New Jersey
Domestic Violence Fatality Review Board
Report

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Information is a critical component for this project. The Attorney General's Office through the Division of Criminal Justice was the catalyst to encourage County Prosecutors' collaboration on Board review of cases. The Division of Criminal Justice's effort in facilitating the exchange of information is gratefully acknowledged. The following County Prosecutors' Offices forwarded critical information to the Domestic Violence Fatality Review Board in the initial review process: Atlantic, Bergen, Burlington, Camden, Essex, Gloucester, Middlesex, Morris, Passaic, Sussex, Union and Warren. The Division of State Police and The State Medical Examiner's Office also provided valuable data and information. We thank each of these organizations for their enthusiastic support of this project. Their assistance is gratefully acknowledged.

The efforts of the members of the Domestic Violence Fatality Review Board and the research team who review the individual case files is deeply appreciated. Each case provides information about the last weeks, days, hours and even the last moments of a person's life. Often the files are very difficult to read. Reviews are a sobering process because in the final analysis there is nothing that can be done to change the outcome of the case under review. The people associated with this endeavor commit their time and energy to this project in the hope of preventing future tragic events.

Finally, and most importantly, the people who have suffered and lost the most in these events are especially remembered. This report is dedicated to them.

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Executive Summary

The NJ Domestic Violence Fatality Review Board (DVFRB) was officially established by Executive Order Number 110 on March 15, 2000. Planning for the DVFRB began in 1998. The lead agency for the project is the Department of Community Affairs' Division on Women. The purpose of the DVFRB is to review cases of domestic violence that have resulted in fatalities in order to identify strategies for improving New Jersey's response to this problem. A decision was made to review only homicide-suicide[1] (H-S) cases in the first year of the project, since these cases are closed for law enforcement purposes and the records are more readily available. The DVFRB project was undertaken to help understand the circumstances surrounding fatal acts of domestic violence, which will also help to understand acts of domestic violence that have not resulted in homicide. The project is being conducted in a manner that honors the victims who have died; that their deaths do not go unnoticed and unexamined.

The DVFRB project consists of two major components. The first component is the review and recommendation deliberations of the Domestic Violence Fatality Review Board. The second component is a research project being conducted in collaboration with the DVFRB. The overarching goal of these two components is to reduce domestic violence homicides. The more specific goal of the research project is to develop a database to describe domestic violence homicide-suicide cases in New Jersey. The research project quantifies through data analysis the cases studied, while the board conducts a qualitative review of cases to ascertain whether or not policy or system changes are needed.

Cases of domestic violence homicide-suicide (H-S) from the years 1994-1999 were reviewed to gain information regarding possible antecedent risk factors and/or prior help seeking behaviors. These cases of H-S were the basis for the Domestic Violence Fatality Review Board to establish a process by which qualitative reviews are conducted and recommendations are developed. The research team has identified sixty-seven (67) cases, representing more than one hundred forty-five (145) fatalities[2] for review. The team has extracted data on thirty-three (33) cases, representing seventy-one (71) fatalities. The DVFRB has conducted a qualitative review on twenty (20) cases, representing forty-five (45) fatalities. This progress report contains preliminary statistics and recommendations.

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[1] In these cases, the perpetrator kills himself or herself after killing the victim(s) or in a few cases, the perpetrator causes himself or herself to be killed during apprehension by police.

[2] The 145 include 67 victims of homicide plus 67 suicides plus 11 associated fatalities (one responding police officer, seven friends or family members of the victims, two children of victims, and one caregiver who was not a relative). The final total number of fatalities will be determined when the research team completes the review of all case data.

Summary of Recommendations

Recommendations and future areas for review for the prevention of domestic violence fatalities in New Jersey are presented on page 24 of this report. In summary, the recommendations of the Board are:

- **To permanently establish the New Jersey Domestic Violence Fatality Review Board through state statute.** This will allow the Board to continue its work of reviewing facts and circumstances surrounding domestic violence related fatalities, enhancing a public private collaboration and developing a process for change in policies, procedures and protocols to accomplish improvement in the prevention of domestic violence fatality.

- **To sponsor a Statewide Public Education Campaign.** The New Jersey Domestic Violence Fatality Review Board recommends that the State of New Jersey sponsor a new public education campaign that addresses domestic violence prevention. The campaign will educate citizens of New Jersey on what can be done to help family, friends, co-workers, and neighbors who are experiencing domestic violence. The campaign must address the needs of the culturally diverse population of New Jersey, which includes people of all races and ethnicities as well as recent immigrants to this country.

- **To organize a committee of the Board to study domestic violence in the law enforcement community.** The Domestic Violence Fatality Review Board recommends that a committee of the Board establish an expert panel to study the special issues that are associated with domestic violence among law enforcement officers and their families. The members of the panel will include a broad representation from law enforcement and experts in the field of domestic violence. The committee of the Board will be charged with addressing those issues that can prevent deaths of officers and their families.

- **To conduct Community Safety and Accountability Audits.** 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 Audit(s).

A Brief History of the New Jersey Domestic Violence Fatality Review Board

Introduction

The New Jersey Domestic Violence Fatality Review Board project was developed through the efforts of many individuals. These efforts were initiated by people concerned about the number of deaths due to domestic violence. This local effort coincided with a national effort to establish fatality review as a method of addressing the problem of domestic violence. It was from these origins that the New Jersey DVFRB was created. The staff and members of the DVFRB developed an organizational structure including protocols and procedures that establishes the Domestic Violence Fatality Review process. Currently, the DVFRB is working toward accomplishing the goals with which it has been charged.

At the beginning of the local effort in 1998, the Department of Community Affairs' Division on Women reviewed domestic violence homicide statistics available from the New Jersey Uniform Crime Report over a thirteen-year reporting period (1986 - 1998). The review established that an average of fourteen percent (14%) of total homicides in the state were related to domestic violence.[3] *See table 1 below*.

Table 1

year	homicides total	dv homicides total	% of dv homicides to total homicides total
1986	397	64	16.12%
1987	350	36	10.29%
1988	408	65	15.93%
1989	394	49	12.44%
1990	432	57	13.19%
1991	410	61	14.88%
1992	397	60	15.11%
1993	419	54	12.89%
1994	396	42	10.61%
1995	408	61	14.95%
1996	337	43	12.76%
1997	334	50	14.97%
1998	321	62	19.31%
totals	**5003**	**704**	**14.07%**

[3]Department of Law and Public Safety. (1986-1998). Crime in New Jersey: uniform crime report, (NJ UCR) Trenton, NJ: Division of State Police. For the purpose of the UCR a victim of domestic violence is defined in NJSA 2C: 25-19d as any person who is 18 years of age or older or who is an emancipated minor and who has been subjected to domestic violence by a spouse, former spouse, or any other person who is a present or former household member. "Victim of domestic violence" also includes any person, regardless of age, who has been subjected to domestic violence by a person with whom the victim has a child in common or with whom the victim anticipates having a child in common, if one of the parties is pregnant. "Victim of domestic violence" also includes any person who has been subjected to domestic violence by a person with whom the victim has had a dating relationship.

While less than ten percent (10%) of total male homicides were related to domestic violence incidents, as much as forty-four percent (44%) of total female homicides were related to domestic violence incidents.[4] *See table 2 below*.

Table 2								
	homicides			dv homicides			% of dv homicides to total homicides	
year	total	male	female	total	male	female	male	female
1986	397	279	118	64	17	47	6.09%	39.83%
1987	350	248	102	36	13	23	5.24%	22.55%
1988	408	292	116	65	29	36	9.93%	31.03%
1989	394	269	125	49	8	41	2.97%	32.80%
1990	432	310	122	57	19	38	6.13%	31.15%
1991	410	279	131	61	16	45	5.73%	34.35%
1992	397	285	112	60	17	43	5.96%	38.39%
1993	419	291	128	54	13	41	4.47%	32.03%
1994	396	285	111	42	17	25	5.96%	22.52%
1995	408	297	111	61	19	42	6.40%	37.84%
1996	337	248	89	43	9	34	3.63%	38.20%
1997	334	253	81	50	16	34	6.32%	41.98%
1998	***321***	***230***	***91***	***62***	***22***	***40***	***9.57%***	***43.96%***
totals	**5003**	**3566**	**1437**	**704**	**215**	**489**	**6.03%**	**34.03%**

Women were victims in fifty-five (55%) to eighty-four percent (84%) of the yearly domestic violence homicide cases, averaging sixty-nine percent (69%) for the thirteen years reviewed.[5] *See table 3 below*.

Table 3					
	dv homicides			% of total dv homicides	
year	total	male	female	male	female
1986	64	17	47	26.56%	73.44%
1987	36	13	23	36.11%	63.89%
1988	65	29	36	44.62%	***55.38%***
1989	49	8	41	16.33%	***83.67%***
1990	57	19	38	33.33%	66.67%
1991	61	16	45	26.23%	73.77%
1992	60	17	43	28.33%	71.67%
1993	54	13	41	24.07%	75.93%
1994	42	17	25	40.48%	59.52%
1995	61	19	42	31.15%	68.85%
1996	43	9	34	20.93%	79.07%
1997	50	16	34	32.00%	68.00%
1998	62	22	40	35.48%	64.52%
totals	**704**	**215**	**489**	**30.54%**	***69.46%***

[4] Ibid.
[5] ibid.

These facts were troubling to the Division on Women. A strategy was developed to further understand the problem of domestic violence homicide through the establishment of the New Jersey Domestic Violence Fatality Review Board.

To connect to the national effort of fatality review, in October 1998, a four person team[6] representing the NJ Coalition for Battered Women (NJCBW), NJ Department of Law and Public Safety, Division of Criminal Justice (L&PS-DCJ) and the Department of Community Affairs, Division on Women (DCA-DOW), attended the *Domestic Violence Fatality Review: A National Summit.* The National Association of Juvenile and Family Court Judges sponsored the summit. This summit consisted of best practice workshops, lectures and seminars focusing on the problem of domestic violence fatalities. The team participated in a simulated fatality review and group discussions in which critical issues were identified and addressed that can make the domestic violence fatality review process more effective.

When they returned, the team met to discuss an initial board development and research plan. This team reorganized as the genesis group and discussed DVFRB purpose and approach, structure and process, membership, scope of review, authority and confidentiality as well as other critical issues. An expansion of the genesis group brought into these organizational discussions a law enforcement professional, an assistant prosecutor, a psychologist and a medical professional. This expanded group continued refining board structure and process and began practice fatality review sessions. The first practice session was on October 13, 1999.

At the same time, a research team was organized to move forward on the research plan for the project. The research team completed a literature review of professional journals and developed an initial research design. The College of New Jersey, Seton Hall University, and the Graduate School of Social Work-Rutgers the State University of New Jersey provided interns throughout various stages of the project.[7]

Meanwhile, efforts to gain executive branch approval for the project succeeded through Executive Order 110, granting authority for the establishment of the Domestic Violence Fatality Review Board, being signed on March 15, 2000.[8] The Governor's office organized a press conference to announce the initiative. After gubernatorial appointments were finalized in September, the official board met for the first time on November 29, 2000.[9] Meetings were also held on January 10, 2001, February 14, March 14, April 19th and May 30th. The DVFRB has reviewed twenty (20) cases, representing forty-five (45) fatalities. Subsequent meetings are scheduled for the remainder of the year.

National efforts once again assisted the local process when the STOP Violence Against Women Grants Technical Assistance Office held a second national conference in November 2000. New Jersey sent a team of five DVFRB members[10] to hear current developments in the area of Domestic Violence Fatality Review Boards. A victim's family spoke about their perspective of the

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[6] Attending the first conference were Sandy Clark (NJCBW), Jessica Oppenheim (L&PS-DCJ), Grace Hamilton and Carol Vasile (DCA-DOW).

[7] For the first year the research team was Andrea Fleisch, MPH, Grace Hamilton, MSW, and Louise Taylor, Ph.D. Interns on the project were Viviana Morales (Seton Hall), Mary Taylor (Rutgers) and Kim Greiner (The College of New Jersey).

[8] See appendix for text of Executive Order #110.

[9] See appendix for list of current members with brief biographies.

[10] Attending the second conference were DVFRB members Sandy Clark, Grace Hamilton, Anna Trautwein and research team members Andrea Fleisch and Sue Rovi.

fatality review process. Projects that function complementary to the fatality review process were also presented.[11] The conference served to enhance the planning work of the New Jersey board as well as to confirm that New Jersey was successfully grappling with the pertinent issues in this endeavor.

Purpose and Approach

In national discussions one common purpose of domestic violence fatality review boards is to honor domestic violence homicide victims by learning from their deaths. In this spirit it is generally agreed that the person ultimately responsible for the fatal incident is the perpetrator of the crime. This is the case for the New Jersey DVFRB.

Primarily, the DVFRB reviews all available facts and circumstances of domestic violence related fatalities to identify and develop a process for change in policies, procedures and protocols that can lead to the prevention of domestic violence. The purpose is to see how, where and if systems change can be affected to help prevent domestic violence homicide, homicide-suicide and suicide. It is also an opportunity to enhance the cooperation between public and private entities that deal with domestic violence issues. Building trust among community service providers in delivering a coordinated community response to domestic violence is an intrinsic purpose of the DVFRB.

Goals of the Domestic Violence Fatality Review Board

- Describe domestic violence fatalities in New Jersey
- Identify trends and patterns in domestic violence fatalities and integrate understanding of possible antecedent risk factors into service system functioning
- Develop policy and systems change recommendations from qualitative case review of facts and circumstances of domestic violence fatalities

Board members fully recognize and acknowledge the differences in the circumstances of domestic violence occurring in different races, cultures and ethnicities. The approach of the board is to take such differences into account when reviewing each case and making recommendations.

Structure and Process

Many models of fatality review boards have been developed throughout the United States. There is no preferred model. Each organizing group adjusts its development to fit the needs, resources and structure of its community.

One of the first issues discussed in developing the DVFRB was the authority from which the DVFRB would function. There were several choices depending on whether the board would be a formal or informal structure. An informal structure might be a group of like-minded people from a discreet geographic area that agree to work together on a common issue, perhaps have worked together in the past and agree to go forward with little red tape. Since the DVFRB is dealing with confidential issues and source documents and is covering cases from the entire

[11]Two such projects are the Duluth community safety and accountability audit and the development of domestic violence lethality and risk assessments.

state that cross many jurisdictions, a formal structure better fit the needs for the New Jersey model. Two options for authority for a formal structure were available, namely, authority derived from either an Executive Order or from a state statute. An Executive Order was written which affords an opportunity to recommend legislative authority to enhance the operation of the DVFRB. Included in this report is draft legislation that incorporates such changes.

Some boards review all death certificates, all female deaths, or all domestic violence deaths, some include suicides and others include near fatalities. It was decided to begin this project by reviewing all cases of domestic violence homicide where the perpetrator follows the homicide with his or her own suicide. These cases were chosen because they are completed investigations. Homicide-suicide cases need no prosecution because there is no defendant. These files typically do not include information that is as comprehensive as when there is a need to support the prosecution of a case. More extensive information would assist the DVFRB in developing more comprehensive recommendations. However, these cases have provided the DVFRB an opportunity to develop and become accustomed to the review process and to foster an "esprit de corps" for the open exchange of ideas and information. It was decided that this single board would review cases from throughout New Jersey.

The research team has identified sixty-seven (67) cases of domestic violence homicide-suicide for review. They represent more than one hundred forty-five (145) fatalities. The DVFRB adopted a broader definition than the statutory criteria[12] of domestic violence fatality within the context of the homicide-suicide. Fatalities that fall outside of the statutory criteria (deceased was a completed suicide in domestic homicide-suicide, deceased was the child of the homicide victim or completed suicide, deceased was a law enforcement officer, emergency medical personnel or other agency responding to a domestic violence incident, deceased was another family member or other person in the homicide-suicide related to domestic violence) are included in the fatality count to capture a clearer representation of domestic violence fatality and its impact. In the future the DVFRB is interested in reviewing cases within the adopted broader definition of domestic violence homicide, homicide-suicide, suicide and cases of near fatality.

The membership of the DVFRB is its greatest asset. There are governmental and non-governmental members who are committed to the mission of fatality review. They provide valuable amounts of time, information and expertise.

Current membership of the DVFRB includes state and public members. Members from state agencies are the Attorney General, the Commissioner of the Department of Community Affairs, the Commissioner of the Department of Health and Senior Services, the State Medical Examiner, the Superintendent of the State Police, the New Jersey Public Defender, the director of the Division on Women, the supervisor of the Office on the Prevention of Violence Against Women and the project director of the Domestic Violence Fatality Review Board grant.

Public members appointed by the Governor are a representative from the New Jersey Coalition for Battered Women, a county domestic violence assistant prosecutor, a licensed psychologist, a law enforcement representative, a registered nurse and a child protective service worker with experience in family violence and child death review.

[12] As defined by NJSA 2C:25-19d

The draft legislation recommends that new members be included on the DVFRB. A delicate balance between inclusiveness and Board size must be achieved and maintained in order to ensure that the group is effective.

A key to ensuring successful operation of the DVFRB review is confidentiality of information brought to the meeting and the DVFRB deliberation. Without this, sensitive personal information concerning victims and victims' children and family members could be disclosed and open communication and coordination among participants in the review process could be effected. A confidentiality agreement was created and is signed by members prior to each meeting and each time a file is reviewed by a member.[13] The DVFRB is in the process of discussing guidelines to address internal confidentiality and professional ethics conflicts. Legislation providing the DVFRB review process and any records within that process and its members with confidentiality or exemption from public access, testimonial privilege and immunity from civil or criminal liability would enhance board functioning and is contained in the proposed legislation.

Case review protocol

- Staff identifies cases for board review.
- Information about the case is requested from the source agency. To date the primary source files have been the police and prosecutor files. Receipt of files can take 6-8 weeks. Once received, four copies are prepared. Board members read these copies. Each case has a separate research copy. All files are kept locked in a file cabinet in a secure office at the Division on Women.
- All members of the board are responsible for reading all cases on each meeting's agenda. A case information review form was created to assist reviewers in organizing the case information. Primary and secondary reviewers are asked to volunteer to present a case at the board meeting.
- A schedule of dates and times is provided for members to read case files at the Division on Women. Primary and secondary readers are allowed to take a copy of the file to prepare for the presentation; all other files must be read at the Division office. Members of the DVFRB travel to Trenton from throughout the state to read the case files. The primary and secondary reviewers return their respective file at the scheduled meeting.
- The entire board reviews scheduled cases. The primary and secondary reviewers present the facts of the case and discuss any system problems. Each board member also participates in the discussion. Preliminary recommendations are explored and recorded. At the conclusion of the review, two copies of the files are archived and all others are shredded.

A work group meets to analyze the discussion and bring fully developed recommendations to the Board.

A typical case may require ten to fifteen staff hours of preparation time (copying, organizing, extracting data and entering into SPSS® [14]) prior to the actual board review. The research team has extracted data from thirty-three (33) cases, representing seventy-one (71) fatalities. Additionally, each case takes on average two hours to read for each board member prior to the meeting and the DVFRB spends one to one and one half-hour discussing the case.

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[13] A sample of the confidentiality agreement is contained in the appendix.

[14] SPSS® is a statistical software package by SPSS, Inc. It is used by the research team of the DVFRB to store and analyze the data collected.

Funding

The STOP Violence Against Women grant has funded the DVFRB project for two years. A third year of funding has been approved for the project; this will continue the project until April 30, 2002. Currently the grant primarily funds two staff positions and a research consultant. Board members volunteer their time to the project. An appropriation proposal is included with the proposed legislation in the Appendix and a proposed budget plan is available from the DVFRB project director.

The remainder of this report will review the preliminary statistical results of the research project and present the recommendations and areas for future review resulting from the qualitative review conducted by members of the Board.

Research Report: A Description of Domestic Violence Fatalities in New Jersey

Purpose

To provide information about domestic violence (DV) fatalities in New Jersey to the DVFRB. Towards this end, the research team[15] developed a database designed to describe cases of domestic violence fatalities.

Scope of Investigation

In some DV homicide cases, the perpetrator kills him or herself after killing the victim(s). These cases became the primary focus of our research investigations for the past year.[16] To date, 67 cases have been identified as domestic violence H-S between 1994 and 1999.[17]

It is important to note that the literature on DV fatalities indicates that H-S cases may differ in significant ways from DV homicides in which the perpetrator does not kill him or herself.[18] In H-S, it's nearly always men who kill their current or former wives, lovers, or girlfriends. Some researchers have suggested that perpetrators in H-S cases may be less likely to have a criminal history or a documented history of domestic violence. Several studies have looked for psychological factors or possible precursors that might explain why some men (and in a few cases women) kill their intimate partners and then themselves, such as depression, jealousy or hopelessness. Additional research is needed to better understand these homicide-suicides. It is also necessary to consider the social context in which these crimes take place-of violence generally and violence against women in particular.

Data Sources

A primary source for data about these fatalities was police and prosecutors' case files. The contents of files varied considerably, but typically included some of the following documents: autopsy and toxicology reports, death certificates, investigators' reports, interviews with witnesses, family, friends, employers and others, previous police reports, (including warrants, restraining orders, etc.), weapons reports and suicide notes. Media reports provide another source of information about these cases. Additional data sources are being explored.

Data

Of the 67 DV homicide-suicide cases identified thus far, 33 cases were received from the prosecutors' offices and reviewed by the research team for inclusion in this report. The remaining 34 cases have been requested. A full report based on all cases will be made in the future.

Methods

The literature on DV in general and DV fatalities in particular was reviewed and the data/variables to be extracted from case files identified. Selected variables included

[15] For the past year, the research team was Andrea Fleisch, MPH, Grace Hamilton, MSW, & Sue Rovi, PhD and Kim Greiner an intern from TCNJ

[16] These "homicide-suicide" cases are often considered 'closed' cases because the perpetrator is known and dead. Such cases were selected because of confidentiality issues discussed above.

[17] The primary sources for case identification were media reports, county prosecutors' offices and the state police.

[18] There is a considerable body of literature on DV fatalities. See Suggested Readings located at the end of the report.

demographic data on the victims and perpetrators (e.g., sex, age, race/ethnicity, education, employment, etc.), data about the relationship between the victim and perpetrator (e.g., legal status, if any, and if the relationship was current, evidence of previous domestic violence in the relationship, etc.), and incident data (e.g., methods and locations of deaths, types of weapons, involvement of police, family/friends, children and others at the incident, etc.). The types of data sources were also recorded.

Procedures to standardize case review for research purposes were developed along with a data extraction form with over 200 variables and an associated data definition dictionary. Two and sometimes all three members of the research team reviewed each case, completed data extraction forms and then compared them. Differences in coding were discussed and modifications made as needed in procedures and forms. Approval of the research project was secured from the New Jersey Department of Health and Senior Services and New Jersey Medical School's Institutional Review Boards in June 2000.

Findings

Of the 33 H-S cases reviewed to date, 30 were intimate partners.[19] In the three remaining cases: 1) the victim and perpetrator were brothers, 2) a son, whose parents had been intimate partners and whose relationship involved domestic violence, was killed by his father, and 3) the victim and perpetrator were acquaintances and the male perpetrator may have wanted an intimate relationship with the victim, but case review showed no evidence of such a relationship. In all, there were 33 perpetrators and 33 'primary' victims (i.e., in cases with more than one victim, only the victim who was the primary target of the perpetrator in the H-S is reported here.) There were also five associated (or secondary) victims, bringing the total number of fatalities to 71.

Important note*: The research team took a conservative approach to data extraction. The findings presented here are based on information that was in the case files, i.e., it was NOT missing or UNKNOWN. For example, the absence of documentation in the file of previous restraining orders, does not necessarily mean there were none, rather they may 1) not be in the file, or 2) not discovered during the case investigation. In general, the research team did not make assumptions or record data from statements that were not substantiated. The effect of this conservative approach may be underreporting on some variables.*

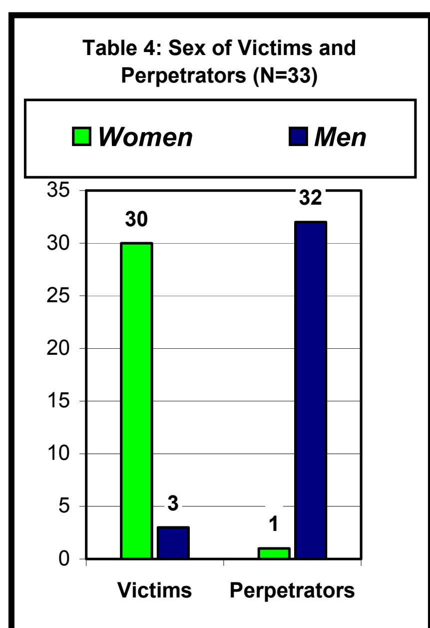
Key findings based on the 33 cases reviewed thus far are similar to findings of other researchers:

- **Mostly men killing women.**
- **Most cases involve intimate partner relationships.**
- **In most, evidence of recent separation or threat of separation.**

Firearms are most frequently used.

[19] Intimate partners include current or former spouses and boyfriends/girlfriends. All of the 30 intimate partner couples were opposite sex, i.e., the relationships were heterosexual.

Demographic Characteristics of Victims and Perpetrators (N=33)



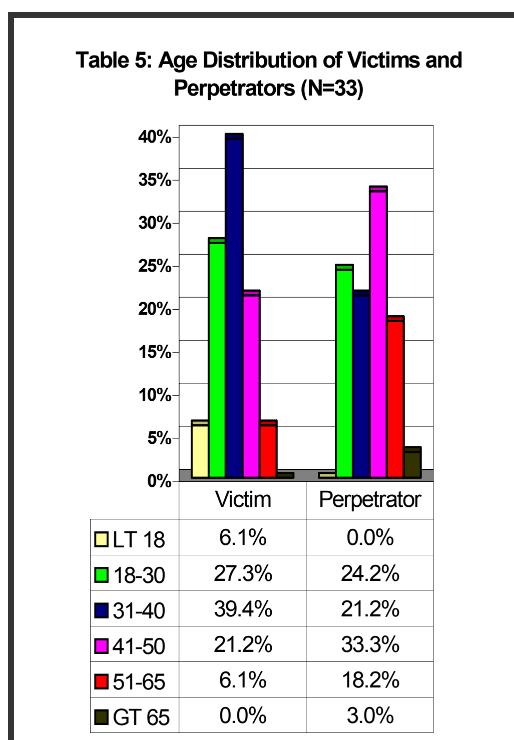
In nearly all of the reviewed cases of DV homicide-suicide in NJ, the victims were women (30 or 90.9%) and men were the perpetrators (32 or 97.0%). *See Table 4.*

With respect to the racial/ethnic identities[20] of the primary victims and perpetrators:

- Approximately 2/3 of victims (66.7%) and perpetrators (63.6%) were White.
- Roughly 1/4 of victims (24.2%) and perpetrators (27.3%) were Black or African-American.
- 9% and 6% of victims and perpetrators respectively were Asian.
- And, one perpetrator was identified as multi-racial.

The identification of victims and perpetrators as Hispanic was inconsistently noted in case files, however, in three cases (9.1%) the victim was so identified and in six cases (18.2%) the perpetrator.

The mean age of victims was 35, ranging from 4 to 59 years, whereas the mean age of perpetrators was 41, ranging from 18-66 years.[21] Similar mean ages and a mean difference of several years between the perpetrator and victim are reported in the research literature. *See Table 5 for age distributions of perpetrator and victims.*



	Victim	Perpetrator
LT 18	6.1%	0.0%
18-30	27.3%	24.2%
31-40	39.4%	21.2%
41-50	21.2%	33.3%
51-65	6.1%	18.2%
GT 65	0.0%	3.0%

In effect, it's mostly men killing their slightly younger intimate partners.

Using NJ Uniform Crime Report definitions, the location of these crimes, or the rural, suburban or urban classification was determined based on the city or town in which the homicide took place. [22] Most often, this location was also the same for the suicide

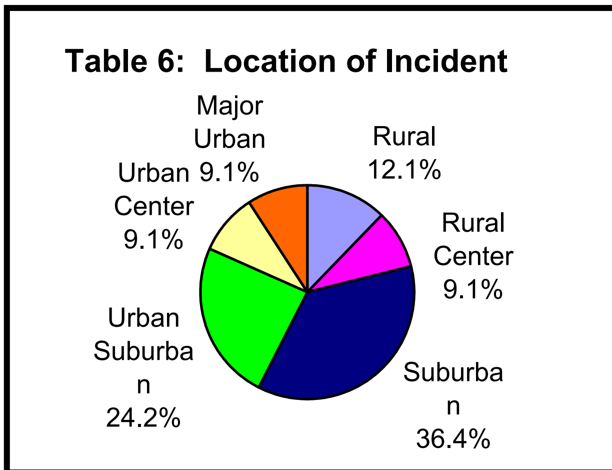
[20] CDC definitions were used for race/ethnic identity. See US Department of Health and Human Services. (1999). Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements (pp. 11-14). Atlanta, Georgia: Author.
[21] There was considerable variation in the ages of the perpetrators and victims, with standard deviations of 11.82 and 11.47 respectively. Also recall that in one case, the primary and only victim killed was a child who was 4 years of age, and this case was omitted from the age calculations.
[22] For additional information about the rural/suburban/urban classifications, see New Jersey Uniform Crime Report for 1999, pages: 5-6. Note: Designations may change over time.

and/or it was the residence of the victim. *See Table 6.*

- Nearly 2/3 or 60.6% were in suburban or urban-suburban areas.

- 21.2% were in rural areas, including rural centers.

- 18.2% were in urban areas.



As outlined above, other demographic data about the victims and perpetrators were extracted when available, such as education, employment (both status and occupation), income, and immigration status, among others. In most cases, however, there was insufficient data in the files for reporting purposes. Nonetheless, based on available data, these cases demonstrate, as the literature has already shown, that domestic violence occurs among all socio-economic statuses. Among our cases, there were factory workers, lawyers, carpenters, teachers, police officers, waitresses, students, the retired and the unemployed.

Intimate Partner Relationships (N=30)
Homicide-suicides of intimate partners predominated in the cases reviewed thus far and because these differ legally and socially from other types of relationships, they are reviewed separately. For example, intimates may marry and/or cohabitate.

For the 30 cases in which the victim and perpetrator were intimate partners,[23]

- In all but one case, the victims were women who were killed by their current or former male intimate partner.

- In 17 cases (56.7%) the couple was currently married or separated; and of these, over half (10) were married for 10 or more years.

- In nearly three-fourths of the cases (73%), there was evidence that the victim was planning to separate, already separated or in the process of separating from the perpetrator. In the remaining cases (27%), the relationship was reportedly current at the time of death, although information about whether or not the couple could have been separating may not have been documented in the case files.

- Of those reported to be in the process of breaking up (40%), over half had been separated less than three months.

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[23] Information about the relationship was sometimes based on the victim's filing a complaint, a police report, or a suicide note, but it was also supplied by friends, family and others and therefore reflects who the police interviewed, what was asked and the responses given. More so than other data being reported on here, these findings are likely to under-report the number of couples breaking up, with a history of domestic violence and in which the perpetrator demonstrated jealousy, possessiveness, or suspected infidelity of the victim. For example, even the legal length of the relationship was inconsistently mentioned and in some cases it was not mentioned at all.

- In two cases, the victims were pregnant, and in both cases, it was known that the couples were arguing over the pregnancy.

- In half of the cases (50%), there was a history of physical or sexual DV by the perpetrator as evidenced in police reports (33.3%: e.g., prior reports of violent episodes or issuance of restraining orders) and/or by family, friends or employers who said they suspected DV when interviewed by the police (16.7%). *For the remaining half, a history of DV may not have been in the case files, however, since we know that DV is often not known by others or known but not acknowledged, we expect it may have existed in some of these cases*.

- Family and friends who were interviewed by police also reported emotional or psychological abuse[24] by the perpetrator in 53.3% of the cases and in another 20% of cases, such abuse was suspected.

- In 40% of police reports, there were statements of the perpetrator's jealousy, possessiveness or perceptions of the victim's infidelity, sometimes in the victim's or perpetrator's own words (e.g., complaint reports or suicide notes), and also by family and friends interviewed by police after the deaths.

- Current Final Restraining Orders (RO) had been issued in three of the 30 cases, all of which had RO violations according to police reports. Two other victims had prior Final ROs. And, two other victims had prior Temporary Restraining Orders (TRO), and in both cases, there were RO violations in police reports.

- In over a third of cases (36.7%), there were police reports of calls to the residence(s) of the victim and/or perpetrator specifically for domestic violence.

After the deaths occurred, family or friends, who were interviewed by police, reported instances of abuse (physical, sexual, emotional or psychological) by the perpetrator towards the victim in 60% of the cases, and in another 13.3% of the cases, they suspected it. Some employers, who were interviewed by police, also reported knowing about the DV in 26.7% of cases. In most of these reports, those interviewed did not often refer to the abuse as DV, thereby suggesting that more education about DV is warranted.

[24] "*Psychological or emotional abuse* involves trauma to the victim caused by acts, threats of acts, or coercive tactics, including but not limited to: 1) Humiliating the victim, 2) Controlling what the victim can and cannot do, 3) Withholding information from the victim, 4) Getting annoyed if the victim disagrees, 5) Deliberately doing something that makes the victim feel diminished, 6) Deliberately doing something that makes the victim feel embarrassed, 8) Using money that is the victim's, 9) Taking advantage of the victim, 11) Disregarding what the victim wants, 12) Isolating the victim from friends or family, 13) Prohibiting access to transportation or telephone, 14) Getting the victim to engage in illegal activities, 15) Using the victim's children to control victim's behavior, 16) Threatening loss of custody of children, 17) Smashing objects or destroying property, 18) Denying the victim access to money or other basic resources, 19) Disclosing information that would tarnish the victim's reputation." See Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0 Atlanta, GA: National Center for Injury Prevention and Control, CDC, 1999: 61-66.

Sources for Interventions

In order to begin to identify other individuals in the community, such as various professionals and/ or individuals working in agencies that may have interacted with the victim or the perpetrator for any reason in the last five years or may even have interacted with them about domestic violence in particular, we looked in the files for any "mention" of such interactions. Along with law enforcement and agents of the courts, 37 'helping' agencies, professionals or community individuals were tracked in this way. These 'helping' agencies and/or professionals include: city and county prosecutors, courts and judges, probation and parole officers, programs such as anger management, batterer's intervention, substance abuse, health care providers, hospitals, battered women's shelters, religious community, Division of Youth and Family Services (DYFS), Office of Victim Witness Advocacy (OVWA), among others. Three notable examples are provided here:

- In 12.1% of cases, perpetrators saw mental health professionals (MHP) specifically about the violence in the relationship and they saw MHPs for other reasons in another 24.2% of cases. Slightly fewer victims (21.3%) saw mental health providers for any reason in the last five years.

- Victims saw attorneys in 27.3% of cases, typically to discuss possible separation or divorce, compared to 15.2% of perpetrators.

- Contacts with health care providers were recorded for victims in 27.3% of cases and 18.2% for perpetrators.

Despite the fact that case files are unlikely to record the contact information sought here and therefore seriously underreport contacts with victims and perpetrators, these examples nonetheless suggest possible important sources for future interventions aimed at avoiding these fatalities.[25]

[25] Methods to enable confirmation of contacts or to initiate reports of contacts by these helping agencies or agents are being explored.

Incident-Specific Characteristics (N=33)

Perpetrators most often shot their victims (75.8%), and they also most often shot themselves afterwards (81.8%) with shotguns, handguns, and in one case an Uzi semi-automatic. *See Table 7* for other methods used to kill the victim and other methods of suicide. In two incidents (6.1%), the perpetrator was shot by a police officer, and in both cases the perpetrator's death resulted from his dangerous and threatening actions towards police or others at the scene.[27]

Table 7: Methods of Homicide/Suicide (N=33)		
Methods	**Victim**	**Perpetrator**
Shooting	75.8%	81.8%
Vehicle Crash	0%	3.0%
Stabbing	6.1%	0%
Asphyxiation	3.0%	3.0%
Strangulation	6.1%	0%
Hanging	0%	3.0%
Poisoning	3.0%	3.0%
Multiple Methods[26]	6.1%	0%
Shooting by Police Officer	0%	6.1%

In the 27 cases in which a gun was used, the perpetrator typically owned the gun (66.7%), although in one-fourth of these cases (25.9%) gun ownership was unknown.[28] And in four cases, it was established that the gun was purchased within one month of the incident. In another four cases, the perpetrator was a law enforcement officer who used his service weapon to commit the homicide and suicide.[29]

In all but one case, the time between the homicide(s) and the suicide was less than 24 hours, and typically within an hour of the murder.

In more than half of the cases (57.6%) or 19 of the 33 reviewed, the perpetrator made explicit threats to kill: himself or herself (24.8%), the victim (36.4%), and/or others (18.3%).[30] And, these threats were reported to the police in nearly half of these cases (9 of the 19).

[26] The multiple methods used in these two incidents were: one victim was bludgeoned with hammer and fists (blunt trauma) and stabbed multiple times, and the other victim was strangled (asphyxiation) and stabbed.

[27] Technically, these cases are homicides, however, the perpetrator's behavior in effect forced the police to kill him. For example, in one case the perpetrator was reported to have repeatedly stated, "kill me" as he threatened to kill others at the scene. Such cases are sometimes referred to in the literature as "suicide by cop".

[28] Ownership is broadly defined here because most case files did not provide weapons report. Therefore, whether or not the perpetrator 'owned' the gun was determined by reviewers from: 1) a weapons report, 2) reports by friends and family who knew the perpetrator had the gun, and 3) a bill of sale for the gun.

[29] Since in 4 of the 33 cases, the perpetrator was a law enforcement officer, this means that in all four (100%) of these cases, the perpetrator used his service revolver to kill the victims and then himself.

[30] In some cases, perpetrators threatened to kill themselves and someone else, and therefore the total percent is greater than 100%. However, 57.6% represents 'any' threats to kill.

Most often, the location of the homicide(s) and suicide were the same (87.9%). The victims were often killed within what might be considered one's 'safety sphere'[31]: their homes (63.6%) and workplaces (12.1%). *See Table 8 for locations of fatalities.*

Of victims killed in their homes, 42.4% shared the residence with the perpetrator. Victims were also killed in the perpetrator's residence (15.2%), a car (3.0%) and other locations (6.1%). Perpetrators' suicides were committed in shared residences (36.4%), the victim's residence (21.2%) or their own (i.e., not shared with victim) residences (15.2%), as well as the victim's workplace (9.1%), cars (9.1%), or other locations (9.1%).

Table 8: Locations of Suicide & Homicides (N=33)		
Locations	**Homicide**	**Suicide**
Shared Residence	42.4%	36.4%
Victim's Residence	21.2%	21.2%
Perpetrator's Residence	15.2%	15.2%
Victim's Workplace	12.1%	9.1%
Car	3.0%	9.1%
Other	6.1%	9.1%

In 21.2% of cases, there were children at the scene of either the homicide or suicide or both; and at 39.4% friends or family members were present; at 31.3% police were present and at 18.2% there were others at the scene. In one incident, a child, who was not the primary victim, was killed and another child wounded. Also killed were three family or friends of the victim and one police officer. In all, there were five additional fatalities.

Toxicology reports were available in nearly all cases[32] These reports showed that 24% of perpetrators had a blood alcohol level (BAL) greater than zero, ranging from .025 to .088 with two above the legal limit at .164 and .330. Two victims had a BAL below .05. Illegal drugs were found in six perpetrators (e.g., cocaine, PCP).

Contents of case files

As to the contents of the case files, the types of reports included:
(Note: reports may be separate for perpetrator (P) or victim (V).)

- Weapons (30%)
- Computerized Criminal Histories or CCH (P: 6% and V: 3%)
- Report of prior calls (36%)
- Psychiatric evaluations (P: 6%)
- Autopsy (P: 97%, V: 97%),
- Toxicology (P: 94%, V: 97%),
- Death certificates (P: 46%, V: 40%),
- Suicide notes written by the perpetrator (21%) or personal statements by victims (18%) were sometimes found in police reports.

[31] The safety sphere is the personal circle in which an individual feels secure. It is typically the places that one inhabits on a daily basis, for example: one's home, friends' and families homes, the place where one works, and the streets one travels regularly. For the context of the report we assume that a victim's safety sphere is her home, work, school and family's home.
[32] In several cases, alcohol or drug use could not be assessed because the perpetrator or victim did not die at the time of incident and may even have been given drugs as part of life-saving efforts or organ harvesting procedures.

Other reports mentioned earlier were also among the file contents. The contents of case files differed considerably, as did the cases themselves, and the mean number of pages per file was 102, ranging from 7 to 455 pages. In addition, newspaper articles or media reports were available for 94% of the cases.

Data limitations

It is important to acknowledge the limitations of these findings:

- Most of the data reviewed was collected for the purposes of police investigations and therefore these data were not collected for research purposes. This means data collection was not systematic or consistent.

- Since the cases described in this report are homicide-suicide cases, and as such often considered ‘closed’ cases, there may have been a less extensive investigation than if the perpetrator was alive and/or not known.

- Investigation and reporting procedures in NJ differ by county and jurisdiction.

- As stated earlier, data for selected variables was often missing from case files. Therefore, the findings presented here represent information that was NOT missing or UNKNOWN and most likely result in underreporting of various statistics (e.g., the numbers of police arrest, warrants, restraining orders, or DV related calls to residences, among others).

- The limited number of cases and the considerable variation among cases limits the generalizability of these findings.

Subsequently Identified Cases (N=67 or 34 additional cases)

Subsequent to the initial research investigation reported on above, 34 additional DV homicide-suicide cases were identified through police and prosecutors' files, searches of media databases and other sources. Case files have been requested and need to be reviewed. However, the research team has read news reports about 31 of the 34 incidents, and preliminarily, no significant changes are anticipated in the key findings presented above.[33] As with the initial review, we again found mostly men killing their current or former intimate partners, and guns continued to be the weapon used in most of the incidents. In all, there were 145 fatalities (67 primary victims, 67 perpetrators and 11 associated deaths). A report based on all 67 cases will be made in the future.

To summarize the key findings in New Jersey's homicide-suicide cases that have been reviewed by the research team of the DVFRB: in nearly all cases, the perpetrators were men, who typically killed their intimate partners. In most of these cases, the woman was planning to leave or the couple had recently separated. Often in case files, there was evidence of a history of DV including police reports of prior incidents of violence or threats of violence and/or reports or suspicions of DV by family, friends and employers. Lastly, guns were used most frequently in these fatalities. These findings match the more commonly reported scenario of these deaths nationwide.

Although the findings reported here on DV-related homicide-suicides tend to support the common equating of domestic violence and intimate partner violence (IPV), other violence in the home that ended in deaths was also evident. These fatalities included violent relationships between siblings as well as parents and children.[34] Such cases may share important similarities in the violence perpetrated when compared to cases of IPV, but they may be even less likely to be identified as DV and to get support from families, friends or communities. Although we are likely to continue to find that IPV predominates in DV-related fatalities, it is important to develop a definition of DV fatality that is as inclusive as possible. In so doing, we can learn from the similarities and differences among cases and work to prevent these deaths in the future.

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[33] Nonetheless, our review suggests that there are more cases in the subsequently identified H-S incidents, which do not fit the 'typical' case (9 of the 34 compared to 3 of the 33). For example, in the initial review, there were no cases of older adults killing partners and then killing themselves. In the subsequently identified cases, there are four incidents in which the victims and perpetrators are over 70 years of age. The circumstances surrounding these H-S cases may cause them to be referred to as 'mercy killings,' i.e., older adults killing partners in poor health and then killing themselves. These cases are appropriate for review by the DVFRB. Other 'atypical' cases include H-S cases that involved lover's triangles and family members who were not intimates (e.g., siblings, parents and children, etc.). In effect, the research team expanded the definition of Domestic Violence fatalities to include cases that are not always identified as such.

[34] A Child Fatality Review Board exists in New Jersey for review of children's deaths that may have been caused by parental abuse. Deaths resulting from violent relationships between parents and their adult children including emancipated minors are of interest to the DVFRB.

DVFRB Recommendations

The Domestic Violence Fatality Review Board (DVFRB) has been charged with the task of reviewing domestic violence-related fatalities and offering recommendations for systems change that may prevent these fatalities in the future. Four themes emerged during the deliberative process. They centered on the areas of education, law enforcement, a coordinated community response to domestic violence, and the court system. Within each of these themes numerous ideas for recommendations to facilitate systems change were generated. In this section of the report, the four themes are presented followed by four recommendations.

EDUCATION - In the DVFRB's review of homicide-suicide case files, two distinct education needs were identified around the issue of domestic violence.

- **Public education and community awareness**. In the case files family members, friends, co-workers and neighbors typically reported that they knew about the abuse of the victim by the perpetrator. They showed remorse for the victim and concern over what happened, but they seemed unable to clearly identify or articulate the dynamics as domestic violence and/or they did not know how, or if they could have helped. Through effective public and community education, New Jersey can educate family members, friends, co-workers and neighbors about what domestic violence is and what they can do.

- **Professional education and training**. In addition to family and friends, the review found that many community professionals had indications of the domestic violence. These professionals were the doctors visited, the attorneys consulted, the psychiatrists, psychologists, counselors, and clergy that victims or their abusers reached out to during the year, month, weeks or days prior to the fatal incident. There are indications that many of these professionals had, but did not recognize, clues to the domestic violence within the family. Education and training is needed to understand how to recognize domestic violence. Identifying that domestic violence is present would enable a professional to provide appropriate assistance, referrals and evaluations and may prevent a tragic end. Professional education must include learning how to assist a victim with creating a safety plan. [35]

LAW ENFORCEMENT- The Domestic Violence Fatality Review Board discovered several areas for recommendations within law enforcement. Issues for law enforcement are two-fold.

- **Domestic violence in the families of law enforcement personnel**. Over 10% of the homicide-suicide cases in the time period examined (1994-1999) involved law enforcement families. In the cases reviewed by the DVFRB, law enforcement personnel who killed intimate partners and others and then completed suicide used their service weapon to carry out these crimes. The DVFRB suggests immediate attention to the complex constellation of issues specific to law enforcement families.

- **Other issues involving law enforcement.** The continued possession of firearms, firearms purchaser cards or firearms identification cards by domestic violence offenders, inconsistencies in the initial charging of domestic violence offenders who may have

[35] A ‘safety plan’ is one method through which victims can reduce their risk of harm. A victim can evaluate her/his own life and strategize about ways to promote safety.

committed the same offense, and development of a hostage rescue response protocol that is specific for domestic violence incidents are among the identified issues needing further analysis.

COORDINATED COMMUNITY RESPONSE - In reviewing case files the DVFRB found that in several instances many members of the community, e.g., service providers, the courts, medical personnel, child protective services, mental health providers, and even animal control, knew part but not the full extent of the domestic violence. Had they possessed knowledge about the full scope of the problems they may have been able to facilitate more effective interventions. Coordinated community approaches to domestic violence have been shown to increase the chance that a victim will receive the services needed.[36]

The Domestic Violence Fatality Review Board model is one that follows the principles of coordinated community response. The DVFRB is a multidisciplinary group working together to develop strategies to end domestic violence fatalities. For the work of this group to continue, the DVFRB must be established through legislation.

THE CRIMINAL JUSTICE/COURT SYSTEM RESPONSE - The criminal justice system response includes all the activities of the system from the initial complaint that is made through the involvement of the police to the involvement of the prosecutor's office and the decision making process that is conducted by the courts. During case review the DVFRB saw many examples where victims of domestic violence reached out to the system in efforts to protect themselves. These efforts were met with responses that did not result in victim safety.

While the DVFRB is not prepared at this time to address specific recommendations to the criminal justice/court system, it is anticipated that there are many improvements that can be made to the process. Some of these improvements might include offender evaluations that are tailored to the special dynamics of domestic violence, bail conditions that protect victims, and trial scheduling that enables victims of domestic violence to move forward and begin to protect themselves from their abusers. Changes to the system would create an environment that ensures safety for victims and accountability of the offenders. Many states have initiated the use of domestic violence courts that are tailored to the special needs of domestic violence victims and offenders. These are often special sessions when only domestic violence cases are heard separately from other court issues. The DVFRB also supports the findings and recommendations of the Pro-Prosecution Taskforce of the Advisory Council on Domestic Violence. The Taskforce's report: Model Criminal Justice System Response to Domestic Violence addresses many of the concerns of the DVFRB.[37]

From these four themes the Domestic Violence Fatality Review Board developed four recommendations for the prevention of domestic violence fatalities in New Jersey. While these measures do not address all of the issues they are an important first step. The DVFRB hopes to continue its work developing ideas and to submit subsequent recommendations.

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[36] Hart, B. 1995. Coordinated Community Approaches to Domestic Violence. *Mincava Electronic Clearinghouse.* http://www.mincava.umn.edu/hart/nij.htm

[37] Pro-Prosecution Taskforce of the Advisory Council on Domestic Violence. 2000. Model Criminal Justice System Response to Domestic Violence. State of New Jersey. Copies can be obtained by contacting The Advisory Council on Domestic Violence c/o Division on Women PO Box 801 Trenton, NJ 08625. (609) 292-8840

The Domestic Violence Fatality Review Board recommends the following:

1. **TO PERMANENTLY ESTABLISH THE NEW JERSEY DOMESTIC VIOLENCE FATALITY REVIEW BOARD THROUGH STATE STATUTE**

The New Jersey Domestic Violence Fatality Review Board recommends the permanent establishment of the DVFRB through state statute. This will allow the DVFRB to continue its work of reviewing domestic violence-related fatalities. The DVFRB will strengthen collaboration between public and private agencies and develop a process for change in policies, procedures, protocols, and systems to prevent domestic violence generally and domestic violence-related fatalities specifically. Based on the evidence that has been compiled thus far, the DVFRB feels that a permanent board is warranted.

2. **TO SPONSOR A STATEWIDE PUBLIC EDUCATION CAMPAIGN**

The New Jersey Domestic Violence Fatality Review Board recommends that the State of New Jersey sponsor a new public education campaign that addresses domestic violence prevention. The campaign will educate citizens of New Jersey what can be done to help family, friends, co-workers, and neighbors when they are experiencing domestic violence. It has been well over a decade since the State has addressed domestic violence through a public education campaign.

Professionals with knowledge in the field of domestic violence should create the public education campaign, with the assistance of a professional public relations organization. A community needs assessment should be performed to get an up-to-date view of what types of education the people of New Jersey need in order to absorb the message that communities can end domestic violence. The campaign must address the needs of the culturally diverse population of New Jersey, which includes people of all races and ethnicities as well as recent immigrants to this country. In addition, it is imperative that domestic violence services and law enforcement agencies are prepared for the increased need for services as a result of such a campaign.

The DVFRB requests adequate funds be appropriated for a statewide public education campaign to the Office on the Prevention of Violence Against Women in the Division on Women who will then oversee its creation and implementation.

3. **TO ORGANIZE A COMMITTEE ON DOMESTIC VIOLENCE IN THE LAW ENFORCEMENT COMMUNITY**

The Domestic Violence Fatality Review Board recommends that a committee of the Board establish an expert panel to study the special issues that are associated with domestic violence among law enforcement officers and their families. The members of the panel will include a broad representation from law enforcement and experts in the field of domestic violence. This committee of the Board will be charged with addressing those issues that can prevent deaths of officers and their families

The purpose of the Committee must be 1) to identify issues relevant to preventing/reducing and handling domestic violence cases where the perpetrator is a law enforcement officer; 2) to develop a plan to effectively address these issues; and 3) to ensure implementation of the plan. These issues include but are not limited to*:*

- education for law enforcement officers on the consequences of committing domestic violence;[38]
- general support for law enforcement especially in high risk situations, i.e., divorce and separation;
- information to partners and family members of law enforcement officers on domestic violence policies;
- support for victims and family members;
- a process for victims to obtain immediate assistance with problems related to law enforcement perpetrator or the law enforcement agency;
- development of a statewide policy regarding the handling of incidents of domestic violence by law enforcement officers.[39] Among other issues, this policy would address intervention for law enforcement perpetrators, evaluations of law enforcement perpetrators and a weapons seizure and rearming policy. Currently the state has a weapons seizure policy that would be reviewed and updated if necessary.

4. TO CONDUCT COMMUNITY SAFETY AND ACCOUNTABLITY AUDITS

The Domestic Violence Fatality Review Board recommends that New Jersey begin evaluating the state's response to domestic violence by conducting Pilot Community Safety and Accountability Audit(s).

Several organizations around the state that deal with issues of domestic violence have begun to employ coordinated community approaches to domestic violence. These efforts include the creation of crisis intervention teams by domestic violence agencies and law enforcement agencies around the state, the publication and distribution of the *Model Criminal Justice System Response* by the Pro-Prosecution Task Force of the Advisory Council on Domestic Violence and the meetings of statewide and county Domestic Violence Working Groups. In fact, Coordinated Community Response was the topic of the statewide STOP Violence Against Women Conference held in November of 1999. The DVFRB applauds these efforts and suggests a specific model for communities to evaluate their own responses to domestic violence. The Domestic Abuse Intervention Project of Minnesota has developed the Domestic Violence Safety and Accountability Audit. "A safety audit is a systematic observation and analysis of the intra- and inter-agency routines and paper trails used in processing 'cases' of domestic abuse. It is not a performance review of individual staff members; it is not meant to uncover personal inadequacies and prejudices, or assess an individuals effectiveness."[40]

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[38] Work in this area has been started by The Department of Law and Public Safety's Employee Assistance Program, which had developed a program called "Domestic Violence and the Law Enforcement Family."

[39] Please see: International Association of Chiefs of Police. 1999. Model Policy on Police Officer Domestic Violence.

[40] Minnesota Program Development, Inc. 2000. Domestic Violence Safety and Accountability Audit. Distributed at STOP TA Conference on November 15-17 in Nashua, NH.

There are many ways that communities can conduct a safety audit. The safety audit can be directed toward one component that needs to be reworked or it can review the entire system from the minute a victim reaches out for services, law enforcement or the courts through the prosecution of a case. Outside consultants can be brought in to conduct the safety audit and observe the process. The result of the audit is a report, which will point out weaknesses in the system as well as point out opportunities for improvement. Then communities can effectively begin to change the system where it is needed and prevent victims from falling through the cracks.

The Domestic Violence Fatality Review Board suggests that adequate funds be allocated to the Office on the Prevention of Violence Against Women in the Division on Women to implement the community safety and accountability audit(s).

There is much work to be done to protect New Jersey families from abuse and domestic violence related deaths. The Domestic Violence Fatality Review Board requests the authority to implement these four recommendations in its mission to prevent domestic violence deaths.

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Appendix

The appendix contains the following sections:

- Executive Order 110
- Brief Biographies of DVFRB Members
- Proposed draft legislation

Governor Christine Todd Whitman

Executive Order No. 110 (2000)

Domestic Violence Fatality Review Board

Issued: March 15, 2000

Effective: March 15, 2000

WHEREAS, domestic violence is a pervasive problem in American Society and in the State of New Jersey; and

WHEREAS, domestic violence devastates its victims and threatens the health and safety of families; and

WHEREAS, domestic violence imposes staggering costs on society associated with legal and medical expenses, law enforcement, social services, the courts and lost productivity in the workplace; and

WHEREAS, people die each year in New Jersey as a result of domestic violence, in circumstances that may be preventable; and

Whereas, a function of the Office on the Prevention of Violence Against Women (the "Office") in the Division on Women of the Department of Community Affairs is to implement strategies to prevent violence against women and to explore prevention initiatives;

NOW, THEREFORE, I, CHRISTINE TODD WHITMAN, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of this State, do hereby ORDER and DIRECT:

1. There is hereby established the Domestic Violence Fatality Review Board (DVFRB) within the Office to study domestic violence related deaths and make recommendations regarding how these fatalities may be prevented.

2. The purposes of the DVFRB are to:

a. Enhance the cooperation between public and private entities that deal with domestic violence issues with the goal of reducing premature deaths involving domestic violence.

b. Review facts and circumstances of domestic violence related fatalities to identify correlates of domestic violence related fatalities, and to perform other research as necessary toward the prevention of domestic violence related fatalities.

c. Develop a process for change in policies, procedures and protocols necessary to accomplish improvement in the prevention of domestic violence related fatalities.

3. The DVFRB shall consist of the following 15 members:

a. The Attorney General, the Commissioner of the Department of Community Affairs, the Commissioner of the Department of Health and Senior Services, the State Medical Examiner, the Superintendent of the State Police, the New Jersey Public Defender, the director of the Division on Women, and the Project Director of the Domestic Violence Fatality Review Board Grant or their designees.

b. Public members appointed by the Governor shall include one representative each from the following: a representative of the New Jersey Coalition for Battered Women, a county domestic violence assistant prosecutor, a licensed social worker or a psychologist with demonstrated expertise in the field of domestic violence, a law enforcement representative with experience in domestic violence, a licensed physician or registered nurse or nurse practitioner knowledgeable in the field of domestic violence and/or forensic pathology, and a child protective service worker with experience in family violence and child death review.

4. The DVFRB shall:

a. Collect, review and analyze information including death certificates and death data, investigative reports, police, medical and counseling records, victim service records, employment records, or other information concerning domestic abuse fatalities, survivor interviews and surveys, and other information deemed by the DVFRB as necessary and appropriate concerning the causes and manner of domestic violence fatalities.

b. Determine whether a domestic violence related death might have been prevented with improved policies or procedures of the health care system, social services system, law enforcement, the courts, or any other public or private entity. The DVFRB may make recommendations based on an analysis of information gathered through this process.

c. No domestic violence related fatality may be reviewed if there is an on-going investigation or prosecution, unless the law enforcement agencies having responsibility for the case certify that the DVFRB's review will not impede the investigation or prosecution.

d. The DVFRB may establish committees or panels to whom the DVFRB may assign some or all of its responsibilities.

e. The Office shall develop operation guidelines for the administration of the DVFRB.

f. Develop a database for the analysis of an aggregate population of domestic violence related fatalities. The DVFRB shall not permit dissemination of non-aggregate information except as provided by law.

g. Research data analysis committee may be established to gather data from institutions and individuals and to organize and summarize information for the full DVFRB to develop a process for system change.

5. The DVFRB is authorized to call upon a department, office, division or agency of this State to supply it with data and other information or assistance it deems necessary to discharge its duties under this Order. Each department, office, division or agency of this State is hereby required, to the extent not inconsistent tw9ith law, to cooperate with the DVFRB and to furnish it with such information and assistance a is necessary to accomplish the purposes of this Order.

6. The DVFRB shall report to the Governor, no later than one year form the date of this Executive Order, on the DVFRBs progress and findings, and to make any recommendations regarding the DVFRB's operation, including whether legislative authority would enhance the operation of the DVFRB.

7. To the extent not inconsistent with current law, any information received from an institution, agency, individual, board, court, legislative committee, or other entity shall be kept confidential, and shall not be disclosed by the DVFRB or its membership except in an aggregate form for research purposes by the DVFRB and its members.

8. This Order shall take effect immediately.

Published April 3, 2000 in the New Jersey Register at 1101(a).

Brief Biographies of Domestic Violence Fatality Review Board Members

Linda B. Bowker
Director, Division on Women

New Jersey Division on Women Director Linda Bowker has a rich history of public service in advancing the status of women in New Jersey and throughout the Nation. Ms. Bowker was elected President of NOW-NJ, and served on the National Board of Directors. She was the Special Projects Organizer with the Feminist Majority and Campaign Director of NOW-NJ's "Elect a Women for a Change". She was nominated in March of 1994 by Governor Whitman to be Director of the Division on Women and has since served in that position. Ms. Bowker is a graduate (BA 1971, Political Science) of Drew University, Madison, NJ.

Ruth Charbonneau, RN., J.D
Director, Policy and Research
Department of Health and Senior Services

Ms. Charbonneau is responsible for coordinating the planning and research of departmental policy initiatives that affect multiple interests and divisions. Prior to her assuming her current position, she served as the Acting Director for the Center for Health Statistics for the Department. In this capacity, she coordinated the programs efforts related to the collection, analysis and dissemination of health statistics. She has also served as the General Counsel to the Office of the Public Guardian for the Elderly Adults, a fiduciary agent for seniors in the state of New Jersey. She is a graduate of Case Western Reserve University School of Law, served as a New Jersey governor's Fellow, a graduate of Clark University, Worcester Massachusetts (BA in Psychology); and a graduate of the Faulkner Hospital School of Nursing (RN), Boston, MA.

Sandy Clark
Associate Director
NJ Coalition for Battered Women

Ms. Clark is responsible for the development and presentation of NJ Coalition for Battered Women (NJCBW) public policy positions. She is the NJCBW point of contact for the NJ Legislature and many state government agencies. Ms. Clark attended the National Summit on Domestic Violence Fatality Review Boards and was a member of the genesis development group. Ms. Clark is certified as a Domestic Violence Specialist (DVS) and is a graduate of Catholic University of America, Washington, D.C.

Shamita Das Dasgupta, Ph.D.
Co-founder and program director Manavi
Psychologist

Dr. Das Dasgupta is a nationally recognized expert in the field of domestic violence and the South Asian community. She is a member of the editorial Board, Violence Against Women-An International and Interdisciplinary Journal, Sage Periodicals Press. Dr. Das Dasgupta has extensive experience in conducting national training for health educators, activists, advocates, judiciary and law enforcement on issues related to gender and violence including race relations, domestic violence and sexual assault, development of cultural competency, transnational family laws and immigration. She is certified as a Domestic Violence Specialist (DVS) and received her Ph.D. and MA from the Ohio State University (Developmental Psychology).

Col. Carson J. Dunbar, Jr.
Superintendent, NJ State Police

Col. Dunbar has 28 years of law enforcement experience on the local, state and federal level. He was sworn-in as the

12th Superintendent of the New Jersey State Police on November 1, 1999. Col. Dunbar served with the NJ State Police from 1973 until 1977. From 1977 until November of 1999 superintendent Dunbar served with the Federal Bureau of Investigation. While with the FBI, Col. Dunbar served in the Pittsburgh, Washington, and New York field offices. In addition, he served for a two-year period at FBI headquarters. Col. Dunbar is a graduate of Glassboro State College (now Rowan University) receiving a Bachelor's degree in 1973 and Master's in 1976.

Andrea Fleisch, MPH
Research Associate, DVFRB

Ms. Fleisch joined the Division on Women in the summer of 1999 after completing her Masters of Public Health (MPH) at New York University. Throughout her training she has gained invaluable experiences in the field of violence against women including working a rape crisis center where she developed advocate training programs and dating violence prevention program. Currently, Ms. Fleisch has developed the Data Extraction Form and the Data Dictionary for the DVFRB project. She has organized the research data for the project to date. Ms. Fleisch is a graduate of the University of Rochester (BA in Biology and Women's Studies) and a member of the American Public Health Association.

Grace Hamilton, MSW
Project Director, DVFRB

Ms. Hamilton joined the Office on the Prevention of Violence against Women (OPVAW) in March of 1996. Ms. Hamilton was the executive director of Women's Crisis Services, the domestic violence and sexual assault program in Hunterdon County, New Jersey. She is currently the project director for the DVFRB and attended the National Summit on Domestic Violence Fatality Review Boards. Ms. Hamilton was a member of the genesis development group and is a certified Domestic Violence Specialist (DVS) and licensed social worker (LSW). She is graduate of Rutgers University School of Social Work, receiving her masters of social work in 1995.

Laura Hook, JD
Supervisor, Union County Prosecutor's Office
Domestic Violence Unit

As an assistant prosecutor in Union County Laura Hook has day to day contact and experience with victims and perpetrators of domestic violence. She supervises the Union County domestic violence unit and implements the NJ prevention of domestic violence act on the front line. She received her law degree in 1988 from Union University Albany Law School. She is a member of the Statewide Domestic Violence Working Group and the NJ Advisory Council on Domestic Violence ad hoc committee on a Model Criminal Justice System Response to Domestic Violence.

M. Diana Johnston, MSW, JD
Assistant Public Defender
Office of the Public Defender

Ms. Johnston was admitted to the NJ Bar in 1976, and is also a member of the U.S. District Court for the District of New Jersey, U.S. Court of Appeals for the District of Columbia and the U.S. Court of Appeals for the Third Circuit. She served in the Public Advocates office from 1976-1994 and has been an Assistant Public Defender since 1988. Her work has encompassed duties as diverse as the operation of the Division of Rate Counsel, criminal appeals and investigation, mediation and litigation of matters relating to legal rights of inmates. Prior to her career as an attorney Ms. Johnston practiced clinical social work with drug abuse and neuro-psychiatric populations.

Jane M. Kenny
Commissioner, Department of Community Affairs

Governor Christine Todd Whitman appointed Jane Kenny as Commissioner of the New Jersey Department of Community Affairs after having served as the Governor's Chief of Policy and Planning. She worked on major Whitman Administration initiatives, including the Economic Master Plan, and the Sustainable State Initiative. She also formulated the policy for the Governor's Urban Agenda.

During her tenure as Community Affairs Commissioner, the Department has instituted new urban redevelopment programs, encouraged sensible state planning, established the nation's first building rehabilitation code, broadened many neighborhood revitalization programs, promoted the sharing of local services to benefit taxpayers, and helped finance a record number of affordable housing units.

Major Fredrick H. Madden
Records and Identification Section, New Jersey State Police

Major Madden is in his twenty-seventh year of service with the New Jersey State Police. During his tenure, he has been assigned to various supervisory, management, and leadership positions encompassing operational and administrative responsibilities. Major Madden has sixteen years experience developing and analyzing domestic violence data collection systems. Major Madden is an adjunct professor at three New Jersey colleges. He teaches graduate and undergraduate studies addressing Leadership, Constitutional Issues, and "Violence in America" - which includes spousal abuse, child maltreatment, and elderly abuse. Major Madden is a 1996 graduate of Saint Joseph's University, Philadelphia, PA. He holds a Master of Arts degree in Criminal Justice Administration.

James Murphy
Deputy Chief, Washington Twp. Police Department

A veteran law enforcement officer, Jim Murphy served on the NJ Advisory Council on Domestic Violence ad hoc committee on Model Criminal Justice System Response to Domestic Violence. He worked closely with the Gloucester County Prosecutor's office on the development of their DIVERT team, a domestic violence crisis response system to assist victims of domestic violence. Deputy Chief Murphy is a graduate of Rowan University (BA 1998, Criminal Justice) and Seton Hall University (M.Ed. 2000)

Jessica Oppenheim, JD
Deputy Attorney General
Police and Prosecutors Bureau
Division of Criminal Justice

A Deputy Attorney General since 1986, DAG Oppenheim has argued cases in the New Jersey Supreme Court and Third Circuit Court of Appeals. As Assistant Bureau Chief, she is legal counsel to the State Office of Victim-Witness Advocacy, providing legal advice and oversight for the State's implementation of provisions of the Violence Against Women Act and Victim's of Crime Act. She assists in the implementation of the Division's domestic violence training programs and oversees implementation by the County Prosecutor's Offices of the provisions of Megan's law. She chairs the State Sex Offender Management collaborative Team and sits on the Best Practice Committee of the Northern Regional Unit housing sexually violence predators. She was one of a four-member team New Jersey sent to the National Summit on Domestic Violence Fatality Review Boards and of the genesis development group for the New Jersey Board.

Donna Pincavage, MSW, MPA
Director, Office on Child Abuse Prevention

As the director of the Office on Child Abuse Prevention, Ms. Pincavage is responsible for directing the NJ Task Force on Child abuse and Neglect and the Children's Trust Fund. She is also a member of the NJ Child Fatality and Near Fatality Review Board. Ms. Pincavage is a graduate of Rutgers University with master's degrees in social work and public administration. Ms. Pincavage is a licensed social worker (LSW) and a certified public manager (CPM). She is a former vice-president of the National Association of Social Workers - New Jersey Chapter (NASW-NJ).

Faruk Presswalla, MD
State Medical Examiner

Governor Whitman appointed Dr. Presswalla the State Medical Examiner in 1997. He is responsible for the general supervision over the administration and enforcement of the provisions of NJSA 52:17-78-94: He assures quality death investigation and forensic pathology services to New Jersey citizens through enactment and enforcement of the State Medical Examiner Act and regulations. Dr. Preswalla received his M.D. from the University of Bombay, India. Dr. Presswalla served as a Captain in the Medical Corp, United State Naval Reserve and is a graduate of the Naval War College. He is a member of the Child Fatality Review Board and the Sudden Child Death Autopsy Protocol Committee.

Sue Rovi, Ph.D.
Assistant Professor, UMDNJ
Principle Investigator

Dr. Rovi is a researcher in the Department of Family Medicine at New Jersey Medical School at UMDNJ's Newark campus. Her primary responsibility with the department is to facilitate faculty research activities by providing expertise in research design, methodology, implementation, analysis, interpretation, presentation and publication. Her own research agenda focuses on issues related to violence against women, and she has conducted research projects on domestic violence and sexual assault, (e.g., physician's use of diagnostic codes for child and adult abuse, and most recently, an educational needs assessment of rape care program advocates on the their knowledge of and experience with HIV prophylaxis for victims/survivors). Dr. Rovi is trained and experienced in both quantitative and qualitative methodologies. She is a member of New Jersey Medical School's Institutional Review Board and also a member of the Violence Against Women's Working Group of the Violence Institute at UMDNJ. Dr. Rovi received her doctorate in 1995 from Rutgers University.

Since March 2000, Dr. Rovi has been working as a consultant and co-investigator for the DVFRB's Research Project, collaborating with Andrea Fleisch and Grace Hamilton in the development of a database of NJ DV fatalities.

Anna Trautwein, RNC, CPCE
Perinatal Clinical Educator for the Women and Children's Division
Saint Peter's University Hospital

As the Perinatal Clinical Educator at Saint Peter's University Hospital, Ms. Trautwein has been responsible for in-service education for hospital staff. She works collaboratively with her colleagues on the development of policy and procedures on standards of care. She recently introduced an innovative program of medical screening protocols for domestic violence currently in use at Saint Peter's Hospital. Ms. Trautwein serves on the executive committee of the NJ Advisory Council on Domestic Violence.

Carol Vasile
Supervisor, Office on the Prevention of Violence against Women

Ms. Vasile was appointed as the Supervisor of the Office on the Prevention of Violence Against Women in 1994. She is responsible for the overall supervision of the Office's projects and policy analysis on domestic violence, sexual assault, stalking and other forms of violence against women. Prior to her appointment Ms. Vasile worked as a consultant on women's issues including violence against woman well as other issues of equality. Ms. Vasile attended the National Summit on Domestic Violence Fatality Review Boards and was a member of the genesis development group. Ms. Vasile is a graduate of the College of New Jersey (formerly Trenton State College), Ewing, New Jersey.

Elizabeth Welch
Sergeant First Class, New Jersey State Police

Assistant Bureau Chief, State Bureau of Identification 21 years in law enforcement. Past duties included general patrol duty, undercover narcotics investigations, background investigation, applicant interview boards, State Police academy instructor, liaison between State Police and municipal and County police agencies in Uniform Crime Reporting and Court Disposition Reporting. Now responsible for the NJ Sexual Offender Registry and oversees the creation of the Computerized Criminal History (CCH) files from criminal fingerprint cards, electronic mugshot submissions, the release of CCH information for criminal justice as well as licensing and employment purposes. Responsible for managing the state expungement processes, providing National Instant Criminal Background checks for firearms licensing and manages the automation of firearms licensing system database. Oversees the Criminal Justice Information System providing information to all law enforcement agencies via automation. Works closely with AOC for the purpose of streamlining automation of court disposition reporting and electronic update of CCH files. BA from Rowan University (Business Admin) MA from Seton Hall University (Supervision and Administration) Graduate of Northwestern University's School of Police Staff and Command.

Proposed Draft Legislation

Definitions:

Domestic violence fatality review: the deliberative process for identifications of deaths, both homicide and suicide, caused by or related to domestic violence, for examination of the systemic intervention into known incidents of domestic violence occurring in the family of the deceased prior to the death, for consideration of altered systemic response to avert future domestic violence deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to prevent domestic violence.

Domestic violence fatality: In order to ensure consistent and uniform results, cases may be reviewed and data may be collected and summarized by the domestic violence fatality review board to show the statistical occurrence of domestic violence deaths in the State of New Jersey that occur under the following circumstances:

- The deceased was a victim of a homicide committed by a current or former spouse, fiancé(e), or dating partner.
- The deceased was the victim of a suicide, was the current or former spouse, fiancé(e), or dating partner of the perpetrator and was also the victim of previous acts of domestic violence.
- The deceased was the perpetrator of the homicide of a former or current spouse, fiancé(e), or dating partner and the perpetrator was also the victim of a suicide.
- The deceased was the perpetrator of the homicide of a former or current spouse, fiancé(e), or dating partner and the perpetrator was also the victim of a homicide related to the domestic homicide incident.
- The deceased was a child of either the homicide victim or the perpetrator, or both.
- The deceased was a current or former spouse, fiancé(e), or dating partner of the current or former spouse, fiancé(e), or dating partner of the perpetrator.
- The deceased was a law enforcement officer, emergency medical personnel, or other agency responding to a domestic violence incident.
- The deceased was a family member, other than identified above, of the perpetrator.
- The deceased was the perpetrator of the homicide of a family member, other than identified above.
- The deceased was a person not included in the above categories and the homicide was related to domestic violence.

AN ACT establishing the Domestic Violence Fatality Review Board within the Office on the Prevention of Violence Against Women in the Department of Community Affairs' Division on Women and making an appropriation.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

There is established the Domestic Violence Fatality Review Board. For the purposes of complying with the provisions of Article V, section IV, paragraph 1 of the NJ Constitution, the Board is established within the Department of Community Affairs' Division on Women, in the Office on the Prevention of Violence against Women, but notwithstanding the establishment, the board shall be independent of any supervision or control by the department or any board or officer thereof.

The purpose of the Board is to review the facts and circumstances surrounding domestic violence related fatalities, including suicides and near fatalities to identify causes and their relationship to government and non-government service delivery system and to perform other research as necessary toward the prevention of domestic violence fatality. Further, to enhance a public private collaboration with the goal of reducing deaths where interpersonal violence is linked to the cause of death and to develop a process for change in policies, procedures and protocols necessary to accomplish improvement in the prevention of domestic violence fatality.

Membership, terms of board members.

The board shall consist of members as follows: the Attorney General (1), the Commissioner of the Department of Community Affairs (1), The Commissioner of the Department of Health and Senior Services (1), the State Medical Examiner (1), Commandant of the State Police (1), the New Jersey Public Defender (1), the Director of the Division on Women (1), Supervisor of the Office on the Prevention of Violence against Women (1), and the Program Manager of the Domestic Violence Fatality Review Board (1), who shall serve ex officio; and nine public members appointed by the Governor that shall include one representative each from the following: The New Jersey Coalition for Battered Women, a county domestic violence assistant prosecutor, a licensed social worker or licensed clinical social worker with demonstrated expertise in the field of domestic violence, a psychologist with demonstrated expertise in the field of domestic violence, a law enforcement representative with experience in domestic violence, a licensed physician or registered nurse or nurse practitioner knowledgeable in the field of domestic violence and/or forensic pathology, a child protective service worker with experience in family violence and especially child death review, a superior court judge with experience in family court and a domestic violence case load, a municipal court judge with experience with a domestic violence case load, a probation officer, a member of the clergy, a representative from a batterer's intervention program, and a representative from the military with experience in the field of domestic violence.

The public members of the board shall serve for three-year terms. Of the public members first appointed, four shall serve for a period of two years, and five shall serve for a term of three years. They shall serve without compensation but shall be eligible for reimbursement for necessary and reasonable expenses incurred in the performance of their official duties and within the limits of funds for this purpose. Vacancies in the membership of the board shall be filled in the same manner as the original appointments were made.

Duties and powers of the Board

The Domestic Violence Fatality Review Board may collect, review and analyze information including death certificates and death data, investigative reports, police, medical and counseling records, victim service records, employment records, child abuse reports or other information concerning domestic abuse fatalities, survivor interviews and surveys, other information deemed by the Board as necessary and appropriate concerning the causes and manner of domestic violence fatalities. The Board may review records for which public records exemptions are made.

The Board may determine whether the death might have been prevented with improved policies or procedures of the health care system, social services system, law enforcement, prosecution, the courts, or any other public or private entity. The Board may recommend interventions based on an analysis of information gathered through this process.

As part of any review the Board shall have the power and authority to administer oaths and to compel the attendance of witnesses whose testimony is related to the death under review and the production of records related to the death under review. This subpoena process will be effective throughout the State and service will be made by any sheriff. Failure to obey such a subpoena will be punishable according to the Rules of the Court.

Determinations of the Board; composition of panels; report

The Board may establish committees or panels to whom the Board may assign some or all of its responsibilities.

Panels or individual persons with information specific to one or more cases under review may be established for presenting specific information regarding those cases. For these purposes they are considered members of the Domestic Violence Fatality Review Board and are included under the confidentiality, exempt, privilege and immunity sections of this act.

A research data analysis panel may be established to gather all data from institutions and individuals and to organize and summarize information for the full Board to develop a process for system change.

The Board shall submit a report to the Governor and the Legislature on a yearly basis, from the effective date of the law. The report shall include the Board's progress and findings, and to make any recommendations regarding policies, procedures, protocols and legislation.

Confidentiality, Immunity, Subpoena and Review of Records

The Board is authorized to call upon a department, office, division or agency of this State to supply it with data and other information or assistance it deems necessary to discharge its duties under this legislation. Each department, office, division or agency of this State is hereby required, to extent not inconsistent the law, to cooperate with the Board and to furnish it with such information and assistance as is necessary to accomplish the purpose of this law.

A person who has attended a meeting of a domestic violence fatality review board shall not be required to testify in any civil or disciplinary proceeding as to any records or information produced or presented to the Board during meetings or other activities authorized by the Board.

Any information or records otherwise confidential or exempt according to the Open Public Access which are obtained by or provided to the domestic violence fatality review board conducting authorized activities shall remain confidential or exempt. Any portion of the reports produced by the domestic violence fatality review board which contains any information that is otherwise confidential or exempt shall remain confidential or exempt as otherwise provided by law. The proceedings and meetings of the Domestic Violence Fatality Review Board regarding domestic violence fatalities and their prevention are exempt from public access.

The proceedings, records, opinions and deliberations of the domestic violence fatality review board shall be privileged and shall not be subject to discovery, subpoena, or introduction into evidence in any civil or criminal action in any manner.

The review process, and any records created therein, including all original documents and documents produced in the review process with regard to the facts and circumstances of each fatality shall be confidential, and shall be used by the Board only in the exercise of its proper function and shall not be disclosed. The records and proceeding shall not be available through court subpoena and shall not be subject to discovery. No person who participated in the review nor any member of the Board shall be required to make any statement as to what transpired during the review or information collected during the review. The Board, at its discretion, may release statistical data and recommendations based on the reviews.

Members of the Domestic Violence Fatality Review Board, members of any panel, as well as their agents or employees shall be immune from claims and shall not be subject to any suits, liability, damages or any other recourse, civil or criminal, arising from any act, proceeding, decision or determination undertaken or performed or recommendation made, provided such persons acted in good faith and without malice in carrying out their responsibilities; good faith is presumed until proven otherwise, with the complainant bearing the burden of proving malice or a lack of good faith. No organization, institution or person furnishing information, data, testimony, reports or records to the review panels or the Board as a part of a review shall, by reason of furnishing such information, be liable in damages or subject to any other recourse, civil or criminal.

Any oral or written communication or a document shared within or produced by the domestic violence death fatality review board related to a domestic violence fatality is confidential and not subject to disclosure nor discoverable by a third party. An oral or written communication or document provided by a third party to the domestic violence review board or between a third party and the domestic violence fatality review board is confidential and not subject to disclosure nor discoverable by a third party. Notwithstanding the foregoing, recommendations of the Domestic Violence Fatality Review Board may be disclosed at the discretion of the board.

Each organization represented on the Domestic Violence Fatality Review Board may share with other members of the Board information in its possession concerning the facts and circumstances surrounding the fatality that is under review or any person who was in contract with the victim or other person relevant to the review. Any information shared by a person or organization with other members of the Board is confidential. This provision shall permit the disclosure of the members of the board any information deemed confidential, privileged, or prohibited from disclosure by any other statue.

The disclosure of written and oral information authorized under this act shall apply notwithstanding attorney-client privilege , psycho-therapist-patient , victim-counselor privilege , priest penitent privilege .

There is appropriated from the General Fund $1,350,000.00 to the Domestic Violence Fatality Review Board Fund to effectuate the purposes of this act.

This act shall take effect immediately.

History and Statutory Notes

The legislature finds that it is a public necessity that information this confidential or exempt remain confidential or exempt when in the custody of the Domestic Violence Fatality Review Board, together with any portions of any reports containing such information. The legislature further finds that it is a public necessity that proceedings and meetings of the Domestic Violence Fatality Review Board, which relate to domestic violence fatalities or domestic violence incidents and their review process and where specific persons or incidents are discussed, be confidential and exempt form public meeting requirements. Otherwise, sensitive personal information concerning victims and victims' children and family members would be disclosed and open communication and coordination among parties involved in the domestic violence fatality review process would be hampered. Accordingly, the Legislature finds that the harm that would result in the release of such information substantially outweighs any minimal public benefit derived therefrom.