

Domestic Violence Fatality Review Teams: Critical Tensions and Promising Practices

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Over the last fifteen years, domestic violence fatality review teams have emerged in North America as an innovative and promising means of understanding and preventing domestic violence deaths, homicides and suicides resulting from domestic violence (Websdale, 2003). As of 2006, twenty-eight states in the United States and one province in Canada had established at least one domestic violence fatality review team (Watt and Allen, 2008). However, given there is often more than one team in each state or province, the total number of domestic violence fatality review teams far exceeds this number, amounting to approximately seventy-five teams in total. For instance, at the time this estimate of the prevalence of domestic violence fatality review teams was made, the state of California alone had twenty-two county wide teams. The total number of domestic violence fatality review teams operating in North America continues to grow at a rapid pace and very few teams have disbanded over the years, which is likely a reflection of the perceived need and effectiveness of these efforts.

Domestic violence fatality review teams involve a collaboration among stakeholders from a variety of agencies (e.g., law enforcement, health care, social services, education) to identify and review cases of domestic violence deaths and to develop strategies to prevent or reduce future fatalities. The process used by these teams to review cases is reminiscent of mortality reviews that routinely occurred in the fields of medicine, aviation, and nuclear fuels (Websdale, 2003). Specifically, teams typically conduct a systematic analysis of the events leading up to a series of domestic violence deaths to determine what risk factors were present and how the system could have responded differently to prevent their occurrence (Websdale, 1999). Following this

review process the vast majority of teams publish a report that describes the work of the team, summarizes their findings, and outlines their recommendations for systems change (Thompson, 2006). In general, recommendations aim to prevent or reduce future domestic violence deaths by promoting public awareness and education, increasing coordination and communication across existing services, improving practices, procedures, and policies in the system response, and creating additional funding or resources (Watt & Allen, 2008).

Anecdotal evidence suggests that patterns identified by domestic violence fatality review teams could contribute to a wide variety of changes to the system response and ultimately prevent future deaths (Thomson, 2006; Websdale, 2003). For example, the Washington State Domestic Violence Fatality Review (2004) reported increased public awareness regarding domestic violence homicides by disseminating their reports widely to community stakeholders and generating media attention through press releases. In addition, the State of New Hampshire Governor's Commission on Domestic and Sexual Violence Domestic Violence Fatality Review Committee (2002) witnessed better coordination between courts and crisis centers following the implementation of one of their recommendations. Improvements to practice were observed by the Maine Domestic Abuse Homicide Review Panel (2004) when one of their recommendations resulted in changes to law enforcement policies related to weapons removal in cases of domestic violence. Lastly, the Ontario Domestic Violence Death Review Committee (2004) noted increased funding for domestic violence when the provincial government announced a sixty-six million dollar action plan to address a range of needs outlined in their report.

Although domestic violence fatality review teams share an overarching goal of

understanding and preventing domestic violence deaths, how they go about reaching this goal varies widely across teams. For instance, teams differ with respect to their underlying philosophy, where they are established, who is included as members, how they review cases, and what recommendations they make (Watt, 2006). These differences are often a reflection of important tensions faced by teams in the course of their development. Tensions refer to dilemmas or tradeoffs teams encounter when making a choice between alternative courses of action that each has their relative costs or benefits (Stake, 1995).

This paper reviews five critical tensions commonly faced by domestic violence fatality review teams. These tensions were developed based on discussions with experts in the field, review of the literature on coordinated community responses to domestic violence, attendance to national and regional domestic violence fatality review team conferences, and interviews with thirty five domestic violence fatality review teams as part of a national study of their efforts. Identifying tensions is critical in the examination of domestic violence fatality review teams because it highlights how the dilemmas teams face and the choices they make shape how these teams operate and position themselves to affect change. Furthermore, tensions within teams often stimulate the development of promising practices as teams attempt to resolve conflicts or solve problems.

No Blame or Shame versus Accountability

The vast majority of domestic violence fatality review teams initially adopt a philosophy of *no blame or shame* to guide their work in order to make stakeholders feel more comfortable coming to the table and sharing information about their involvement in a case prior to a fatality (Websdale, 2003). Team members are encouraged to focus on

building trust and relationships between members as opposed to placing blame on any single individual and agency for a domestic violence death. Risk and error as inevitable aspects of coordinated delivery of complex services and perpetrators are ultimately held responsible for the deaths of their victims (Websdale, Town, & Johnson, 1999). This approach contrasts with the philosophy of accountability that underlies traditional strategies for reviewing domestic violence deaths (e.g., agency reviews, public inquests) which emphasizes holding individuals or agencies accountable for past behaviour and future change (Watt, 2008). This philosophy encourages the identification and correction of specific gaps or failures in the system response and places little to no emphasis on relationship building.

Tension sometimes arises between the philosophies of *no blame or shame* and *accountability* when domestic violence fatality review teams begin to review cases. This tension may become particularly strong when teams observe a clear failure in the system response or desire to make more specific and targeted recommendations than a *no blame or shame* approach allows. During these times, some teams report feeling that it is important to hold individuals, agencies, or systems responsible for past behaviour and for future change and believe that their philosophy of no blame or shame prevents them from doing so. Although emphasizing a philosophy of *accountability* may make stakeholders feel uncomfortable coming to the table and discussing past mistakes, some teams feel that holding others accountable is critical for making change.

“No blame or shame was important in terms of creating the right atmosphere for our discussions and encouraging people to come to the table. It was important for people to know that they were not going into this process to be attacked in the course of the meeting or knifed publicly as a result.”(Ontario)

“The cost of promoting no blame or shame is that sometimes you really want to blame someone. I think we honestly had to back off in some cases so that we would not play the blame/shame game.” (Calvert, Maryland)

Several promising practices have emerged as a result of the tension between *no blame or shame* and *accountability*. Teams that traditionally emphasized *no blame or shame* as their underlying philosophy have considered several strategies to hold individual and agencies *accountable* without harming carefully fostered relationships. For instance, if teams choose to make targeted or specific recommendations for system change, they may first inform the agency privately of the observed system failure or ask the agency for their input into the wording of the recommendation.

Freedom of Information versus Confidentiality

Tension between *freedom of information* and *confidentiality* tends to emerge within domestic violence fatality review teams when the information sharing guidelines of the team conflicts with those of a single agency represented by one of the members. As a consequence disagreements may emerge regarding what type or amount of information should be shared. In these cases, instead of emphasizing *freedom of information* a team member may emphasize the victim, perpetrator, or agency’s right to privacy and limit the information they are willing to share. For instance, several teams reported that members from domestic violence shelters were not willing or able to share information with the team because they felt they had not obtained the victim’s consent to do so and as a consequence believed this constitute a violation of this person’s right to privacy. However, the lack of information from shelters was often seen by other team members as a lost opportunity to evaluate potential gaps in the system response to domestic violence.

“I think we can really identify the issues that need to be addressed and help make significant improvements to the system by sharing the information honestly and openly within the group.”

“The shelters perspective was that if you share information about a woman who died after being in the shelter that is the ultimate form of violating that women’s sovereignty. They just flat out refused to share information.”

The establishment of domestic violence fatality review teams under legislative or statutory authority and executive orders is one very important promising practice that has emerged to allow teams to both share information and maintain the confidentiality of information shared. Formal authorization allows the teams to have access to confidential information related to review of a death, prevents information reviewed from being subject to subpoena or discovery, and provides immunity for each member of the team from civil or criminal liability (Websdale, Sheeran, & Johnson, 2001). When formal authorization and protections have not been obtained, teams often establish interagency and confidentiality agreements to allow agencies to share information with one another.

Betterment versus Empowerment

Most teams have been structured based on a *betterment* model in which teams have been formed at a state level where agency leaders shape the development of the team (Himmelman, 2001). The members of the team are typically not directly involved in providing services to the perpetrators or victims prior the fatality. As a consequence of the membership of the team and where it is based, improvements to programs, services, systems and policies tend to be directed at a state level. In contrast to the *betterment* model, a minority of teams are based on an *empowerment* model in which teams have been formed at a county or regional level, where community residents (e.g., local service providers, family members, victims) shape the development of the team (Himmelman,

2001). The members of the team are often directly involved in providing services to the perpetrators or victims prior the fatality. As a result, improvements to programs, services, systems and polices tend to be directed at a county or regional level.

One of the ways the tension between the *betterment* and *empowerment* model emerges is with respect to who is included as a member of a team. Many teams that have traditionally been based on a *betterment* model have debated about including community residents who were more directly involved in the cases reviewed, which would be more consistent with an *empowerment* model. For instance, teams have considered including family members of victims of domestic violence deaths as part of their efforts. The primary reason for doing so was often to gain access to additional information and out of respect for the victim and their surviving family. However, some members have argued against the inclusion of family members due to concerns about the possibility of violating confidentiality, the quality of the information that would be obtained, the potential harm to family members by opening up old wounds, and the inability to provide follow up services due to lack of expertise or resources.

“We want the family’s permission to review the case because we do not want to offend them by making them feel like the government is sneaking around and prying into their affairs. We also want them to participate by coming in and talking to us because we gain enormous amounts of information that our file does not reflect.”

“We do not contact families to ask them for additional information. We really hold true to the fact our value of confidentiality and I do not think we could insure that if we included family.”

Although the structure of most teams continues to be heavily influenced by a *betterment* model, many teams have attempted to incorporate elements of an *empowerment* model by including community residents in a variety of innovative ways

and several promising practices have emerged. Specifically, teams have invited victims of domestic violence to be members of their team, interviewed surviving family and friends about their experiences and perspectives, and conducted focus groups with community residents related to specific issues that arise.

Biography versus Epidemiology

Domestic violence fatality review teams have chosen diverse methods to collect and analyze information. Most teams use some form of a *biographical* approach in which detailed information is collected about a small number of cases, sometimes referred to as a case specific or systems approach (Websdale et al., 1999). The primary goal of this approach is to obtain an in depth understanding of the dynamics of a single case. For instance, teams may spend several days collecting and reviewing information about one death. Fewer teams use some form of an *epidemiological* approach in which general information is collecting about a large number of cases, sometimes referred to wide-angle or investigative model (Websdale et al., 1999). The primary goal of this approach is to obtain an understanding of trends across cases. Therefore, teams may spend as few as ten minutes collecting and reviewing information per death.

Tension most frequently emerges within domestic violence fatality review teams about *biography* and *epidemiology* when initially selecting a method to analyze cases. However, tension may also arise over the course of reviewing cases if the costs of the approach they are using begin to outweigh the benefits. Proponents of the *biographical* approach argue that in depth information is critical for revealing the complex dynamics of each case and the gaps or failures in the system response that could have potential implications for informing system change. In contrast, proponents of the *epidemiological*

approach warn against the dangers of basing any decisions about system change on a single case. They argue that any recommendation for systems change should be based on trends observed across cases.

“Because domestic violence is such a complex issue, we really need to gather a lot of information and take an in depth look to get at the complexities and the uniqueness of each case. It gives you the opportunity to really identify gaps and increase cooperation and collaboration. If you do not dig deep into a specific case the likelihood that you are going to be able to identify these things is pretty slim.”

“We worry about making recommendations based on six to ten cases. While those are very well researched cases, how much of the patterns that we have seen are indicative of the other twenty or thirty cases we have not reviewed? If we can gather more data it will help substantiate some of the policy recommendations we are trying to make.”

Many teams that have debated about the costs and benefits of *biographical* and *epidemiological* approaches to collecting and analyzing data have resolved this tension by adopting a mixed methods approach. For instance, teams may collect a limited amount of information about all cases of domestic violence deaths and in depth information about a subset of these fatalities. As a consequence they are able to capitalize on the benefits of both approaches with respect to identifying system failures and making recommendations for system change.

Understanding versus Action

Domestic violence fatality review teams appear to have very different models regarding how to promote systems change. Some teams approach systems change by emphasizing *understanding*. They tend to view themselves as independent fact finding bodies whose responsibility it is to educate others about changes that need to be made to policies, procedures, and practices. They may make recommendations for systems change but are not involved in monitoring or implementation of those recommendations. In

contrast, other teams approach systems change by emphasizing *action*. These teams see themselves as part of the system response and believe it is their responsibility to implement changes to policies, procedures, and practices. In addition to making recommendations for systems change they are involved in monitoring or implementing those recommendations.

Tension typically emerges within domestic violence fatality review teams between *understanding* and *action* when teams consider the extent to which they should be involved in promoting systems change. Initially many teams emphasize increasing understanding as their primary means of promoting systems change. However, over time tension arises in some teams when they begin to examine whether their recommendations were being implemented by others and observe that very few changes are being made to the system response. This finding emphasizes to these teams that in order to more effectively promote systems change they needed to become more actively involved in the implementation of recommendations.

“The most teams can do is point out the problem and make suggestions about how to make a difference. It is up to other people to act.”

“The team never expected to have to follow up with implementation of recommendations. It learned, however, that its efforts were futile otherwise.”

The increased recognition of the limitations of solely relying on increasing *understanding* as a means of promoting systems change has led many domestic violence fatality review teams to make changes to their practices to increase the likelihood their recommendations will be put into *action*. For example, teams have followed up with agencies to monitor whether recommendations were implemented, to assist agencies with implementation of the recommendations, and to document improvements made to the

agencies practices or policies subsequent reports.

Domestic violence fatality review teams are very promising venues for promoting system change. Increasing understanding of the tensions faced by teams in the course of their work may help to explain the diversity of their goals, structures, processes, and outcomes. Furthermore, actively grappling with these tensions could stimulate teams to establish promising ways to improve policies, procedures, and practices. Although this discussion is by no means an exhaustive list of all the tensions encountered by teams or the many ways they impact on the operations of the team, hopefully it will stimulating thinking about how choices made by teams about these types of issues may have important implications for what they ultimately accomplish.

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