

## NDVFR I STAFF

**Dr. Neil Websdale**  
Director  
Phone: 928-523-9205

**Briana Sherinian**  
Program Coordinator  
Phone: 928-523-2355

Editorial Team:  
**Denise Mariscalas**  
**Lydia Wielgus**  
**Sarah Yercich**

National Domestic Violence  
Fatality Review Initiative  
Northern Arizona University  
P.O. Box 15005  
Flagstaff, AZ 86011  
<http://www.ndvfri.org>

## INSIDE THIS ISSUE:

<b>Editor's Introduction</b>	<b>1</b>
<b>Lydia Wielgus</b>	<b>2</b>
<b>Shirley Bostrom</b>	<b>5</b>
<b>Frank Mullane</b>	<b>8</b>
<b>Jerald Monahan</b>	<b>9</b>

## Editor's Introduction

In this edition of the Fatality Review Bulletin we feature four timely articles that preface the upcoming NDVFR I conference to be held in Phoenix, Arizona, August 16-17, 2010. A NDVFR I intern (Wielgus) reports information gleaned from teams across the country. In particular she maps the rapid geographical expansion of fatality review and a deepening of the process to include a wider range of cases, an increasing sophistication with regards to data collection, and a broader array of those people contributing information and insights. We are in the process of editing, organizing and ultimately posting these results onto the website ([ndvfri.org](http://ndvfri.org)). A significant component of these new postings will consist of a plethora of reports from the teams, documenting, among other things, the social changes recommended or made, at least in part, because of fatality review work.

As Wielgus demonstrates, one of the most significant developments in fatality review work has been the increased role of surviving family members. In the second article, Shirley Bostrom, who lost her daughter in an intimate partner homicide, explains the significance of her involvement in the fatality review process. Shirley's article provides a partial response to one of the most commonly asked questions we entertain at NDVFR I, "How do we approach family members and what questions do we ask them?" As Shirley notes, survivors vary tremendously, not in the least because they are human beings at the same time as they are survivors. Put simply, there is no formulaic approach, short cut model, or cookie-cutter set of questions. The limited number of teams that have worked with surviving family members generally report gleaning rich insights, often unavailable from other sources of information. As Shirley's observations suggest, survivors that contribute to the review process tend to report the experience as cathartic, something that can provide a renewed sense of purpose.

Shirley and Larry Bostrom became members of the Connecticut Fatality Review Team, coming to occupy what appears to be a unique role on teams across the country. Our third contribution comes from Englishman Frank Mullane. Frank's involvement in fatality review work stems from the tragic loss of his sister, Julia Pemberton, and his nephew, William Pemberton, both murdered by Frank's brother-in-law, Alan Pemberton. Alan subsequently committed suicide. In the wake of this infamous familicide, Frank agitated the British Home Office to listen carefully to the voices of surviving family members in the process of homicide review. The resulting review, known as the Pemberton Homicide Review (PHR), sets a high standard for meticulous inquiry, detailed reporting, and incisive recommendations. With

regard to family involvement in the review process, Recommendation 19 of the 323 page report notes, "Given the potentially important contribution of family and friends to the review process, the nature and scope of family involvement needs to be clearly established at the earliest opportunity and at all stages of the process."

The article that appears in the Bulletin was originally published, in slightly different form, in the Guardian Online.

The final contribution comes from Police Chief Jerald Monahan. A 30-plus year law enforcement veteran, Monahan heads up the Arizona Governor's Office workgroup on domestic violence fatality review. The Chief has contributed greatly to the rise of fatality review in Arizona. He shares his insights in this piece, emphasizing in particular, the role of collaboration, cooperation, and coordination of resources, ideas and people.

Finally, we hope you'll find these articles useful and we also re-invite you to attend our upcoming conference. Presenters and facilitators include OVW Director the Honorable Susan Carbon, Evan Stark, Connie Sponsler-Garcia, David Adams, Jacquelyn Campbell, Sue Osthoff, Kathleen Ferraro, Barbara Hart, Sarah Buel, David Sargent, Larry and Shirley Bostrom, Frank Mullane and a host of others doing exciting work to help prevent domestic violence and homicide/suicide. As per the last newsletter, if you have any interesting developments in your communities that you'd like to share please drop me at line at [Neil.Websdale@nau.edu](mailto:Neil.Websdale@nau.edu).

Neil Websdale

Director, NDVFR I

This project was supported by Grant No. 2009-X1167 -AZ-TA awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

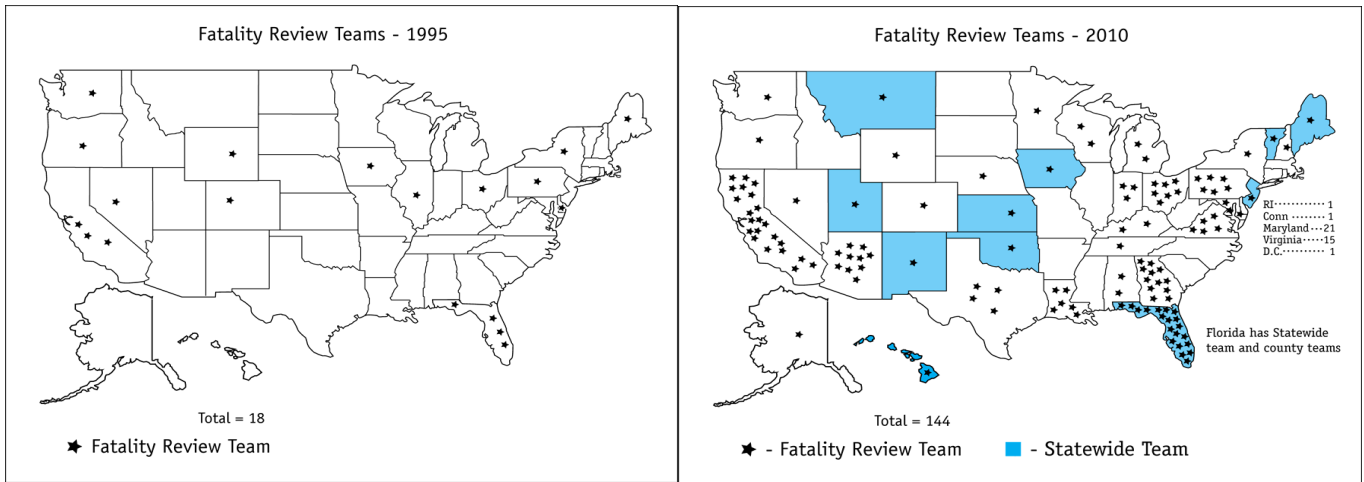
# National Trends and New Developments in Fatality Review

By Lydia Wielgus, NDVfri Intern and graduate student at Northern Arizona University

The number of fatality review teams in the U.S. has increased rapidly throughout the last fifteen years. In 1995, there were 18 established teams and four developing teams in seven states. Between 2002 and 2006 the number of teams increased from 56 to 86 and by 2006 a majority of states were conducting

fatality review work. In the last four years at least 60 new teams formed and at least 40 states perform fatality reviews to varying degrees.

**Diagram: Fifteen Years of Fatality Review in the United States**



## Data Collection Tools

Many teams have expressed a desire to gather data so they can look for patterns and trends and run statistical analyses. As a result, several teams have developed data collection tools. The Miami-Dade team, for example, has developed a comprehensive 267-question data collection instrument to use when they review a case. The tool is divided into sections such as “General Case Information,” “Relationship of Decedent and Perpetrator,” “Medical Examiner’s Office,” “Law Enforcement Involvement,” “History of Domestic Violence Between Decedent and Perpetrator” and many other categories. Under each category, there are a series of questions designed to help the team gather more information about the case. For a link to this form, please click here (Miami-Dade Data Collection Instrument <http://www2.nau.edu/ndvfri-p/wp-content/uploads/florida/DATACOLLECIINSTRUMENT.pdf>).

Many of Florida’s twenty teams use this form to collect data when they review cases. However, some teams have been unable to use the form in its entirety due to time constraints. As a result, Susan DeBeaugrine with the Domestic Violence Program of the Department of Families and Children is in the process of condensing this form to make it easier for teams across the state to use.

In Ohio, the Cuyahoga County team uses a data collection tool amenable to entry into the Statistical Package for the Social Sciences (SPSS). For a link to this form, please click here (Cuyahoga

County) <http://www.ndvfri.org/wp-content/uploads/ohio/Ohio%20Domestic%20Violence%20Homicide%20Data%20Collection%202010%20Final%20Cuyahoga%20Co..pdf>.

The City of Phoenix fatality review team has developed a comprehensive data collection form to help gather data about cases the team reviews. This form is a compilation of data collection forms from other states, which are featured on the NDVfri website. The Phoenix team uses the form to solicit information from a wide array of people involved in the cases, including detectives and surviving family members. To view the City of Phoenix Data Collection Instrument, please click here ([http://www2.nau.edu/ndvfri-p/wp-content/uploads/arizona/Phoenix\\_Data\\_Collection\\_Form.pdf](http://www2.nau.edu/ndvfri-p/wp-content/uploads/arizona/Phoenix_Data_Collection_Form.pdf)).

The Kansas statewide fatality review form was adopted from the Florida Department of Law Enforcement Data Collection Form. The team is currently reviewing the data to determine if cases primarily occur in a particular geographic area, if the perpetrator had a prior history of criminal behavior, or if either the victim or perpetrator experienced any mental health issues. To view the Kansas statewide team data collection form, please click here <http://www.ndvfri.org/wp-content/uploads/kansas/Kansas%20Data%20Form%20Final.pdf>.

For more examples of fatality review data collection instruments, please visit the NDVfri website, <http://www.ndvfri.org/> and click on the Protocols/Tools section.

### Including Family Members in the Fatality Review Process

Many teams have attempted to contact surviving family members and friends in the hope that they may provide insight into the lives of victims that would otherwise not be obtained through document analysis alone. Family members and friends often have knowledge that may be extremely valuable for team members.

However, team members may feel wary about contacting victims for fear that this process can further victimize them. However, many family members report that sharing their stories with an interested, caring listener can be cathartic. Some family members report that contributing to the fatality review process gives them a sense of purpose. Teams who are interested in establishing protocols to guide family involvement may find Appendix G of the Hawaii fatality review team protocol manual helpful (Appendix G-Hawaii) <http://www.ndvfri.org/wp-content/uploads/hawaii/Appendix%20G-%20Family%20Involvement.pdf>

While many fatality review teams across the nation would like to involve family members in the review process, they may be unsure about how to go about making initial contact with family members. One way to reach out to family members is to send them a sympathy card. The Miami-Dade team sends a sympathy card to victim's families as a way to offer condolences and to initiate contact with family members (Miami-Dade Sympathy Card <http://www2.nau.edu/ndvfri-p/wp-content/uploads/florida/SYMPATHYCARD.pdf>). Additionally, the Alaska fatality review team sends a letter of notification to family members which notifies them the team will be discussing the case and encourages them to provide any thoughts, memories, or points of view about the tragic loss of their loved one (Alaska Notification letter to family members <http://www.ndvfri.org/wp-content/uploads/alaska/Alaska-Fatality%20Review%20Letter%20of%20Notification%20to%20Family%20Members.pdf>

Team members may also be hesitant to contact family members because they are unsure what to say to them during the interview. One way to prepare for an interview is to read over case materials so interviewers have a good understanding of the case. Interviewers might start the interview by asking the family member "tell me about (family member); what was he/she like?" Additionally, team members may wish to view the sample interview questions for family and friends <http://www.ndvfri.org/wp-content/uploads/georgia/Georgia%20Questions%20for%20Fam%20and%20Friends.pdf> that the Georgia Fatality Review Team uses during the interview process. In addition, the Oregon fatality review team uses questions that were developed from the Virginia DVFR (Questions from Virginia DVFR Most Appropriate for Family and Friends F:\Oregon\FRT questions for interviews.pdf). Once family members have agreed to speak with team members, it is important to allow adequate time for an interview to take place. An interview may last several hours, and it is important that an interviewer allot sufficient time to allow a family member to tell their full story.

It is important that teams recognize that the perpetrator and the perpetrator's family may also be able to provide a great deal of information about the case that might otherwise remain unknown. Baltimore City's fatality review team uses a family interview sheet to interview perpetrators who are currently in prison for killing their partners <http://www.ndvfri.org/wp-content/uploads/maryland/Baltimore%20City%20Family%20Interview%20Maryland.pdf>

(Baltimore City Family Interview.) This form may be helpful for other teams who may be interested in interviewing perpetrators about the case. (See also, Neil Websdale, "Of Nuclear Missiles and Love Objects: The Humiliated Fury of Kevin Jones," *Journal of Contemporary Ethnography*, August 2010, Volume 39, number 4).

Ultimately, not all family members will want to participate in the fatality review process. However, many may wish to assist with a process that can help them heal while providing invaluable information for the fatality review team.

### Fatality Review and Social Change

As part of the fatality review process, teams make recommendations that may help to prevent domestic violence related deaths. Many fatality review team members are concerned that recommendations will not be implemented and others working in the field wonder if fatality review teams succeed in effecting change throughout the community.

Many teams work very hard to ensure that the recommendations that they make are enacted in a timely manner. For instance, in 2004 the Pinellas County Fatality Review Team recommended in its annual report to "review fatality review team recommendations at least twice each year during regular Domestic Violence Task Force meetings (to remind members and not lose momentum in implementing changes)" (Pinellas County Annual Report 2004 pg. 13). The Domestic Violence Task Force has also formed a recommendations subcommittee. This subcommittee is responsible for addressing recommendations made in the annual reports and ensuring that these recommendations are implemented.

In June of 2000, the Pinellas County Fatality Review Team recognized the need to "increase outreach to senior populations," to provide information for friends and families of victims, and develop brochures to provide information for youths who may be in violent relationships. Pinellas County fatality review data also revealed that African American women accounted for 20% of the fatalities in 2007 (Annual Report 2007 pg. 18). In response to this finding, the team made the recommendation to the task force to "create a brochure that specifically focuses on the high lethality rate for Blacks, find funding for printing the brochure, and then disseminate it appropriately among Blacks" (Annual Report 2007 pg. 22). To ensure this brochure would provide adequate information and present solutions that would be helpful for African American women, the Domestic Violence Task Force prevention committee consulted with African American shelter workers, various community organizations that provided services to African Americans, and churches. The brochure features a section entitled "know the cold hard facts." This section provides statistical information about black women and domestic violence. The second section of the brochure, "check for the signs," provides examples of a partner's actions that may indicate to a victim that they are in an abusive relationship. The brochure also provides suggestions for what a victim can do to seek help and provides phone numbers for several community agencies who can provide assistance for someone who may need help. In 2008, this brochure was created and circulated throughout the community.

Whereas the Pinellas County Team makes specific community recommendations, the Kansas statewide team makes recommendations for the entire state. One of the team's recommendations for the last few years has been to "pass a domestic violence bill which would identify all domestic violence offenders who commit any criminal action" (State of Kansas 2009 Report 2010 pg. 11). In 2010, during the Legislative Session, the Kansas Legislature passed House Bill 2517 unanimously. Governor Mark Parkinson signed the bill on April 12, 2010. This bill "substantially changes the process by which domestic violence is tracked." For example, "it creates a standard definition of domestic violence, the trier of fact to determine if a domestic violence offense was committed and it places a domestic violence designation on the criminal case" (State of Kansas 2009 Report 2010 pg. 11). Additionally, HB 2517 "requires assessments of domestic violence offenders and those that enter into a domestic violence offense diversion agreement and requires the attorney general to adopt rules and regulations regarding the assessment process" (State of Kansas 2009 Report 2010 pg. 11). This bill also has an impact on law enforcement practices. Specifically, HB 2517 "requires law enforcement to make changes to its domestic violence policies" (State of Kansas 2009 Report 2010 pg. 11). Lastly, to ensure that the Kansas Fatality Review Board (FRB) can easily access all domestic violence data that they need, the bill requires that the "Kansas Bureau of Investigation provide domestic violence crime data to the FRB" (State of Kansas 2009 Report 2010 pg. 13).

Additionally, the Fatality Review Board made the recommendation to increase public awareness initiatives. To accomplish this recommendation, the FRB collaborated with the Kansas Coalition Against Sexual and Domestic Violence (KCSDV) to implement the public awareness campaign "Believe It. Help Change It." This campaign consists of video and radio PSAs, billboards, newspaper ads, online ads, and establishing a website, [www.HelpChangeKansas.com](http://www.HelpChangeKansas.com). These sources were displayed throughout the state, and according to the FRB, they "had a tremendous impact on drawing attention to the issue" (State of Kansas 2009 Report 2010 pg. 13).

(Thanks to all fatality review teams who provided information about recommendations and their implementation.)

## Conclusion

Fatality review teams have accomplished much in the past fifteen years. Many new developments have emerged, including the creation of forms and team protocols to aid in the review process. These forms can benefit developing teams who are in the early stages of development. Additionally, many teams are now including family members in the review process. These teams can provide valuable insights to other review teams who would like to interview

family members, but who might be unsure as to how to go about this. As teams continue to develop tools to aid them in the review process, and work closely with those who may be closest to the case, they will no doubt make important recommendations that may save lives in the future. Hopefully, as more teams are established and others continue their important work, teams will make recommendations that result in social change, including the reduction of domestic violence related deaths in their respective communities. Over the next few years, it will be interesting to follow new developments in fatality review as they occur.

## References

- City of Phoenix Fatality Review Team (2008). "2007 City of Phoenix Domestic Violence Fatality Review Team Report" 1-40, available online at <http://www.ndvfri.org/wp-content/uploads/ndvfri/83650.pdf>
- Pinellas County Fatality Review Team (2002). "An Examination of Domestic Violence Homicides in Pinellas County Florida: 2001-2002 Report." 1-7, available online at <http://www.ndvfri.org/wp-content/uploads/ndvfri/60389.pdf>.
- Pinellas County Fatality Review Team (2004). "An Examination of Domestic Violence Homicides in Pinellas County Florida 2004 Report." 1-14, available online at <http://www.ndvfri.org/wp-content/uploads/ndvfri/60391.pdf>
- Pinellas County Fatality Review Team (2007). "2007 Annual Report: Examination of Domestic Violence Homicides and Near Fatalities." 1-25, available online at <http://www.ndvfri.org/wp-content/uploads/ndvfri/60756.pdf>
- State of Kansas Fatality Review Board (2010). "State of Kansas Governor's Domestic Violence Fatality Review Board 2009 Report" 1-16.

# A Survivor's Point of View

by Shirley Pierce Bostrom

## A Survivor's Point of View

As survivors of our daughter's intimate partner homicide, my husband Larry and I have a unique point of view, which we share with Fatality Review Teams (FRTs). Our personal loss and our relationships with other survivors give us a broad view of the variety of survivor reactions. Many survivors are not weak, fragile people defeated by life. They are strong and courageous with a passion to do everything they can to give meaning to their murdered loved one's life and death.

*Remember that every survivor is different. We can't be lumped together. These differences reflect our personalities that aren't changed fundamentally because of a tragedy. If we were self-centered, complainers or blamers before the homicide, we are not going to become advocates for others. Therefore, it may not be helpful to interview some survivors—ever. However, if survivors were rational, reasonable, responsible people before the murder, we will usually be so again, after the initial shock and grief subside.*

*Be ready to listen.* Most survivors need to tell their story over and over as part of the healing process. Your interest and support can help the survivor heal.

During the first three months after the murder, survivors are usually in shock and dazed—not the best time to try to get them to organize and share their thoughts. However, a team member may contact the survivors to express sympathy and tell them about the team, leaving a door open to future contact. One of the co-chairpersons of the Connecticut Fatality Review Team (CTFRT) is a domestic violence advocate and works with the Town of Manchester's Police Department. She becomes involved with the survivors sometimes as early as when the 911 call comes in. Unfortunately, most agencies that provide services to victims of domestic violence lack funds for training and cannot financially support this level of service. Money is always going to be an issue in non-profit agencies, but as a survivor I say, "Find a way." Approximately three women each day are victims of intimate partner homicide. How many could have been kept alive? How many more will have to die before prevention becomes a priority in our society? It is a delicate balance that is skewed against intimate partner homicide victims. Some delays are unavoidable. In a case where the suspect has been caught and arrested and in the criminal justice system, it needs to be adjudicated before FRT involvement can officially begin.

*How the survivors were notified of the death of a loved one sets a tone for future encounters.* A kind and caring messenger may have a positive influence on the survivors' level of trust for any group that

appears official. However, if the notification was impersonal and unsupportive, the survivor may have a negative response. My husband was alone at home when he received a phone call telling him our daughter was dead—murdered. Fortunately, he didn't have a heart attack, he was able to reach another daughter and arrangements were made to bring him to her home.

The fatality review team has no control of how a survivor learns of the death. However, the manner of learning of the death of a loved one impacts how survivors will trust team members. Phone calls should only be used when a better option is not available. Imagine yourself relaxing in your favorite chair; the television news is on, you hear familiar names of streets and neighbors being interviewed. You recognize your daughter's home. Fully alert now, you hear this statement—the name of the victim is not being released at this time.... This survivor might have preferred a call to hearing it on the television news.

*The team member that makes the initial contact with the victim's family needs to stress that the survivors will be helping others—even though they can't bring back their own loved one. Knowing that they are helping to prevent more violence and murder helps most survivors heal. Larry and I first learned about fatality review teams in September of 2000 when I spoke at a Department of Justice Symposium, which met at then-Attorney General Janet Reno's request. I was there to share my feelings with the researchers and domestic violence advocates. Larry and I gave real voices and faces to victims and survivors of domestic homicide, which helped participants make a connection with us, but more importantly to be a little more comfortable when they meet the next survivor. Caregivers make a big mistake if they think all survivors are alike, that they are wounded and can't help themselves and most certainly cannot be a positive force or advocate for victims and survivors. Asking survivors to revisit that devastating time when they learned of their loss is exploitive and inhumane. However, harnessing that pain and loss in a way that it can help others gives us a renewed sense of purpose.*

*Survivors do not like to feel that officials are keeping certain information secret or purposely misleading them. Be honest about your purpose, expectations, their role and what they might get out of it. When Margie was murdered, the FBI agents would not tell us whether Margie was getting into the shower or out of it when she was killed. Their response to all our questions went like this, "You will know what you need to know when you need to know it." If a fatality review team member had called us then, they would have received an extremely negative response. Sometimes waiting to contact the survivors may be wiser. Learn what you can from law enforcement, victim advocates, newspaper reports and other available sources.*



*Try to find out what the survivor's relationship with the deceased was at the time of the murder. Were they close or estranged? Were there issues about lifestyles, etc.? How much guilt or responsibility for the death does the survivor feel—rationally or irrationally? Their insights and answers may reflect their feelings of guilt or anger at the victim for leaving them. When Margie was murdered, we had lost touch with her sister, who depended on Margie for help with her illness. She trusted Margie's love and advice. She felt abandoned by her sister and alone in the world. For the first few years following Margie's death, she would not have been a reliable reporter because she either didn't accept that Margie was dead or blamed herself for the murder. "I should have been there to protect her." "I'm the one who should be dead." They confided in each other as sisters do. After she stopped abusing alcohol and drugs, if interviewed alone, she would have valuable information about Margie's perception of her marriage and any emotional or physical abuse she had endured. She would have shared little in an interview with another family member present, fearing our anger or that she was betraying Margie's trust. It would have helped her heal if she knew the information she shared was confidential and that it might help another abused woman survive.*

*Are the police or the media blaming the victim for contributing to her own death—even indirectly or by inference? These survivors are likely to be less cooperative and open, fearing that what they say may be used against the victim or themselves. In our society, women who are prostitutes and 'party girls' tend to be blamed for their own murders. Many times there are no family members or friends to pursue justice for these women.*

*A trained, sensitive, skilled interviewer who is familiar with fatality review work should interview each family member or friend of the victim alone. This will help avoid volatile family interactions regarding the victim and the murder. The interviewer will also be assessing the survivor's mental and physical condition and ability or willingness to communicate further with the group. Trust and confidentiality are essential. Listen to each survivor's expectations and be honest about whether these issues will or can be discussed by the team.*

*Survivors want to know what the team learned. One way to share information is to invite survivors to a team meeting, or part of one, where the team shares how the survivors' contributions have helped the team better understand intimate partner homicide. If the team has concerns about what to tell the survivors, they should discuss the issues and reach agreement on the troubling details before meeting with the survivor. The team facilitator should set boundaries and expectations for this meeting and these should comport with any statutory guidelines or requirements.*

*No blame. Another way to share findings is for one person or a small group from the team to meet with the survivors. If team members have any doubts about how to proceed—take the least problematic path—meet one-on-one. If the person who conducted the initial interview still has a positive relationship with the survivor, that person should report the team's findings. When a survivor asks a question that you fear will cause them more pain or suffering, it is best to let them know that the answer may be painful for them to hear. Be ready, most survivors will want to know everything they*

can. If you are still uncomfortable about giving an answer that you think will be hurtful, remember what this survivor has been through already: he or she has heard that his or her daughter is dead, killed by someone who said he loved her—someone who was part of the family—endured a funeral, emptied her home, and assumed responsibility for her children and pets. Believe me: if they say they can handle it, they can. Survivors, by definition, are resilient and persistent. The trust the FRT is able to build with survivors often empowers survivors to become advocates for victims.

At least one permanent member of the team is usually qualified to be the team's contact with the survivors. Social workers, psychologists and nurses are often trained in family relationships, domestic violence and homicides. If no one is qualified, the team needs to provide appropriate training for at least one team member.

If the team finds that a police officer, nurse or a victim advocate already interviewed by the team has a special rapport with a survivor, ask that person for help. You may ask them for advice on how to approach an interview with a certain survivor or you may ask them to conduct the interview and/or the informational meeting to share what the team will recommend.

Teams need to agree on what will be included in their reports and develop a procedure that reassures the survivors that confidentiality rules and regulations have been followed. Recommendations will not include information that can identify the victim or survivor.

Larry and I brought the idea of a CTFRT to the Connecticut Coalition Against Domestic Violence and have served as permanent members of the team from the beginning. Other teams may want to have select survivors, who are not involved with the cases to be reviewed, on their team, to give a survivor and victim's perspective. That is one of Larry's and my roles on the CTFRT.

We also send a letter to survivors, on team stationery, to introduce ourselves as survivors and members of the CTFRT. We ask for their help. If (a) survivor(s) is (are) receptive, we meet and discuss the team's purpose and how the survivor can help. I also give them a copy of *Funny—He Doesn't Look Like A Murderer: But Margie Is Dead*, which is our story. This helps to establish a relationship and opens a dialogue about the crimes. As Margie's mom and dad, the fatality review team has become an important part of our healing process. At times, the enormity of the task is daunting, but we know that Margie, a PhD in Clinical Psychology, is guiding us and neither she nor we are ready to stop working to end domestic violence. We thank everyone who is helping our dream come true—no more intimate partner homicide.

# The Victim's Perspective should permeate domestic violence murder reviews

by Frank Mullane

An earlier version of this article was published in The Guardian Online ([guardian.co.uk](http://guardian.co.uk)), Sunday April 25, 2010.

The government recently issued interim guidance on undertaking domestic violence homicide reviews. Presented to Parliament in 2004 as section 9 of the Domestic Violence Crime and Victims Act, these reviews are not yet in force but many areas are undertaking them.

Following personal tragedy, I inquired widely about responses to these murders, including talking with experts about "fatality" reviews in the US and "death" reviews in Canada. In 2008, the Pemberton Homicide Review into the murders of my sister and nephew was published. Later, I was offered a role contributing to the review model, including this interim guidance.

The UK legislation states that the purpose of reviews is to identify lessons to be learned. That certainly means fixing problems with current services but it's also an invitation to identify new ways to protect people. If the reviews have a broad outlook and input from a range of sources including the families, perhaps of the perpetrator as well as of the victim, it's more likely that innovation will occur.

This approach means reviewers may access where those being abused are sharing information. The Pemberton Review, described by Professor Neil Websdale as a "landmark achievement" setting a "gold standard," included interviewing the perpetrator's employer, the family's general practitioner and the family and many friends of the victims, as well as approaching the Catholic Church.

These people may hear about the abuse well before any criminal justice agencies, but will almost certainly not recognize the level of risk. Although we had made many strenuous efforts to engage police, when my sister reminded me, 10 days before the murders, that her husband Alan was coming for her, I replied that he wouldn't do it while I was alive. We should spread knowledge of risk factors to help communities begin to conceive safe and early interventions.

Families can help professionals to see the tragedy through the victim's eyes so they can understand the context in which victims made decisions. A strong theme of fatality review development in the US is that until this perspective is taken effectively, public bodies

may still design services based on what they believe they can offer rather than what is required.

Critically, family and friends may hold information that public bodies are unaware of, for example contact made with agencies where no records were made.

Meeting families bereaved in these tragedies can help reviewers to appreciate and engage with the huge emotional toll of domestic violence. Professionals shouldn't miss the opportunity to inform their thinking with these perspectives.

The UK government recently set up the National Victims Service partly to help secondary victims of homicide. Participation in reviews may help these people too. So far, they are usually held in private with limited publication of the findings. This allows families to disclose more than they might at an inquest that is public. It may satisfy their needs to tell someone their story and to feel they have done their bit to help others – without being exposed publicly.

The victim's perspective should permeate these reviews throughout, and they should take place after every domestic violence murder. It's not just about preventing murder but increasing understanding so other victims can be helped to become free of abuse. We should review some suicides, serious injury and near misses too, so we can avert tragedy without having to study one first.

Comprehensive, fearless and thorough reviews should conceive action plans that are clear and capable of being tracked. Readers should simply be able to follow actions that address findings of the review and which lead to defined outcomes that better protect vulnerable people.

# Arizona's Domestic Violence Fatality Review Initiatives: the Importance of Networks, Partnerships and Relationships

**By Chief Jerald L. Monahan, Apache Junction Police Department  
Chair, Governor's Commission Task Force on Fatality Review**

Arizona's interest in domestic violence-related deaths dates back at least a decade. Grant funding provided by the Violence Against Women Office produced two Arizona Coalition Against Domestic Violence (ACADV) publications: *The Arizona Domestic Violence Fatality Review: A Review of 2000 & 2001 Murder Suicides* and the *Arizona Domestic Violence Fatality Report: A Review of Domestic Violence Related Deaths from 2005 – 2007*. See [www.azcadv.org/domestic-violence-info](http://www.azcadv.org/domestic-violence-info).

During the summer of 2003 Arizona Governor Janet Napolitano charged the Governor's Commission to Prevent Violence Against Women with creating a State Plan on Domestic and Sexual Violence (Arizona State Plan, 5). Over 150 individuals from around the state participated in the creation of the plan. Thirty of those were from the law enforcement community, while the rest were from a variety of agencies and organizations that worked with and had a concern for victims of domestic and sexual violence. The Arizona State Plan became the centerpiece for all the parties involved in addressing these important issues. The plan contained 56 recommendations, one of which encouraged local communities to develop fatality review teams.

The formal partnerships at the state level involved the AZCADV, The Governor's Office for Domestic Violence Prevention, and the Arizona State Agency Coordination Team (SACT). The SACT is made up of ten state agencies, all of which have a role in serving victims of sexual and domestic violence. By meeting on a regular basis, the members were able to coordinate services, share resources, and more effectively address the needs of those victims (Napolitano, 2006). The SACT continues to meet and fatality review comprises one of its strategic goals (SACT Annual Report, 2008).

The strength of the partnerships and working relationships were formed prior to coming together to work on this project. This carried the draft work of the plan forward to fruition in spite of the differences of opinions about one strategy or another.

Legislation authorizing the creation of teams through local units of government and protecting the fatality review process from litigation was passed in 2004 (Arizona Revised Statute § 41-198). This was a significant victory for the movement as prior to this, teams that attempted to form and conduct reviews were told by their legal advisors not to participate unless the process was confidential. Significantly, the National Domestic Violence Fatality Review Initiative (NDVFRI) held a fatality review training conference

in Phoenix. The conference encouraged team formation and ensured the prominence of the idea of fatality review as a preventive intervention.

The City of Phoenix and Pinal County teams (formally recognized by their local units of government as per the state law) emerged following the passage of the legislation and the NDVFRI conference of 2004. Both teams began review work, producing reports in 2007. The City of Phoenix 2007 report is available at the following web-address: <http://phoenix.gov/CITZASST/facdomvio.html>.

During the summer of 2008, the Governor's Commission to Prevent Violence Against Women reorganized under the leadership of Chairperson Vikki Shirley, First Lady of the Navajo Nation. The Commission selected several of the 2004 State Plan recommendations to focus on. DVFR development was one of those selected and a workgroup under the Governor's Office Division of Women was formed. This workgroup focused on building from the foundation of the earlier efforts and enlisting the assistance of many interested individuals from around the state to move this recommendation forward. The initial workgroup meeting held November 6, 2008 at the state capital kick-started several of the teams that formed in 2009.

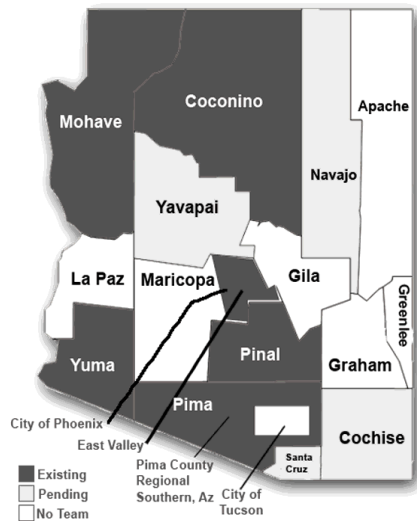
The workgroup recognized the importance of not being viewed as trying to dictate how local communities and regions would develop and implement teams. Many of the individuals invited to this meeting were active in the earlier efforts to have DVFR work in their region of the state, or they were identified as leaders in their region who cared about domestic violence-related issues. The combined qualities of leadership and passion for the topic were considered in the selection of attendees. Locating and inviting those individuals who could and would go back to their communities and champion this effort was crucial to later success. Over sixty individuals were invited, with thirty-five from nine counties attending. Both the City of Phoenix and Pinal County DVFR members gave presentations. Representatives from the AZCADV and the Governor's Office Division for Women offered support and direction, as did Dr. Neil Websdale of NDVFRI and Dr. Kathleen Ferraro.

In the wake of these developments, Arizona experienced a renewed interest in reviewing domestic violence-related deaths. In 2009, the Town of Sahuarita, a southern Arizona community located north of the border city of Nogales, approved their police department to form and manage a multi-jurisdictional team. Law



enforcement leaders from the northern Arizona city of Flagstaff partnered with Coconino County leaders to form a joint city/county team. The border county of Yuma in the extreme southwest part of the state formed a county team, as did Mohave County in the extreme northwest part of the state.

### Arizona DVFRT in existence as of May of 2010



The Chief of Police of the Town of Sahuarita is one example of an attendee at the initial workgroup meeting in November 2008 returning to a local community and championing the cause. Sahuarita Police Chief John Harris persuaded the Town of Sahuarita Council to approve a resolution authorizing his police department to lead a multi-jurisdictional effort in Southern Arizona. Chief Harris was aware that the Town of Sahuarita did not have many domestic violence-related death cases in their files. He saw the value of his town being a part of a larger effort, knowing that the entire region would benefit from these reviews. Coincidentally, following the November meeting of 2008, the Town of Sahuarita experienced a domestic violence-related murder-suicide. A man murdered his wife and then committed suicide. Both parties were correction officers and trained firearm and defensive tactic instructors. In a DVFRT orientation, Chief Harris pondered whether he or his department could have prevented the deaths.

This year commenced with team number seven in the works. Several large cities in the eastern part of the Phoenix metropolitan area joined forces through Inter-Governmental Agreements (IGA) allowing their police agencies, under the leadership of the East Valley Police Chiefs Association, to conduct DVFR work. This team was approved individually by the various city councils, and formally adopted by the East Valley Police Chiefs Association at their May 2010 quarterly meeting in Apache Junction.

With the addition of these teams around the state, individuals who come together at various meetings have discussed the needs and desires that exist in their regions. This has led to planning meetings and orientation visits by Dr. Websdale, Stephanie Mayer of the Arizona Coalition Against Domestic Violence, and the workgroup chair-

person for the Governor's Office Division for Women. These meetings were held in the state's southern border counties of Cochise and Santa Cruz, and to the eastern and central mountain regions of Navajo and Yavapai counties. Discussions are on going between the City of Tucson and Pima County, as well as the Western cities of the Phoenix metro area to form additional review teams.

Review teams formed and operated in ways that met the needs and desires of the local community. The state statute provides general guidance and also has specific requirements about reporting and team formation by the local unit of government. However the statute also recognizes the need for team autonomy. There are several different fatality review models in Arizona. Having teams operate with local control was recognized as an area of concern early on by the workgroup. At one meeting the chairperson was told by a community leader that they did not need "any do gooders" telling that community how to do their job. Although a temporary setback, this incident reminded us of the need to stress local autonomy. The job of the workgroup, as stated in the state plan, was to encourage local communities to develop and implement DVFRT, not to dictate to anyone how their team should form and operate.

The networks that exist in Arizona have proven to be invaluable to the rapid growth and success of fatality review. Involved individuals from around the state assist each other by sharing their reports and council action documents such as resolutions and inter-governmental agreements. They also share their experiences, emotions and commitment to stopping domestic violence in Arizona. These individuals are passionate about this work but, just as important, they are leaders and people of influence in their local communities. They are the champions of this cause and are directly responsible for the successful growth of DVFR in Arizona.

The Arizona story continues to evolve, with efforts to form a statewide oversight body, currently underway. This body is not to dictate to the existing teams, but to be a resource and have the ability to combine the efforts of the various teams so that each may learn from the efforts and review work of others. Through this oversight committee, fatality review work done in one part of the state would therefore benefit other parts of the state as well inform legislative and policy change.