

# Children as Victims and Witnesses of Domestic Homicide: Lessons Learned from Domestic Violence Death Review Committees

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## ABSTRACT

Domestic Violence Death Review Committees (DVDRCs) are interdisciplinary teams dedicated to examining domestic homicide and recommending how to prevent future tragedies by comprehensively examining individual cases. This article summarizes the findings of 15 DVDRCs concerning children as victims and witnesses. The findings reflect that an alarming number of children are victimized by domestic violence. Themes in the recommendations are grouped in relationship to: (1) training and policy development; (2) resource development; (3) coordination of services; (4) legislative reform; and (5) prevention programs. The recommendations are critical for criminal and civil courts as well as enhancing collaboration between the justice system and community partners in preventing domestic homicide.

vented (Hilton et al., 2004). A recent approach to preventing these fatalities is the formation of domestic violence death review committees (DVDRCs), comprised of coroners, medical and mental health professionals who specialize in domestic abuse, criminologists, prosecutors, shelter staff and women's advocates, law enforcement staff, and representatives

from child protection services (CPS) (Websdale, 2003). DVDRCs are dedicated to understanding how and why domestic homicides occur through a detailed examination of individual cases, and to providing recommendations about how to prevent future deaths (Jaffe & Dawson, 2003; Websdale, Town, & Johnson, 1999). The typical cases reviewed include intimate partner: (1) homicide; (2) homicide-suicide; (3) attempted-homicide followed by suicide; (4) attempted-homicide followed by related accidental death (e.g., the perpetrator was killed in a car accident during a police pursuit); and (5) attempted-homicide followed by related homicide (e.g., the perpetrator was killed in a police shooting).

**C***“Children bereaved by the death of one parent at the hands of the other, almost always the father, in effect lose both parents. The children are then uprooted, losing their home and, quite often, their familiar routine in essential relationships. The combined effects of trauma, dislocation and loss are dramatic, but little has been written so far about such tragedies and the implications for everyone concerned in the future of the affected children.” (Harris-Hendriks, Black, & Kaplan, 1993, p. 1).*

Between 1994 and 2003, there were 1,695 family-related homicides in Canada, with 47% classified as intimate partner homicides (Statistics Canada, 2005). In the United States, 1,000 to 1,600 women are murdered each year by their partners (Durose et al., 2005). When a woman is murdered by a current or former intimate partner, the public often wants to know why the woman was not protected and the homicide thus pre-

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Reviewed cases also include the deaths of any individuals connected to incidents of domestic violence, such as third-party interveners, friends, neighbors, co-workers, new partners, extended family members, and children.

When children are victimized or killed as a result of fatal domestic violence, the cases are often seen as “high profile” by the public and media. Although most states have a Child Fatality Review Committee that focuses on child abuse and accidental deaths of children under 18, children killed in the context of an adult relationship (domestic violence) are often overlooked since they don’t fit the profile of typical child abuse and neglect matters. (For more information on Child Fatality Reviews, please see the website: <http://ican-ncfr.org>.) This article attempts to expand our awareness and knowledge of the plight of these children by reviewing the information available from DVDRCs on the number of children affected and the recommendations being suggested to improve community prevention and intervention efforts.

In addition to the traumatic exposure to non-fatal domestic violence that often long precedes a homicide, the most frequent forms of child victimization that DVDRCs encounter include: (1) children left parentless following homicides and/or suicides; (2) children exposed to their parents’ violent deaths; (3) children indirectly killed as a result of attempting to protect a parent during a violent episode and being “caught in the crossfire”; (4) children directly killed by a parent as revenge against the partner who decided to end a relationship or for some other perceived betrayal; (5) children directly or indirectly killed as part of an overall murder-suicide plan by a parent who decides to annihilate family members; and (6) adolescents killed as a result of violence in dating relationships (not a focus of this article).

We argue that danger to children in potentially lethal domestic violence cases may be mistakenly overlooked because the cases do not fit the traditional view of child abuse (because the mothers are the primary targets) or of domestic violence (because the children may be intended or unintended victims of domestic violence perpetrators). Child maltreatment and domestic violence are overlapping issues (Edleson, 1999); however, it appears that many individuals still view the problems in a dichotomous fashion. For example, estimates of

violent child fatalities often do not include the deaths of children in homicide-suicides and familicides (Websdale, 1999). Viewing child abuse and domestic violence as separate problems may lead professionals, researchers, and policymakers to overlook the potentially lethal harm that domestic violence poses to children.

Senior researchers of domestic homicide have pointed to the paucity of literature describing the connection between adult domestic homicide and child homicide (Websdale, 1999; Websdale, Town, & Johnson, 1999). The need for public and professional attention to this social problem is urgent because “in child homicides, the three antecedents that emerge from the literature are a history of child abuse, prior agency involvement with the family, and [importantly] a history of adult domestic violence in the family” (Websdale, 1999, p. 24).

In 83 cases of child homicide, Websdale (1999) found that approximately 50% of cases were preceded by child abuse or neglect (28% were preceded by child abuse or neglect without domestic violence, and 22% were preceded by child abuse or neglect *with* domestic violence). In 26 cases, the child had only one caregiver, but when Websdale (1999) further examined the cases involving 57 couples, he found that 53% had histories of domestic violence (32% were in combination with child abuse and neglect, and, importantly, 21% had a history of domestic violence *without* child abuse or neglect).

These findings suggest that a subgroup of children may be at risk for homicide, although the risk for lethality may not appear obvious due to the *absence* of a history of direct child abuse by domestic violence perpetrators. Furthermore, after investigating these families’ prior contact with agencies, Websdale (1999) discovered that CPS was involved in only 25% of the cases, and that interventions ranged from lengthy and frequent to minimal contact provided long before the deaths. Additionally, although the majority of perpetrators were abusive to their partners, it was found that only 43% had criminal records, that recorded criminal involvement was not a characteristic of men who committed familicides, and that only 27% of perpetrators of child homicide had criminal backgrounds (Websdale, 1999).

These research findings imply that relying solely on prior CPS or police involvement as indicators of danger that domestic violence perpetrators pose to children may lead to erroneous conclusions regarding children’s

safety. Perpetrators were characterized by those affected, including former partners, as not posing a danger to children because the perpetrators “professed a deep and abiding love for the child murdered” (Websdale, 1999, p. 181). Domestic violence perpetrators may be lethally dangerous to children even when lacking a history of direct child maltreatment or prior involvement with police.

### **Children as Victims of Domestic Homicide**

Child homicide in the context of domestic violence differs from child maltreatment-related homicide. The latter type often “results from misguided, albeit sometimes brutal, efforts to discipline, punish, or quiet children ... [by] individuals who have never learned any other way than physical abuse to discipline their children” (Ewing, 1997, p. 97). According to Lawrence (2004), child homicide in the context of domestic violence usually involves the termination of the parents’ relationship as the precipitating factor. Pitt and Bale state that “aggression directed at the child [is] displaced from the spouse” (as cited in Ewing, 1997, p. 99). The man reacts to the end of the relationship with rage or depression and murders his child or stepchild as a form of revenge (Lawrence, 2004). The act is primarily the result of a desire to hurt the former partner rather than an underlying psychological disorder (Ewing, 1997). In some cases, multiple children are murdered, and sometimes the former partner, a competing partner, or other relatives are also killed (Websdale, 1999). A substantial number of the violent acts are followed by perpetrator suicide (Websdale, 1999). These homicide-suicide perpetrators are overly controlling and extremely dependent on family members (Ewing, 1997). They view themselves as the core of their families, which they believe to be extensions of themselves. According to Marzuk, Tardiff, and Hirsch, the homicide-suicide perpetrator “commands a relationship in which he perceives only he can satisfy the needs of the victims” (as cited in Ewing, 1997, p. 135). When these beliefs are threatened (e.g., by separation or custody/access disputes), the perpetrator resorts to homicide in an effort to sustain control and prevent the breakup of the family (Ewing, 1997).

Of the 1,695 family-related homicides in Canada,

25% involved children as victims (Statistics Canada, 2005). A parent was the offender in 90% of these cases, with fathers as perpetrators in 58% of cases (Statistics Canada, 2005). In 25% of parent-child murders, the perpetrator had a history of domestic violence, and this history was twice as likely when the offender was the father as opposed to the mother (31% versus 16%, respectively; Statistics Canada, 2005). Between 1961 and 2003, there were 1,994 homicide victim deaths followed by perpetrator suicide; 76% were committed by family members, of which 57% were intimate partner homicides, and 33% were committed by parents against children (Statistics Canada, 2005). In 85% of the homicide-suicide cases, men killed only their partners, but in 15% of the cases they killed others, with the next most common victim being their children (Statistics Canada, 2005). In addition to the 834 women killed in homicide-suicides, there were an additional 214 victims, of which 71% were children (Statistics Canada, 2005). In the U.S., an average of 1,945 children were murdered *each year* from 1976 to 1994 (Greenfeld, 1996), with parents or other family members responsible in 27% of the cases (Finkelhor & Ormrod, 2001). Fathers were perpetrators roughly 60% of time (Finkelhor & Ormrod, 2001). In 1997 alone, 115 children died in homicide-suicides (Finkelhor & Ormrod, 2001).

### **Children as Witnesses of Domestic Homicide**

No epidemiological studies address parental loss due to domestic violence, but Lewandowski, McFarlane, Campbell, Gary, and Barenski (2004) estimate that approximately 3,300 children lose parents to domestic homicide every year in the U.S. These researchers also estimate that roughly three attempted-homicides occur for each completed homicide, raising even higher the number of children affected. In 121 cases of femicide and attempted-femicide, Lewandowski et al. (2004) found that children witnessed 35% of the femicides and 62% of the attempted-femicides, and discovered the bodies of their mothers in 37% of the femicides and 28% of the attempted-femicides. “The traumatic nature of a child’s experience viewing [such] catastrophic family violence is a relatively underreported area of exploration” (Eth & Pynoos, 1994, p. 287). In fact, pioneers of research in this field emphasize that the incidence of children impacted

by domestic homicide is comparable to children affected by childhood leukemia (approximately 3,441 children in 2001); however, the former children receive nowhere near the same amount of attention from professionals, researchers, and policymakers (Parker, Steeves, Anderson, & Moran, 2004). Most knowledge of this population has been attained through case studies or small groups (Eth & Pynoos, 1994).

Some children display amazing resilience in the wake of the murder of their parent, but none are invulnerable to the trauma (Eth & Pynoos, 1994). As a result of the pathological and traumatic grief, these victims "[become] overwhelmed, resort to maladaptive behavior, or remain frozen in misery" (Eth & Pynoos, 1994, p. 296). Documented effects, likened to post-traumatic stress disorder, include "enuresis, sleep disturbances, temper tantrums, flashbacks, dissociation, anxiety and psychosomatic disorders, and passive and aggressive behaviours" (Burman & Allen-Meares, 1994, p. 29). Some youngsters face ongoing loyalty conflicts with maternal and paternal family systems along with the traumatic memories of the perpetrator's violence and the victim's injuries (Burman & Allen-Meares, 1994; Eth & Pynoos, 1994). There may be profound feelings of the victim's helplessness and the child's powerlessness, accompanied by guilt, anger, and depression (Burman & Allen-Meares, 1994; Eth & Pynoos, 1994). Revenge fantasies against the perpetrator, or fears of retaliation, can also be overpowering (Eth & Pynoos, 1994).

In some cases, feelings of self-blame stem from children's beliefs in their failure to protect their parent (Eth & Pynoos, 1994). Other children fantasize about reunions with deceased parents and this may lead to suicidal thoughts and attempts (Eth & Pynoos, 1994). These youths endure social identity problems and develop insecure attachment styles that hinder their ability to form new relationships (Kaplan, Black, Hyman, & Knox, 2001). A follow-up study with the referral sources of 61 children who witnessed domestic homicide revealed that 50% of "these children, who needed security and stability more than most, seemed to have many changes of placement" (Kaplan et al., 2001, p. 10). Children may experience fear over these disruptions, including changes in schools, and fear may impact both academic performance and the formation and maintenance of

peer relationships (Burman & Allen-Mears, 1994; Eth & Pynoos, 1994). Youngsters who experience such dramatic changes may also react with losses in self-esteem and confidence (Eth & Pynoos, 1994).

Further trauma may occur from participating in legal matters that force the recall of violent memories or from the stigma of being the child of a killer as publicized in media coverage (Eth & Pynoos, 1994). Adolescents exposed to domestic homicides may experience feelings of betrayal, shame, and rage, and some react in antisocial ways characterized by frequent absence from school, high-risk sexual activity, and substance abuse (Eth & Pynoos, 1994). Sadly, the devastating effects of experiencing these tragedies, including the perpetration of violence in future intimate relationships and enduring violence in future relationships, may carry over into adulthood (Parker et al., 2004). "It may well prove difficult for these children to successfully distinguish themselves psychologically from an imagined shared destiny with the parent victim, or perhaps the aggressor" (Eth & Pynoos, 1994, p. 290).

Children affected by domestic homicide may not receive the help they need, as new caregivers may not recognize trauma symptoms in the desire to re-establish some routines in the children's lives or in their anticipation of changes in child care (Kaplan et al., 2001). Black and Kaplan (1988) found that the range in treatment hold-up for children exposed to domestic homicide was anywhere from two weeks to 11 years. They also discovered that only a minority of these children received further ongoing therapy, even though it was recommended in legal proceedings by mental health professionals, and that several children (who were found to be disturbed) were even placed back into the care of perpetrators (Kaplan et al., 2001).

### Method

The most recently published online annual reports of 14 DVDRCs from across the U.S. were accessed from the National Domestic Violence Fatality Review Initiative (NDVFRI) (<http://www.ndvfri.org/>) and reviewed, as well as two online annual reports from Ontario's DVDRC in Canada. (<http://www.mpss.jus.gov.on.ca/english/home/pubs.html>). To be included in this review, the reports must have had some data avail-

**TABLE 1**  
**Summary of Most Recent Findings by DVDRCs on Children as Victims and Witnesses of Domestic Homicide**

DVDRC	Total Incidents	Total Deaths	Total Number of Children Killed	Total Number of Child Witnesses	Percentage of Cases with a Child Witness	Total Number of Children Affected <sup>1</sup>	Percentage of Cases with a Child Affected
California –							
Santa Clara County	6	6	0	7	-	10	-
California –							
San Diego County	61	61	0	12	-	52	-
California –							
Contra Costa County	17	20	2	3	-	10	-
Ohio –							
Cuyahoga County	31	31	8	-	-	-	-
State of New Jersey <sup>2</sup>	58	125	2	-	19	-	-
State of Maine	12	13	1	-	-	-	58
State of New Mexico	33	45	1	7	21	-	50
State of Delaware	30	41	-	-	20	-	37
State of Georgia	25	34	1	30	60	-	-
State of Oklahoma <sup>3,4</sup>	113	126	-	-	36	-	43
State of New Hampshire	133	133	26	-	-	-	-
State of Washington <sup>2</sup>	313	416	147	40	6	-	35
State of Florida <sup>3</sup>	60	67	6	14	-	-	-
State of New York <sup>3</sup>	57	62	2	-	42	-	63
Ontario, Canada	20	35	4	8	30	18	65

<sup>1</sup> For example, left parentless  
 - Not reported

<sup>2</sup> This State only reviewed cases of murder-suicide

<sup>3</sup> This State reported aggregate data, not necessarily data from the cases reviewed

<sup>4</sup> Perpetrator fatalities not counted under total number of fatalities

able on children as witnesses or victims of domestic homicide or made some recommendations to address this vulnerable population.

## Findings

Table 1 summarizes the number of children involved as victims and witnesses of domestic homicide according to the DVDRC annual reports, as well as the percentage of cases in which children were affected.

The findings in Table 1 should be interpreted with caution because they are limited in several ways. Not all committees randomly selected their cases for review, so these cases may not be representative of all fatal domestic violence cases. For example, New Jersey's Board

reviewed only cases of homicide-suicide. Some DVDRCs reviewed only homicides in their counties while other committees reviewed homicides that occurred across their state, and some DVDRCs reported only their yearly findings, while others reported the findings that they accumulated over years of conducting death reviews. Therefore, it should not be concluded that the frequency of homicide in one region is higher than that in another region. The reader should also be aware that, although many DVDRCs are required by law to conduct these reviews in their jurisdictions, not all committees are in the practice of recording or reporting certain data, as many of them operate on a volunteer basis and do not receive funding for their efforts.

Table 1 reflects the reality that an alarming number of children are being victimized in various ways due to the actions of domestic violence perpetrators. The number of children who are killed by parents in the context of domestic violence is significant. Too many children and adolescents are exposed to the horrifying acts, as well as children who may have not necessarily been present to witness the deaths, but are nonetheless affected by the loss of parents and undoubtedly haunted by the traumatic nature of the deaths. The numbers in Table 1 reflect only the "tip of the iceberg" in relation to children impacted by domestic homicide because no standardized method among DVDRCs records or reports findings. The absolute total number of children exposed to the homicides in many states is not known. For example, Oklahoma's Board found that in 113 reviewed incidents, children were witnesses in 36% of cases; however, they also reported that anywhere from one to 30 children witnessed a single death case (Oklahoma Domestic Violence Fatality Review Board [Oklahoma DVFRB], 2003). Furthermore, the numbers in the table do not capture the horrific circumstances that many children face. For example, of Florida's 60 reviewed cases, perpetrators made prior threats to kill the victims' children or other family members in seven cases (State of Florida Domestic Violence Fatality Review Team, 2003). In addition, New York's Commission found that three children were physically injured during three separate homicides. As the violence erupted in one case, a couple's 8-year-old son attempted to protect his mother, until his father grabbed him by the throat and tossed him to the ground. The man then killed the boy's mother and grandmother (Commission on Domestic Violence Fatalities, 1997). It is clear that the simple statistics do not do justice to the horrors represented by individual cases.

### **Available Demographic Information on Children Impacted by Domestic Homicide**

*Ages of children impacted.* The domestic violence literature points to the fact that the most serious incidents involving police intervention tend to be associated with younger families with vulnerable infants and toddlers (Fantuzzo, Boruch, Berriama, Atkins, & Marcus, 1997). Many of the homicides reported by DVDRCs involved younger children, although only several have dispersed this information. Santa Clara County reported

that children left parentless were between 9 months and 15 years of age (Santa Clara County Domestic Violence Council [Santa Clara County DVC], 2004). Oklahoma's Committee noted that child witnesses ranged from less than 1 to 17 years old, with a mean age of 7 (Oklahoma DVFRB, 2003). Washington's review found that, of the children present during the murders, 37% (43) were 5 or younger (Washington State Domestic Violence Fatality Review [Washington State DVFR], 2004). Of the children living at home at the time of the murders, 13% were under 2, 16% were between 3 and 5, 26% were between 6 and 10, and 19% were between 11 and 17 (the ages of 17% of children were unknown) (Washington State DVFR, 2004). At least 20 of 88 women had adult children who often had to assume responsibility for younger siblings, indicating that children of all ages are affected by domestic homicide. The needs of these children are diverse since age and developmental level affect the expression of trauma and course of recovery (Eth & Pynoos, 1994).

*Child Protection Service involvement.* Child protection agencies were involved in five of eight child homicides in Cuyahoga County, Ohio. Two of the deaths were open abuse or neglect cases, three cases had been closed within the year of the homicides, and one of the cases was a new referral (Domestic Violence Fatality Review Committee of Cuyahoga County, 2000). Importantly, three of the child victims had no prior history with CPS, supporting the argument that a subgroup of children may be at risk for homicide, but the potential for danger may go unrecognized due to the absence of a documented history of child abuse.

*Child custody/access disputes.* In 2003, four of Ontario's nine reviewed cases of homicide involved custody/access disputes. Two of the homicides were non-custodial parents murdering their children as punishment to partners who ended relationships. In one case, access to the adult victim was restricted to supervised exchanges of children, and in another case, a court order refused to allow any contact between the adult victim and perpetrator (Ontario Domestic Violence Death Review Committee [Ontario DVDR], 2004). In 21 of Oklahoma's cases, the perpetrator and partner had children in common, and in 12 of these cases, the adult victim and offender were living separately. In one case a

child was kidnapped, and in four other cases, the perpetrators used their children to send threatening messages to their ex-partners (Oklahoma DVFRB, 2003).

Three femicides in Oklahoma occurred during child exchanges (Oklahoma DVFRB, 2003). Additionally, New York's Commission stated that custody/access disputes were present in three of 36 cases where victims had children. Furthermore, two femicides occurred in association with child exchanges (Commission on Domestic Violence Fatalities, 1997). Collectively, these findings support the existing literature that warns of the danger domestic violence perpetrators pose when they utilize children in the context of post-separation parenting arrangements to victimize former partners (Bancroft & Silverman, 2004; Jaffe, Crooks, & Poisson, 2003; Sheeran & Hampton, 1999).

*Hidden victims: Pregnancy and domestic homicide.* It has been established that the risk for domestic violence increases when a woman is pregnant (McFarlane, Parker, & Soeken, 1995). Experts in risk assessment also recognize the association between battering experienced during pregnancy and femicide (Campbell, 1995; Hardesty & Campbell, 2004). Georgia found that of 25 cases reviewed, two victims were pregnant at the time of death (Georgia Domestic Violence Fatality Review Project [Georgia DVFRP], 2004). In Oklahoma, two of their 58 female victims were also pregnant (Oklahoma DVFRB, 2003). Washington's Review reported that at least four women murdered were pregnant (Washington State DVFR, 2004).

### **Themes in Recommendations by DVDRCs Relevant to Children and Domestic Homicide**

Every DVDRC uses the benefit of hindsight to suggest what could have been done in their community to prevent each fatality with the goal of preventing the future deaths of those who find themselves in similar situations. After reviewing all of the DVDRCs' recommendations and selecting those that made reference to children, consistent themes emerged that were grouped in relationship to: (1) training and policy development; (2) resource development; (3) coordination of services; (4) legislative reform; and (5) prevention programs (see Table 2).

*Training and policy development.* Overall, the

DVDRCs suggest enhanced training for front-line professionals on risk assessment in domestic violence cases in order that lethality factors are recognized and appropriate safety planning can begin. This training is suggested across many sectors, including more thorough and frequent screening for domestic violence for all women receiving pre-natal care. According to the State of Washington's Review, over a quarter of women killed by their intimate partners since 1997, who had children in the home, had given birth to a child in the previous five years. Furthermore, over half of the women had children who were two years old or younger (Washington State DVFR, 2004). Review members were aware that at least four of their homicide victims were pregnant at the time of their deaths. This Review historically recorded the number of abuse-related miscarriages, but due to the lack of available information that would provide the frequency of these tragedies, the data were no longer collected. However, Washington's Committee recommends that public health researchers take up the task of tracking abuse-related miscarriages to illustrate this hidden and devastating effect of domestic violence (Washington State DVFR, 2004). Importantly, Washington's Review highlights that medical appointments may be the only interaction that victims have with potential interveners if they are involved with extremely isolating abusers and recommends that nurses and physicians screen all pregnant women for domestic violence at each trimester and postpartum to ensure safety (Washington State DVFR, 2004).

Areas in need of further training and enhanced policy development are those that provide risk management during custody/access disputes of children. The State of Maine's Panel expresses a need for increased public and professional awareness regarding the potential for danger during the sharing and exchanging of children when parents have a history of domestic violence. Maine's Panel highlights that the direct exchange of children creates ongoing contact between the victims and the perpetrators and may put the victims and children at further risk for violence. This Panel notes a lack of supervised visitation options in their state. In the Panel's fatality review cases, supervision was often provided by a family member of the abuser or other biased third parties (e.g., an abuser's new partner). As

**TABLE 2**

**Summary of Themes in Recommendations by DVDRCs Relevant to Children and Domestic Homicide**

**THEMES AND RECOMMENDATIONS**

**Training and Policy Development**

- Increased education regarding domestic violence lethality indicators for Child Protection Services, judges, and lawyers
- Monitoring and follow-up of all child, elder, and partner abuse cases before any closure
- Risk management during child custody and access disputes in domestic violence cases
- Routine and frequent screening of domestic violence for women receiving pre-natal care
- Continuing education on domestic violence for family lawyers

**Resource Development**

- Increase in services for domestic violence victims involved in civil legal issues
- Increase in funding for mental health services for children exposed to domestic violence
- Support for new caregivers of children who lost their parent(s) to domestic homicide

**Coordination of Services**

- Research into the association between contact with Child Protection Services and lethal domestic violence
- Revise Child Protection Services policy regarding responding to families with a history of domestic violence
- Sharing of information with Child Protection Services
- Research into state practices regarding care of children when a parent has a serious mental illness
- Greater communication between criminal justice and family law courts
- Increase police understanding of domestic violence
- Overlap between child death review committees and DVDRCs

**Legislative Reform**

- Increased effort in reporting all suspected instances of child abuse and neglect
- Legislature to increase resources for domestic violence programs for victims

**Prevention Programs**

- Encouragement of parental enrolment into healthy parenting education classes
- Increase the role of childcare facilities in providing information to domestic violence victims
- Increase the role of alternative dispute resolution and child impact programs for families in the justice system
- Training for school staff on how to respond to children who reside in violent homes
- School curricula aimed at educating children and adolescents about domestic violence

a result, it was recommended that the Department of Human Services conduct research with the Department of Public Safety and Maine's Coalition to End Domestic Violence on the ability to provide supervised visitation centers (Maine Domestic Abuse Homicide Review Panel [Maine DAHRP], 2004).

Washington's review argues that it is essential for those who supervise visitation and exchanges to be trained in matters pertaining to domestic violence, the possibility for perpetrators to use access to children as a means to stalk and manipulate their victims, and the increased risk to children when a parent has a history of domestic violence (Washington State DVFR, 2004). Georgia's Project found that there were several instances among their cases when judges were relying on the abusers and victims to sort out and decide on visitation agreements, thereby putting the abusers in a situation of ongoing control and manipulation of the victims and children (Georgia DVFRP, 2004). The Project recommends that judges should decide on details relating to visitation after reviewing and analyzing all information relevant to the case, such as the history of violence and safety concerns for the children and former partner. The New York Commission took a more restrictive approach stating that two rebuttable presumptions be adopted regarding custody and visitation of children: that sole or joint custody of a child not be granted to a perpetrator of domestic violence, and that visitation, if granted at all, be supervised (Commission on Domestic Violence Fatalities, 1997). These concerns are mirrored in a model by Bancroft and Silverman (2004) that provides guidelines for assessing perpetrators' risks to children following parental separation.

Many DVDRCs stress the importance of the possible opportunities for the family law sector to address domestic homicide. DVDRC reports often mention the necessity of continuing education on domestic violence for lawyers practicing in family law. Ontario's Committee urges that family lawyers receive ongoing training in identifying and understanding risk for lethality when couples are separating and disputing child custody/access. The Committee comments that family lawyers have a unique opportunity to develop plans to enhance safety where there is conflict over child custody, support, or possession of the matrimonial property (Ontario DVDRC, 2004). There is also a need

to recognize the danger inherent in family law cases that involve applications for financial support. Maine's Panel articulates the need to inform all litigants requesting child support from their spouses or ex-spouses, via letter, that the risk for violence may escalate during times of separation and that their safety may be jeopardized after a letter requesting child support has been sent, thereby creating opportunity for risk assessment and safety planning (Maine DAHRP, 2004). The developmentally appropriate safety planning strategies for children and their mothers outlined by Hardesty and Campbell (2004) echo these recommendations.

Another common recommendation falling under the umbrella of enhanced training and policy development is the need for increased monitoring and follow-up of all child and spousal abuse cases. San Diego County stresses that all abuse and neglect cases reported to intervention systems must be monitored as long as any risk for lethality is present. Children at risk must be assessed and followed-up in person with specialized domestic violence case service workers before the closure of any case. These children should not be interviewed in the presence of any parent, and collateral contacts should be interviewed as well (County of San Diego Domestic Violence Fatality Review Team [DVFRT], 2004). The recommendations are relevant when considering the findings of Websdale (1999), who recorded that interventions in the 25% of child homicide cases where CPS was involved ranged from brief and long before the deaths to frequent and close in relation to the time of the deaths.

Furthermore, all sectors should work to identify and manage danger to staff. DVDRCs recognize the risks to professionals trying to intervene in cases. Georgia's Committee emphasizes that many of these professionals are put in danger daily. To manage this danger, it is recommended that all staff, including (but obviously not limited to) those in CPS, have access to law enforcement in high-risk situations (Georgia DVFRP, 2004).

*Resource development.* Many recommendations address the exacerbating role that poverty, inequality, and isolation play in adult and child domestic homicides (Websdale, 1999). DVDRCs have come to realize that many tragedies will continue to occur unless there is enhanced investment in resources, services, and professionals. A recommendation from Washington's Review

expresses a need for more resources directed to the immediate needs of abused women and children including housing, employment, and financial support. This need is evidenced in a direct quote in the Washington report from a woman just prior to her homicide, "Before I can do anything, I have to find a new job that pays more and save some money, so I can take care of my girls and pay the rent for a few months until I get some sort of child support" (Washington State DVFR, 2004, p. 55). The Review expresses a need for domestic violence programs to assist with material support for victims, including costs associated with child-rearing assistance and deposits for attorney and housing fees.

An even more specific recommendation by Washington's Review is an increase in services for victims involved in civil legal issues. Review members recommend that increased funding be directed to legal aid programs for domestic violence and family law issues, and that these programs work in partnership with advocates to provide the most widespread service. The Review feels that funding should be allocated to advocacy programs to allow for the contract hiring of attorneys, specialized in domestic violence issues, to represent victims. It is further recommended that state and local bar associations partner with domestic violence programs to create pro bono panels to represent victims in criminal and family law proceedings. The members state that individuals who participate in such efforts should be recognized and receive free continuing legal education for taking such cases. Lastly, it is suggested that low-cost and/or free legal representation services be provided to allow for accessibility of services to victims, and that these services be flexible (e.g., providing various times for intake appointments). Efforts should be made so that victims are given priority status. In some fatal cases, the perpetrators attained legal services first, resulting in the denial of victims' cases due to conflicts of interest (Washington State DVFR, 2004).

Many DVDRCs also notice a startling lack of support for new caregivers of children who lost their parents. Delaware's Team recognizes that relatives, friends, or acquaintances who take the role of guardian following the fatalities are also traumatized (Delaware Fatal Incident Review Team [Delaware FIRT], 2004). Georgia's Project found that most of these individuals are not linked to advocates or professionals who could assist

them (Georgia DVFRP, 2004). The myriad challenges these individuals encountered included, for example: grief; newly acquired child-rearing responsibilities and costs; funeral costs and resolving the financial issues of the deceased; problems with evidence and property recovery; and feelings of isolation or betrayal from the community (especially if the family was involved with multiple systems prior to the homicide; Delaware FIRT, 2004). Delaware's Team asserts that these new caregivers have good intentions, but may be overwhelmed with the tragedies and, as a result, may not be equipped to monitor the effects of the fatalities on the children. The Delaware Team states that agencies such as the Division of Family Services and the Violent Crimes Compensation Board may be able to assist with providing support (Delaware FIRT, 2004). Georgia's Project suggests that such advocacy and services should be provided by a broker that has not been previously involved with the family, as many of those connected to the tragedy may be upset with how former agencies did or did not assist them (Georgia DVFRP, 2004). These suggestions are relevant when considering a study by Kaplan et al. (2001) that examined traumatized children who experienced domestic homicide and were placed with either grieving relatives or relatives who anticipated changes in living arrangements (e.g., to return the children to the care of perpetrators when released from custody; Kaplan et al., 2001). The findings supported the hypothesis that the youth would be less able to speak of his or her deceased parents, less likely to receive the therapy he or she needed, and would fail to make secure attachments in new relationships (Kaplan et al., 2001).

*Coordination of services.* Many committees have pointed to the importance of existing services and systems trying to better coordinate risk assessment and intervention strategies. Often, one service provider may have critical information that needs to be shared with other services and systems to ensure that decision makers, such as the court, have access to a full picture of the dangers inherent in the family circumstances. For example, members of Ontario's Committee urge that there be ongoing training for police officers on intervention in domestic violence cases, especially those involving custody/access disputes. The Ontario Committee suggests that these particular cases are high-risk and demand special vigilance, along with the development of a high-

risk case management protocol. This need is underlined in cases where the family is involved in both criminal and family law proceedings. The Ontario Committee states that confusion often exists in the field regarding the roles and responsibilities in dealing with children in the context of domestic violence (Ontario DVDRC, 2004). The criminal court properly assumes innocence until the allegations are proven beyond a reasonable doubt. The process of preliminary hearings and trials may take many months, and in some cases may take years. However, the victims and children may need an immediate safety plan that either suspends contact with the abusers or requires supervised visits or exchanges between the parents. These matters can be further complicated if the family finds itself in the middle of child protection hearings. There is much uncertainty regarding whether intervention should be on the state's behalf as opposed to an issue for parents to settle privately through civil laws after separation. The Committee highlights that there are often no formal mechanisms in place to foster communication between family court and criminal court in coordinating issues around child custody and safety of individual family members. There is recognition for a need for better guidelines that encourage coordinated practices and protocols within and between family and criminal courts, as well as court-related services such as victim-witness services, mediation, supervised access, CPS, batterer intervention programs, and probation (Ontario DVDRC, 2004).

Delaware's Team stresses that CPS be given access to the criminal histories of all family members under investigation. Such criminal information would aid in the assessment of lethality risk and would allow CPS to prioritize responses to complaints received (Delaware FIRT, 2004). Washington Review members realized that CPS was a significant point of intervention for perpetrators and victims, and states that it is imperative that CPS policies address safety as a priority. The Review insists that the interactions between CPS staff and families should focus on three main goals: to protect the child, to help the abused parent protect herself and her children through the use of supportive and empowering interventions, and to hold the perpetrator responsible for stopping the abusive behavior (Washington State DVFR). Moreover, the New York Commission advocates against charging the non-violent parent with failure to

protect the child. The New York Commission believes that this response is inappropriate, as it places the responsibility of ending the violence on the victim rather than the perpetrator (Commission on Domestic Violence Fatalities, 1997). Washington's Review suggests that policies should: (1) include universal and helpful screening for domestic violence with each parent that includes the identification of any homicidal or suicidal threats; (2) probe for any current or defunct protection orders, domestic violence convictions, and attain copies of protection orders; (3) institute joint information-sharing relationships with the family court system and service providers who conduct domestic violence and parenting evaluations for the civil courts; and (4) include regular referral to agencies specialized in providing services to women who have experienced domestic violence (Washington State DVFR, 2004). Washington's members believe that CPS staff requires intensive training to allow for appropriate implementation of policies and procedures, and that training should also involve local domestic violence advocates to ensure sharing of information between resource providers. It is also recommended that research into the association between contact with CPS and lethal domestic violence be conducted. The Washington Review urges CPS and State Coalitions Against Domestic Violence to network with researchers to examine how many domestic violence victims later killed had come into contact with their services, if they were assessed for domestic violence, if any interventions were utilized, and how this group compares to their larger caseload (Washington State DVFR, 2004). A related recommendation from San Diego County suggests that membership overlap between DVDRCs and Child Death Review Committees must exist, so that all relevant cases of child homicide in the context of domestic violence are reviewed for altered systemic responses and to ensure coordination of efforts between the two bodies (County of San Diego DVFR, 2004).

Lastly, Delaware's Team raises the special concern involving parents suffering from a serious mental illness. The Team claims that clear policy is badly needed for the efficient assessment and monitoring of children whose custodial parent is afflicted. They suggest that the State Division of Adult Mental Health conduct further research into how other states manage children in

these precarious positions (Delaware FIRT, 2004).

*Legislative reform.* The New York Commission recommends increased effort in reporting all suspected instances of child abuse and neglect. To assist with this recommendation, the Commission suggested that the law be amended to consider the commission of any violent act against an adult or child in the family or household by any person legally responsible for the care and custody of the child as sufficient for a charge and conviction (Commission on Domestic Violence Fatalities, 1997). The law that was enacted (Endangering the Welfare of a Child (NY Penal Law 260.10), has been interpreted by the higher court to include exposure to domestic violence as injurious to children's welfare (Stone, 2001). Other states have enacted similar legislation which specifically criminalizes "domestic violence in the presence of a child," e.g., Idaho Code § 18-918(7)(b), or provides specifically for enhanced sentencing for assault where children witness the attack, e.g., Oregon Rev. Stat. § 163.160(3) (class A misdemeanor assault becomes a class C felony when it is "committed in the immediate presence of, or is witnessed by, the [defendant's] or the victim's minor child or stepchild or a minor child residing within the household of the [defendant] or the victim").

The Santa Clara County Committee also asserts that because children are the most vulnerable population in society, when any child expresses genuine fear of a parent or if they appear in danger of abuse or neglect, then those who are aware of the danger must report the information to CPS (Santa Clara County DVC, 2004). These recommendations are consistent with Ontario's belief that the duty to report child abuse and neglect needs to be more widely publicized (Ontario DVDRC, 2004). At the same time, the concern that victims of domestic violence should not be re-victimized by the child protection system, but rather offered support and access to services, must be addressed (Edleson, 2004; Feldheim, 2005).

The law focuses on the taking of a life, not the losing of one, and is usually forgetful of the heinous loss suffered by these children (Eth & Pynoos, 1994). Many DVDRCs see the necessity for changes in legislation to address the needs of children living in the aftermath of homicides. Maine's Panel members identify the absence of any protocol or process for responding to the needs

of a child left parentless. They state that when the parents of children are unavailable as a result of death, hospitalization, incarceration, or some other cause, then law enforcement agencies must report the case to the Department of Human Services Central Intake where the safety of the child must be assessed, and the appropriate steps outlined by Maine Law and Department policy can be carried out. Panel members reviewed cases of children who witnessed the deaths and were left parentless, and this led them to recommend that courts and prosecutors consider the emotional injuries inflicted on a child who has witnessed homicide in sentencing perpetrators (Maine DAHRP, 2004).

*Prevention programs.* The goal of preventing these tragedies before they occur would not be feasible without the existence of prevention programs aimed at addressing the problem of domestic violence and homicide. One such recommendation put forth is the widespread encouragement of parental enrolment into healthy parenting education classes (see Crooks, Scott, Francis, Kelly & Reid, 2006, for an example). Santa Clara County notices that programs that discuss the impact of children's exposure to domestic violence are badly needed. Parents can be targeted by strengthening the role of alternative dispute resolution and child impact programs for families (Santa Clara County DVC, 2004). New Hampshire's Committee recommends that any parties who are involved in divorce or child custody proceedings receive educational information on domestic violence, separation, and danger to assist them with the stress that may occur. If certain families are not involved with the justice system, they can also be targeted through other community agencies and businesses, such as childcare facilities (State of New Hampshire Governor's Commission, 2002). Georgia's Project recognizes that childcare facilities are among the few places that overly controlling and isolating perpetrators are less likely to restrict victims' regular visits. Therefore, members recommend that domestic violence information be provided at all day-care centers (Georgia DVFRP, 2004).

Another badly needed and promising primary prevention strategy involves school curricula aimed at educating children about domestic violence (see Jaffe, Wolfe, Crooks, Hughes, & Baker, 2004, for an example). Children of all ages require age-appropriate education

surrounding healthy and unhealthy peer and family relationships. Many adolescents require awareness and skills aimed at reducing the risk for domestic violence, dating violence, and stalking. The Ontario DVDR (2004) sets forth what it believes to be core aspects of such an educational program. The program should include: (1) a continuum of educational materials from kindergarten to grade 12 to foster skill-building and strategies for positive interpersonal relationships; (2) instruction to develop awareness of the warning signs of abuse and the potential for abusive behavior; (3) a recognition of the different ways that children and adolescents come in contact with domestic violence, including exposure to violence at home, in the media, and in dating relationships as victims, perpetrators, and peer groups; (4) community resources enlisted to sustain and support healthy interpersonal relationship choices; and (5) the input of teachers and community agencies that have a unique opportunity to collaborate on program development and implementation (Ontario DVDR, 2004).

Community agencies and teachers, as a team, have the opportunity to promote awareness, understanding, and skills such as the program developed by SafePlace in Austin, Texas, entitled "Expect Respect: A School-Based Program Promoting Safe and Healthy Relationships for Youth" (Rosenbluth & Bradford Garcia, 2004). Members of Delaware's Team assert that professionals in the education system require intensive in-service training aimed at identifying children who live in homes characterized by domestic violence and how to respond to them (Delaware FIRT, 2004). Similarly, the State of Maine's Panel encourages the education system to promote the use of its professionals (e.g., teachers and guidance counselors) to identify children and adolescents engaging in maladaptive behavior, such as aggression and exploitation. Panel members highlight that schools should document all known information and provide forums for discussion around such troubling behaviors. If training for school staff on responding to children who reside in violent homes is actively promoted and provided, then such prevention programs would be maximally effective. It is imperative to note that this kind of training and these prevention programs should not be limited to the school system, but should be widespread (Maine DAHRP, 2004). Washington's Review recommends that the legislature should fund community-

based juvenile delinquency and child abuse prevention programs in a variety of trusting and credible agencies (Washington State DVFR, 2004).

## Conclusion

There is growing recognition that children are severely victimized in the context of domestic violence, and not necessarily in the way that many professionals, researchers, and policymakers conceptualize as direct child abuse. Those employed in the criminal justice system (e.g., police, probation officers, judges, lawyers, custody/access evaluators, forensic clinicians, etc.), and those involved in related helping professions (e.g., mental health professionals, family doctors, shelter staff, CPS, teachers, religious leaders, family counselors, etc.) must be aware that some children living with domestic violence are at risk for homicide. On the surface, the risk for lethality may not be clearly visible, as not all of these children have a documented history of having been directly abused by their mother's partner. They may be killed in the crossfire of a violent altercation, by perpetrators who are seeking revenge against a former partner, or by parents planning to annihilate all family members before killing themselves. Many children are exposed to these horrifying acts of violence. Some children may not have witnessed the tragedies, but are nonetheless profoundly affected by the loss of parents.

Both criminal and family courts need to be aware of these findings in their daily work with families in crisis. What may appear to be conflict or minor allegations of an assault may pose a significant danger to adult victims and their children. Judges need to be more aware of risk assessment strategies and safety planning in domestic violence cases. Specialized advocacy and treatment programs need to be developed or accessed where already available. Thoughtful consideration of bail and release conditions as well as sentencing that recognizes the harm for children as well as adult victims is important. Supervising visitation and a thorough assessment of domestic violence perpetrators are essential tools for the family court. As well, there needs to be closer coordination of services for abused children and domestic violence victims. A wealth of information is developing on this topic on a national basis because of the closer working relationship between Child Fatality Review Committees

(<http://ican-ncfr.org>) and Domestic Homicide Review Committees (<http://www.ndvfri.org>) that now have links to each other's websites.

To date, there has not been a systematic evaluation of the domestic violence fatality review initiative. Based on the annual reports of individual committees, there would seem to be a high level of community engagement and collaboration. Enhanced partnerships among the justice system professionals and community agencies are reported as common outcomes. Individual communities and states often refer to their fatality committees as a rationale for new practices, policies, or legislation. For example, in Ontario, Canada, there has been a broad-based initiative to educate friends, family, and neighbors about lethal domestic violence in light of all the common warning signs overlooked in many

homicides. Some jurisdictions monitor specific recommendations such as the Santa Clara Committee's work to enhance safety planning for victims of domestic violence involved in criminal proceedings. The success of their work is highlighted by the fact that there were no deaths in the 5,337 domestic violence cases referred to the District Attorney's office for prosecution in 2004 (Santa Clara County DVC, 2004). Many committees report that in their view, fatality reviews save lives of children and adult victims of domestic violence through public awareness and systemic changes in the justice system. In the words of the Santa Clara Domestic Violence Council, "We will continue to track and study domestic violence related death cases, and we are convinced that this work saves members of our community from early and tragic death" (Santa Clara County DVC, 2004, p. 14).

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