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New York State Domestic Violence Fatality Review:

Report to the Governor and Legislature

NEW YORK STATE

Office for the Prevention of Domestic Violence

Contents

New York State Office for the Prevention of Domestic Violence

The Office for the Prevention of Domestic Violence (OPDV), created in 1992, is the country's only Cabinet level executive state agency dedicated to the issue of domestic violence. It replaced the former Governor's Commission on Domestic Violence established in 1983. Our mission is to improve New York State's response to and prevention of domestic violence with the goal of enhancing the safety of all New Yorkers in their intimate and family relationships. Through its work, OPDV strives to ensure Statewide domestic and gender-based violence service delivery is survivor-centered, trauma-informed and culturally responsive.

DEDICATION

The New York State Domestic Violence Fatality Review Team would like to dedicate this report to the individuals who have lost their lives to domestic and gender-based violence, to their surviving loved ones, to those individuals who continue to live with abuse every day, and to the responders and service providers who work to end domestic and gender-based violence in our communities.

FROM THE EXECUTIVE DIRECTOR

As Executive Director of the NYS Office for the Prevention of Domestic Violence, I am pleased to present this report of the NYS Domestic Violence Fatality Review Team. The team has worked diligently to thoroughly examine cases from across the state, keeping OPDV's three pillars of being survivor-centered, trauma-informed and culturally responsive, at the heart of each one. This work is intense, in-depth, interdisciplinary, and confidential. These case reviews reveal important lessons, and the findings inform our current policy recommendations to the Governor and the Legislature. This year, the Governor made responding to and combatting domestic violence a priority, investing $35 million to implement the Statewide Targeted Reductions in Intimate Partner Violence (STRIVE) initiative, to improve the public safety response to intimate partner abuse and domestic violence, and committing a recurring $5 million each year in immediate cash assistance to help survivors combat financial barriers to safety, known as the Survivors Access Financial Empowerment (SAFE) program. I thank the Governor for her support and encourage our community partners to use the findings in this report to better serve survivors and help us save lives.

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1 Accurate as of October 10, 2024

OVERVIEW OF THE NYS DOMESTIC VIOLENCE FATALITY REVIEW TEAM

Created in 2012, pursuant to NYS Executive Law §575 (10), the NYS Domestic Violence Fatality Review Team analyzes domestic violence deaths and near-deaths in a collaborative and in-depth manner. The purpose of this work is not to assign blame for the death, but to learn from these difficult cases to improve the overall response to domestic violence in New York State. We hope such improvements may help prevent similar outcomes in future cases.

The team is led by the NYS Office for the Prevention of Domestic Violence and is comprised of representatives from state and local agencies relevant to domestic violence, including law enforcement, domestic violence and crime victim programs, legal services, sexual assault and health services. The team reviews case records and will conduct interviews with family members and offenders, if those individuals are interested in providing information to the team.

The information from the records and interviews is used to create a detailed timeline. This timeline does not focus only on the homicide; rather it incorporates relevant information such as previous relationships, criminal history in addition to the domestic violence, and incidents leading up to the homicide. The team uses the timeline to guide its review of the case.

2 DCJS, Uniform Crime Reporting File (as of 08/12/2024). Since 2008, DCJS has been publishing annual statewide domestic homicide reports. Please see the full reports for additional information: https://www.criminaljustice.ny.gov/crimnet/pubs.htm

3 United States Census Bureau: Quick Facts: New York, United States. Accessed 10/22/24. https://www.census.gov/quickfacts/fact/table/NY,US/PST045223

Intimate Partner Homicide in New York State

According to the NYS Division of Criminal Justice Services (DCJS),[2] during the 5-year period from 2018–2022:

- There were 613 domestic homicides in New York State, with 313 perpetrated by intimate partners.
- Intimate partner homicide made up 9% of all homicides statewide.
- 79% of victims of intimate partner homicide were female, 20% were male, and 0.3% were unknown/missing.
- Of all women over age 16 killed, 40% were killed by an intimate partner, as opposed to 2% of men of the same age.
- The weapons used in intimate partner homicides were: 45% knives/cutting instruments, 34% firearms, and 21% other weapons.

RACE AND ETHNICITY

In New York State and nationally, intimate partner homicide disproportionately affects women of color, especially Black women. Among victims of intimate partner homicide in New York State between 2018 and 2022, 35% were White, 33% were Black, and 25% were Hispanic, while current Census data shows that New York State's population is 69% White, 18% Black and 20% Hispanic.[3] Because it is important to recognize the systemic inequalities that contribute to this disparity and consider them when crafting policy solutions, the Fatality Review Team intentionally grounds reviews in an understanding of the cultural issues involved in its cases. This is achieved by receiving education from experts, ensuring culturally responsive providers are represented in the team's interaction with local responders, and working to maintain a team that reflects the diversity of New York State and its residents by prioritizing the recruitment of representatives from historically marginalized communities.

Reviews are conducted in the location where the death or near-death occurred. Responders who were involved in the case are invited to meet with the team to discuss their roles and help the team answer any questions arising from its review of case records. The team sends follow-up information to meeting attendees, which can include recommendations based on the group discussion.

The work of the team is strictly confidential. The team does not make public which cases it reviews or where reviews are conducted, and requires local responders who participate in reviews to maintain that confidentiality. As such, team members and any local responders who meet with the team sign confidentiality agreements. Any information made public by the team is not case-specific.

*In the U.S., Black women are **six times more likely** to be killed than their white counterparts, and an estimated **51%** of Black women's homicides are related to intimate partner violence.*

http://www.thelancet-press.com/embargo/FemaleHomicideUSA.pdf

https://assets.speakcdn.com/assets/2497/dv_in_the_black_community.pdf

FATALITY REVIEW CASES REVIEWED

The team generally conducts four reviews per year and has reviewed 35 cases in total as of June 2024. Cases are either chosen by the team or referred by outside individuals/entities. Cases that are referred are given priority.

According to the enabling statute, cases reviewed by the team must involve deaths or near-deaths caused by a family or household member (as defined in Family Court Act §812 or Criminal Procedure Law §530.11) and must be closed.

The team selects its cases based on factors including case dynamics and location. Because New York is a geographically diverse state, it is important to review cases from all the different regions across the state, from densely populated urban environments to rural communities, and everything in between. The team also tries to review cases with as many different issues and dynamics as possible (e.g., cases involving older individuals, LGBTQIA+ individuals, immigrants, and domestic violence victims who kill their intimate partners, as well as cases where officers are involved and cases that take place on college campuses and in the workplace).

The team reviewed 10 cases since issuing its last report in June 2021. Cases were reviewed between September 2021 and June 2024.

Since the team often selects cases based on verifiable systems involvement and other factors, cases reviewed do not represent a random sample of domestic violence homicides. As such, the team's findings are for informational purposes and should not be viewed as representative of all domestic violence-related homicides.

LETHALITY INDICATORS

Lethality assessment involves the use of commonly recognized evidence-based indicators to determine if a domestic violence victim is at an increased risk of being killed by their intimate partner. Lethality assessment tools, such as Dr. Jacqueline Campbell's Danger Assessment and variations thereof, are used by some domestic violence advocates, law enforcement and others in many jurisdictions within New York State. The NYS Domestic Incident Report (DIR), a report prepared by officers when responding to a domestic incident, includes questions designed to help officers assess potential lethality. While

lethality assessments should not be the only method used to determine lethality risk, they are a useful tool when paired with proper training and implementation. Lethality assessments also create the opportunity for professionals and victims to engage in informed conversations about the dangers they may face. This allows professionals and victims to better understand the risk of lethality and identify necessary supports.

The team identifies common lethality indicators uncovered in its review of the records. Some lethality indicators were likely unknown to responders, because the team has access to more complete information after the fatality. However, often these factors may have been discovered if lethality assessments had been conducted, along with referrals to advocates for high-risk victims.

Of the 35 cases the team has reviewed:[4]

- 31 involved a known history of domestic violence
- 23 involved substance use disorder
- 23 involved threats of suicide/suicidal ideation
- 23 involved access to firearms
- 23 involved non-fatal strangulation
- 22 involved the victim expressing fear
- 22 involved threats to kill
- 20 involved a criminal history in addition to domestic violence
- 20 involved separation or attempts to separate
- 19 involved breaking through doors/windows
- 16 involved evidence of escalating violence

In more than half of the cases, the team found previous instances of offenders breaking through doors or windows to reach, or try to reach, victims. The team has not seen this identified in other research as a lethality indicator, yet since it is present so often in the team's cases, it is being tracked as a red flag. The threatening message sent by such violation of physical boundaries is clear, and it leaves tangible evidence that can be documented by law enforcement.

4 The team records lethality indicators identified at any point in the case, including lethality indicators related to previous victims or offenders.

PRIOR SYSTEMS CONTACT

The team identifies the systems victims and/or offenders had contact with before the homicide. Each contact with a system presents an opportunity for victims or offenders to receive assistance that could potentially lessen the risk of a lethal outcome. Understanding where these opportunities exist can be useful to communities as they consider outreach, screening, and intervention. Of the 35 cases the team has reviewed:

- 32 involved contact with law enforcement
- 30 involved contact with the DA's office
- 30 involved contact with the courts
- 23 involved contact with the mental health system
- 18 involved contact with probation
- 17 involved contact with the department of social services (including child protection services)
- 14 involved contact with a domestic violence program

In addition to formal systems, the team notes informal systems involved in its cases. For example, in 31 cases, family and/or friends had some awareness of the domestic violence in the relationship and in 21 cases, there was some involvement with the victim and/or offender's workplace.

In cases in which there was prior systems contact, there was often evidence that systems were operating independently and not communicating with each other. Fatality reviews show that this lack of coordination can put victims at greater risk and allow offenders to manipulate systems and avoid accountability.

FINDINGS:

Highlighted Issues from Cases Covered in This Report

Findings of the team are not offered as a cause of the deaths, but they do provide insight into the many points in a case where interventions and supports could have been offered. Domestic violence cases are complex, and the team's timelines show there are several points over the course of any case where interventions might have been made, services might have been offered, or steps toward accountability might have been taken. Other than the actual murder and the person who committed the crime, fatality review helps make clear that no single event or action is solely responsible for the deaths or near-deaths in these cases. Rather, each individual case can reveal several opportunities to improve response to all cases.

The ten cases reviewed by the team since issuing its last report highlighted several issues and challenges, including:

COORDINATION AND INFORMATION SHARING

While many communities have close coordination and collaboration among local domestic violence stakeholders, that is not always the case. There are varying degrees of coordinated community responses to domestic violence across the state and information-sharing between systems is often challenging. We know that when there is not close coordination, victims can suffer consequences. Additionally, victims may not always understand whether systems' players have confidentiality or legal privilege.

CULTURAL ISSUES

Cases reviewed highlighted various cultural issues, such as:

- ***The disproportionate impact of intimate partner homicide of women of color and trans individuals***
  As discussed above, intimate partner homicide is an issue that disproportionately affects women of color. Research shows that trans individuals may also be at increased risk for intimate partner violence and intimate partner homicide, and at least 20 percent of violent deaths among trans people stem from intimate partner or family violence.[5]

- ***Continued challenges around language access within systems***
  Cases demonstrated the lack of trained interpreters for some languages and dialects,

5 https://everytownresearch.org/freedom-from-fear-of-hate-fueled-violence-preventing-transgender-homicides/

as well as victim concerns using existing interpreters due to fear of their community learning of the abuse. Some responders inappropriately use family members as interpreters to fill this void.

- ***The need for culturally specific training and services based on the unique demographics of communities***

  There is a lack of culturally specific services available for victims and survivors based on the specific demographics of their communities. Similarly, there is a lack of cultural knowledge and awareness based on the unique make-up of communities on the part of responders, and there is often no one locally who can provide training to these entities. Programs that do exist and can provide training are often very small and underfunded, so providing education in addition to serving clients within the community is difficult.

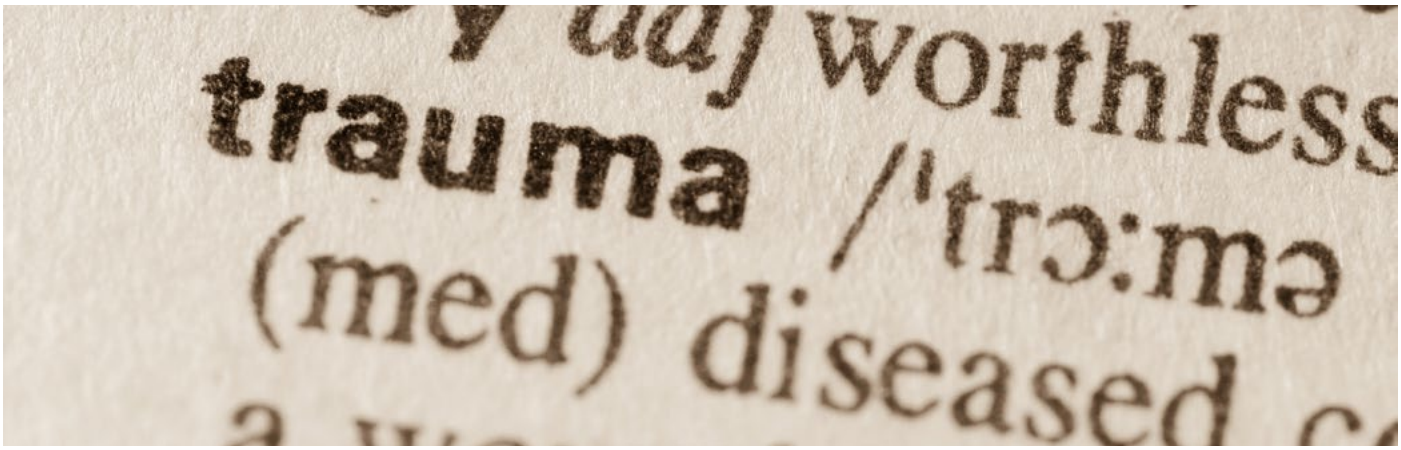
Case clip: In a homicide reviewed, local responders, including police and child protective services, used a family member to interpret for a victim who did not speak English as their first language. When an interpreter *was* sought, the victim requested an interpreter who spoke a dialect different than their own due to fear that members of their community would become aware of the abuse.

WORKPLACE

The cases contained in this report continue to show the prevalence of domestic and gender-based violence in the workplace. The majority of workplaces do not have policies or procedures to address these issues, leaving employees unsure how to assist victims or hold offenders accountable. Even in workplaces that do have policies in place, cases reviewed showed implementation and adherence to those policies to be inconsistent. The absence or improper application of workplace policies creates a safety risk for victims and represents a lost opportunity to provide support, education and resources to employees.

In 2022, Governor Hochul required that all state agencies have a Gender-Based Violence and the Workplace policy. The team encourages local governments and private employers to establish these policies within their own organizations. For more information and resources for both public and private employers, please visit https://opdv.ny.gov/gender-based-violence-and-workplace.

Case clip: In a homicide reviewed, an offender began stalking their partner at work when the partner attempted to end the relationship. They routinely showed up at the victim's workplace and stood outside for several hours staring in at the victim. The offender ultimately attacked the victim at work, killing them in front of other employees and customers.



TRAUMA

Cases continue to show many of the victims and offenders had experienced trauma in their lives, including childhood, racial and generational trauma, prior to the domestic violence. In some cases reviewed, individuals had a history with child protectives services or the juvenile justice system as children.

MENTAL HEALTH AND SUBSTANCE USE ISSUES

Cases reviewed continued to show the consistent presence of mental health and substance use issues. Often providers view domestic violence as the result of these other issues. There seems to be an erroneous belief in some cases that addressing mental health or substance use issues will "fix" the domestic violence and therefore domestic violence-related interventions are not provided.

COURT ISSUES

Several court-related issues were prevalent in the cases reviewed, including:

- ***Arraignment Issues***

  The local responders who met with the team discussed their experience with judges not setting bail in domestic violence cases, even when the charges are bail eligible under the law. Additionally, the team learned that while defense attorneys are now present at all arraignments due to the establishments of Centralized Arraignment Parts (CAPs), prosecutors in many jurisdictions are often not present. This can result in judges making pre-trial determinations for domestic violence defendants without hearing a bail recommendation from the prosecution.

- ***Family Court Orders of Protection***

  Criminal Procedure Law §530.12(3-a) & (3-b), which outlines the ability of Criminal and Supreme court judges to issue or modify Family Court orders of protection when Family Court is not in session, and which could have been helpful in some of the cases reviewed, is rarely used.

  Additionally, there are inconsistencies in ex-parte hearing protocols across the state. Cases reviewed showed victims did not always get an order of protection on the day they filed their petition with Family Court, but rather were given a return date and left without an order of protection until the next court appearance. Other victims may have received a temporary ex-parte order; however, it may not have been timely served by local law enforcement. Since orders are not effective until served on the

other party, issues relating to service of orders can leave victims unprotected and subject to further acts of violence.

- ***Litigation abuse***
  In some cases, domestic violence victims are further victimized by their intimate partners through the weaponization of the court system against them. As their partners manipulate the court system, victims are further abused by being forced to see their partners regularly for court proceedings. Victims suffer from mounting legal bills due to their partners' continued filings against them. This form of abuse and manipulation can happen through similar misuse of other systems as well, such as Child Protective Services.

Case clip: In a homicide reviewed, a victim went to Family Court on a Friday and a stay away order of protection was issued. A new crime was committed on Monday, but the order of protection had not yet been served, resulting in the inability to charge criminal contempt, which would have been available had there been sufficient notice.

LAW ENFORCEMENT AND CRIMINAL JUSTICE

Law enforcement continues to be the most accessed system before the homicide in the cases reviewed by the team. As such, law enforcement must be knowledgeable of the dynamics of domestic violence and also well connected to available resources and services in the broader community. Cases reviewed have shown that mandatory arrest is sometimes inconsistently applied across the state. Domestic Incident Reports (DIRs), a form completed by police every time they respond to a domestic incident, are not always shared as widely as they could be. The DIR Repository is also not as effective a tool as it could be in its current state. For example, there is a lack of non-criminal justice, community-based responses available for individuals who do not wish to access the criminal justice system.

Case clip: In a homicide reviewed, interviews with family members revealed the victim was unwilling to call police to report the abuse because the offender had previously been incarcerated and the victim did not want to be the reason for their children's father to go back to prison. It should be noted that while this was the victim's view, the offender's actions would have been the reason the offender went back to prison.

LETHALITY ASSESSMENT

There is inconsistent use of lethality assessment across the state. In organizations that are conducting lethality assessments, including law enforcement, social services, and domestic violence service providers,

cases reviewed showed there was often unclear direction on how to respond to cases identified to be at an increased risk of lethality.

In 2016, the NYS Domestic Incident Report (DIR) was revised to include several lethality indicators. Current statewide police model policy and training directs officers to use the DIR to assess lethality when responding to domestic incidents. Reviews have shown a lack of understanding that the DIR revision was designed to help officers assess lethality and in some cases, officers said no when asked if they are currently conducting lethality assessment, even though they are completing DIRs each time they respond to a domestic incident.

STAFFING

A lingering consequence of the COVID-19 pandemic is the lack of a stable workforce, and many organizations in this field face challenges hiring and retaining staff. The team heard this challenge many times across the state from multiple systems. Providers are stretched even thinner than they have been in the past and some programs and services that used to exist have been reduced or eliminated. This creates a real gap because if practitioners are assessing cases appropriately and identifying cases as high risk for lethality, staff need to be available to provide assistance in these cases.

ABUSIVE PARTNER INTERVENTION PROGRAMS

Abusive Partner Intervention Programs (APIPs), also known as programs for people who cause harm or batterer intervention programs, are often used as a condition or sanction in domestic violence cases. Local responders report a lack of available programs across the state as well as inconsistency in the types of programs that do exist. There is a lack of evidence-based programming statewide in this space and in its absence, individuals are sometimes referred to inappropriate programs such as anger management that do not adequately address the dynamics of domestic violence. Alternatively, they may not be referred to any program at all.

VICTIM ENGAGEMENT

Case records and interviews with friends and family reveal the importance of responders' interactions with victims and survivors. In many cases, the team heard how a judge, police officer or other responder made a positive impression on a victim by expressing concern, showing compassion or offering assistance. These interactions can help victims feel more confident in their decision to seek assistance and increase the likelihood they will reach out for help in the future.

Case clip: In a homicide reviewed, a victim was sexually assaulted by her partner prior to the homicide. An interview with a friend revealed the police officer who responded to the sexual assault was trained in providing a trauma-informed response to sexual assault victims. The officer's compassionate response helped the victim feel comfortable enough to consent to having photos and a rape kit conducted.

Fatality Review Accomplishments

STATE ACCOMPLISHMENTS

The learning from fatality review continues to have a significant impact in informing and shaping New York State policy changes. The following accomplishments since the team's last report are inspired, at least in part, by the work of the fatality review team:

- The first ever statewide Lethality Summit, "Learning the Signs: Assessing the Risk of Lethality in Domestic Violence Cases," was co-hosted by OPDV and DCJS in October of 2024. The summit brought together approximately 200 representatives from law enforcement and criminal justice, victim services programs, health care, local departments of social services and other systems from across the state, to learn about lethality assessment from state and national experts and examine how to effectively institutionalize the practice into our statewide response to domestic violence.
- OPDV and OMH partnering to provide cross-training for domestic violence advocates and suicide prevention professionals, and OMH bringing greater intimate partner violence awareness and training to county suicide prevention coalitions.
- Enhancements, including the addition of lethality indicators, to the Municipal Police Training Council's Basic Course for Police Officers and the Law Enforcement Domestic Incident Model Policy.
- Insight used to inform and enhance the New York State Gender-Based Violence and the Workplace Policy, training, and technical assistance program established by OPDV pursuant to Executive Order 17.
- Creation of OCA working groups and resource lists on supervised visitation, APIPs, the issuance and modification of orders of protection by criminal courts when Family Court is not in session, and Family Court ex-parte petition and hearing protocols.
- Judicial training on firearm removal and surrender and the recent NYS bail and discovery changes.
- DOH and OPDV social media campaigns focused on becoming a better ally for survivors.
- OASAS, in conjunction with OCFS and OPDV, making overdose emergency response kits available to all residential and non-residential domestic violence programs via their Project COPE initiative, which also provides training on prevention and response to overdoses.
- OCFS became a partner agency with the Safe and Together Institute[6] to expand the Safe &

6 For more information About the Safe & Together™ Model | Safe & Together Institute: safeandtogetherinstitute.com

Together™ Model to all local departments of social services (LDSS) in New York State. In partnership with OPDV, the Safe & Together Model one-day overview is incorporated in the mandated Child Welfare Foundations Program training for all new LDSS case workers. OPDV has provided 94 trainings to over 1,500 new case workers. OCFS has onboarded 24 LDSS counties in the Safe and Together™ Model with nearly 500 LDSS staff trained in the 4-day core in 2024.

- Several widely attended system-specific webinars by OPDV, DCJS and NYS Police based on fatality review team learning for various professionals, such as probation and law enforcement.
- Several presentations based on fatality review team learning at various annual statewide conferences, including the NYS Sheriffs' Institute VINE conference, the NYS Probation Officers' Association conference, the New York Public Welfare Association conference, the NYS Association of Counties conference, the DCJS Public Safety Symposium, and the NYS Adult Abuse Training Institute.
- Several domestic violence-related State of the State initiatives, including:
    - Investing $35 million to implement the Statewide Targeted Reductions in Intimate Partner Violence (STRIVE) initiative, to improve the public safety response to domestic violence offenders.
    - Expanding the DOCCS Supervision Against Violent Engagement (SAVE) program to support closer supervision of parolees at high risk of committing domestic violence, ensuring that specially trained parole officers, who are trained by OPDV and have smaller caseloads, are assigned to these individuals.
    - Establishing the Survivors Access Financial Empowerment (SAFE) Fund to support domestic violence survivors' ability to gain stability by providing flexible microgrants that can be used to cover expenses in emergency situations.
    - Funding for training and technical assistance for community-based organizations to help potential Extreme Risk Protection Order (ERPO) petitioners identify extreme risk behavior and navigate the court process to further increase the use of this critical public safety law.
    - Funding to modernize the use of critical data available to law enforcement when answering domestic calls for service through the NYS Domestic Incident Report (DIR) and expanding the use of the National Incident Based Reporting System (NIBRS) so critical and potentially life-saving information and reports are electronic, shareable, and searchable statewide.
    - Requests for additional funding and updates to public health law to improve the treatment of sexual assault patients in emergency departments.
- The enactment of several OVS domestic violence-related bills such as:
    - Expanding which documents can be used to show identity theft in certain circumstances relating to debt collection (L.2022, c. 238)
    - Expanding Eligibility to Victims of Unlawful Surveillance Crimes (L.2022, c.239)
    - Expanding Eligibility to Victims of Reckless Endangerment Crimes and for Reimbursement of Crime Scene Cleanup and Securing a Crime Scene (L.2022, c.343.)

LOCAL ACCOMPLISHMENTS

In addition to the accomplishments on the state-level, local responders who met with the team reported positive steps taken in their communities stemming from their participation in fatality reviews and the recommendations made by the team, including:

- A parole office establishing a domestic violence-specific caseload and receiving training from state and local partners.
- A department of probation establishing a partnership with the local domestic violence program to institute regular training and establish an abusive partner intervention program (APIP) in consultation with the program.
- An addiction treatment agency instituting trauma-informed training for clinicians and reviewing current client screening with the local domestic violence program to add domestic violence screening questions.
- Several communities conducting training following reviews, such as domestic violence in the LGBTQAI+ community and law enforcement response to domestic incidents.

Recommendations

The team offers the following recommendations based on its analysis:

COORDINATED COMMUNITY RESPONSES

Fatality reviews repeatedly demonstrate the necessity of systems working together in their response to domestic and gender-based violence. The team recommends the state dedicate resources to the establishment or enhancement of these responses, as well as ensure agencies receiving domestic violence-related state funding are supported to meaningfully participate in local coordinated community responses. Further, local government and system leaders should work towards increasing collaboration and coordination between agencies, whether that be through the establishment of high-risk teams, task forces, or other mechanisms. Localities should establish formal agreements to solidify these partnerships and identify the goals of the collaboration.

LETHALITY ASSESSMENT

The team recommends that agencies institutionalize the use of evidence-based lethality assessments in domestic violence cases and establish procedures for response in cases with documented higher risk of lethality. The implementation of these assessments should be accompanied by training and collaboration with local partners, such as domestic violence programs, to

ensure the professionals who are conducting the lethality assessments understand how to administer them in a trauma-informed way and have connections with local community-based organizations to which they can make warm referrals for individuals in need of assistance. Agencies using lethality assessments should have clear policies directing responders' actions in cases found to be at an increased risk for lethality.

Law enforcement agencies should follow the guidance in the Law Enforcement Domestic Incident Model Policy regarding lethality assessment. The policy directs that officers take specific action if victims answer the lethality assessment questions in the victim interview and prior history sections of the DIR in the affirmative. Officers are directed to offer immediate connection to an advocate, either by calling the New York State or a local domestic violence provider hotline to conduct immediate safety planning for the victim, or arranging for an advocate to arrive on scene; consult with the District Attorney's Office prior to arraignment; and to consider utilizing all evidentiary tools to build their case during the investigation. Similarly, prosecutors should be considering lethality assessments in evaluating cases and should endeavor to build strong cases so they have leverage to avoid plea offers or conditional discharges without responsive programming.

PREVENTION

Prevention is an issue that is discussed often in reviews since the team's analysis considers the totality of individuals' lives and experiences, not only the death or near-death being reviewed. Based on this analysis as well as routinely hearing from providers about the vital need for prevention resources, the team recommends the state dedicate funding for primary prevention education and programming. Local governments and boards of education should also explore dedicating funding to develop programming for community members, and school-based programs for youth in particular, to learn about healthy relationship dynamics and resources.

CULTURALLY RESPONSIVE SERVICES AND NON-CRIMINAL JUSTICE, COMMUNITY-BASED INTERVENTIONS

Fatality reviews have demonstrated that certain groups are reluctant to seek services or assistance from traditional response systems. In recognition of the important role they play in many communities, the team recommends the state explore dedicating funding to support culturally responsive domestic violence services, ensuring more equitable access to services statewide. The team further supports funding for the examination and establishment of non-criminal justice, community-based domestic violence interventions and responses. Localities should ensure there are partnerships between culturally responsive community-based organizations and law enforcement, social services, and other systems.

WORKPLACE POLICIES

The team recommends all workplaces implement gender-based violence in the workplace polices that provide clear procedures to assist and support employees who are victims, as well as provide direction on responding when an employee abuses their intimate partner. Workplaces with existing policies should routinely conduct staff training and internal audits to ensure the policies are being correctly applied. Workplaces without existing policies should seek information and assistance in developing and implementing comprehensive policies: workplace@opdv.ny.gov.

ABUSIVE PARTNER INTERVENTION PROGRAM STANDARDS AND OVERSIGHT

As noted earlier in this report, the team continues to hear from responders that while there is a need for programming, there is currently a lack of abusive partner intervention programs, also known as programs for people who cause harm or batterer intervention programs, throughout the state. Similarly, the programs that exist are not always evidence-based or guided by standards. The team recommends the State explore creation of standards for Abusive Partner Intervention Programs, as well as mechanisms for providing oversight. At least one high-quality program should exist in every county.

TRAINING

While much domestic violence training has been conducted, there is a need for ongoing and regular training for professionals responding to domestic violence cases. Training should include:

- Lethality assessment training for all systems, especially police, prosecutors, judges
- Domestic violence training for judges and court staff, including training on orders or protection and changes to New York State bail statutes
- Training on mandatory arrest, primary aggressor and trauma-informed interviewing for police and prosecutors
- Domestic violence training for mental health and addiction professionals
- Training for journalists and members of the media who share stories about gender-based violence on best practices for reporting on these stories, such as including resource information in all articles and maintaining survivor confidentiality

*Training efforts should include **all** responders within each entity and not only those in specialized domestic violence units or with domestic violence caseloads. The team found that in agencies with specialized domestic violence caseloads, such as probation and district attorneys' offices, general practitioners handle as many, if not more, cases than those who specialize in domestic violence.*

SAFE & TOGETHER™

As highlighted in the accomplishments above, the Safe & Together™ Model, created by the Safe and Together Institute, is a model for child welfare professionals that focuses on the following core principles: (1) keeping children safe and together with non-offending parents; (2) partnering with non-offending parents as the default position; and (3) intervening with perpetrators to reduce risk and harm to children. New York State should continue to implement the Safe & Together™ model in child welfare and expand to other systems throughout the state so that system representatives understand the dynamics of coercive control and have the skills to work collaboratively to find solutions that keep children and non-offending parent safe.

STRENGTHENING OUR RESPONSES TO CHILDREN WHO ARE VICTIMIZED

Child Advocacy Centers provide vital response services to victims of child abuse and maltreatment. It is critical that staff in these centers receive training on how to conduct forensic interviewing in domestic violence cases to adequately determine the dynamics in the home and the impact on the child. These centers should also review

their current procedures related to domestic violence and ensure they are taking trauma-informed, survivor-centered, and culturally responsive approaches.

PUBLIC EDUCATION CAMPAIGN

The team recommends a statewide public education campaign to assist individuals to see the signs of domestic and gender-based violence in their own lives as well as the lives of their friends, neighbors, co-workers and loved ones. This campaign should educate the public about common lethality indicators, how to best approach a conversation with someone who may be a victim and what help is available.

COURT GUIDANCE

As noted earlier in this report, the NYS Office of Court Administration (OCA) has created working groups and resource lists on a variety of issues. The team recommends those workgroups issue specific guidance to each judicial district clarifying or creating protocols to guide practice, specifically:

- The issuance or modification of orders of protection by criminal courts when Family Court is not in session and
- Family Court ex-parte petition and hearing protocols.

Additionally, OCA should take steps to ensure that any interpreters being used for domestic violence cases receive specialized culturally specific domestic violence training. Policies should be in place directing the use of interpreters in domestic violence cases, such as assigning interpreters of the same gender when possible.

DOMESTIC VIOLENCE SURVIVORS JUSTICE ACT (DVSJA)

The team has reviewed cases in which individuals who were abused by their intimate partners were the defendants in murder cases against their abusive partners. Several survivors in such cases may be eligible for reduced sentencing under the DVSJA, enacted in New York State in 2019. To ensure the statute is as effective as lawmakers intended, it is critical to prioritize legal assistance for survivors and judicial understanding of the goals and implementation of this critical legal remedy.

Conclusion

The team recognizes that every case that contributed to the information in this report represents tragic loss of life, lasting trauma for families, and ripples that reverberate through communities. As difficult as these cases are, the learning that comes from fatality review is important. The team remains committed to the review of domestic violence deaths and near-deaths, and to continuing to share what is learned to enable communities and the State to work toward reducing domestic homicides.

OPDV and its partner agencies are available to assist communities in applying the learning from fatality review locally. To learn more about assistance available, or to refer a case for possible review, please contact the New York State Domestic Violence Fatality Review Team: opdvfatalityreview@opdv.ny.gov.

Appendix A: Case Chart

Case Variables		Cases																																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
Victim Gender	Female	X	X	X		X	X	X		X	X	X		X	X	X	X		X	X	X	X	X		X	X		X	X	X	X	X		X	X	X
	Trans Female																										X									
	Male				X				X				X					X						X									X			
Offender Gender	Female				X				X				X		X									X									X			
	Male	X	X	X		X	X	X		X	X	X		X		X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X		X	X	X
Victim Age	Under 20					X																														
	20-39	X	X	X			X		X	X					X			X	X	X		X	X	X		X	X	X		X		X		X	X
	40-59				X			X			X	X		X		X					X				X				X		X		X	X		
	60 and above												X				X																			
Offender Age	Under 20																															X				
	20-39		X	X		X	X		X	X	X		X		X			X		X		X	X	X		X		X		X			X		X	X
	40-59	X			X			X				X		X		X			X						X		X			X				X		
	60 and above																X				X															
Victim Race/Ethnicity	White	X	X	X		X			X	X		X	X			X	X		X	X			X		X	X		X		X	X			X		
	Black				X		X				X			X	X			X				X					X					X	X			
	Hispanic																				X			X											X	
	Asian							X																				X								X
Offender Race/Ethnicity	White		X	X		X			X			X				X	X		X	X		X	X		X	X				X	X	X		X		
	Black	X			X		X			X	X		X	X	X			X						X			X	X					X			
	Hispanic																				X														X	
	Asian							X																				X								X
Relationship	Intimate Partner	X	X	X	X	X	X		X	X			X	X	X			X	X	X		X	X	X		X	X	X		X			X	X		
	Spouse/Ex-Spouse							X			X	X				X	X				X			X				X		X	X			X	X
Weapons Used	Firearm	X	X				X	X	X		X			X		X			X		X		X*			X				X			X			
	Knife/cutting instrument			X	X					X		X	X		X		X	X						X	X						X			X	X
	Blunt Object/Hands, Fists					X				X							X			X		X						X	X		X					
	Other																										X						X			
Murder/Suicide	Yes	X	X					X			X			X		X			X		X					X			X	X						
Children Present	Yes		X	X				X				X		X										X				X			X		X			X
Children or Third Parties Killed	Yes							X						X		X														X				X		

Red indicates victim near-death.

*Victim threatened with a firearm

Appendix B: Percentage of Case Variables