Responding to the Victims

The New Jersey Domestic Violence Fatality and Near Fatality Review Board Report

June 2006

NEW JERSEY DOMESTIC VIOLENCE FATALITY AND NEAR FATALITY REVIEW BOARD MEMBERS

Government Representative **NJ Department of Human Services** Charlene Womack Division of Prevention and Community Partnerships	**Government Representative** **New Jersey State Police** Detective Dawn Dalrymple Victim Services Unit
Government Representative **Office of the Attorney General** William Zaorski Deputy Attorney General Division of Criminal Justice Department of Law and Public Safety	**Government Representative** **NJ Department of Health & Senior Services** Peri Nearon Director, Office on Women's Health Division of Family Health Services
Government Representative **Office of the State Medical Examiner** Laura Cerminara Forensic Administrator	**Government Representative** **Domestic Violence Fatality & Near Fatality Review Board** Erica Olson Program Director
Government Representative **NJ Department of Community Affairs** Commissioner Susan Bass Levin	**Government Representative** **Office on the Prevention of Violence Against Women** Carol Vasile Supervisor
Government Representative **Division on Women** Michelle E. Richardson Acting Director	**Government Representative** **Office of the Public Defender** Yvonne Smith Segars NJ Public Defender
Government Representative **New Jersey Task Force on Child Abuse & Neglect** Donna Pincavage Executive Director	**Public Member** **New Jersey Coalition for Battered Women** Sandy Clark Associate Director
Public Member **County Prosecutor's Association** Linda Estremera Assistant Prosecutor Middlesex County	**Public Member** **Batterer's Treatment/Intervention** Bernie Hodgdon Catholic Charities

Public Member **Psychologist** Dr. Shamita Das Dasgupta Manavi, Inc NYU Law School	**Public Member** **Health Care Professional** Anna Trautwein – Chair Patient Education Coordinator Perinatal Clinical Educator St. Peter's University Hospital
Public Member **Law Enforcement** Jim Murphy Former Deputy Chief Washington Township	**Resource Member** Dr. Sue Rovi – Research Consultant UMDNJ-Department of Family Medicine
Resource Member Laura Hook Union County Prosecutor's Office	

FOREWORD

The New Jersey Domestic Violence Fatality Review Board was created in 2000 pursuant to Executive Order No. 110. The New Jersey Domestic Violence Fatality Review Board project was undertaken to help identify and understand the circumstances surrounding fatal acts of domestic violence in the sate of New Jersey. In 2003, the New Jersey Domestic Violence Fatality Review Board drafted this report, which contains several recommendations based on findings from reviewing domestic violence-related homicide suicide cases in which an abusive partner kills his/her intimate or former intimate partner and then commits suicide.

In 2004, the New Jersey Domestic Violence Fatality Review Board was expanded in scope, purpose and membership during the final writing phase of this report. The newly expanded program was permanently established under N.J.S.A. 52-27D-43.17 as the New Jersey Domestic Violence Fatality and Near Fatality Review Board. After the newly expanded New Jersey Domestic Violence Fatality and Near Fatality Review Board organized its membership and internal structure, the full Board voted to move forward with publishing the prior Board's work because the information gleaned from these cases had not yet been fully shared with the community. Board members found the recommendations still relevant for the systems and agencies which impact the safety and lives of victims and perpetrators of domestic violence. In order to honor and preserve the original work and voice of the earlier Board members who worked tirelessly on this report, the New Jersey Domestic Violence Fatality and Near Fatality Review Board voted to retain the original text with a new Foreword and any necessary updates on progress of recommendations. The New Jersey Domestic Violence Fatality and Near Fatality Review Board added this Foreword to illuminate why the reader may find language, descriptions or dates from when the report was written in 2003. For some of the recommendations, if pertinent, an updated footnote is included regarding the current status of a recommendation if different since the original writing.

These recommendations are a result of qualitative and quantitative reviews of domestic violence related homicide-suicide cases in New Jersey. The New Jersey Domestic Violence Fatality and Near Fatality Review Board encourages their adoption as a means for communities to work towards keeping victims safe and batterers accountable.

"A police officer on the scene when the bodies were taken away told [a neighbor] 'We didn't have anything to worry about, that it was between them.'"

The two-year-old son of one victim is "very, very sad," said a relative. "He cries at night. He sobs during the day. He's really angry."

"If you leave me, you'd better leave the country."

"I didn't think there was going to be anything violent at all."

"She always thought Prince Charming would rescue her."

"Friends and family members say [she] wanted a divorce, and that her husband could not let go."

"He knew he could hurt me by using or hurting [our son]."

"He just snapped. He was a good man."

"You're not even safe going to church."

"I saw the fright in her eyes. It was complete terror. It was like she knew she was going to be killed."

The above statements were abstracted from New Jersey newspapers. [1-10] The Domestic Violence Fatality Review Board's responses to these statements are as follows:

- *Domestic violence is a problem that affects the family, friends, and neighbors of the victim and perpetrator, and the entire community in which they live.*
- *Children in families where there is domestic violence are often harmed physically and emotionally by this violence; sometimes they are even killed. More often, children learn and imitate violent behavior, or accept being abused as a normal part of life.*
- *We need to listen to the victims.*
- *We need to take threats to kill seriously.*
- *The perpetrator does not 'just snap.' There is often a history of abuse prior to the fatal acts. There are warning signs.*
- *As a community, we need to be prepared to help victims, their families, friends, co-workers and the perpetrators.*

Annually, there are over 1,000,000 domestic violence incidents in the U.S., and over 1300 women are killed each year by their current or former intimate partners. [11] Most of these women were shot, some were beaten to death, others stabbed or strangled, and their children often witnessed these murders. In 2001 there were 82,373 incidents of domestic violence crimes reported to the police in New Jersey; 40 of these were homicide incidents. [12] Domestic violence is a **preventable** cause of death according to the World Health Organization and U.S. Centers for Disease Control. [13] The purpose of the New Jersey Domestic Violence Fatality Review Board (NJ DVFRB) is to work towards the prevention of domestic violence-related deaths and all domestic violence in New Jersey.

Domestic violence fatality review is a national initiative that began in the early nineties to investigate the deaths of women killed in domestic violence incidents. Similar to medical morbidity and mortality reviews and child fatality reviews, domestic violence fatality reviews are intended to work towards the prevention of future deaths. Through review of the circumstances surrounding these fatal acts, strategies can be identified to improve our response to domestic violence in our communities. Membership on the Board includes representatives from a variety of disciplines derived from all levels of government as well as from the public and private sectors. The Board meets regularly to review available information about domestic violence-related fatalities that occurred in New Jersey with the goal of identifying trends and patterns, and developing a process for change in policies, procedures and protocols that can lead to the prevention of domestic violence and related fatalities.

In the future, this Board will broaden the scope of case review to include domestic violence-related homicides, suicides, and cases of near fatalities. To date, the Board has reviewed 58 cases of domestic violence homicide-suicides that have occurred throughout New Jersey between 1994 and 1999. Case review includes the files of police and prosecutor investigations, autopsy and toxicology reports, death certificates, weapons and media reports. **The total number of fatalities from these cases is 125**: 58 'primary' victims, 58 perpetrators, plus 9 associated or secondary victims. In most cases (n=48), the victim and perpetrator were current or former intimate partners. Non-intimate partner homicide-suicides included parents killing children, older children killing their parents, and several deaths in which the perpetrator and victim were not related. Two progress reports on the Board's work are available (July 2001 and February 2003). In the latest report, case reviews were summarized as follows.

In most New Jersey homicide-suicides, the perpetrators were men, who killed their female intimate partners, typically when the woman was planning to leave or the couple had recently separated. Repeatedly, experts in the field of domestic violence report that the most dangerous time for the victim begins when she decides to leave the perpetrator. There was often evidence of a history of domestic violence including police reports of prior incidents of violence or threats of violence and/or reports or suspicions of abuse by family, friends and employers. Firearms were used in nearly all of these fatalities. Findings in New Jersey match the commonly reported scenario of these deaths nationwide. The Board's review of cases found victims and perpetrators represented the diversity of New Jersey residents in the general population with one exception: nearly all perpetrators were men and nearly all victims were women.

- Racial/ethnic identities were consistent with census data for New Jersey: three-quarters of victims and perpetrators were White, one-fifth Black or African-American, and there were several Asians, although Hispanics and Latinos were slightly over-represented in the cases reviewed.
- Although most victims and perpetrators were between the ages of 18 and 50 years, the full spectrum of the life cycle was represented in the case files – from young children to the elderly. Three couples were over 74 years old and the Board discerned that one or both parties reported having a serious physical illness, such as Alzheimer's or heart disease, which may have played a role in these fatalities.
- Geographically, 2/3 of cases were in suburban or urban-suburban areas, 1/5 were in urban areas, and the rest were in rural areas including rural centers.
- Educational achievement varied such that nearly 1/2 of victims and a 1/3 of perpetrators had some college experience or a college degree.
- Victims and perpetrators were employed in all types of occupations: teachers, police officers, homemakers, construction workers, office managers, bakers, lawyers, secretaries, as well as students, retired persons; and some were unemployed.

Furthermore, the Board found:

- Most of the victims were killed within what many of us would consider 'safe' havens, with nearly 2/3 killed in their homes.
- Firearms were used in nearly all cases. Perpetrators shot their victims in 83% of cases before shooting themselves.
- Among intimate partner cases, the Board found:
  - 67% of partners were separated or in the process of separation
  - 52% of perpetrators exhibited jealous or obsessive behavior
  - 54% of perpetrators threatened to kill themselves, the victim, or others
  - 44% had a known history of domestic violence
  - 35% of cases documented police calls to the residences prior to the homicide
  - 81% of cases reviewed by the Board had no documentation of restraining orders issued
- In most cases family, friends and/or employers were aware of the abuse, threats, and jealousy exhibited by the batterer or they suspected abuse.

- Numerous individuals within the community had contact with the victims and/or perpetrators prior to their deaths, including mental health professionals, health care providers and attorneys, among others. In several cases, perpetrators saw mental health professionals specifically about relationship violence.

In the Board's first progress report, "Remembering the Victims" released in July 2001, the following four broad recommendations were made, with committees formed to develop strategies for implementing each recommendation.

- To permanently establish the New Jersey Domestic Violence Fatality Review Board through state statute.
- To sponsor a Statewide Public Education Campaign.
- To organize a committee of the Board to study domestic violence in the law enforcement community.
- To conduct Community Safety and Accountability Audits.

The Board has since made great strides toward achieving those goals. The New Jersey Domestic Violence Fatality and Near Fatality Review Board was permanently established under state statute in January of 2004, and is now the expanded New Jersey Domestic Violence Fatality and Near Fatality Review Board. A committee on domestic violence in the law enforcement community was organized and later formalized as a full Panel with expanded scope and authority under the new statute. Members of that committee completed a model law enforcement policy to address the special issues and concerns involved when domestic violence occurs in the law enforcement community. A pilot Community Safety and Accountability Audit (CSAA) is coming to a close in Gloucester County. Other counties have expressed an interest in conducting a CSAA in their communities. In 2005, legislation was signed establishing a Public Education and Awareness Campaign on Domestic Violence for the state of New Jersey.
Following the release of the Board's second progress report in February 2003, the Board developed more specific recommendations, which are contained in this report, based on the review of cases. The Board strongly urges their implementation to further the goals of preventing future domestic violence fatalities and the elimination of violence against women. The Board acknowledges that for many of these recommendations to be put into practice, additional resources are needed and existing programs should be augmented. Not all of the recommendations, however, require additional funding. All recommendations require collaboration by multiple agencies and organizations, both public and private. This mutual collaboration is essential to the successful implementation of these recommendations and to the safety of victims of abuse.

To address the epidemic of domestic violence and related fatalities in our State, and to prevent future incidents from occurring, we must forge and foster a coordinated community response to the issue. A coordinated community response requires that all members of the community are prepared to identify a victim of domestic violence, are able to recommend or offer services that are appropriate and sensitive to the victim's needs, promote safety for victims and demand accountability from batterers. This type of response by an entire community leads to early detection and prevention of future domestic violence incidents and deaths. It provides a safe and supportive environment within which victims may reach out for help and receive services

when they are needed. It is essential that community agencies, organizations and citizens work together to prevent domestic violence.

A coordinated community response has several components. These include:

- Public awareness of the issue
- Professional education about domestic violence and how to address it
- Interventions and Referrals (mental health, substance abuse and batterer treatment, weapons possession, legal assistance, housing, job training, economic assistance, safety planning, etc.)
- Appropriate and effective responses by law enforcement and the courts
- System sensitivity to issues of safety
- System sensitivity to cultural diversity
- Ongoing evaluation of the system response

The following recommendations of the Domestic Violence Fatality Review Board address these components. Each recommendation was developed after review of domestic violence homicide-suicide cases. The Board believes that these recommendations will bring the State of New Jersey closer to a safe and effective response to domestic violence. As such, these recommendations are our way of ***responding to the victims.***

PUBLIC AWARENESS OF DOMESTIC VIOLENCE RISK FACTORS AND HOTLINES

The perpetrator had threatened to kill the victim, himself or others in over half of the cases reviewed. Usually friends and family of the victim heard these threats. People close to the victim and/or perpetrator either did not understand the behaviors/experiences of the victim or perpetrator as domestic violence, or they did not recognize the gravity of the situation. The Board also found that a victim's decision to leave the relationship placed her in the greatest risk in abusive relationships. In 2/3 of intimate partner homicide cases the victim had stated her intention to leave the perpetrator, was in the process of leaving or they had already separated. These findings are consistent with national trends. The DVFRB is concerned that there has not been a statewide public education campaign about domestic violence in over 10 years. New Jersey's residents need information about what domestic violence is, how to identify a victim of abuse and offer assistance to victims of violence, the indicators of increasing danger and lethality, and how safety planning works. It is critical that everyone is fully aware of the seriousness and implications of suicide threats in domestic violence relationships. This message needs to be delivered in ways that will reach the different cultural and socio-economic groups that exist within the State of New Jersey. Campaigns need to be designed in culturally sensitive and linguistically appropriate ways.

There is no "one size fits all" solution in holding batterers accountable while promoting the safety of victims. Communities must take into account the fact that certain populations face additional barriers or concerns in regards to obtaining safety and support. One group of victims in particular – intimate partners of abusers who work in law enforcement – are at increased risk. Victims of abusers who are law enforcement personnel cannot always utilize formal community safety services (i.e. calling the police, pursuing criminal remedies or a restraining order, or going to their county domestic violence shelter). In the Board's review of domestic violence fatalities in New Jersey, several cases involved a law enforcement batterer murdering his intimate partner, then killing himself. The new statute establishes a Panel to Study Domestic Violence in the Law Enforcement Community to respond to these particularly vulnerable victims.

Individuals close to the victim and perpetrator, as well as the victim and perpetrator themselves, need support and information about where to go for information or help in addition to the police. Many people involved did not know where to call for help when there was a threat to harm or commit suicide. In some communities, there was a reluctance to call the police because of concerns around immigration issues. As stated previously, 67% of cases reviewed revealed danger signs such as attempts at ending the relationship or threats to kill. Yet in only 35% of cases were the police contacted and only 19% yielded restraining orders. This disparity between the discovery of danger indicators and appropriate interventions must be bridged through education and information. Access to information must be considered where language barriers exist. Victims, especially those with additional barriers or fears, such as immigrant victims or in cases where the batterer is a law enforcement officer, need multiple sources of information and alternative places to call in addition to the police. Coordinated and alternative resources can make the difference between life and death for victims of domestic violence.

PUBLIC AWARENESS OF DOMESTIC VIOLENCE RISK FACTORS AND HOTLINES

RECOMMENDATION 1a

The Domestic Violence Fatality Review Board recommends that the DVFRB coordinate with the Division on Women, the New Jersey Coalition for Battered Women, and other government entities in the creation of a statewide public education campaign promoting awareness of domestic violence in a manner that is culturally sensitive and linguistically appropriate to the diverse communities within New Jersey. The campaign should include the following areas of concern:

- How to help victims of domestic violence and how to help victims and those close to them identify local resources
- Outreach specific to different cultures, ethnicities, and socio-economic groups
- Education about the increase in danger and lethality for a victim during separation and the importance of safety planning
- Suicide prevention and awareness within a domestic violence relationship
- How to recognize the warning signs which have been shown to signal an increase in danger and lethality
- Promotion of the domestic violence hotlines, in diverse languages, as a place to call in addition to the police

Note: On July 23, 2005, legislation was signed authorizing a statewide campaign to raise awareness of domestic violence and to help victims access resources they need.

RECOMMENDATION 1b

The Domestic Violence Fatality Review Board recommends that domestic violence hotlines be given sufficient resources to enhance their ability to answer calls from:

- Individuals concerned about threats to harm another
- Callers that speak a language other than English
- Family and/or intimate partners of law enforcement personnel

The resources given to the hotlines will be used to prepare for a higher volume of calls that will come from promoting its use and letting the public know about its expanded function. Agencies that work within specific cultural, religious, and linguistic communities could be valuable partners in this effort. Training provided to and collaborations with these organizations would facilitate the outreach and education process.

EDUCATION OF HEALTH AND MENTAL HEALTH PROFESSIONALS ABOUT DOMESTIC VIOLENCE

In cases where there was a medical, psychological, or behavioral assessment or evaluation of the batterer, there was no evidence that the professional conducting the assessment or evaluation had addressed the issue of domestic violence. There were several instances in which batterers were evaluated but the evaluator determined them not to be harmful to themselves or others. Ultimately, they proved to be both. Professionals may improperly assign batterers' behaviors to culture and mitigate their culpability. It is important that evaluators understand the difference between cultural issues and battering behavior in order to assess the batterer correctly. Releasing these men without examining for known factors which increase the likelihood of lethality, a history of domestic violence or speaking with their partners can be a deadly mistake.

Several states such as Pennsylvania, New Hampshire and New York already have laws in place that mandate training for health and mental health professionals on domestic violence. New Jersey should establish similar laws. Models already exist within the state, such as the training conducted by the New Jersey Department of Human Services' Case Consultation Project for Therapists that Deal with Child Abuse.

RECOMMENDATION 2a

The Domestic Violence Fatality Review Board recommends that professional groups such as the New Jersey chapters of the American Medical Association, American Psychological Association, National Association of Social Workers and others develop mandatory standards for education and training on domestic violence for their respective members. Professional groups should collaborate with the New Jersey Coalition for Battered Women to ensure that the training is based on valid and reliable data in the domestic violence field and reflective of victim's needs.

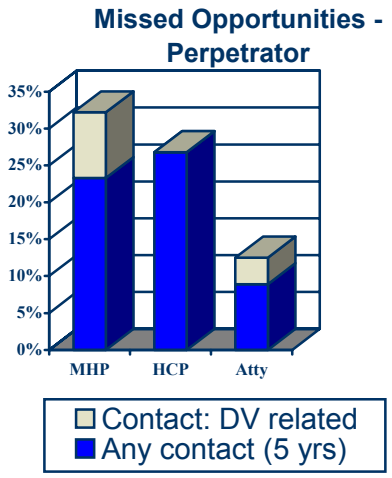
RECOMMENDATION 2b

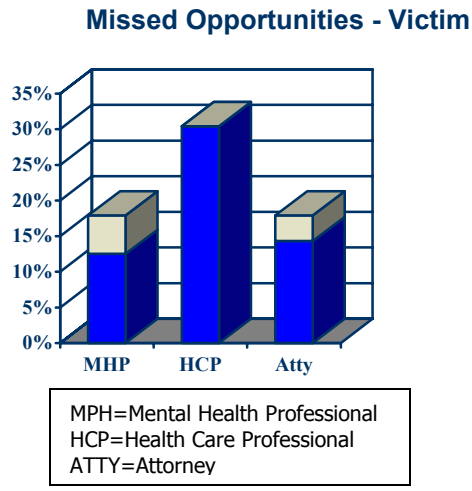
The Domestic Violence Fatality Review Board recommends that the Courts utilize professionals who are trained in the dynamics of domestic violence and in the appropriate standards to conduct evaluations of batterers.

DOMESTIC VIOLENCE SCREENING BY HEALTHCARE PROFESSIONALS

Contact with healthcare providers were recorded for victims in 31% of cases and for perpetrators in 27% of cases within five years of the incident. The DVFRB asserts that this is an undercount due to a lack of health care information in case files. Healthcare providers see victims and perpetrators during routine health care visits as well as for acute illnesses and chronic injuries. Health care providers also have contact with adult victims when they bring their children in for pediatric health care. These contacts provide an opportunity for identification of victims of domestic violence by healthcare professionals and for interventions and/or referrals.

Legislation that mandates domestic violence screening by healthcare professionals has already been enacted in Pennsylvania, California, and New York. New Jersey legislators can look to other states as models and pass similar laws in New Jersey.





RECOMMENDATION 3

The Domestic Violence Fatality Review Board recommends that the New Jersey Legislature pass legislation mandating culturally sensitive domestic violence training & education to personnel on identifying patients in healthcare settings who may be victims of domestic violence. This legislation should include development of screening and intervention protocols in all healthcare settings, including home healthcare.

COMMUNITIES WORK TOGETHER

Victims and perpetrators came in contact with various helping systems prior to the fatal incident. Along with the medical community these systems include religious or spiritual places of worship, schools, and government agencies such as the Division of Youth and Family Services. In the Board's case reviews, professionals who came in contact with the victim failed to demonstrate knowledge about domestic violence essential to provide appropriate care, information and referrals. There was no mechanism in place for these agents to communicate with each other to evaluate the totality of the response provided to the people involved. As a result, no one communicated the danger that existed. In other words, there was not a coordinated community response, which might have been able to prevent the deaths from occurring.

RECOMMENDATION 4a

The Domestic Violence Fatality Review Board recommends that New Jersey begin evaluating the State's response to domestic violence by sponsoring Pilot Community Safety and Accountability Audits through the Division on Women.

Note: As of the publication of this report, the Gloucester County Team is wrapping up a Pilot Community Safety & Accountability Audit.

RECOMMENDATION 4b

The Domestic Violence Fatality Review Board recommends that county and local governments work with crisis intervention teams, domestic violence advocates at hospitals and other important system participants to identify shared resources. This will facilitate the development of a coordinated community response. There should be coordinated training of all levels of responders.

EDUCATION OF ATTORNEYS ABOUT SAFETY PLANNING

Separation is a dangerous time for victims of domestic violence. For example, in one of the cases reviewed, the delivery of divorce papers to the perpetrator was one trigger that contributed to the fatal event. In all cases that the Board reviewed where an attorney was involved, there was no evidence they helped the victim with a safety plan to prepare for the special dangers associated with leaving a violent relationship. First and foremost, those serving as legal counsel, as well as their assistants and other staff, must be cognizant of the unique safety issues involved with working with victims of domestic violence, such as possible ramifications of contacting their clients in any manner that may inform the abuser that the victim has sought counsel. Also, attorneys, paralegals, and legal staff who work with victims during this time must have proper training in order to inform the domestic violence survivor of her risk and help to keep her safe. Legal professionals should screen and identify clients who are experiencing or have experienced domestic violence in their relationship and be familiar with "red flags" which are known to indicate an increase in danger and lethality for their clients. Over 20% of victims in the Board's study consulted an attorney within five years prior to their death.

RECOMMENDATION 5

The Domestic Violence Fatality Review Board recommends that the New Jersey Bar Association, in conjunction with the Institute for Continuing Legal Education, provide education for attorneys and others in the legal community that is sensitive to the needs of diverse cultural and ethnic groups as well as victims who may be especially vulnerable or face unique barriers to safety and support. Such training should include screening for domestic violence, advising clients about risk during separation, developing safety plans with clients who need them, and offering appropriate resources as recommended by the New Jersey Coalition for Battered Women or their local domestic violence agency. The educational programs should utilize the resources of experts in the field of domestic violence who can be recommended by the New Jersey Association of Domestic Violence Professionals.

DOMESTIC VIOLENCE TRAINING FOR SCHOOL PERSONNEL

In many of the cases reviewed, children under 18 years of age were present in the home at the time of the fatal incident. Children in domestic violence homes are likely to be victims of abuse as well and may have a propensity to commit future acts of violence.[14] In fact, children who witness intimate partner violence are at a higher risk for emotional and behavioral problems, and they may even react like victims of abuse themselves.[15] School personnel need to recognize students who are experiencing violence at home and respond appropriately. Keeping a watch on our children may save their lives as well as the lives of their parents and possibly the lives of that child's future family.

RECOMMENDATION 6

The Domestic Violence Fatality Review Board recommends that the Department of Education, along with Local Boards of Education, conduct domestic violence training in the schools for teachers and administration, giving faculty and staff the ability to identify children exposed to domestic violence. All professionals who have regular student contact should be trained to: look for indicators of domestic violence in the family; safely, appropriately, and actively provide information and referrals; and be knowledgeable about appropriate resources including resources for confidential assistance such as adolescent pregnancy programs, domestic violence & sexual assault programs and school-based intervention services for children with problems. The educational programs should utilize the resources of experts in the field of domestic violence who can be recommended by the New Jersey Association of Domestic Violence Professionals.

DOMESTIC VIOLENCE INFORMATION AVAILABLE IN DIVERSE LANGUAGES

In cases where the victim, perpetrator or others involved were from an immigrant community, there were issues in addition to the domestic violence to overcome such as language and cultural barriers, immigration status concerns and fear of police involvement. These barriers made it difficult for the victims and their families to access services that may have saved lives.

RECOMMENDATION 7

The Domestic Violence Fatality Review Board recommends that county and local government agencies have information and resources available in languages that reflect the make-up of their community thereby facilitating communication in the language most comfortable to those involved in the case. Government and social service agencies should work with immigrant communities on identifying sources of intervention and assistance. The New Jersey Coalition for Battered Women and its member agencies should create an outreach project geared towards underserved communities and teach individuals about the dynamics of domestic violence.

DEVELOP WORKPLACE VIOLENCE POLICIES

Domestic violence homicides sometimes occur at the victim's workplace. Businesses, especially small businesses, are not typically prepared to deal with domestic violence that spills over into the work environment. Homicides that occurred at the victim's workplace might have been prevented if the employer and co-workers were educated about the dynamics of domestic violence and safety plans had been put in place. In March 2003, the Centers for Disease Control published a report outlining the cost of intimate partner violence to businesses stating, "More than 13.5 million total days are lost from job and housework productivity, which is equivalent to 47,339 person-years."[16] In some cases, co-workers who knew about abuse in the relationship observed the perpetrator approaching, however they looked on helplessly as their co-worker was killed. Currently New Jersey has no laws or policies addressing workplace violence, which includes domestic violence. While a few businesses work with domestic violence professionals on this issue, more needs to be done to protect employees while they are at work.

RECOMMENDATION 8a

The Domestic Violence Fatality Review Board recommends that the New Jersey Workplace Violence Taskforces develop legislation that will require businesses in New Jersey to develop and adopt workplace domestic violence policies and safety protocols. These protocols and policies should be culturally sensitive.

RECOMMENDATION 8b

The Domestic Violence Fatality Review Board recommends that the New Jersey Coalition for Battered Women and its member programs provide culturally sensitive domestic violence educational materials, including written resources and training, for local corporations and their Employment Assistance Programs, as well as small businesses in their counties.

NEW INVESTIGATION PROTOCOLS TO ENHANCE THE WORK OF THE NJ DVFRB

Information about cases that was given to the DVFRB to review varied greatly from case to case. For purposes of the Board's review of homicide-suicide cases, data collection and reporting by law enforcement is not consistent throughout the state. Interviews with family, friends, and witnesses – which can provide insight about the incident and about actions taken by the victim and/or the perpetrator prior to the incident – are not always provided nor do they include the information necessary to understand the circumstances of the case. Records often excluded from the case files the Board receives include: transcriptions of interviews/statements by victims, family/friends of victims or perpetrators, transcriptions of 911 calls, copies of (suicide) notes written by the perpetrator and other similar relevant material. These documents can provide a first hand accounting of the events leading up to the deaths. Most importantly, these documents can reveal behaviors and warning signs that contributed significantly to the victims' safety or risk and therefore provide key information to Board staff and researchers in formulating safety measures and policy recommendations. The work of the DVFRB to prevent domestic violence homicide is severely impeded by inadequate data collection.

In addition, there are insufficient state standards for data collection and reporting by a medical examiner for purposes of review. There is also a lack of information for review about the medical history of victim and perpetrator, and a prior history of domestic violence, criminal history, Division of Youth and Family Service involvement, and other relevant history.

In order to have sufficient information and to utilize case information to improve response and prevention of domestic violence, more detailed information is needed in all investigations.

RECOMMENDATION 9

The Domestic Violence Fatality Review Board recommends that a committee of the Board identify and forward recommendations regarding domestic violence-related fatality case investigations to the Attorney General. The purpose of the recommendations is to enhance the fatality review process by establishing a follow-up policy or protocol for conducting a more detailed, culturally sensitive investigation following police investigation of domestic violence fatalities. (Consideration should be given to the creation of an investigative position within the DVFRB).

Note: This recommendation regarding data collection may be specific to homicide-suicides, since it is probable that less investigation takes place because the perpetrator is known and dead and therefore will not be prosecuted. In homicide cases, police and prosecutors conduct a more detailed investigation for evidence at a trial.

POLICY FOR RESPONDING TO DOMESTIC VIOLENCE IN LAW ENFORCEMENT FAMILIES

The DVFRB identified a complex constellation of issues in the review of cases of domestic violence homicide-suicide involving law enforcement personnel and their families. These issues were raised in previous reports of the Board and they include: the need for education of police officers on the consequences of committing domestic violence, support for personnel at times of high personal stress, support for the family of police officers and a process by which they can hold their violent partner accountable for his actions while victims are protected from further harm.

The Domestic Violence Fatality Review Board has formed a specialized committee of the Board as recommended in the July 2001 report. The committee focuses on the special issues that are associated with domestic violence among law enforcement officers and their families. The members of the committee include a broad representation from law enforcement and advocates, all of whom have experience and knowledge regarding domestic violence.

The Board recognizes a need for a more specific, standardized policy/process for the response to and investigation of acts of domestic violence involving law enforcement personnel or affecting their family. This policy needs to go beyond the existing Attorney General guidelines for weapons seizure and beyond the Attorney General's Internal Affairs guidelines for investigation of internal affairs complaints.

Concerns of the committee include: an officer's continued access to firearms, having the complaint reported to the same agency where the perpetrator is employed, and identifying warning signs that might help to prevent an incident before it occurs.

RECOMMENDATION 10

The Domestic Violence Fatality Review Board recommends that the Law Enforcement committee of the Board continue to develop its model policy and protocol for the response to and investigation of acts of domestic violence involving law enforcement personnel. This model policy and protocol will be forwarded to the Attorney General for review and implementation.

Note: As of publication of this report, the Domestic Violence in the Law Enforcement Community committee has been expanded into a legislated Panel on Domestic Violence in the Law Enforcement Community as part of the new DVFNFRB. The committee/Panel completed the Model Policy for Domestic Violence in the Law Enforcement Community. This policy has been forwarded to the Attorney General for review and implementation.

DEVELOP STRATEGIES TO PREVENT DOMESTIC VIOLENCE FATALTIES BY FIREARMS

As is true nationally, the overwhelming majority of the New Jersey cases reviewed by the DVFRB involved the use of a firearm. The type of gun and how the perpetrator obtained it varied from case to case. While the Board found a number of instances where the perpetrators purchased the firearms illegally, in many cases the perpetrator had legal possession of the firearm used to kill his/her partner and then themselves.

The DVFRB has identified several problems with respect to firearms that impacts the safety of victims. Specifically there is no system or process set up to immediately enter a firearms ID card revocation, no automated way to check if a firearms ID card is still valid, and no requirement for private sellers to check if a firearms ID card is valid or has been revoked. Strategies that decrease the number of illegal firearms and that monitor more closely the legal possession of firearms are needed to prevent these fatalities.

RECOMMENDATION 11

The Domestic Violence Fatality Review Board recommends that the Attorney General develop a firearm purchaser identification card, with a photo and electronic information transfer capability. The card must be supported by a network that provides for the instantaneous revocation of a cardholder's purchasing privileges. This network should allow the Prosecutor's office and appropriate agencies within the Criminal Justice system to submit instant entry of the revocation of the firearms license into the Division of State Police firearms licensing system. Until the system can be developed, the Attorney General should promulgate directives requiring the immediate faxing of court orders revoking firearms privileges to the Division of State Police firearms unit. Additionally, state statutes should be amended to require private sellers of firearms to obtain verification from the State Police that the status of a buyer's firearms purchasing privilege is valid at the time of sale. State statutes should also be amended to make it a crime for private sellers to fail to comply with this requirement.

PROCEDURES FOR FIREARM REVOCATION

The DVFRB identified that when law enforcement, prosecutors, or the judiciary learn that a person becomes disqualified by judicial order from possessing firearms there is not routine seizure and revocation of firearm's permits. Even if the firearms are seized the card may not be, thus allowing the perpetrator to buy another weapon. According to Federal law these perpetrators should not have had access to any firearms, regardless of the fact that they still possessed their ID card. Law enforcement and gun dealers must have a method for identifying individuals who are not permitted to buy a gun.

RECOMMENDATION 12

The Domestic Violence Fatality Review Board recommends that the Attorney General, the State Police and the Administrative Office of the Courts work collaboratively to develop procedures to require that when a person is disqualified from possessing a firearm, applications are made to revoke firearms permits/ID cards, firearms are seized, and any revocation information is immediately provided to State police for entry into the firearms database.

CONCLUSION

The recommendations of the New Jersey Domestic Violence Fatality Review Board are the result of three years of reviewing domestic violence related homicide-suicide cases in New Jersey. Although there are limited resources currently available, it is vital that these recommendations be implemented. New Jersey women, men and children are dying, and many more are injured and emotionally scarred. Through government and community partnerships it is possible to carry out the important work outlined in this report. New Jersey can improve domestic violence prevention efforts with a coordinated community response. This response includes safety and support for survivors of domestic violence and holding the perpetrators of that violence accountable for their actions. Communities need to be able to identify residents who are at risk and provide safety and support. Early identification, appropriate intervention and preventative education can make the difference in saving someone's life. By working together and implementing these recommendations, New Jersey can work towards saving lives and ***responding to victims***.

ENDNOTES

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Domestic Violence Fatality Review Board
2003 Recommendation Report

QUICK LIST OF RECOMMENDATIONS

1a. The Domestic Violence Fatality Review Board recommends that the DVFRB coordinate with the Division on Women, other government entities and the New Jersey Coalition for Battered Women towards the creation of a statewide public education campaign promoting awareness of domestic violence in a manner that is culturally sensitive and linguistically appropriate to the diverse communities within New Jersey. The campaign should include the following areas of concern:

- How to help victims of domestic violence and how to identify local resources
- Outreach specific to different cultures, ethnicities, and socio-economic groups
- Deliver the message that relationship separation is a dangerous time
- Suicide prevention and awareness within a domestic violence relationship
- The recognition of signs/factors associated with increased risk of lethality and danger
- Promotion of the domestic violence hotlines, in diverse languages, as a place to call in addition to the police

1b. The Domestic Violence Fatality Review Board recommends that domestic violence hotlines be given sufficient resources to enhance their ability to answer calls from:

- Individuals concerned about threats to harm another
- Callers that speak a language other than English
- Family and/or intimate partners of law enforcement personnel

The resources will allow the agencies to prepare for the higher volume of calls that will come from promoting its use and letting the public know about its expanded function. Agencies that work within specific cultural, religious, and linguistic communities could be valuable partners in this effort. Trainings provided to and collaborations with these organizations would facilitate the outreach and education process.

2a. The Domestic Violence Fatality Review Board recommends that professional groups such as the New Jersey chapters of the American Medical Association, American Psychological Association, National Association of Social Workers and others develop standards for education and training on domestic violence for their respective members. Professional groups should collaborate with the New Jersey Coalition for Battered Women to ensure that the training is reflective of victim's needs and safety.

2b. The Domestic Violence Fatality Review Board recommends that the Courts utilize professionals who are trained in the appropriate standards to do evaluations of batterers.

3. The Domestic Violence Fatality Review Board recommends that the New Jersey Legislature pass legislation mandating culturally sensitive domestic violence training & education to personnel on identifying patients in healthcare settings who may be victims of domestic violence. This legislation should include development of intervention protocols in all healthcare settings, including home healthcare.

4a. The Domestic Violence Fatality Review Board recommends that New Jersey begin evaluating the State's response to domestic violence by sponsoring Pilot Community Safety and Accountability Audits through the Division on Women.

4b. The Domestic Violence Fatality Review Board recommends that county and local governments work with crisis intervention teams, domestic violence advocates at hospitals and other important system participants to identify shared resources. This will facilitate the development of a coordinated community response. There should be coordinated training of all levels of responders.

5. The Domestic Violence Fatality Review Board recommends that the New Jersey Bar Association, in conjunction with the Institute for Continuing Legal Education, provide education that is sensitive to the needs of diverse cultural and ethnic groups in the immigrant community. Such education for attorneys and others in the legal community should include screening for domestic violence, counseling their clients about risk during separation and developing safety plans with their clients who need them. The educational programs should utilize the resources of experts in the field of domestic violence who can be recommended by the New Jersey Association of Domestic Violence Professionals and the New Jersey Coalition for Battered Women.

6. The Domestic Violence Fatality Review Board recommends that the Department of Education with Local Boards of Education conduct domestic violence training in the schools, giving faculty and staff the ability to identify children at risk of physical and emotional harm. All professionals who have student contact should be trained to look for indicators of domestic violence in the family, actively provide information and hand out brochures on resources for confidential assistance such as adolescent pregnancy programs and school-based intervention services for children with problems. The educational programs should utilize the resources of experts in the field of domestic violence who can be recommended by the New Jersey Association of Domestic Violence Professionals.

7. The Domestic Violence Fatality Review Board recommends that county and local government agencies have information and resources available in languages that reflect the ethnic make-up of their community thereby facilitating communication in the language most comfortable to those involved in the case. Government and social service agencies should work with immigrant communities on sources of intervention and assistance. The New Jersey Coalition for Battered Women and its member agencies should create an outreach project geared towards these underserved communities and teach individuals about the dynamics of domestic violence.

8a. The Domestic Violence Fatality Review Board recommends that the New Jersey Workplace Violence Taskforce develop legislation that will require businesses in New Jersey to develop and adopt workplace domestic violence policies and safety protocols. These protocols and policies should be culturally sensitive.

8b. The Domestic Violence Fatality Review Board recommends that the New Jersey Coalition for Battered Women and its member programs provide culturally sensitive domestic violence awareness materials, including written resources and training, for local corporations and their Employment Assistance Programs, as well as small businesses in their counties.

9. The Domestic Violence Fatality Review Board recommends that a committee of the Board identify and forward recommendations regarding homicide, homicide-suicide and suicide case investigation to the Attorney General. The purpose of the recommendations is to enhance the fatality review process by establishing a follow-up policy or protocol for conducting a more

detailed, culturally sensitive investigation following police investigation of domestic violence homicides.

10. The Domestic Violence Fatality Review Board recommends that the Law Enforcement committee of the Board continue to develop its model policy and protocol for the response to and investigation of acts of domestic violence involving law enforcement personnel. This model policy and protocol will be forwarded to the Attorney General for review and implementation.

11. The Domestic Violence Fatality Review Board recommends that the Attorney General develop a firearm purchaser identification card, with a photo and electronic information transfer capability. The card must be supported by a network that provides for the instantaneous revocation of a cardholder's purchasing privileges. This network should allow the Prosecutor's office and appropriate agencies within the Criminal Justice system to submit instant entry of the revocation of the firearms license into the Division of State Police firearms licensing system. Until the system can be developed, the Attorney General should promulgate directives requiring the immediate faxing of court orders revoking firearms privileges to the Division of State Police firearms unit. Additionally, state statutes should be amended to require private sellers of firearms to obtain verification from the State Police that the status of a buyer's firearms purchasing privilege is valid at the time of sale. State statutes should also be amended to make it a crime for private sellers to fail to comply with this requirement.

12. The Domestic Violence Fatality Review Board recommends that the Attorney General, the State Police and the Administrative Office of the Courts work collaboratively to develop procedures to require that when a person is disqualified from possessing a firearm, applications are made to revoke firearms permits/ID cards, firearms are seized, and any revocation information is immediately provided to State police for entry into the firearms database.