Q&A About Domestic Violence Fatality Review

New York State Office for the Prevention of Domestic Violence

OPDV Bulletin/Fall 2009

IN THIS ISSUE

From the Executive Director ................................................................. Cover
Domestic Violence Homicides and Fatality Review ............................... Cover
Did You Know .................................................................................. Cover
Domestic Violence and Disabilities ....................................................... Page 2
Q&A About Domestic Violence Fatality Review ..................................... Page 3
Legislative/Legal Update .................................................................... Page 4
Domestic Violence and the Workplace Report .................................... Page 4
NYS Division of Parole Domestic Violence Unit .................................... Page 4

IN THIS ISSUE

Domestic Violence Homicides and Fatality Review

Most communities have had the unfortunate experience of dealing with a domestic violence homicide at one time or another. It can be traumatic for the entire community, especially those systems that respond to domestic violence. Recently, some communities in New York State have seen multiple domestic violence homicides, citing an increase in local domestic violence deaths and serious incidents.

In an effort to address these local tragedies, some communities have implemented local fatality review teams. These interdisciplinary teams examine domestic violence deaths to determine what might have gone wrong in an effort to prevent future occurrences. While some states have legislation establishing structures and protections for domestic violence fatality review, New York State currently does not (although New York City has local legislation mandating aggregate City-wide domestic violence fatality review). Even so, communities can still implement similar practices locally. Many communities have embarked on modified versions of fatality review, depending on the resources available to them. Considerations for local teams include developing review guidelines, accessing information, and crafting specific confidentiality agreements.

See page 3 for Questions and Answers on domestic violence fatality review.

Did you know...

In the first year since the passage of the Expanded Access to Family Court Law, 12% of all order of protection petitions filed in NYS Family Courts came under the new definition of intimate relationship (for a total of 7,600).

This information provided by the NYS Unified Court System Office of Court Administration, 2009.
Domestic Violence and Disabilities

Paul B. Feuerstein, President/CEO, Barrier Free Living

Barrier Free Living, an agency in New York City serving people with disabilities, commissioned a study of the public’s perceptions of people with disabilities. While “access,” “jobs,” and “health care” were common issues identified, no one thought of domestic violence.

Surveys of women with disabilities tell a different story. A recent survey showed domestic abuse to be the number one concern of women with disabilities1. That was no surprise—a 1990’s study showed the same2. People with disabilities not only have higher rates of abuse, but also stay in abusive relationships twice as long3.

Some individuals are disabled prior to becoming victims of domestic violence. In some cases, however, domestic violence can be the cause of an individual’s disability. An emergency room study of head assaults found that while stranger assaults tended to focus on the jaw, intimate violence assaults tended to focus on the upper part of the head—areas that lead to vision or hearing loss or traumatic brain injury4,5. A resident of Freedom House (Barrier Free Living’s shelter) became disabled when her abuser threw her out of a second story window.

UNIQUE CHALLENGES

Victims of domestic violence with disabilities experience many of the same challenges and tactics of control as other victims, but they may be further challenged and experience additional forms of abuse because of their disabilities. Withholding use of medications, wheelchairs, or other adaptive equipment is a typical pattern of abuse. The threat of losing children if abuse is reported can be greater for a woman with a disability. Along with fears of being charged with “failure to protect” if a child witnesses the abuse, if the mother is deaf or has a disability that involves communication ability, being charged with “educational neglect” is an added concern as there can be a perception that her disability makes her unable to provide educational support to her child. If a victim has left critical equipment at home in the process of finding safety, they may need to wait to get it back because an order of protection is often required before police will escort someone back into the home to retrieve items. For these reasons, collaboration with legal services is critical.

See box at right: “Working with Victims with Disabilities”

RESOURCES

Barrier Free Living has a newsletter on topics related to domestic violence and disability; sign up at www.bflnyc.org. Freedom House has accepted women with disabilities from 19 states and the Commonwealth of Puerto Rico, as well as from other parts of New York State. Call for training (212-539-1526) or for shelter referrals (212-400-6470). Additionally, the U.S. Department of Labor recently launched Disability.gov (formerly DisabilityInfo.gov) which provides access to thousands of resources on disability-related issues, programs, and services.

WORKING WITH VICTIMS WITH DISABILITIES

Working with victims with disabilities requires a comprehensive evaluation and a multi-disciplinary approach. In many situations, the abuser is also the victim’s care-giver. An evaluation of Independent Activity of Daily Living skills is a critical addition to the intake process—skills like money management, cooking, traveling independently. Individual skills can vary from fairly independent to having to start learning independence from scratch. Collaborating with a hospital or outpatient facility that has occupational therapist is another important strategy. Without skills for independence in place, individuals can end up in another abusive relationship with a “care-giver.”

When working with victims with disabilities, physical accommodations are necessary. Different physical accommodations are required for different disabilities. Wheelchair users are the first to come to mind, but there are other considerations to take into account. Some strategies we have employed are:

- Signage with white letters on black background for better visibility for individuals with low vision.
- Raised letters as well as Braille for individuals who are blind. A Braille label maker can be purchased to attach Braille to existing signs.
- Kits in shelter to accommodate deaf residents: a radio-controlled doorbell that flashes a light; a light or vibrator connected to a crying baby alarm; a flashing light for telephone calls; and a Telecommunication Device for the Deaf (TDD) to assist with making and receiving phone calls.

Working with victims with disabilities is not without costs, but we all live with a mandate to provide services under both the Americans with Disabilities Act (ADA) and the Rehabilitation Act 504 regulations. One thing programs can do is seek out equipment donations. Some of our inventory of adaptive equipment has been donated to us.

1 http://www.unitedspinal.org/2009/03/12/no-excuse-for-abuse-and-neglect/
2 Berkley Planning Associates, 1995-6 Study
3 Peg Nosek, Baylor University Study, 1997
5 See the NYS Office for the Prevention of Domestic Violence (OPDV) website for information on domestic violence and traumatic brain injury.
Q&A About Domestic Violence Fatality Review

This Q&A was conducted with Neil Websdale, Ph.D. (pictured right), Director of the National Domestic Violence Fatality Review Initiative.

Q: What is domestic violence fatality review?

A: Domestic violence fatality review involves an analysis of a death caused by, related to, or somehow traceable to domestic violence. The review creates a greater understanding of the tragedy and ideally leads to the implementation of preventive interventions. Teams review many different types of cases, including serious (non-fatal) incidents, intimate partner homicides, homicide suicides, familialicides (perpetrator kills former or current spouse one or more of their children and often commits suicide), suicides (especially those of battered women who exit violent, tyrannical and controlling relationships), cases where bystanders die (e.g. police officers, workplace colleagues), cases where one sexual competitor (usually a previously abusive man) kills another and indirect deaths where decedents die from causes traceable to domestic violence, including the deaths of homeless women, HIV-infected women, and drug addicts.

Q: Why is fatality review a useful tool for communities?

A: Comprehensive fatality review allows us to make sense of the death(s) by recreating the experiences of the victims, perpetrators and other parties involved in the case, exploring the compromises and challenges parties faced in accessing services, making decisions and exploring strategies. The review prioritizes the experiences of victims, giving us new ways of improving services, plugging gaps, increasing communications between those agencies typically involved and increasing the links between services and community members. Fatality review also provides opportunities for learning how we might better serve families that lost loved ones. It sharpens our understanding, allowing us to think about the relationships between coordinated community responses to domestic violence, safety audits, safety planning, and risk assessment and management.

Q: What are the steps in reviewing domestic violence fatalities?

A: Teams gather available information by a variety of means, including the use of Freedom of Information Law (FOIL) requests, through the public record. In a limited number of cases the testimony of family members, workplace peers, neighbors, friends, and others augments this information. Members discuss confidential information in different ways, some having a facilitator, others not, some being tied to a prescriptive process defined by state statute, others not. Although the depth of review varies, most teams follow similar and interrelated steps. One common step involves constructing a timeline of important events in the case, capturing how the case changed over time and how the nature of violence, tyranny, threats, and attempts to control perhaps intensified toward the death. Teams note the warning signs that might have suggested the case was moving toward a lethal outcome. Efforts are also made to identify the parts played by various agencies and community members and the level of coordination between these entities. Finally, teams suggest a number of recommendations based on the outcomes of their review(s), the goal being to make realistic recommendations that can be effectively implemented and that contribute to more effective coordinated community responses to domestic violence.

Q: How can communities structure fatality review when there is not state legislation in place?

A: State statutes enabling entities to review cases of domestic violence related deaths provide a variety of guidelines, assurances, prescriptions, and protections for teams and their members. Most teams work within the frameworks of these statutes. Reviews have taken place without statutory guidelines and protections but they are tricky. It is entirely feasible for a group of professionals to conduct thorough reviews using only public record materials, perhaps utilizing the insights of family members if the group chooses. It is also possible for surviving family members to convene reviews in combination with other supportive and interested parties, gathering information through the public record or making requests for information under the Freedom of Information Act. It is also possible for family members to access personal information, documents and records although it is important to know the difference between public, private, and confidential data. Teams may consider obtaining waivers of confidentiality from surviving family members if appropriate.

Legislative/Legal Update

The Governor's Domestic Violence Program Bill (Chapter 476) was signed into law on September 16, 2009, providing a strong package of responses to domestic violence. (Various sections of the law become effective on different dates.) The new law establishes procedures to ensure that domestic violence is appropriately factored into custody and visitation decisions; strengthens training for attorneys for children; designates certain sexual assault crimes as family offenses; and holds abusers accountable by requiring law enforcement to forward domestic incident reports to probation and parole officers, and by providing for certain violation-level harassment convictions to remain unsealed and accessible to law enforcement, thereby providing a more complete history of abuse.

Other new laws clarified unemployment benefits, crime victim benefits, and divorce protections. In addition, the mandatory arrest provision for family offenses was extended for another two years, until September 1, 2011. For a summary of 2009 laws affecting domestic violence victims, see OPDV's website.

New Court Decision

The New York Law Journal reported a decision of interest regarding interpreting the 2008 statute that expanded the definition of family and household member in family offense cases. Justice Ann Elizabeth O'Shea, Kings County Family Court, decided in the Matter of Winbrone v. Winn, (8/20/2009 N.Y.L.J. 30, (col. 1)), that the petitioner and respondent had no direct or cognizable relationship with each other. The petitioner had sought an order of protection against the respondent, whom she asserted was the live-in boyfriend of the mother of his children. The court found, that "For a relationship to be 'intimate' within the meaning of the statute, it must be direct, not one that is based upon multiple degrees of separation or that exists only through a shared connection with a third party."

Domestic Violence and the Workplace Report

Domestic violence is a problem that permeates all aspects of the lives of those it touches, including the workplace. It impacts the workplace in a variety of ways, including lost productivity, employee turnover, health care costs, and absenteeism.

To address the impact of domestic violence on the NYS workforce, Executive Order 19 was signed in October of 2007. The Order mandates all NYS agencies and designated authorities to develop and implement domestic violence and the workplace policies. In addition to protections for victims and measures to hold employees who commit domestic violence at work accountable, the policies provide for training, support, and information for employees.

Pursuant to Executive Order 19, OPDV has recently drafted its first report to the Governor detailing the implementation of this initiative. The report will be issued in October 2009. It contains information on policy development, implementation, and training, as well as aggregate data collected from agencies. Data includes: number of employees who requested information about domestic violence, number of domestic violence incidents that happened in the workplace, number of employees who came forward to report that they were victims of domestic violence, and number of employees who were referred for domestic violence services.

For more information and to access the report when it's available: www.opdv.state.ny.us/professionals/workplace

NYS Division of Parole Domestic Violence Unit

As part of the NYS Division of Parole’s Re-entry Unit, the Domestic Violence Unit (DV Unit) provides guidance to Parole staff though policy and training. Since May 2008, some exciting policy and procedural changes have enhanced the Division’s response to domestic violence.

The Division has expanded its Domestic Violence Manual Item which instructs Parole staff in the identification, investigation, and response to domestic violence incidents, which includes a standardized case review process in which all parolees are screened for domestic violence, whether or not they were incarcerated for domestic violence. It provides direction in the supervision of releasees with a history of domestic violence behavior to reduce the opportunities for domestic violence to occur.

This has included the revision of the Domestic Violence Alert (DV ALERT) system which ensures that all available domestic violence history is captured in the Case Management System and forwarded to the Re-entry/DV unit and Supervising Staff.

The Division has also implemented a policy with the NYS Police by which all domestic incident reports involving parolees are sent to the DV Unit and forwarded to supervising staff. Many local police departments have adopted this policy as well.

As part of the implementation and expansion of these new policies, the DV Unit has been conducting statewide domestic violence training for all Parole employees which also includes a domestic violence and the workplace component. This training began in April 2009 and to date, approximately 1000 staff have been trained.