted by the death of one or both of their parents, with 12 children actually witnessing the murder of their parent(s) and 4 children being the first ones to find the victim's body.¹⁷⁹

Policy Recommendations

The SDDVFRT focused the recommendations in their 2004 Report on "access to firearms" due to the high percentage of cases (44 percent) in which firearms were used to perpetrate a homicide or suicide. They recommended that agencies (i.e., courts, law enforcement, prosecution and probation) be more proactive in ensuring that domestic violence offenders subject to court-ordered

gun restrictions actually relinquish their weapons, including taking the following steps:

- Law enforcement should inquire if there are weapons in the home and if the weapons were used in the incident, as well as confiscate any weapons found at the scene of a domestic violence incident;
- A registered firearms check should be made at the first court hearing in a domestic violence case and, after conviction, court orders should require that the defendant show proof of relinquishment of firearms as a condition of probation;
- A registered firearms check should be made in a domestic violence restraining order proceedings upon the entry of an order after a hearing. The firearms registration information should be included in the restraining order; and
- Local courts, law enforcement and prosecutors should work together to develop and implement standardized policies and procedures for the safe relinquishment and destruction of weapons.¹⁸⁰

The SDDVFRT also made recommendations for improving their case review process, including placing a greater focus on attempted domestic violence murders and suicides with a history of domestic violence, conducting follow-up services for children who have lost their parent(s) due to a domestic violence fatality and refining their case investigative reports to be more inclusive of lethality risk factors.¹⁸¹

SACRAMENTO COUNTY DOMESTIC VIOLENCE DEATH REVIEW TEAM

The Sacramento County Domestic Violence Death Review Team (“SCDVDRT”) is a sub-committee of the Sacramento County Domestic Violence Coordinating Council. The SCDVDRT was established in 1998 and issued its first annual report in 2000. Its most recent report reviews six (6) cases occurring from November 2002 to September 2003 and combines these findings with the

findings from previous SCDVDRT case reviews, analyzing a total of thirty-one (31) cases occurring from 1993 through September 2003.¹⁸²

Key Findings

Key findings included, but were not limited to, the following:

- There was a history of domestic violence in virtually all of the thirty-one (31) reviewed cases;¹⁸³
- There were a disturbing number of cases in which the victim had previous contact with agencies (e.g., law enforcement, courts, probation, child protective services, etc.), but still lost her life;¹⁸⁴
- Of the six (6) cases occurring from November 2002 to September 2003, eleven (11) children were exposed to domestic violence, with one child dying after a premature birth due to injuries cause in utero;¹⁸⁵
- Two of the six (6) victims killed from November 2002 to September 2003 were pregnant at the time of their murder;¹⁸⁶ and
- There is a serious shortage of shelter beds available to domestic violence victims.¹⁸⁷

Policy Recommendations

The SCDVDRT's policy recommendations, which were presented to the Sacramento County Board of Supervisors and the Sacramento County Domestic Violence Coordinating Council, included the following:

- The County should seek outside funding to implement model guidelines for effectively intervening in domestic violence and child maltreatment cases;¹⁸⁸
- The County should seek ways to raise public awareness about the impact of domestic violence on children;

- The County should seek funds to increase shelter bed capacity;¹⁸⁹
- The County should encourage all service providers to explore the implementation of lethality assessments to better identify and address the safety needs of families experiencing domestic violence;¹⁹⁰ and
- The County should explore the idea of funding support staff for the SCDVDRT to increase the team's ability to collect and analyze data on domestic violence fatalities.¹⁹¹

CONTRA COSTA COUNTY DOMESTIC VIOLENCE DEATH REVIEW TEAM

The Contra Costa County Domestic Violence Death Review Team ("CCDVDRT") was established in 1998 and issued its first annual report in 2000.¹⁹² The CCDVDRT's most recent annual report bases its analysis on the team's review of 38 deaths occurring from 1997 through 1999, only twenty (20) of which were determined to be domestic violence deaths.¹⁹³

Key Findings

Key findings included, but were not limited to, the following:

- The time of separation is the most dangerous time in the relationship;¹⁹⁴
- Firearms were used in the majority of homicides and suicides in domestic violence cases;¹⁹⁵
- Domestic violence deaths are not confined to any specific region or specific ethnic/cultural group in the county;¹⁹⁶
- Children remain both direct and indirect victims of domestic violence;
- The majority of individuals involved in the reviewed cases were not known to have sought services from public or private domestic violence service agencies; and

- A majority of deaths involved individuals who were neither subject to or protected by restraining orders.¹⁹⁷

Policy Recommendations

Policy recommendations included, but were not limited to, the following:

- All people working with individuals in violent relationships should be aware of the potential for lethality during separation and promote the development of safety plans in such situations;
- When restraining orders are in place and/or arrests occur, firearms should be confiscated whenever possible;
- Community outreach, education and services must reflect the cultural/ethnic diversity of the County;
- The safety and welfare of children should be assessed and documented in all domestic violence incidents;
- Government and private agencies must continue to develop and implement methods for identifying and coding cases involving domestic violence; and
- Public and private agencies that provide domestic violence-related services should be provided with ongoing fiscal and political support.¹⁹⁸

The fact that various DVDRT annual reports make the same findings and recommendations for improving legal and community responses to domestic violence underscores the need for improved statewide coordination of data collected by the local DVDRTs, as well as collaborations aimed at implementing county recommendations on a regional and/or statewide level.

Independent Domestic Violence Death Reviews

Independent domestic violence death reviews are conducted by private individuals or grassroots advocacy groups that have no connection to government supervision or funding. Independent reviews typically do not operate within a team setting or have the benefit of open communication and cooperation with government agencies, such as local police departments and prosecutor's offices. Rather, these reviews tend to involve more individualized investigative work, including combing through public records and conducting interviews with the families and friends of the victim and perpetrator.¹⁹⁹

Independent reviews were developed largely in response to the belief among victim's advocates that government-sponsored reviews fail to promote open and meaningful evaluations of domestic violence deaths. Because government-sponsored reviews are conducted primarily by the very agencies that may have, in fact, contributed to the victim's risk of murder, some advocates believe that such reviews involve inherent biases and conflicts that inhibit true agency assessment and reform. In fact, independent death reviews are often conducted as a form of grassroots advocacy when local criminal justice agencies have failed to take action or make adequate reforms after a particularly egregious intimate murder occurs in a community.

Independent reviews of domestic violence homicides by grassroots advocacy groups began to surface as counties first experimented with DVDRTs in the mid-1990s. Two organizations that were responsible for conducting some of the first independent reviews of domestic violence homicides in California are the Purple Berets and the Women's Justice Center. Over the past decade, these organizations have worked together and separately to produce more than a dozen independent reviews of domestic violence deaths in Northern California.²⁰⁰

Independent reviews were developed largely in response to the belief among victim's advocates that government-sponsored reviews fail to promote open and meaningful evaluations of domestic violence deaths.

The Purple Berets and the Women's Justice Center describe the two primary goals of conducting an independent review as: (1) humanizing the victim and (2) exposing the ineffectiveness of local agency responses to domestic violence.²⁰¹ Unlike DVDRTs, these organizations do not keep the detailed information that they gather about a case confidential. To the contrary, they publicize this information in order to incite public outrage and action by directly and unabashedly pointing out problems with how specific agencies respond to domestic violence.²⁰² In fact, the Purple Berets and Women's Justice Center have advocated for reforms in local agency responses to domestic violence by using case information to organize media campaigns, lobby for local and statewide policy changes, make direct pleas for reforms to public officials and offending agencies, and stage public demonstrations.²⁰³

The most noted campaign conducted by the Purple Berets and Women's Justice Center involved the murder of Maria Teresa Macias by her husband, Avelino Macias. On April 15, 1996, Teresa was shot in the head and killed by Avelino as she and her mother arrived for work. Avelino then shot and seriously injured Teresa's mother before shooting and killing himself.²⁰⁴ Advocates from the Purple Berets and Women's Justice Center became interested in the case after reading about the murder-suicide in a local newspaper.²⁰⁵ Within a few days, they began a month-long investigation into the history of Teresa's case.

The Purple Berets and Women's Justice Center searched court documents and conducted interviews with family members, friends, and other witnesses to produce a detailed chronology of events leading up to Teresa's murder.²⁰⁶ The chronology documented Teresa's repeated attempts to seek help from government and community agencies for domestic violence by Avelino. In the year prior to her murder, Teresa fled to a battered women's shelter with her children, solicited the help of family members, friends and counselors, obtained a restraining order against Avelino, and contacted law enforcement more than 20 times to report stalking, violence and restraining order violations by Avelino.²⁰⁷

The Purple Berets and Women's Justice Center organized a memorial vigil for Teresa where they announced the results of their investigation, including detailing the history of law enforcement's failure to protect Teresa.²⁰⁸ This event ignited a public campaign aimed at putting pressure on local law enforcement and prosecutors to institute reforms addressing the failures evidenced by Teresa's case.²⁰⁹ In addition, the organizations used the information gathered through their investigation to point out inaccuracies in law enforcement and prosecutor's accounts of their prior contacts with Teresa. For example, when then Country Sheriff Mark Ihde told the media that his office had no records of Teresa's restraining order, the Purple Berets published an article countering this statement with information from witnesses who confirmed that Teresa delivered a copy of her restraining order to the Sheriff's substation soon after it was issued and that she would always show a copy of her order to sheriff deputies when they responded to her calls for assistance.²¹⁰

Ultimately, the organizations used their information on the Macias case to file a federal civil rights lawsuit against the Sonoma County Sheriff's Department for failing to adequately respond to Teresa's complaints of domestic violence by Avelino. The lawsuit resulted in a landmark Ninth Circuit Court of Appeal decision recognizing that domestic violence victims have a constitutional right to non-discriminatory police services, as well as a \$1 million settlement for Teresa's family.²¹¹

In addition to conducting their own investigations, both the Purple Berets and the Women's Justice Center also encourage private individuals to conduct independent reviews of domestic violence murders involving women they know or women in their community. Both organizations have even developed step-by-step investigation guides for conducting an independent review.²¹² These guides include information on how to research public documents, strategies for conducting personal interviews, and tips for documenting findings from the investigation.²¹³ Further, the organizations advise individuals on how to publicize and advocate for reforms concerning their findings.²¹⁴

Independent domestic violence death reviews are a valuable complement to the reviews performed by county DVDRTs.

Independent reviews are a valuable complement to the reviews performed by county DVDRTs. As mentioned above, because county DVDRTs are government agency-driven, much of the information discovered and shared during team meetings is confidential, not to be shared with the general public. Independent reviews empower communities and individuals to take matters into their own hands by investigating and publicizing what went wrong in a particular case. In fact, even the National Domestic Violence Fatality Review Initiative has recognized the value of, and need for, more grassroots investigations of domestic violence deaths.²¹⁵

WHERE ARE WE NOW?

CWLC conducted interviews with both county DVDRTs and organizations that conduct independent death reviews to gain insight into the current status of domestic violence death review in California.

Government-Sponsored Domestic Violence Death Review Teams

There are currently 24 county DVDRTs in California.²¹⁶ CWLC surveyed ten (10) DVDRTs, covering both urban and rural counties, in order to assess current practices and gather feedback on possible improvements from teams. Questions were posed to the Chairs of the DVDRTs and covered issues such as team organization and structure, areas of strength, suggestions for improvement, and current frustrations.²¹⁷

Team Establishment

- The establishment of county DVDRTs was often community driven. Most teams (9 out of 10) established their DVDRT due to the individualized efforts of government agency representatives (i.e.,

prosecutors, health department directors, etc.) and/or advocates who were currently working in the domestic violence field, or in response to community events, such as the establishment of a county domestic violence council or the occurrence of an egregious intimate partner murder. Only one team formed solely due to the 1995 Authorizing Legislation.

- All teams had a written protocol, with the majority of teams (6 out of 10) copying the statewide protocol or another county's protocol.

Team Membership

- The number of team members on each DVDRT depends largely on the size of the county that the team represents. Smaller counties reported having anywhere from 7 to 12 team members, while larger counties reported having as many as 27 members.
- Agencies represented on the 10 surveyed DVDRTs include the following: law enforcement (i.e., local police, county sheriffs and state highway patrol officers), district attorneys, city attorneys, county counsel, coroners, probation officers, family court personnel, family law attorneys, criminal defense attorneys, victim-witness assistance representatives, child protective services representatives, public health workers, mental health professionals, military personnel, battered women advocates and shelter workers, sexual assault advocates, and community advocates specializing in public policy, immigration and gay/lesbian issues.
- Most DVDRTs teams (7 out of 10) feel that all relevant agencies were adequately represented on their team. Only 3 teams identified a need for greater depth and diversity of involvement on

The establishment of county DVDRTs was often community driven.

Most DVDRTs do not have any source of funding to support their work.

the team, particularly with regard to family members of the victim, medical professionals (e.g., representatives from local hospitals, health care workers, etc.) and community advocates who represent marginalized groups, such as the gay/lesbian, disabled and immigrant communities.

- Almost all of the teams (9 out of 10) feel that the DVDRT functions well in bringing in new domestic violence agencies as team members and guests, when needed. Five (5) of the teams attributed their success in this area to the fact that there are generally strong working relationships among all local domestic violence-related agencies in their community.

Team Funding

- Most (7 out of 10) DVDRTs do not have any source of funding to support their work. Rather, team members participate on a volunteer basis as part of, or in addition to, their regular job duties. Two (2) teams have their costs absorbed by the county, and one team has a coordinator who is funded to spend up to 5 percent of his/her time on team activities pursuant to a federal grant.

Case Selection

- A majority of teams (6 out of 10) identify cases by having local agencies (i.e., law enforcement, coroners offices, district attorney offices, and probation departments) flag suspected domestic violence deaths for review by the team. Four (4) teams review all deaths that have occurred in the county to see whether they qualify as a domestic violence death, without utilizing any initial screening process. One of these teams has reviewed all county deaths dating

back 18 years. Having an initial screening process for selecting cases was especially critical for teams from large counties where, due to their large populations, it would be impossible for these teams to review every domestic violence death, let alone every death, in their county.

- The types of domestic violence deaths reviewed by each team varied among counties. With regard to domestic violence homicides, half of the teams (5 out of 10) have a policy of only reviewing “closed cases” in which all the parties have died (i.e., murder-suicides) or all civil and criminal proceedings involving the case are completed, though some teams do not wait until all criminal appeals are exhausted before starting their review. Two (2) teams have more flexible “closed case” policies that allow them to review deaths in pending criminal cases, if needed, and 3 teams have no policy one way or the other. Only 3 teams also review individual suicides where there has been a history of domestic violence, and only one team reviews blue suicides²¹⁸ and domestic violence-related fatal accidents in addition to the above deaths.
- Four (4) out of 10 teams are planning to expand the range of domestic violence deaths that they review to include cases such as suicides with a history of domestic violence, attempted domestic violence homicides, and domestic violence-related fatal accidents.

Case Review Process

- Most teams meet on a monthly basis. Only one team met less often due to the fact that their county only experienced a few domestic violence deaths each year. Teams reported that participation at any given meeting tends to fluctuate due to the fact that many members participate on the team in addition to their other job functions.

The range of domestic violence deaths reviewed by each DVDRT varies among counties.

Most teams make it a point to consider and quantify cultural factors, race and sexual orientation in their analysis of cases.

- All 10 teams use a confidentiality agreement which they have members and guests sign before each meeting. All teams feel that the use of confidentiality agreements is beneficial to the review process.
- A majority of teams (6 out of 10) gather case information by having team members bring relevant information and research from their respective agencies to team meetings that relates to the case subject to review, as well as contacting non-member agencies for information, when needed. Two (2) teams designate a specific person on the team to collect information from agencies on cases. One team had members review and give input on the coroner's report during a case review meeting. For 4 of the teams, the DVDRT Chair was responsible for doing the majority of work and research for case reviews. Finally, two (2) teams had the person who investigated or prosecuted the case present the case to the team for review.
- Although no agency may be compelled to produce case-related information, all teams reported that they generally function well in obtaining information for their reviews. They attributed this success to good working relationships between agencies, coupled with guarantees of confidentiality. However, several (3 out of 10) teams identified difficulties in getting access to shelter information and information from family members of victims and perpetrators.
- Eight (8) of the 10 teams made it a point to consider and quantify cultural factors, race and sexual orientation in their analysis of cases. However, one of the teams that did not consider these factors has only experienced cases of domestic violence murder between white husbands and wives in their county.

- Teams reported the following trends from their recent case reviews:

Increase in the involvement of children in domestic violence homicides and murder-suicides; increase in extremely heinous and brutal murders;

Increase in domestic violence deaths among immigrant communities;

Several teams reported that murder-suicides were the most common form of domestic violence deaths in their county;

Noticeable connections between intimate murders and elder abuse; and

Some teams reported overall decreases, while others reported increases, in the number of domestic violence deaths in their county.

Data Collection and Reporting

- Nine (9) of the 10 teams use a data collection form for gathering and documenting case information. One team documents its data in a timeline format, and another team uses meeting notes to compile information.
- Four (4) of the teams felt that having standardized data collection forms for DVDRTs would be beneficial for ensuring consistent and accurate data and reporting among teams. Only one team strongly felt that each county should have their own unique, specialized data collection forms that reflect what is most important and relevant to that particular community.
- Almost all of the teams (9 out of 10) compile and assess their data in an annual (or bi-annual) report.

Most teams use a standard data collection form to gather and document case information and issue annual or bi-annual reports assessing this data.

- Only 3 out of 10 teams are either currently using or developing a local a database for their DVDRT data.
- Three (3) of the teams conduct community education and outreach regarding data, findings and recommendations from their case reviews.

DVDRT Successes

Teams identified the following major successes:

- Noticeable decreases in the number of domestic violence homicides in their county;
- Increased dedication and accountability among county agencies in examining their own practices for responding to domestic violence;
- Improvements in how individual team members carry out their duties in the field, based upon what they learn during team meetings;
- Increased outreach among county agencies to Native American and Latino groups;
- Improved working relationships among county agencies;
- Successful implementation of DVDRT recommendations; and
- Increased community awareness about the complexity of domestic violence relationships.

DVDRT Frustrations and Recommendations for Improving DVDRT Operations

- Teams identified the following frustrations concerning the operation of the DVDRT:

Lack of sufficient funding;

Lack of sufficient time to dedicate to each case review;

Difficulties in accessing family court and shelter information, and lack of involvement by victim/perpetrator family members in the review process;

High turnover of team members resulting in more inexperience and less dedication among team members;

Difficulties in scheduling regular meetings due to schedules and workloads of team members; and

Team members lacking the full support and commitment from the leaders of their agencies.

- Most teams (8 out of 10) felt that it would be beneficial to local prevention efforts if the data collected by county DVDRTs is centralized on a statewide basis. Some of the reasons for centralizing DVDRT data included using the information to support local or legislative reforms and gaining additional insight into “risk factors” for domestic violence deaths. However, teams stressed the importance of ensuring that counties have the freedom to tailor their data collection practices and responses to meet their community’s unique needs. Teams also stressed the importance of analyzing, rather than merely collecting, statewide data and making both county and statewide data accessible to the public.

Most teams felt that it would be beneficial to centralize the data collected by county DVDRTs on a statewide basis.

- Seven (7) out of 10 teams felt that regular regional and/or state meetings would be the most important way to improve DVDRT communication and information-sharing among teams, particularly if funding was available for teams to participate in these meetings. Four (4) teams felt that electronic list serves and/or newsletters would also be beneficial and more cost-effective.
- Teams felt that the actual implementation of DVDRT recommendations was one of their biggest challenges and that significant improvements could be made concerning DVDRT follow-up on recommendations, as well as concerning the willingness among the leaders of member agencies to cooperate in implementation.

DVDRT Recommendations for Improving Legal and Community Responses to Domestic Violence

Teams made the following recommendations for improving legal and community responses to domestic violence:

- Increase domestic violence intervention and education for elementary, middle and high school aged youth, including additional services for children who have been exposed to domestic violence;
- Increase anger management services and resources for youth;
- Increase community education on domestic violence, including education aimed at increasing reporting by informing family, neighbors, friends, employers and co-workers, etc. about the risk factors for domestic violence homicide;
- Increase training on domestic violence for law enforcement and judges;

- Transform the language concerning domestic violence from being a “woman’s issue” to a “human rights” issue;
- Improve “first response” to domestic violence calls by local agencies, including reports of child abuse;
- Improve policies and procedures within hospitals for screening for domestic violence, and increase training on domestic violence for emergency medical personnel;
- Develop protocols for law enforcement and child welfare agencies concerning the co-occurrence of domestic violence and child abuse;
- Increased outreach to communities with language and other barriers to accessing services; and
- Establish more proactive policies and practices aimed at removing firearms from domestic violence offenders.

Independent Domestic Violence Homicide Reviews

CWLC surveyed the directors of the two primary organizations that currently conduct independent domestic violence death reviews in California (the Purple Berets and Women’s Justice Center) to assess the current practices and concerns of organizations and individuals involved in independent reviews.

Establishment of Independent Review

- Both organizations began conducting grassroots, independent reviews of domestic violence murders in response to a particularly

Independent domestic violence death reviews are not supported by government funding or resources.

heinous case that occurred in their county that involved a long history of reported domestic violence by the victim. At the time of this murder, there was also no established DVDRT in their county.

- Prior to their review of this murder, both organizations had completed numerous investigations of non-fatal domestic violence cases involving faulty law enforcement and prosecutor responses.

Funding of Independent Reviews

- Both organizations are funded purely by private donations and grants. Neither organization receives any local, state or federal government funding.
- Both organizations cite their lack of financial and other ties to government as contributing to a more advocacy-based, and less government-biased, review of domestic violence deaths.

Case Selection

- Independent reviews are conducted on an ad hoc basis, and the decision about whether a case will be subject to review is motivated by the personal choice of the reviewer.
- Independent reviews primarily involve domestic violence homicides and murder-suicides, as opposed to individual suicides and domestic violence-related fatal accidents.
- Most often, reviewers have a personal connection to the case (i.e., are a friend or relative of the victim) or have read news articles about a case that highlights a history of agency inaction concerning domestic violence.

- Like government-sponsored reviews, the number of cases that an organization or individual is able to independently review depends largely on their available time and financial resources.

Case Review

- Independent reviews are conducted on an individual, rather than a team, basis. Sometimes the person conducting the review will have the help of other people, but no formalized team structure exists for conducting such reviews.
- Both organizations provide written protocols and guidelines for conducting independent reviews on their websites, and use these protocols/guidelines in conducting their own reviews. The protocol/guidelines were composed from the personal experience of the organizations' directors in investigating domestic violence homicides.
- Reviews often start with a search of public records. Although there is generally no "closed case" policy for conducting an independent review, a search of public records is typically more effective after a criminal trial has been completed.
- Independent reviewers use confidentiality agreements in conducting interviews with witnesses, agency representatives and public officials in order to ensure that they are getting complete information about the case, as well as to maintain their credibility and working relationships with those involved in the case.

Like DVDRTs, independent reviewers utilize written protocols and confidentiality agreements to conduct their domestic violence death reviews.

Independent reviewers use the data gathered from their case reviews to advocate for systemic reforms.

Data Collection and Reporting

- The information gathered from an independent review is typically documented in a written narrative and/or chronology detailing events leading up to the murder/murder-suicide.
- Both organizations have used the information gathered from their reviews to advocate for systemic reforms by organizing public demonstrations, conducting media campaigns about the case, filing complaints with offending agencies, and filing civil rights lawsuits.
- Due to the relatively small number of independent reviews, as well as individualized styles of reporting, centralizing the data collected from these reviews is not a major concern of independent reviewers. However, one organization suggested that centralizing government data on these murders would be beneficial assuming that these deaths are being accurately identified by law enforcement and the coroner's office.

Independent Review Successes

- Both organizations identify the major benefits of conducting independent reviews to include the ability to gather and report case information in a way that humanizes the victim, contributes an advocacy-based perspective to domestic violence murders, and exposes specific system and agency failures.
- The organizations' efforts have led to a substantial increase in media coverage on intimate partner murder.
- The organizations used information gathered in one of their

case reviews to file a federal civil rights lawsuit against a local law enforcement agency for failing to adequately respond to domestic violence complaints by the victim, resulting in a \$1 million settlement.

- Independent reviewers have been more successful than government-sponsored review teams in working with the families of victims and perpetrators to investigate and publicize cases, particularly with regard to cases involving immigrant families.
- Although the organizations cited no fewer domestic violence homicides and no greater enforcement of domestic violence restraining orders in their area, they reported having improved relationships with local agencies and positive policy changes, such as the creation of law enforcement domestic violence units, as a result of local attention to domestic violence issues.

Independent Review Frustrations

The organizations identified the following frustrations associated with conducting an independent domestic violence homicide review:

- Lack of sufficient funding and resources, including the inability to hire an investigator and support staff;
- Lack of sufficient staff time to review cases;
- Minimal support and cooperation among local government agencies for grassroots reviews;
- Not enough advocacy organizations and individuals engaging in independent reviews; and

Independent reviewers reported being more successful than DVDRTs in working with the families of victims and perpetrators to investigate and publicize cases.

- Negative impact of political backlash against their organizations from local government officials and agencies that are criticized in their reviews.

Recommendations for Improving Legal and Community

Responses to Domestic Violence by Independent Reviewers

- Both organizations stated that education is not the solution for improving responses to domestic violence. Thus, in this regard, they differed significantly from government-sponsored review teams which placed a strong emphasis on increasing community education on domestic violence. Rather, the organizations believed that change is best achieved by ensuring that there are effective, sensitive people in positions of leadership and service within all agencies responsible for handling domestic violence cases. Their recommendations include promoting agency leaders who are clearly committed to addressing domestic violence, placing more well-trained, dedicated officers in law enforcement domestic violence units, and increasing the number of women who work in criminal justice agencies.

WHERE DO WE GO FROM HERE?

CWLC makes the following recommendations for improving the domestic violence death review in California:

- **Every county in California should engage in some form of regular domestic violence death review.** Death review can provide valuable information on how to better prevent domestic violence deaths from occurring. Yet, while virtually every county in California has a formal, government-sponsored child fatality review team, less than half of the counties have a DVDRT. Counties that are able to establish formal DVDRTs should do so. However, even counties that lack the agency support and resources needed to establish a formal DVDRT should, at a minimum, engage in some informal process (e.g., ad hoc meetings among local advocates and agency representatives when a particularly egregious death occurs) to assess systemic problems concerning domestic violence deaths in their community.

- **DVDRTs should engage in strategic planning and regular evaluations of their case selection and review process to identify ways to improve the focus and efficiency of their operations.** Although some DVDRTs have been in existence for more than a decade, DVDRTs are still a relatively new phenomenon and many teams are still experimenting with different strategies for selecting and reviewing cases. It is important that all teams constantly evolve and identify ways to improve the effectiveness of their membership, protocols and practices. To this end, DVDRTs should set long-term goals and regularly assess team practices to ensure that their reviews are developing in a way that best promotes efficiency, reflects community needs, and produces accurate and useful information about domestic violence deaths.

- **DVDRTs should engage in community outreach and education regarding their findings, recommendations and general domestic violence prevention.** DVDRT Chairs and team members are uniquely positioned to conduct community outreach and education on domestic violence prevention. DVDRTs are responsible for performing some of the most detailed reviews of domestic violence deaths that have ever occurred to date. Moreover, because DVDRTs are government-sponsored, team leaders have a high level of access to, and credibility among, the general community, government officials and political bodies. Nevertheless, only a few DVDRTs currently engage in active outreach and education regarding their findings and recommendations. DVDRTs can take a lesson from grassroots reviewers by placing a greater emphasis on serving as activists and educators on domestic violence prevention in their communities.

- **Increase government funding and resources to support the establishment and development of DVDRTs.** It was not enough to merely pass the 1995 legislation authorizing the establishment of DVDRTs. The work of existing death review teams suffers from insufficient funding and resources. A lack of funding and resources is certainly a reason that other counties have been slow to establish local DVDRTs. The successful growth and operation of DVDRTs requires an increased commitment from state and local government agencies to support the critical work performed by DVDRTS, whether that support comes in the form of actual financial aid or making participation in death review an ongoing and significant job responsibility of agency representatives who work on domestic violence cases.

- **Counties and municipalities should consider utilizing independent consultants to perform domestic violence death reviews.** One way that cities and counties can maximize the objectivity of their domestic violence death review process is to hire independent consultants to conduct these reviews instead of establishing a formal DVDRT. Independent consultants should be knowledgeable about domestic violence issues, the various roles that government and community agencies play in addressing domestic violence, and fatality review standards and procedures.

- **The state should continue to encourage and facilitate collaboration and information sharing among local DVDRTs.** County teams have benefited from state and federal meetings and resources aimed at fostering the development of DVDRTs. Statewide and/or regional DVDRT meetings should be held annually to discuss team trends and strategies. In addition, teams should continue to be encouraged and provided with funding, when needed, to take advantage of national domestic violence death review meetings and resources. The establishment of statewide DVDRT listservs and newsletters are also an important and possibly more cost-effective way to enhance communication and information sharing among teams.

- **The state should establish a system for collecting and analyzing minimum standard data from local DVDRTs.** DVDRTs are able to collect much more detailed information about domestic violence deaths than that which is currently collected through criminal justice data collection systems. For example, DVDRTs can track the number of prior contacts a victim and/or perpetrator had with community agencies and resources, including social service agencies and hospitals. Standardizing and collecting a basic level of data from DVDRT reviews on a statewide level can help the public and policymakers reach a deeper understanding of the dynamics and risk factors of domestic violence death. This data can also be used to support legislative and policy reforms aimed at improving local and statewide responses. The state should examine whether tools such as a standard, statewide

data collection form for DVDRTs would be useful and efficient for collecting death review data. In order to preserve flexibility and autonomy among counties, DVDRTs should still have discretion to collect supplemental information about cases and develop their own data collection forms so long as these forms include the information tracked by the state.

- **Victim advocates and private individuals should be more proactive in conducting independent domestic violence death reviews.** Independent reviews are an empowering way for community members to gain a clear picture of the different agency dynamics and failures that are contributing to the incidence of domestic violence deaths in their county, rather than simply relying on the highly confidential review and recommendation process of local DVDRTs. Indeed, as independent reviews allow for a more transparent evaluation of local agency response, individuals can use these reviews to organize their communities and place significant pressure on local agencies to improve their practices. While grassroots women's organizations have made great strides in conducting and promoting independent reviews of domestic violence fatalities, it is important to strengthen the impact of these reviews by increasing the number independent reviews across the state.

- **Increase financial support and resources for grassroots organizations that conduct independent reviews.** Grassroots organizations that conduct independent reviews experience the same financial and staffing difficulties as county DVDRTs. Because their ability to conduct open and candid case reviews requires that they do not receive any government funding, these organizations need ongoing support from private foundations and individuals in order to continue their work.

- **Communities must ensure that their local government institutions and leaders have strong, ongoing commitments to domestic violence prevention.** The biggest challenge faced by DVDRTs and independent reviewers is securing the implementation of recommendations and reforms identified as a result of their case reviews. Such change is only possible if government agencies, and those who lead them, are truly committed to addressing domestic violence in their communities. Community members and professionals who work in the domestic violence field must be vigilant in ensuring that their elected and appointed public officials have a clear and actual commitment to addressing domestic violence issues, including taking action to hold these agencies and leaders accountable for making domestic violence a priority.

(Footnotes)

1. Scott Martin, *San Francisco Works to Cure Its Domestic Violence Epidemic*, CNS NEWS & FEATURES, available at <http://www.coastnews.com/dv1main.htm>; Ilene Lelchuk, *Brown Proposes System to Track Domestic Abuse: S.F. Woman's Life Might Have Been Saved*, SAN FRANCISCO CHRONICLE (May 16, 2001) at A15; Elizabeth Fernandez, *Fatal Flaw in S.F. Justice: Domestic Violence Blamed on the System*, SAN FRANCISCO CHRONICLE (March 27, 2002) at A1; Elizabeth Fernandez, *S.F. Takes Tougher Approach to Domestic Violence Cases; Woman's Slaying Becomes Catalyst for New Guidelines*, SAN FRANCISCO CHRONICLE (March 28, 2002); Neil Websdale, et al., *Reviewing Domestic Violence Fatalities: Summarizing National Developments*, VIOLENCE AGAINST WOMEN ONLINE RESOURCES, available at <http://www.vaw.umn.edu/documents/fatality/fatality.html#id2634549> at 5-6.
2. Websdale, *supra* note 1 at 23-4.
3. *Id.* at 21-22.
4. Neil Websdale, *Researching Domestic Homicide*, in UNDERSTANDING DOMESTIC HOMICIDE, (Northeastern University Press, Boston, MA. 1999) at 19-23.
5. *Domestic and Sexual Violence Data Collection: A Report to Congress Under the Violence Against Women Act*, NATIONAL INSTITUTE OF JUSTICE, AND U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, July 1996 at 6. The report argues that: "[t]he availability of comprehensive and reliable statistical data on domestic and sexual violence is a critical imperative because decision-makers at the State and local levels are confronting questions concerning appropriate policies and effective procedures for addressing this problem, and they need more information to guide their thinking."
6. Websdale, *supra* note 4 at 2.
7. *Id.* "Like packaged frozen vegetables that have long since lost touch with a field or the earth, homicide statistics and the data sets they become a part of are convenient but usually bereft of flavor. In short, the use of abstracted empiricism to understand homicide produces accounts and explanations that are about as far removed from social life and historical changes as the dead bodies that generated those statistics in the first place."
8. *Id.*
9. *Crime in the United States*, U.S. DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF INVESTIGATION (2003) at p. 3.
10. *Id.*
11. James Fox and Marianne Zawitz, *Homicide Trends in the U.S.: Intimate Homicide*, BUREAU OF JUSTICE STATISTICS (last updated on September 28, 2004), available at <http://www.ojp.usdoj.gov/bjs/homicide/intimates.htm> (accessed August 30, 2005).

12. *Id.*

13. *Domestic and Sexual Violence Data Collection*, *supra* note 5 at 3-4. This study reports that, as of 1996, 25% of states and territories were not collecting data on domestic violence.

14. Title IV, Violence Against Women Act of the Violence Crime Control and Law Enforcement Act, 42 U.S.C. § 40292(a) (1994); EVE BUZAWA & CARL BUZAWA, *Domestic Violence: The Criminal Justice Response*, (Sage Publications, Thousand Oaks: California 2003) at 123.

15. 42 U.S.C. § 40292(a); BUZAWA, *supra* note 14 at 123. The U.S. Attorney General was also required to report on the feasibility of tracking the victim-offender relationship in federal records of aggravated assault, rape and violent crimes.

16. The Bureau of Justice Statistics is a branch of the USDOJ's Office of Justice Programs. It was established in 1979 to collect, analyze and disseminate information on crime, criminal offenders, victims and criminal justice system operations. About the Bureau of Justice Statistics, BUREAU OF JUSTICE STATISTICS, *available at* <http://www.ojp.usdoj.gov/bjs/aboutbjs.htm> (accessed August 30, 2005).

17. The National Institute of Justice is an agency of the USDOJ that conducts research and development on crime control and justice issues, and evaluates existing programs and responses to crime. *What is NIJ?*, NATIONAL INSTITUTE OF JUSTICE, *available at* <http://www.ojp.usdoj.gov/nij/about.htm> at 1 (accessed August 30, 2005).

18. *Domestic and Sexual Violence Data Collection*, *supra* note 5 at 1.

19. *Id.* at 3.

20. *Id.* at 3-4.

21. *Id.*

22. *Id.*; Ramona Rantala, *Effects of NIBRS on Crime Statistics*, NATIONAL INSTITUTE OF JUSTICE, AND BUREAU OF JUSTICE STATISTICS (July 2000) at 1-4.

23. *Id.*

24. *Id.*

25. *Id.*; *Domestic and Sexual Violence Data Collection*, *supra* note 5 at 4;

26. *Id.*; Rantala, *supra* note 22 at 1-4.

27. California has not fully converted to NIBRS reporting as of August 2005.

28. *See Uniform Crime Reporting, National Incident-Based Reporting System, Volume II, Data Submission Specifications*, NATIONAL INSTITUTE OF JUSTICE, BUREAU OF JUSTICE STATISTICS, *available at* <http://www.fbi.gov/ucr/nibrs/manuals/v2all.pdf> (accessed August 30, 2005)

29. *See NIBRS Manual, Conversion of NIBRS Data to Summary Data*, NATIONAL INSTITUTE OF JUSTICE, BUREAU OF JUSTICE STATISTICS, *available at* <http://www.fbi.gov/ucr/nibrs/manuals/conversion.pdf> (accessed August 30, 2005).

30. *Id.*

31. *Domestic and Sexual Violence Data Collection*, *supra* note 5 at 4.

32. *Id.*

33. The National Crime Victimization Survey is administered by the U.S. Census Bureau on behalf of the BJS. *The Nation's Two Crime Measures*, U.S. DEPARTMENT OF JUSTICE (October 2004), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/ntcm.pdf> (accessed August 30, 2005).

34. *Id.*

35. Households remain in the nationally representative sample for three years and are rotated on an ongoing basis. *Id.*

36. See Charles Kindermann, Ph.D., et al., *Effects of the Redesign on Victimization Estimates*, U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, NCJ 164381 (April 1997) at p. 2.

37. *Id.*

38. Callie Marie Rennison, Ph.D., et al., *Special Report: Intimate Partner Violence*, U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, NCJ 178247 (May 2000), p. 1.

39. *Id.* at p. 3.

40. *Id.*

41. *Id.*

42. *Id.*

43. Callie Marie Rennison, *Special Report: Intimate Partner Violence and Age of Victim, 1993-99*, U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, (October 2001).

44. *Id.* at p. 1.

45. *Id.* at p. 3.

46. *Id.*

47. *When Men Murder Women: An Analysis of 2001 Homicide Data*, VIOLENCE POLICY CENTER (2003), available at <http://www.vpc.org/graphics/WMMW03.pdf> (accessed June 28, 2005) at 2. The Violence Policy Center is a national non-profit educational organization that researches and educates on firearm violence and provides analysis for policy makers. The Violence Policy Center used FBI Supplementary Homicide Report as their source of data.

48. *Id.* at 5-8. The 2001 report found that: the homicide rate among female victims murdered by males in single victim/single offender incidents was 1.35 per 100,000; the average age of female homicide victims was 37 years old, 88 percent where race was known were intra-racial relationships; African American women were murdered at a rate over 3 times higher than Caucasian women; women are more likely to be killed by an intimate acquaintance; firearms were the most common weapon used by males to murder females; and most often women are killed by men in the course of an argument.

49. *Id.*

50. *Id.* at 13.

51. *Id.* at 5 and 14.

52. See *Exposure Reduction or Backlash? The Effect of Domestic Violence Resources on Intimate Partner Homicide*, NATIONAL INSTITUTE OF JUSTICE, (January 2001), available at <http://www.ncjrs.org/pdffiles1/nij/grants/186194.pdf> (accessed August 30, 2005).

53. Jane Koziol-McLain, et al., *Femicide Risk: Reconciling Attempted and Actual Models, Address at the 2001 Annual Meeting of the Homicide Research Work Group, Orlando, Florida* (2001). Study included 11 cities and involved 132 actual femicides, 108 attempted femicides, 328 abused controls, and 407 not abused controls.

54. Attempted murder is generally characterized by the victim's survival of either injury to a major body organ (e.g. head, chest), loss of consciousness, or injury to a minor body area (e.g. arms, legs), coupled with a clear intent to kill on the part of the perpetrator. *Id.* at 17.

55. *Id.* at 21.

56. C. Nicolaidis, *Could We Have Known? A Qualitative Analysis of Data From Women Who Survived an Attempted Homicide by an Intimate Partner*, 18 J. GEN. INTERN. MED (2003) at 788-794.

57. *Id.* at 789.

58. *Id.* at 792-793.

59. *Id.* at 791.

60. *Id.*

61. *Id.* at 793.

62. *Id.*

63. This method of examining attempted murder cases has also been used to study the dynamics and risk factors of female-perpetrated intimate femicide. See Nancy Glass, Jane Koziol-McLain, Jacquelyn Campbell, Carolyn Block, *Female-Perpetrated Femicide and Attempted Femicide*, 10 VIOLENCE AGAINST WOMEN 6 (2004) at 606-625.

64. *Homicide in California, 2002*, ATTORNEY GENERAL OF CALIFORNIA (2002), available at <http://caag.state.ca.us/cjsc/pubs.htm> (accessed August 30, 2005) at 11-22; see Cal. Pen. Code § 13020(a)-(c) (2005). Some of the agencies charged with this duty are: chief of police, city marshal, sheriff, coroner, district attorney, city attorney, city prosecutor, probation officer, and every other person or agency dealing with crimes or criminals or with delinquency or delinquents.

65. *Id.* at 11-22; *Willful Homicide Crimes 2003, Precipitating Event: Domestic Violence, County By Victim To Offender Relationship* from CALIFORNIA DEPARTMENT OF JUSTICE, CRIMINAL JUSTICE

STATISTICS CENTER, (2003) (print out of *Precipitating Event: Domestic Violence by Relationship information*, dated July 12, 2004) (on file with author).

66. December 6, 2004 communication with the Special Requests Section of the California Department of Justice's Criminal Justice Statistics Center (on file with author).

67. In addition, the CADOJ's Criminal Justice Statistics Center tracks the number of murders where domestic violence was a precipitating event and is very responsive to community requests for information relating to these murders (e.g., race of victims, weapons used, location of murder, etc.).

68. However, federal researchers have conducted more in-depth analyses of California intimate partner homicide data. See William Wells and William DeLeon-Granados, *Intimate Partner Homicide Project*, available at <http://safestate.org/documents/dh-ca%20iph%20graphs4.pdf> (accessed August 8, 2005). The report notes that rates of victimization have declined steadily for men and women since 1987, with dramatic declines in victimizations of African American men, and that as of 2000, rates of intimate partner murder were significantly higher for African American and Latina women than for Caucasian women.

69. CAL. PEN. CODE §11163.5 (2005).

70. *Id.*

71. CALIFORNIA STATE SENATE, SENATE CRIMINAL PROCEDURE COMMITTEE, SENATE APPROPRIATIONS COMMITTEE, Senate Bill 1230, (Cal. 1995) at 3; see CAL. PEN. CODE §11166.7 (2005).

72. *Id.* at 3-4. This statute was introduced and adopted shortly after VAWA was passed and around the time of the O.J. Simpson trial for the murder of Nicole Brown Simpson and Ron Goldman. There is no mention in the historical legislative materials of the Simpson trial or VAWA as the motivation of this bill. *NOW Says That Despite Not Guilty Verdict, Simpson Trial Brings Important Public Scrutiny to Domestic Violence* (Oct. 3, 1995), available at <http://www.now.org/press/10-95/10-03-95.html> (accessed August 30, 2005); Buzawa, *supra* note 14, at 123.

73. CAL. PEN. CODE §13731 (2005).

74. LEGISLATIVE COUNSEL'S DIGEST, Assembly Bill 2448 (Cal. 1996), available at http://www.leginfo.ca.gov/pub/95-96/bill/asm/ab_2401-2450/ab_2448_bill_960819_chaptered.html (accessed August 8, 2005).

75. *Id.*

76. *The Nature and Scope of Violence Against Women in San Diego*, SAN DIEGO ASSOCIATION OF GOVERNMENTS, CRIMINAL JUSTICE RESEARCH DIVISION (March 2000) at 103, Appendix A.

77. *Id.* at 13.

78. *Id.*

79. *Id.* at 37-76.

80. *Id.* at 79-92.

81. See *National Incident-Based Reporting System (NIBRS), General Information*, FEDERAL BUREAU OF INVESTIGATION, available at <http://www.fbi.gov/ucr/faqs.htm> (accessed August 30, 2005).

82. *Special Report: Intimate Partner Violence*, *supra* note 38 at p. 8.

83. See *National Incident Based Reporting System and Uniform Crime Reporting System Reference Guide*, STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS, DIVISION OF STATE POLICE EXECUTIVE DEPARTMENT (2000) p. 12; *NIBRS Incident Report – Long Form*, STATE OF SOUTH DAKOTA (revised July 2002) p. 4.

84. Jacquelyn Campbell, et al., *Assessing Risk Factors for Intimate Partner Homicide*, 250 NIJ JOURNAL 14 (Nov. 2003) at 18.

85. Telephone interview with Robin Umash, Criminal Justice Statistics Center, Office of the Attorney General, in Los Angeles, California (January 21, 2005) (summary on file with author); CJSC Data Bases (A brief description of 16 databases), OFFICE OF THE ATTORNEY GENERAL, available at <http://caag.state.ca.us/cjsc/statisticsdatatabs/databss.htm> (accessed August 30, 2005).

86. Incident-based reporting sends individual reports on each crime to the statistics center. *Information Bulletin, Subject: California Crime Statistics Reporting*, OFFICE OF THE ATTORNEY GENERAL (2003) No. 03-01-BCIA.

87. Interview with Robin Umash, *supra* note 85.

88. *Id.*

89. *Id.*

90. *Id.*

91. Electronic mail from Sandra Gaarder, Crime and Violence Prevention Center, California Department of Justice, to Emily Austin, CWLC Intern (July 23, 2004) (on file with author).

92. *Id.*

93. *Willful Homicide Crimes 2003, Precipitating Event: Domestic Violence, County By Victim To Offender Relationship*, CALIFORNIA DEPARTMENT OF JUSTICE, CRIMINAL JUSTICE STATISTICS CENTER (2003) (print out of *Precipitating Event: Domestic Violence by Relationship information*, dated July 12, 2004) (on file with author).

94. *Report to the California Attorney General from the Task Force on Local Criminal Justice Response to Domestic Violence*, ATTORNEY GENERAL'S TASK FORCE ON CRIMINAL JUSTICE RESPONSE TO DOMESTIC VIOLENCE (June 2005), p. 86 (The task force recommended that the following key data elements be submitted by local agencies to the state: crime data; age, race and gender of the victim; relationship of victim to the offender; contributing circumstances; presence of weapons;

weapons seized from the abuser; arrest information; filing and prosecution information; issuance of restraining orders; disposition of the case; and whether a batterer intervention program was ordered and successfully completed).

95. *Id.*; *Homicide in California, 2003*, OFFICE OF THE ATTORNEY GENERAL (1995), available at <http://caag.state.ca.us/cjsc/publications/homicide/hm03/cr1.pdf> (accessed August 30, 2005).

96. Reaves, B., Ph.D., et al., *Census of State and Local Law Enforcement Agencies, 2000*, U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, NCJ 194066 (October 2002), Table 4.

97. *Willful Homicide Crimes, 1999; Precipitating Event: Domestic Violence; County by Victim to Offender Relationship*, CALIFORNIA DEPARTMENT OF JUSTICE, CRIMINAL JUSTICE STATISTICS CENTER (on file with author).

98. Gregg Mansfield, *Lawyer Seeks Lesser Charge in Murder Case; Stabbing Death: Attorney for Man Accused of Killing Live-in Girlfriend Argues for Voluntary Manslaughter*, VENTURA COUNTY STAR (June 2, 2000); Amy Bentley, *Witness: Soto Repeatedly Slammed Car into Van; Trial Under Way: Ventura Woman Faces Charges of Killing Her Husband of 15 Years*, VENTURA COUNTY STAR (November 17, 1999); Philippe Shepnick, *Murder-Suicide Suspected in Fire*, VENTURA COUNTY STAR (December 1, 2000) (lists domestic violence murder-suicides occurring in Ventura County from August 1999 through December 2000).

99. See CALIFORNIA DEPARTMENT OF JUSTICE, *supra* note 97; Bentley, *supra* note 98.

100. Gael Strack and George McClaine, *How To Improve Your Investigation and Prosecution of Strangulation Cases*, SAN DIEGO CITY ATTORNEY'S OFFICE, available at http://www.ncdsv.org/images/strangulation_article.pdf (accessed August 30, 2005) at 2. The study was based on 100 cases of strangulation in domestic violence conducted at Sharp Grossmont Hospital emergency room and the San Diego City Attorney's Domestic Violence Unit.

101. Police officers reported no visible injuries in 62 percent of the cases and reported only minor visible injuries in 22 percent of the cases. *Id.* at 2.

102. *Id.* at 2-3.

103. *Id.* at 2.

104. Strangulation accounts for 10 percent of the violent deaths in the United States, and six females are strangled for every male that dies of strangulation. *Id.* at 3.

105. *Id.* at 13.

106. *Id.* at 7-16.

107. *Id.*

108. *County Offices: Sheriff-Coroner-Marshal*, CALIFORNIA STATE ASSOCIATION OF COUNTIES, available at <http://www.csac.counties.org/default.asp?id=143> (accessed August 30, 2005).

109. Julie Lynem, et al., *Husband Jailed in Slaying*, SAN FRANCISCO CHRONICLE (May 20,

2000) at A1; Alan Gathright, *Police Handling of Clues Criticized*, SAN FRANCISCO CHRONICLE (June 24, 2000) at A17.

110. *Transcripts from the Central California Roundtable Discussion*, CALIFORNIA WOMEN'S LAW CENTER, MURDER AT HOME PROJECT (June 20, 2003) at 17-18 (on file with author).

111. *Id.*

112. *Id.*

113. Seymour Moskowitz, *Golden Age in the Golden State: Contemporary Legal Developments in Elder Abuse and Neglect*, 36 LOY. L.A. L. REV. 589, 604 (2003).

114. Evan Stark, Anne Flitcraft, *Killing the Beast Within: Woman Battering and Female Suicidality*, 25(1) INTERNATIONAL JOURNAL OF HEALTH SERVICES(1995) at 43-64.

115. See *Key Questions: What are the products of fatality reviews?* U.S. DEPARTMENT OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, NATIONAL DOMESTIC VIOLENCE FATALITY REVIEW INITIATIVE, available at <http://www.ndvfri.org/> (accessed July 15, 2005); *California's Domestic Violence Death Review Team Protocol*, (2000) CALIFORNIA ATTORNEY GENERAL'S OFFICE, CRIME AND VIOLENCE PREVENTION CENTER, available at http://safestate.org/documents/dvdr_t_protocol.pdf (accessed July 15, 2005), pp. 5-6.

116. Neil Websdale, et al., *Domestic Violence Fatality Reviews: From a Culture of Blame to a Culture of Safety*, JUVENILE AND FAMILY COURT JOURNAL 61 (Spring 1999) at 62.

117. *Domestic Violence Death Review Interview Summary*, CALIFORNIA WOMEN'S LAW CENTER, MURDER AT HOME PROJECT (July 2004) (on file with author).

118. Websdale, *supra* note 116 at 61.

119. *Id.*; Websdale, *supra* note 1 at 21.

120. *Contra Costa County Domestic Violence Death Review Team Report* (March 2003), available at http://www.cchealth.org/special/pdf/dvdr_t_report_2003.pdf at 3 (accessed August 30, 2005).

121. See *California's Domestic Violence Death Review Team Protocol*, *supra* note 115 at 2; *Senate Rules Committee Analysis of Senate Bill 1230*, CALIFORNIA STATE SENATE, OFFICE OF SENATE FLOOR ANALYSES (September 14, 1995).

122. *Violence Against Women Programs: A Strategic Plan for Twenty-First Century San Francisco*, SAN FRANCISCO COMMISSION ON THE STATUS OF WOMEN, (November 1997), available at http://www.sfgov.org/site/dosw_page.asp?id=20177 (accessed August 30, 2005).

123. *Justice and Courage: A Blueprint for San Francisco's Response to Domestic Violence*, SAN FRANCISCO COMMISSION AND DEPARTMENT ON THE STATUS OF WOMEN, available at http://www.sfgov.org/site/dosw_page.asp?id=19835 (accessed August 30, 2005).

124. *Id.*

125. Martin, *supra* note 1.
126. Websdale, *supra* note 1.
127. *Justice and Courage*, *supra* note 123.
128. *Id.*; *Violence Against Women Programs*, *supra* note 122.
129. Rolanda Pierre Dixon, *Final Report, January 1, 2001 – December 31, 2001*, SANTA CLARA COUNTY DOMESTIC VIOLENCE DEATH REVIEW COMMITTEE (February 2002) p. 13.
130. *Id.* at p. 3.
131. California Assembly Bill 1230 (Solis), Chaptered on October 10, 1995.
132. CAL. PEN. CODE §11163.3, et seq. (2005).
133. CAL. PEN. CODE §11163.3(a) (2005).
134. CAL. PEN. CODE §11163.3(d) (2005).
135. CAL. PEN. CODE §11163.3(c) (2005).
136. *California Domestic Violence Death Review Teams*, CALIFORNIA ATTORNEY GENERAL'S OFFICE, CRIME AND VIOLENCE PREVENTION CENTER, available at <http://www.safestate.org/index-print.cfm?navid=352> (accessed August 30, 2005).
137. CAL. PEN. CODE §11163.4 (2005).
138. *California's Domestic Violence Death Review Team Protocol*, *supra* note 115 at p. 3.
139. The Domestic Violence Death Review Advisory Committee consisted of members of existing domestic violence death review teams and representatives of statewide domestic violence coalitions. *Id.*
140. *California's Domestic Violence Death Review Team Protocol*, *supra* note 115.
141. *Id.* at pp. 7-8.
142. *Id.* at Appendix A – E.
143. *Id.* at p. 3.
144. Correspondence with Sandra Gaarder, *supra* note 91; California Attorney General Bill Lockyer, *Working Together to Eliminate Domestic Violence*, CALIFORNIA ATTORNEY GENERAL'S OFFICE, CRIME AND VIOLENCE PREVENTION CENTER, available at <http://www.safestate.org/index.cfm?navid=219> (accessed August 30, 2005).
145. *Id.*; Correspondence with Sandra Gaarder, *supra* note 91.
146. *Id.*
147. Correspondence with Sandra Gaarder, *supra* note 91.
148. *About NDVFRI*, NATIONAL DOMESTIC VIOLENCE FATALITY REVIEW INITIATIVE, available at <http://www.ndvfri.org/> (accessed July 15, 2005).
149. *Id.*
150. Correspondence with Sandra Gaarder, *supra* note 91.

151. CAL. PEN. CODE §11163.5(a) (2005); California Assembly Bill 1230, *supra* note 131.
152. CAL. PEN. CODE §11163.5(c)(1) (2005).
153. CAL. PEN. CODE §11163.5(c)(2)(B) (2005).
154. *California's Domestic Violence Death Review Team Protocol*, *supra* note 115 at p. 18.
155. CAL. PEN. CODE §11163.6 (2005).
156. For purposes of Penal Code §11163.6, intimate partner includes a current or former spouse, fiancé or dating partner. CAL. PEN. CODE §11163.6 (2005).
157. CALIFORNIA WOMEN'S LAW CENTER, *supra* note 117.
158. *California's Domestic Violence Death Review Team Protocol*, *supra* note 115 at p. 15.
159. *Id.*
160. *Id.*
161. CAL. PEN. CODE § 11163.3(e) (2005).
162. CAL. PEN. CODE § 11163.3(e) (2005).
163. CAL. PEN. CODE § 11163.3(e) (2005).
164. California Senate Bill 218 (Solis), Chaptered on October 10, 1999.
165. CAL. PEN. CODE §11163.3(g)(3): "The disclosure of written and oral information authorized under this subdivision shall apply notwithstanding Sections 2263, 2918, 4982, and 6068 of the Business and Professions Code, or the lawyer-client privilege . . . the physician-patient privilege . . . the psychotherapist-patient privilege . . . the sexual assault victim-counselor privilege . . . and the domestic violence victim-counselor privilege"
166. Robin H. Thompson, Esq., *Confidentiality and Fatality Review*, FATALITY REVIEW BULLETIN, NATIONAL DOMESTIC VIOLENCE FATALITY REVIEW INITIATIVE (2002) p. 105.
167. *California's Domestic Violence Death Review Team Protocol*, *supra* note 115 at p. 15.
168. *Id.*
169. *Id.* at p. 16.
170. In addition to being removed from the team, a member's breach of confidentiality may involve acts that would also subject the member to civil or criminal penalties, as well as negative employment actions, under state and federal law.
171. *Id.*
172. *Speak Up – Save Lives, Santa Clara County Domestic Violence Council Death Review Committee Final Report, January 1 – December 31, 2004*, SANTA CLARA COUNTY DOMESTIC VIOLENCE COUNCIL (2005).
173. *Id.* at pp. 15-17.
174. *Id.* at pp. 18-19.
175. *County of San Diego Domestic Violence Fatality Review Team, 2004 Report*, COUNTY

OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY, OFFICE OF VIOLENCE PREVENTION (2004).

176. *Id.* at p. 11.

177. *Id.*

178. *Id.* at p. 9.

179. *Id.* at p. 10.

180. *Id.* at p. iii.

181. *Id.* at 12.

182. *Sacramento County Domestic Violence Death Review Team, Annual Report* (December 2003), available at <http://www.da.saccounty.net/dvDVRT%20Final%202003.pdf> (accessed July 10, 2005).

183. *Id.* at p. 3.

184. *Id.*

185. *Id.* at p. 2.

186. *Id.*

187. *Id.* at p. 3.

188. *Id.* at p. 4 [citing *Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice (Recommendations from the National Council of Juvenile and Family Court Judges Family Violence Department)*].

189. *Id.* at p. 4.

190. *Id.* at pp. 4-5.

191. *Id.* at p. 5.

192. *Contra Costa County Domestic Violence Death Review Team Report*, *supra* note 120.

193. *Id.* at pp. 5-10.

194. *Id.* at p. 10.

195. *Id.*

196. *Id.* at p. 11.

197. *Id.*

198. *Id.* at p. 11.

199. CALIFORNIA WOMEN'S LAW CENTER, *supra* note 117.

200. *Id.*

201. Tanya Brannan, *Investigating Domestic Violence Homicide: A Guide For Women's Rights Activists & Journalists* (January 2003) PURPLE BERETS, available at http://www.purpleberets.org/violence_investigatingdv.htm (accessed August 30, 2005); Marie De Santis, *How to Investigate Domestic Violence Homicide, A Guide for Investigating the Path Leading Up to Domestic Violence Homicides – For Friends, Activists, Journalists, and All Who Care*, WOMEN'S

JUSTICE CENTER, available at http://www.justicewomen.com/cj_investigate_guide.html (accessed August 30, 2005).

202. *Id.*

203. CALIFORNIA WOMEN'S LAW CENTER, *supra* note 117.

204. Tanya Brannan, *Historic Victory in Macias Case*, PURPLE BERETS (FALL 2002), pp. 1-2.

205. *Id.*

206. Marie De Santis, *The Maria Teresa Macias Case, Instead of Helping Me . . .*, WOMEN'S JUSTICE CENTER, available at http://www.justicewomen.com/macias_story.html (accessed August 30, 2005).

207. *Id.*

208. Tanya Brannan, *The Legacy of Teresa Macias . . . Women's 14th Amendment Right to Equal Protection Established*, PURPLE BERETS (July 2000), available at http://www.purpleberets.org/macias_legacy.html (accessed August 30, 2005).

209. *Id.*

210. Tanya Brannan, *Law Enforcement Lies! Cutting Through the Disinformation on the Macias Case*, PURPLE BERETS (2001), available at http://www.purpleberets.org/macias_lawlies.html (accessed August 30, 2005).

211. *Macias v. Ihde*, 219 F.3d 1018 (2000); Marie De Santis, *supra* note 1. The Macias case is discussed in further detail in the section of this report entitled, *Legal Liability of Law Enforcement*.

212. *How to Investigate Domestic Violence Homicide*, *supra* note 201.

213. *Investigating Domestic Violence Homicide*, *supra* note 201.

214. *Id.*; *How to Investigate Domestic Violence Homicide*, *supra* note 201.

215. *Key Questions, Is There A Need For Grassroots Reviews Rather Than Top Down Models?* NATIONAL DOMESTIC VIOLENCE FATALITY REVIEW INITIATIVE, available at <http://www.ndvfri.org/> (accessed August 30, 2005).

216. *California Domestic Violence Death Review Teams*, *supra* note 136.

217. CALIFORNIA WOMEN'S LAW CENTER, *supra* note 117.

218. "Blue suicides" are cases in which a victim commits suicide by intentionally confronting and/or threatening law enforcement in order to provoke them to react by shooting him/her.