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# Learning from experience: A content analysis of domestic violence fatality review team reports

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## Abstract:

The mounting cost of domestic violence (DV) homicide in the United States has led to increased attention from law enforcement agencies and social organizations and the establishment of domestic violence fatality review boards or teams (DVFRTs) throughout the country. These teams are tasked with reviewing a specified set of DV-related fatality cases to determine the factors that contributed to the fatalities and whether there are changes that can be made to prevent future similar incidents. There exists, however, little to no standardization of practice and procedures among DVFRTs, resulting in wide variability among the reports they produce. The purpose of this study is to empirically analyze the content of DVFRT reports across the United States to summarize standard practices in DVFRT reporting and to inform the procedures of existing and future DVFRTs. The researchers conducted a content analysis of 47 DVFRT reports to determine what information is most typically included in these reports on state, county, and city levels. A summary of findings and recommendations for DVFRTs is included.

**Keywords:** domestic violence homicide | domestic violence fatality review board | intimate partner violence | fatality review

## Article:

The often-silent epidemic of domestic violence (DV) homicide plagues individuals, cities, and states throughout the United States and has garnered increased media attention in recent years. High-profile cases in some areas have driven local governments, law enforcement, and service providers to focus increasing attention on this epidemic and on what can be done to address its pervasiveness. Domestic violence fatality review boards or teams (DVFRTs) have sprung up around the country on city, county, and state levels with a mission to better understand and address domestic violence homicides (and, in many cases, related suicides). The general purpose of a DVFRT is to review a specified set of DV-related fatality cases to determine the factors that

contributed to the fatalities and whether there are changes that can be made to prevent future similar incidents. DVFRTs have grown in prevalence since the early 1990s. However, there appears to be little to no standardization of methods and approaches among teams. Some are large, well-organized groups with formal, documented, and established procedures. Others are smaller grassroots efforts, sometimes struggling to meet their missions with limited resources and minimal knowledge about how other teams operate. If DVFRTs are to become an effective way of addressing the grave issue of DV homicide, more research is needed to better understand and document the ways in which such teams are organized and run.

According to the most recent report from the U.S. Department of Justice, nearly one out of five homicide victims between 1980 and 2008 (16.3%) were killed by an intimate partner (i.e., spouse, ex-spouse, boyfriend, girlfriend, same-sex partner), and another 12.4% were killed by a nonintimate family member (i.e., parent, child, sibling, or other family member; Cooper & Smith, 2011). These statistics are based on 63.1% of documented homicides in that 20-year period for which relationships between the victim and perpetrator were known (Cooper & Smith, 2011). Many DV-related cases go unreported or are filed as "accidents" or "missing persons cases," making the actual impact of DV homicide difficult to assess (Garcia, Soria, & Hurwitz, 2007).

DVFRTs first emerged in the early 1990s in states around the United States, fueled by growing concern for the frequency and severity of DV-related deaths. The initiative evolved out of a similar practice in the medical field (Websdale, Town, & Johnson, 1999). It has since grown exponentially with the help of legislation and grassroots efforts. According to the National Domestic Violence Fatality Review Initiative's (NDVFRI) online clearinghouse, as of 2012, there were more than 20 states, at least 30 counties, and 5 major cities where an organized review team has conducted at least one formal fatality review.

In October 1998, a group of DV fatality review experts met as part of a national summit to openly discuss the process of DVFRT review, effectively taking the first step toward standardization of the review process. The result was a series of recommendations on everything from structure and membership to specific procedures and policies (Wilson & Websdale, 2006). In the same year, the U.S. Department of Justice Office of Violence Against Women began funding the NDVFRI, whose primary charge is connecting DVFRTs through conferences, publications, on-site consultations, and through the organization's website, which has since become a clearinghouse for DVFRT reports (Wilson & Websdale, 2006).

According to Websdale et al. (1999), the primary purpose of DVFRTs is to reduce deaths related to DV by identifying and addressing gaps in services and organizational collaborations. These may include gaps in communication and coordination, data collection, and access to services or training (Websdale et al., 1999). Services addressed often include those provided by the civil and criminal justice system, law enforcement, mental health care, medical care, and social services (Websdale et al., 1999). Representatives from many of the aforementioned organizations as well as numerous others may serve on DVFRTs, which vary in number of members, organization, and procedures (NDVFRI, 2012; Wilson & Websdale, 2006).

In support of their work, city-, county-, and state-based DVFRTs produce formal reports of their findings and recommendations (NDVFRI, 2012). These reports are generally published publicly at rates that vary from every 1 to 20 years (NDVFRI, 2012). Although DVFRT reports all address the goal of informing the public and giving direction to the team's work, there is considerable discrepancy among reports in the type of content provided and the way in which it is organized and delivered. No effort has been made thus far to thoroughly review and summarize the content and reporting practices of DVFRTs nationwide. Consistent with growth in the number of DVFRTs as well as a move toward further standardization of the review and reporting process (Wilson & Websdale, 2006), new guidelines are needed to direct team development. Establishing and upholding standards for best practice in DVFRT reporting will help improve the quality of reports produced and therefore broaden their potential influence on the epidemic of DV homicide. This study offers an in-depth content analysis of all city-, county-, and state-level DVFRT reports available through the NDVFRI online clearinghouse (http://www.ndvfri.org) with a goal of delineating common themes and patterns in reporting.

## METHODOLOGY

This study used content analysis procedures (Stemler, 2001) to determine common themes in the content of DVFRT reports. The research question guiding this research was "What information is most typically included in reports of state, county, and city domestic violence fatality review teams?" The assumption underlying this research question was that the content of DVFRT reports could provide insights into typical DVFRT procedures, such as the composition of the teams and the types of data they review.

### Source of Data

The most recent DVFRT reports that were available on the NDVFRI clearinghouse website as of October 13, 2011 were included in the data analysis. Reports at the state, county, and city level were included. It is important to note that the NDVFRI website does not include all DVFRT reports that exist. The initiative relies on DVFRTs to submit their reports to be included in the clearinghouse. For example, the researchers were aware of one DVFRT report in their state that was not included on the list. However, the decision was made to include only those reports that were available on this site for several reasons. First, the NDVFRI is funded by the U.S. Department of Justice's Office of Violence Against Women. It, therefore, has a national scope and is the only known listing of its kind offering a broad-based representation of DVFRT reports. Second, based on inclusion of reports from very recent years, the listing appeared to be current. Third, as a centralized source of information about DVFRTs, the reports included on this site are likely to be referenced most frequently by practitioners who work in this area. Finally, the NDVFRI website contains a diverse geographic range of reports, inclusive of all of the major levels at which these reviews occur (i.e., state, county, and city).

Only the most recent reports available for each geographic region were reviewed based on the following assumptions: (a) the review teams within each geographic region are likely to use similar procedures from year to year, (b) use of the most recent reports helped to ensure that current practices were being examined, and (c) by limiting the review to one report per geographic region, the researchers avoid overrepresentation of any one geographic region in the

analyses. The NDVFRI website includes multiple forms of documents, including state statutes, supplementary materials, and international reports. For this study, only the final reports of DVFRTs in the United States were selected for the content analysis. Supplementary materials and supporting documents were not included.

## Data Coding Strategy

To provide a standardized approach to coding the data, a comprehensive checklist was developed to document the features of each report reviewed. Because this is the first known content analysis of DVFRT reports and the researchers were unaware of an existing coding system, the emergent coding strategy outlined by Stemler (2001) was used. Following review of a large set of DVFRT reports available on the NDVFRI website as well as existing scholarly literature on DVFRTs, the two lead researchers identified common elements contained in the reviewed reports and developed an initial version of a coding checklist.

The initial version of the coding checklist was subject to multiple rounds of trials and revisions to ensure that it could be applied consistently to the reports, which varied in their content and format. A pilot evaluation of the final drafts of the checklist and rating procedures was conducted by the two lead researchers, both of whom used the checklist to rate six of the same reports (i.e., two state-level, two county-level, and two city-level). The independently coded checklists were compared to ensure consistency in coding. This pilot evaluation yielded a high level of agreement between the researchers' ratings. A small number of additional revisions were made to the checklist before it was considered ready for the full study.

The final version of the checklist included seven items related to background information about the DVFRT and the report (e.g., geographic region and level, year of the report, and number of pages in the final report), and 25 yes-or-no questions indicating whether each report contained the designated information (e.g., when the review team was established, a summary of findings across different cases). Most of the yes-or-no questions also included follow-up questions to provide further depth to the findings. The format of the follow-up questions varied based on the nature of the information addressed in the main question. Some included additional yes-or-no questions to get more specific details about the designated content (e.g., "Does the report include specific recommendations for law enforcement?"). Other follow-up questions were posed in a multiple choice format (e.g., "If a funding source is identified . . . specify which of the following funding sources are mentioned."). Still, other follow-up questions were open-ended, such as asking to describe the eligibility criteria when these criteria are presented in the report.

## Coders and Training

Each DVFRT report was coded by three raters. These raters included all five authors and their backgrounds were as follows: a doctoral-level professor in an accredited counselor education program whose research focuses primarily on DV; a counseling doctoral student with a master's degree in community counseling; two master's-level counseling practitioners with master's degrees in couple and family counseling; and one master's student in a public health department. The two lead authors provided a 1-hr training session to the other coders to ensure that they

understood the procedures and the appropriate use of the coding checklist. In addition, the lead authors were available to the other coders throughout the study for consultation and questions.

Data Analyses

Once all reports were coded by three raters, the researchers compiled the ratings for each item on the checklist. When there was not 100% agreement among all three reviewers for a particular item, a consensus response was determined based on the response (i.e., yes or no) that was rated by the majority (i.e., 2/3) of the raters. These consensus responses are reported in the following section. Because a full-scale analysis of each of the open-ended follow-up questions on the checklist was beyond the scope of this study, a small number of representative quotes for selected items is presented in the next section to provide the reader with a more in-depth understanding of the content of those DVFRT reports reviewed.

## RESULTS

Forty-seven DVFRT reports were reviewed for this study: 4 city reports (8.5%), 28 county reports (60.0%), and 15 state reports (31.9%). Ten reports were excluded from the content analysis because links to the reports on the NDVFRI website were inactive and the reports could not be otherwise located. Interrater reliability was calculated based on the 25 main yes-or-no questions from the coding checklist using average pairwise percent agreement (Freelon, 2010). Average pairwise percent agreement was 76.6%. This section begins with a summary of the background of the reports in Table 1.

**TABLE 1.** Background Information About Domestic Violence Fatality Review Team Reports

| | ***n*(%)** | | | |
|---|---|---|---|---|
| **Background Information** | **City** | **County** | **State** | **Total** |
| Year of publication | | | | |
| 1991–1996 | | 2 | | 2 (4.3%) |
| 1997–2001 | | 3 | 1 | 4 (8.5%) |
| 2002–2006 | 2 | 5 | 5 | 12 (25.5%) |
| 2007–2011 | 2 | 13 | 9 | 24 (51.1%) |
| Not stated/no agreement | | 5 | | 5 (10.6%) |
| Years reviewed | | | | |
| Multiyear review | 3 | 17 | 8 | 28 (60.0%) |
| Single-year review | | 11 | 6 | 17 (36.2%) |
| No agreement | 1 | | 1 | 2 (4.3%) |
| Length of report (no. of pages) | | | | |
| 1–10 | 1 | 9 | 2 | 12 (25.5%) |
| 11–25 | | 8 | 1 | 9 (19.1%) |
| 26–50 | 1 | 8 | 8 | 17 (36.2%) |
| 51–100 | 1 | 2 | 4 | 7 (14.9%) |
| 101–150 | 1 | 1 | | 2 (4.3%) |

Summary information about the content areas identified in the reports can be found in Figure 1. For each content section, the researchers include a brief discussion of themes, accompanied by representative quotes from the reports reviewed.

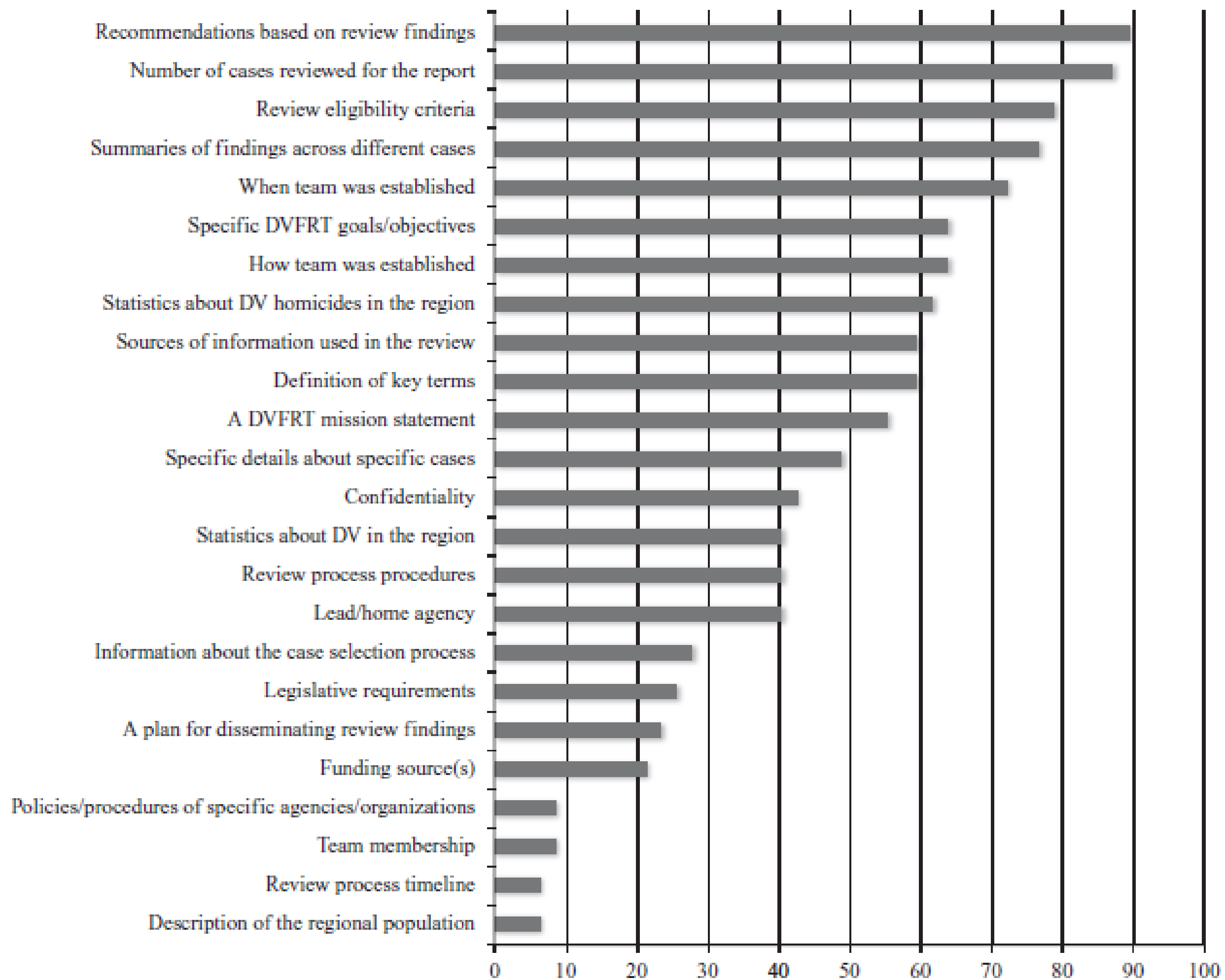


**Figure 1.** Percent of reviewed DVFRT reports containing each content element.
DVFRT = domestic violence fatality review board or team; DV = domestic violence.

## Review Team Establishment

Most of the reports reviewed included information about when (72.3%) and how (63.8%) the review team that developed the reports was established. Thirty-one (66.0%) of the reports reviewed were created by DVFRTs established between 1992 and 2006. Many of these DVFRTs were established by specific legislation that commissioned their creation to address public concerns about DV-related fatalities. Others were the result of grassroots efforts by DV agencies, organizations, and concerned members of the community. Some of these later received legislative backing. Others were supported by public and private grants and continuing collaborations between area agencies.

## Information About the Review Team

Most (83.0%) reports included information about review team membership. Some reports included lists of all team members along with their titles and home agencies, whereas others included summaries of the types of professionals that contributed to their teams (e.g., law

enforcement and legal professionals). Approximately 50% of the reports came from teams of 10-30 members with at least one team of less than 10 members and three teams of 50-100 members. Most teams were composed of representatives from a range of different agencies and professional affiliations. Some reports described established membership structures wherein at least one representative was required from each county in a state (e.g., Georgia, 2010) or from each contributing agency (e.g., Cecil County, MD, 2008). Among the most frequently mentioned professions were staff from DV agencies (including battered women's shelters), law enforcement, legal professionals (e.g., attorneys and judges), medical professionals and health care workers, mental health professionals, representatives from departments of social services and child protective services, and domestic violence advocacy organizations. Less frequently, representatives from local coroner's offices, housing authorities, churches, and government offices were also included. Some teams (e.g., Phoenix, AZ, n.d.) also invited community members to contribute.

Nineteen (40.4%) of the reports reviewed included information about a lead or home agency for the DVFRT. In most cases, these were government-run organizations (e.g., Office of Public Health), domestic violence agencies and coalitions, or organizations affiliated with law enforcement (e.g., police departments or a district attorney). Ten reports (21.3%) included information about the DVFRT's funding source. Most were funded by a single funding source, and the sources of funding that were noted in the reports included tax funds at the state, county, and/or city levels; private funding from foundations; operating expenses of the designated agency; and federal grants.

## Goals and Mission of the Domestic Violence Fatality Review Boards or Team

Twenty-six (55.3%) of the reports reviewed included a specific mission statement for the DVFRT and 30 (63.8%) reports included a list of goals or objectives for the team. Most mission statements included language about the purpose of the team (e.g., "to reduce DV-related fatalities and near fatalities," Baltimore, MD, n.d.), its primary activities (e.g., "examine aggregate information relating to domestic violence fatalities," New York City, NY, 2008), and, in some cases, a goal of producing recommendations for change (e.g., "make recommendations to strengthen system-wide policies and procedures that will help diminish the possibilities of future fatalities," Los Angeles County, CA, 2001). Following is an example of a representative DVFRT mission statement:

> The mission of the Anne Arundel County Domestic Violence Fatality Review Team is to reduce the incidence of domestic violence, to prevent the occurrence of domestic violence fatalities, and to improve the quality of life for victims of domestic violence and their families. (Anne Arundel County, MD, 2004-2007)

Some reports included more specific objectives and/or goals for the review team. Typically, these took the form of bulleted or numbered lists and included a range of goals, from tracking and reviewing current fatality data to making informed policy recommendations to enact community change. In many cases, the reported objectives or goals overlapped considerably with a team's mission statement or were included in its place. An example of a representative list of DVFRT goals from the Philadelphia, PA (2006) report is included in the following:

The four central objectives of the Philadelphia Women's Death Review Team are:

(1) To track the incidence and prevalence of violence-related deaths of women;

(2) To identify the degree to which intimate partner violence (IPV) contributes to the community's premature mortality;

(3) To identify patterns and trends in violence-related deaths of women; and

(4) To formulate key policy and practice recommendations to improve the systems that serve and protect women and their children.

Information About the Geographic Region Reviewed

In some cases, reports included information about the demographics of the population in the geographic region reviewed (6.4%) and statistics about DV (40.4%) and DVrelated deaths (61.7%) in that region. In the few instances where characteristics of the populations were discussed, basic information such as the size of the population and its gender, age, and ethnic composition were reported (e.g., Almeda County, CA, 2005; Philadelphia, PA, 2006). General DV statistics, when reported, were usually reported for the period of time under review. The most frequently reported DV statistics include the number of phone calls to DV hotlines, the number of DV-related arrests, the number of protection orders filed, and rates of service use for DV agencies (e.g., Delaware, 2009). When specific statistics about DV-related deaths were reported, reports included information ranging from the number of deaths/homicides/suicides and fatality cases prosecuted through the criminal justice system to information gathered from local hospitals, service providers, coroner's offices, and other DV- and health-related organizations (e.g., Harris County, TX, 2007).

Information About the Cases Reviewed

Information about the types of cases eligible for fatality review was identified in 79% of the reports reviewed. Among the reports that included eligibility criteria, some themes emerged in the criteria used and in the information presented in the subsequent report. Nearly all reports that included eligibility criteria specified that they only reviewed cases related to DV. However, some reports (e.g., Philadelphia, PA, 2006) allowed for deaths that were indirectly associated with a DV incident (i.e., involved bystanders or children). With some exceptions, the most common criteria included in reports required that reviewed deaths (a) must involve either homicide or suicide (or both), (b) must be fully adjudicated with no pending court hearings or law enforcement investigations, and (c) must have occurred within designated geographical limits (i.e., city or county limits). Most reports indicated that review teams made every effort to investigate all eligible cases within a given time frame (from one year to several years). However, some chose only to review one or two representative cases (often those that raised unusual or complicated issues). Some (e.g., Sacramento County, CA, 2005) specified that only female deaths were reviewed. Most did not include any limitations on gender or sexual orientation of the victim as criteria for exclusion or inclusion. Some reports also included child

fatalities, particularly in geographical areas that did not have separate child fatality review teams. In addition, many of the state review teams indicated that they did not open new case reviews but rather reviewed cases previously identified by county or city review teams and reported summary information and recommendations to generalize based on local reports. Some teams (e.g., Cecil County, MD, 2008; Macomb County, MI, 2006) expanded their criteria to include near-fatalities related to DV as well. The following quote from the Los Angeles County, CA (2001) report is an example of how a DVFRT might describe its review criteria:

> Unlawful killings, involving a present or past intimate partner, as well as those against children, new partners, other family members, friends, or bystanders, which are motivated by a domestic violence relationship may be analyzed by the Team.

A small proportion (27.7%) of reports included information about the case selection process. Reports that described this process included statements about who was responsible for screening cases, the timeline for screening (e.g., within one year of the fatality), and details of the screening protocol. The following excerpt from the Cecil County, MD (2008) report is one example of a description of the case selection process:

> In determining which cases to review, the protocol requires that the case screening committee meet at least four (4) weeks prior to the next scheduled DVFRT meeting. The Chairperson will then submit the victims and offenders names to the team members so that the representatives, who are responsible for reviewing the records of their agency, can identify any information related to domestic violence about the parties.

Most of the reports (87.2%) included the number of DV fatality and near-fatality cases reviewed in the report. The number of cases reviewed in each report, however, varied widely (from 1 to 711). Three of the reports (6.4%) included detailed reviews of a single case, whereas most DVFRT reports contained information about the number of regional DV-related cases and fatalities during particular time periods.

### Information About the Review Process

Some reports included information about the overall review process, including issues of confidentiality (42.6%), legislative requirements (25.5%), review process procedures (40.4%), and a review process timeline (6.4%). Reports that referenced confidentiality typically addressed the ways in which sensitive information was kept confidential by the team (e.g., Vermont, 2011). Frequently, the authors of these reports referred to confidentiality statements or other forms used by the team for this purpose and these forms were sometimes included as appendices to the DVFRT report. The following is an example of wording from one report regarding confidentiality:

> All of the information discussed in a fatality review is confidential either by statute or practice. By design, the Code of Virginia (§32.1-283.3) provides confidentiality protection to the review process in order to facilitate discussion that can lead to insights and interventions that might prevent these fatalities in the future. (Chesterfield County, VA, n.d.)

Information about legislative requirements for the review process was included in some reports. Typically, this information pertained to regulations for team membership (e.g., "Law indicates that the NYPD, NYC Dept. of Health and Mental Hygiene, Human Resources Administration, Dept. of Homeless Services, and Administration for Children's Services are standing members of the FRC," New York City, NY, 2006), types of data to be collected (e.g., aggregate data on family-related homicides, New York City, NY, 2006), and specific procedures to be followed (e.g., "Documents . . . may include medical records, police reports, shelter records, psychological records, and child protection records," Hennepin County, MN, 2007).

Review process procedures, whether dictated by legislation or determined by the review team, were sometimes detailed as part of the reports. For example:

> Each case review begins with a report by the Chief Medical Examiner and the law enforcement agency, which responded to the scene. These reports provide great detail about the homicide as well as the history of the victim and defendant, and where applicable or relevant, the children. Information is also received from the prosecutor and victim advocate involved with the case. Committee members then report on information from their agencies or organizations. (New Hampshire, 2004)

Only a handful of DVFRT reports (three) referenced a specific timeline for the review process. Details about these timelines were not collected.

Specific Details About Specific Cases

Specific details about specific cases were provided in 23 (48.9%) reports. Twenty-two (46.8%) reports included details about the fatality, such as the cause of death, location, child/other witnesses, presence of substances, number of fatalities, and whether the fatality resulted in murder/suicide or both. The most common details listed in the reports included cause of death and location of the fatality. Twenty-three (48.9%) of the reports included characteristics of the perpetrator(s), such as age, gender, race/ ethnicity, nationality, criminal history, relationship status, substance abuse, mental health, and medical history, access to firearms, and employment status. Twenty-two (46.8%) of the reports included characteristics of the victim(s), such as age, gender, race/ethnicity, nationality, relationship status, history of DV, efforts to seek shelter, involvement with service providers, current or previous DV protective orders, criminal history, history of substance abuse, mental health, and medical history, whether victim was pregnant, and employment status. In 42.6% of the reports, information was provided about the characteristics of the relationship between the victim(s) and perpetrator(s). This included marital or relationship status, involvement of children, living arrangements, length of the relationship, whether there was an attempt to end the relationship at the time of the fatality, history of violence and DV protective orders (DVPOs), and changes in the relationship prior to the fatality. Seventeen (36.2%) reports included characteristics of children involved. These characteristics included age, gender, and whether the children were witnesses to the fatalities. Twenty (42.6%) reports included characteristics of abuse prior to the fatality. Such characteristics included history of abuse, previous involvement with law enforcement, whether employer was aware, nature of control in the family relationships, previous DVPOs and violations, history of threats, severity of

abuse, knowledge about the abuse by others, presence of stalking, presence of antisocial behavior by the perpetrator, and history of child abuse. Only 21.3% of the reports that included specific details about the fatality also included outcomes or proceedings of court or legal involvement. Reports that provided this information presented case-specific timelines of court proceedings and pleas, prior incidents, involvement with law enforcement, and postmortem charges. Other reports provided general statistics about the number of DV complaints, misdemeanors, and felonies.

Summary of Findings Across Different Cases

A summary of findings across different cases was provided in 36 (76.60%) reports. Summaries included statistics of demographics of victims and perpetrators, weapons used, age range of victims and perpetrators, location of fatalities, history of DV, involvement of children, and general trends and analyses of DV incidents and fatalities over time. Summaries of the details of the fatalities included cause of death, weapon used, location, child/other witnesses, presence of substances, number of fatalities, relationship status, history of DV, history of law enforcement involvement, whether the fatality was a result of self-defense, whether the fatality resulted in murder/ suicide or both, and general patterns and trends. The most common characteristics of perpetrators listed in the reports included gender, age, nationality/ethnicity, race, substance abuse and mental health history, criminal record, and relationship status. Less common in the reports were history of DV in the family, sexual orientation, employment status, presence of DVPO, weapons used, past services sought, history of threats against victim, and history of child abuse against child. Most commonly listed characteristics of victims included age, gender, ethnicity/nationality, race, relationship status, substance abuse and mental health history, criminal record, and whether there was a history of DVPOs against the perpetrator. Less common in the reports were whether victims had sought help from DV agencies, if service agencies were involved (e.g., social services), medical history, and whether victims were in the process of leaving. Twenty-three (48.9%) reports included summaries of characteristics of children involved, across cases. These primarily included statistics of the number of children involved in DV fatalities, their ages, their genders, whether the children were homicide victims, whether they were witnesses to the fatality, their living arrangements, and their relationships to the perpetrators. Twenty-two (46.8%) reports included summaries of prior abuse history across cases. Information provided included arrest history, involvement with law enforcement, severity of prior abuse, threats made, and stalking behaviors. More specific details were often listed with perpetrator and victim characteristics. Only 12.8% of all the reports included summaries of outcomes or court/legal proceedings. These included the status of current and past cases (e.g., percent of perpetrators serving life sentences, referrals to batterer intervention programs), summary and statistics of charges (e.g., voluntary manslaughter, aggravated murder, involuntary manslaughter, or no charges), types of fatalities (e.g., murder, suicide, or defense), and previous law enforcement involvement and outcomes. For example, in the Iowa state report (2006), the DVFRT noted, "Only two out of the 15 cases where there had been a prior arrest resulted in a conviction leading to referral to a batterer's education program." In 59.6% of the total reports, summaries were provided of the relationship characteristics between victims and perpetrators. These summaries listed relationship status, cohabitation status, age when victim met perpetrator, whether the relationship was with same-sex or opposite-sex partners, whether the relationship began during teenage years, length of the relationship, prior history of abuse, contact with

service providers, prior legal involvement, presence of DVPOs, and whether others were aware of the abuse.

## Sources of Information Used in the Review

The sources of the information that the DVFRTs used in their reviews were included in 28 (59.6%) reports. Generally, those DVFRTs who reported their information sources used a diverse variety of sources, which included the following: mental health and health care records, criminal justice system records, records from public agencies (e.g., the Department of Social Services), interviews with friends and family, interviews with professionals involved in the case, media coverage, autopsy/medical examiner reports, death and birth certificates, shelter and hotline records, emergency department records, census bureau statistics, records from DVFRT members' agencies, batterer intervention program records, animal abuse or neglect complaints, educational records, substance abuse treatment program records, weapon registrations, previous DVFRT reports, and general information sharing among the professionals representing the organizations involved in the DVFRT.

## A Plan for Disseminating Review Findings

About one-quarter (23.4%) of all of the reports provided a plan for how the DVFRT intended to disseminate the report. None of the reports stated whether a copy of the report was to be provided to the local media. Some reports provided very specific details regarding the team's plans for disseminating the result. For example, the Duval County, Florida, report states:

> A copy of this report is provided to all Fourth Judicial Circuit judges, the local sheriff, the local state attorney's office, victim advocates, batterer's intervention programs, local legislators, and the military. A copy is also placed on the web for public access (www.baylor.edu/ndvfri/). (Duval County, FL, 2010)

Other outlets for disseminating reports included specific individuals (e.g., judges, state attorneys, and governors) and organizations (e.g., a DV prevention coordinating council, a law enforcement planning council, school systems, county boards), legislative committees, community-based professionals, through community and conference presentations, and to the general community (e.g., "other key community members" and "throughout the county"). Some DVFRTs stated that the reports would be publicly available through websites or by providing contact information to receive a copy of the report. The report for Vermont included the following relevant statement to request public comment following dissemination of the report:

> The Commission asks all Vermonters to review this report and provide us with comments and suggestions as we continue to study the trends and patterns of domestic violence and related fatalities. (Vermont, 2011)

## Additional Information

*Definition of Key Terms***.** Twenty-eight (59.6%) reports included definitions of key terms in the report. The terms most commonly defined were *DV/abuse*, *intimate partner* and *intimate partner*

*violence*, *DV fatality/homicide*, *DV-related incident*, and other terms used to describe the nature of relationships (e.g., *cohabitant*, *dating relationship*). In most cases, these definitions were included to inform the reader about DV-related terminology with which he or she may not be familiar. In some cases, however, the authors noted that their inclusion of definitions was intended to operationalize eligibility criteria (e.g., some reports defined a domestic violence fatality to include DV-related suicide and some did not).

*Policies and Procedures of Specific Agencies and Organizations*. Only four (8.5%) reports addressed the policies and procedures of specific agencies and organizations reviewed by the DVFRT. Note that this question referred to the agencies involved in the cases reviewed, not to the policies and procedures of the DVFRT. The types of agencies addressed included law enforcement, the court system, medical personnel, governmental agencies (e.g., the Department of Health and the Department of Social Services), and mental health professionals. For the most part, these policies and procedures were noted in the recommendations sections of the DVFRT reports, and two reports provided information about updated policies that were made based on previous DVFRT reports in the designated geographic area.

Recommendations Based on Review Findings

Most (89.4%) of the reports included recommendations based on the findings of the review process. For the most part, these recommendations were detailed and provided in-depth lists of actions to change the various systems that address domestic violence homicides. The nature of the recommendations is detailed in Table 2.

As Table 2 demonstrates, recommendations were made most often for law enforcement and social service agencies, followed by community-wide changes and public policies.

**TABLE 2.** Percentage of Domestic Violence Fatality Review Board or Team Reports That Include Recommendations for Each System

| | **City** | **County** | **State** | **Overall** |
|---|---|---|---|---|
| Recommendations for law enforcement | 100.0% | 82.1% | 80.0% | 83.0% |
| Recommendations for social support systems (e.g., family, friends, and bystanders) | 0.0% | 21.4% | 13.3% | 17.0% |
| Recommendations for specific social service organizations | 100.0% | 78.6% | 86.7% | 83.0% |
| Recommendations for public policies | 50.0% | 50.0% | 60.0% | 53.2% |
| Recommendations for community-wide changes | 50.0% | 67.9% | 53.3% | 61.7% |
| Recommendations for holding organizations and professionals accountable for carrying out recommended actions | 0.0% | 7.1% | 0.0% | 4.3% |

## DISCUSSION

A primary function of most DVFRTs is to review DV-related fatality cases within a designated geographical region and to report their findings and recommendations to the community and to relevant stakeholders. Although most DVFRTs periodically publish their reports, there is little consistency in their content and no evidence of efforts to standardize the way these reports are written. Such standardization would provide a framework for DVFRTs on which to base their practices and would allow for comparison and evaluation of existing DVFRT protocols. The goal of this study was to investigate the types of information that are typically included in reports of

state, county, and city DVFRTs using content analysis. This section includes a review of this study's limitations and implications based on major findings.

## Limitations

This study represents the first known attempt to empirically examine the practice of DV fatality review team reporting. As such, it was faced with some notable limitations. First, relatively low interrater agreement was likely the result of high variability in the way these reports are presented, as well as difficulty operationalizing specific content areas in a way that would clearly differentiate similar content areas from one another. In addition, the sample for this study was retrieved from the NDVFRI clearinghouse website and does not represent all DVFRT reports published in the United States. Future research should evaluate the effectiveness of DVFRTs by assessing outcome measures including changes in policy and public awareness about issues that contribute to DV fatality. The researchers also encourage the development of a standardized method of conducting DV fatality review and a format for producing DVFRT reports. With increased empirical support and advances in the quality and rigor of research methods employed in DV fatality review, this practice will continue to grow and, hopefully, its goal of reducing the number of DV fatalities will come to fruition.

## Implications of This Study's Major Findings

*Domestic Violence Fatality Review Team Composition and Funding*. One notable finding from the content analysis was the diversity of existing DVFRTs. All of the teams that reported on their team composition included representatives from a range of professional affiliations (and, in some cases, nonprofessional perspectives as well). It seems that incorporating different points of view is a goal of many teams. This priority ensures a comprehensive and thorough review of all cases. In some instances, team membership is dictated by legislation, and in others it is based on member availability. The latter would lead to more variation in team membership over time, whereas the former would maintain consistency. DVFRTs may wish to consider the implications of their approach to regulating team membership and how the diversity of the team may impact the review process in the long run. The funding source for a DVFRT process provides an important foundation for its focus, goals, and targeted outcome. Although only about one-fifth of the reports reviewed noted the funding source, the researchers suggest that this information be provided in future DVFRT reports. In particular, whether funding is provided by a public (e.g., tax funding) or private (e.g., foundations or private donors) funding source has implications for the composition of the team and the public's perceptions of the final report.

*Goals and Mission*. Approximately half of the reports included specific mission statements or goals, most of which outlined the team's purpose, activities, and outcomes. Inclusion of these elements may help focus a team's efforts and communicate their purpose and goals to the public, bolstering public awareness and support. The researchers therefore recommend that future reports continue the practice of including team mission statements and/or objectives to assert their goals and the foundations of their work and to reinforce public awareness of their efforts.

*Geographic Regions*. Currently, most DV fatality reviews take place on the county level. There are specific advantages, however, to reporting on the state and city levels as well. City review

teams provide case studies that are more targeted and specific than reports on either the county or state level. State review teams, on the other hand, provide more global analyses of patterns in DV fatality cases. Larger scale reviews can better inform state legislature and have the potential to impact far more people than county or city reviews. The researchers recommend further development of city and state review teams to provide a more comprehensive understanding of DV fatality on all levels. In addition, there were significant inconsistencies in the degree to which DVFRT reports documented regional statistics on demographics and DV. The inclusion of these statistics creates context for the report and informs the public about important issues pertaining to DV fatality. More consistency in statistical reporting would increase awareness of a serious public health issue and contribute to growing standards for research integrity in DV fatality review.

*Information About the Cases Reviewed*. There was considerable ambiguity in the types of content that raters classified as either eligibility criteria or information about the review process. It appears, therefore, that some content was misclassified. Overall, relatively few reports included this information, despite its potential value to other DVFRTs in the effort to standardize fatality review practices. The inclusion of details about screening and review procedures in future DVFRT reports would aid in this effort. Although several common criteria are used across fatality review teams to determine eligibility for review, there was notable variance in the way some teams outline their criteria. As a DVFRT prepares for its next round of reviews, its members may want to consider the following decisions related to eligibility criteria: (a) Will cases be sampled widely, or will the review involve a more in-depth case study? (b) Will any cases be excluded based on gender, sexual orientation, or age of the victim? (c) Is there also a child fatality review team that covers the same geographic region? (d) How directly must a case relate to a domestic violence incident to qualify for review? (e) Will near-fatal incidents be included as well? By answering some of these questions, the members of a review team can more clearly delineate the scope of their work, making it easier to select cases with a particular focus in mind.

The number of cases reviewed by each team varied widely, from single case reviews to 711 fatalities. The reports also varied in how they were reviewed. For example, some reviews reported the total number of regional homicides (e.g., N 5 711), then further identified select fatalities as DV-related (e.g., n 5 30). Furthermore, the number of cases reviewed did not always equate the number of fatalities because multiple fatalities sometimes resulted from individual cases and reports sometimes included near-fatalities as well. DVFRTs may want to consider how they intend to report DV fatalities to the public and what information they hope to disseminate. An overall consideration for DVFRTs may be to standardize fatality reports to be able to more effectively examine both regional and nationwide trends and interventions.

*Information About the Review Process*. Less than half of the reports reviewed for this study included any information about the review process. An even smaller subset included specific details about this process. In the interest of further developing the practice of DV fatality review and building the integrity of the research supporting this practice, future reports should include detailed information about the way reviews were conducted. This information will not only serve as a vital reference for developing DVFRTs but will also allow for comparison and evaluation studies to be conducted in the future.

*Specific and Summary Details About Cases*. Details about specific cases were reported in roughly half of the reports, whereas about three-fourths of reports included general statistics and findings across cases. The fact that a high number of reports included specific information and overall findings about fatality cases highlights the importance of such information. Examining fatality details and trends may be an important tool for more extensively understanding the nature of DV fatalities. It may also help providers target specific interventions and develop safety plans more appropriately with victims of DV.

*Sources of Information Used in the Interviews*. Most (approximately 60%) reports acknowledged the sources of information used for the fatality review process. However, this percentage is low considering the critical importance of the quality of the source(s) of information to understanding the validity of the review findings. The diversity of the sources used in the reports that provided this information demonstrates various potentially useful information sources that can be drawn upon while conducting a DVFRT process. Each potential source of information likely carries some advantages and disadvantages, and these must be considered when making conclusions based on the information. For example, some sources of information may be prone toward biased information (e.g., interviews with friends and family members), whereas other sources of information may contain incomplete information or record-keeping errors. For all of these reasons, the researchers recommend that the largest amount and diversity of information available be drawn upon when DVFRTs conduct their reviews.

*Dissemination Plans*. It is likely that more DVFRTs have dissemination plans than those that are detailed in the reports themselves. However, the fact that less than one-fourth of the reports included report dissemination plans suggests that teams may benefit from paying greater attention to the channels through which the reports can be distributed to key stakeholders and the general public. Given the emphasis on making recommendations based on the findings of the review, it is important for teams to plan to disseminate the reports to ensure that they end up being seen by key decision makers who can carry out these recommendations. Of the reports reviewed, the ones with the most detailed dissemination plans used multiple channels to reach various stakeholders. Based on this model, the researchers suggest that future DVFRTs consider the people and organizations that they want their reports to reach and then plan dissemination strategies designed to target each potential audience.

*Definition of Key Terms*. The researchers recommend that future DVFRTs follow the lead established in 59.6% of the reports reviewed for this study by including specific definitions of key terms in their reports. This practice helps educate the public and key stakeholders about important issues in the study of DV. It also contributes to research integrity by providing concrete operational definitions of terms that might otherwise be open to interpretation.

*Specific Agency Policies and Procedures*. Very few reports discussed specific policies and procedures of the agencies and organizations involved in addressing DV homicides. However, this information is important for understanding the context of recommendations that are made based on the findings of the review. Therefore, these matters may warrant additional consideration by DVFRTs carrying out future reviews.

*Recommendations Included in Domestic Violence Fatality Review Board or Team Reports*. A high percentage of reports contained recommended changes based on the review process. Making such recommendations appears to be an important objective of DVFRTs. This focus underscores the inherent value of conducting fatality reviews in that the comprehensive review process can highlight places where victims "slipped through the cracks" and where opportunities for potentially valuable intervention may have been missed. Depending on the political clout of the funding source and/or supporting agencies of the DVFRT, these recommendations may hold power for creating potentially positive change at various levels. Therefore, DVFRTs should make recommendations carefully and with full consideration of the context surrounding them (e.g., agency policies and procedures, community priorities, and the availability of funding and other resources needed to carry out the recommended actions). Based on this review, it appears that recommendations are made most frequently for changes in law enforcement and specific social service agencies. As such, it is advisable that representatives of these organizations be involved in DVFRTs from the earliest stages of the process to increase their buy-in for making possible changes at the end of the process.

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