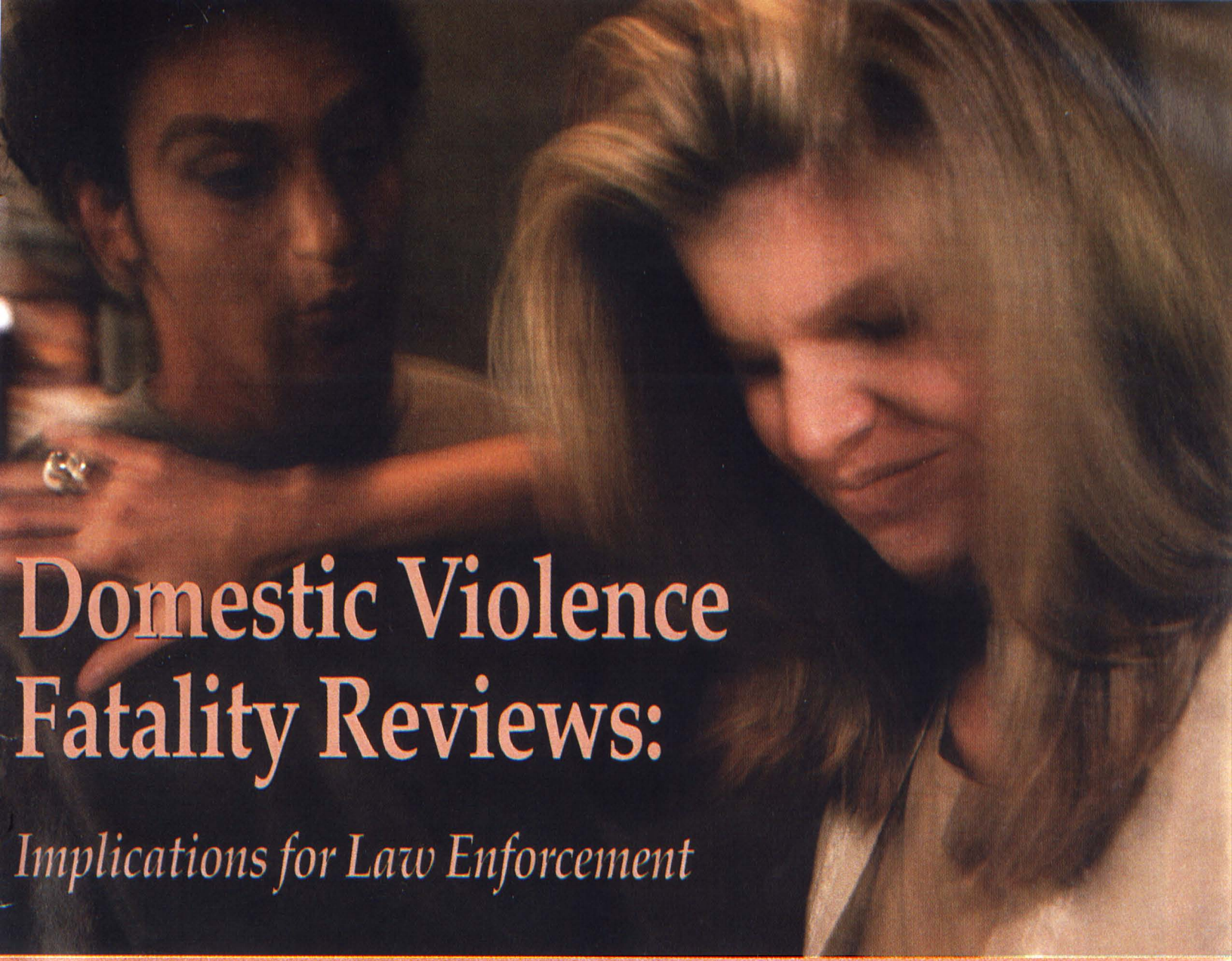

Domestic Violence Fatality Reviews:

Implications for Law Enforcement

By Neil Websdale, Professor of Criminal Justice, Northern Arizona University, Flagstaff, Arizona, and Heather Moss, Research Associate, Fatality Review Initiative, and Byron Johnson, Director, Center for the Study and Prevention of Domestic Violence, University of Pennsylvania, Philadelphia, Pennsylvania

Each year in this country, male intimates kill anywhere from 1,000 to 1,600 female partners.[1] Only recently the federal government and some states began to explore the reasons for these domestic violence deaths in a systematic manner.[2] This article reviews the types of deaths linked to domestic violence, provides a few examples of domestic violence fatality reviews, and discusses the implications of these reviews for law enforcement. These fatality reviews, conducted appropriately and carefully, provide an important means of improving the response of law enforcement agencies to domestic violence. Review findings and recommendations can offer innovative suggestions for officer training, officer safety, and the coordination of policing activities with other agencies involved in dealing with family violence.

In the long term, such reviews offer the promise of a reduction in the number of domestic violence fatalities, officer injuries and deaths at these crime scenes, and dangerous hostage/barricade domestics. As a result, a reduction in the multiple liabilities associated with these (at times) complex and challenging cases is also likely. In short, fatality reviews are a powerful mechanism for enhancing police policies and procedures and developing innovations in training. The term "domestic violence fatality review" refers to a

> *deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence, for examination of the systemic interventions into known incidents of domestic violence occurring in the family of the deceased prior to the death, for consideration of altered systemic response to avert future domestic violence deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to eradicate domestic violence.*[3]

This deliberative process can be formal or informal, relatively superficial, offering basic demographic details of victims and perpetrators, or very detailed. The scope of review activity varies enormously and has involved a review of one case, all such

deaths within a particular jurisdiction, all domestic violence-related deaths within a state, or other variations. The underlying objectives of these reviews are as follows:

- Prevent future domestic violence and domestic homicide
- Provide safer provisions for battered women and their children
- Hold accountable both the perpetrators of domestic violence and the multiple agencies and organizations that come into contact with the parties

Domestic violence fatalities are normally handled by the criminal justice system, which investigates the death and identifies and charges the perpetrator, where appropriate. However, such handling does little to review the effectiveness of the systems charged with serving and protecting those vulnerable to domestic violence and death. Sometimes ad hoc reviews are conducted through the media, but these reviews are often cursory, emphasizing the sensational aspects of the case. Such media analyses rarely access the deeper history of domestic violence, the entrapment of women, the escalation of abuse before death, and the twists and turns in relationships that appear to characterize a significant number of cases.

Domestic Violence-Related Fatalities

Domestic homicide takes a number of different forms, all of which might serve as the basis for a domestic violence death review. "Intimate partner homicide" usually involves a man killing his female partner, often after a long and escalating pattern of domestic violence. When women kill male partners, they typically do so in self-defense, although such defense may not qualify as such in a court of law. Non-intimate partner family members also kill each other in so-called "family homicides." Men sometimes kill other men over a woman in whom they are both interested. These "sexual competitor killings" are much smaller in number than either intimate partner or family homicides.

Many more Americans die from suicide than homicide. Research suggests that a large number of women who commit suicide do so because of their violent victimization at the hands of an intimate male partner. Authors Evan Stark and Anne Flitcraft note specifically, "in most cases we believe battered women are provoked to attempt suicide by the extent of control exercised over their lives."[4] According to these authors, the proximity between woman battering and women's suicide attempts, in general, strongly suggests that battering may be one of the principal causes of the suicide attempts. Stark and Flitcraft point out that a number of studies show abuse as a factor in as many as 44 percent of female suicide attempts.[5] For these researchers, it is very telling that more than a third of the battered women in their sample[6] "visited the hospital with an abuse-related injury or complaint on the same day as their suicide attempt."[7]

As the elderly population in the United States continues to increase, researchers have become more aware of domestic violence between older partners. Social service providers and law enforcement agencies sometimes wrongly assume that because people are elderly they are not capable of committing or being victimized by domestic violence. This attitude can translate into an assumption that homicide-suicides among the elderly usually take the form of "mercy killings" or suicide pacts. Police officers or others who investigate the homicide-suicide and find a note telling authorities that the couple could not live on with ailing health might hastily assume "mercy killing."

Upon further investigation, we find it is nearly always men who commit these

killings and that in a significant number of cases their female victims had expressed to other family members a desire to live not die.[8] Indeed, gerontologist Donna Cohen found that homicide-suicides involving elderly women in west central Florida accounted for 20 percent of the total homicides of people over the age of 55.[9] Cohen also notes that while the health had deteriorated for 50 percent of the women, two-thirds had expressed "no desire to die."[10] Evidence that women killed in so-called mercy killings or suicide pacts had previously expressed "no desire to die" suggests there may have been battering before their demise.

The scope of reviews is broadened considerably if we include deaths of women traceable to domestic violence or directly linked to domestic violence. One might argue that because battered women appear more vulnerable to HIV infections than non-battered women, some deaths of women attributed to HIV, or some complication thereof, might be traceable to the women's compromised status as battered.[11] The same could be said of homeless women dying on the streets, as roughly half of homeless women report "fleeing abuse" as the reason for their homelessness.[12]

Examples of Domestic Violence Fatality Reviews

The Commission on the Status of Women in San Francisco in 1991 conducted one of the earliest and most detailed domestic violence fatality reviews. This review, held in a public forum, highlighted the widespread breakdown of systems in the case of Veena Charan, whose husband Joseph murdered her and then committed suicide. For 15 months before her death, Veena sought the help of various government agencies and made numerous reports to the police. She separated from Joseph and secured custody of their nine-year-old son.

Immediately before Veena's death, Joseph was arrested for felony wife beating and malicious mischief. As a result of his conviction for this offense, Joseph received a 12-month suspended jail sentence. He was put on probation through the Adult Probation Department with the following three conditions: (1) mandated domestic violence counseling; (2) a stay away order; and (3) 30 days in jail, of which he was given four days, the remainder to be served in the Sheriff's Work Alternative Program. Veena also obtained a restraining order that Joseph violated on several occasions. He also attempted to kidnap his son from school. Joseph killed his wife at the school, in front of teachers and students, before taking his own life.

The ensuing fatality review identified a range of problems in the system: gaps in communication and coordination between agencies involved, a failure to collect adequate data on domestic violence cases, a lack of sensitivity to multicultural and sexual orientation issues, a failure to train agencies in multicultural awareness, and a lack of appropriate translation services. With respect to law enforcement, the report found that an investigator at the San Francisco Police Department minimized the prior injuries to the victim. Specifically, the report notes, "had the investigator looked at the pattern of violence established by Mr. Charan, and presented that information to the district attorney's office, stronger measures and responses to the situation may have prevented Joseph Charan from continuing the escalation of violence that led to the murder-suicide."[13] It was also noted that probation services had not adequately trained officers in the dynamics of domestic violence.

While high-profile reviews such as the Charan investigation can reveal many systemic problems, there may be a tendency for other reviews to blame one person or agency for the breakdown. Given that the batterer is the person responsible for the killing, the blame and shame that may arise from such fingerpointing can be counterproductive to long term system change. A blaming approach to the fatality review process, often referred to as "tombstone technology" in fields such as aviation and nuclear power, might encourage the covering up of information in cases of death.[14] It is also the case that men who batter women blame their victims for much that it is negative in their lives. Using reviews to blame others merely perpetuates that negative and destructive style of thinking and contributes little to healing.

Fatality reviews provide an important means of improving the response of law enforcement agencies to domestic violence.

In the years since the Charan investigation, different models have emerged to review domestic violence deaths, many of which report aggregate data rather than the details of individual cases. Without any funding or legislation, the Philadelphia Department of Public Health, with support from the district attorney's office, began the Philadelphia Women's Death Review Team in 1997 to examine all deaths (not just domestic violence cases) of women from 15 to 60 years of age.[15] These deaths could either be directly related to domestic violence or indirectly related in cases where battered women were unable to access health care. Such an approach also means the team is open to studying suicides for any history of domestic violence.

In Florida, death reviews emerged following a recommendation from a statewide research initiative to examine the idiosyncrasies of all domestic homicides.[16] Sixteen teams now operate in Florida, and their deliberations are protected by immunity legislation. Team deliberations

> *are not subject to discovery or introduction into evidence in any civil action or disciplinary proceeding by any department or employing agency . . . and any person who was in attendance at a meeting of such an organization may not be permitted or required to testify in any civil action or disciplinary proceeding as to any evidence or other matters*

produced or presented during the proceedings.[17]

The Florida law enforcement community has assumed a leading role in this initiative. The death review legislation states that

> *each local domestic violence fatality review team shall collect data regarding incidents of domestic violence and collect this data in a manner that is consistent statewide and in a form determined by the Florida Department of Law Enforcement (FDLE). FDLE shall use such data to prepare an annual report on domestic violence. The report shall be submitted by July 1 of each year to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court.*[18]

The Washington State fatality review initiative drew strength from the state's Coalition Against Domestic Violence.[19] The coalition's latest report documents the findings and recommendations based on in-depth analyses of 30 reviews of domestic homicides that occurred between 1997 and 2000. The report notes that between January 1997 and August 2000, current or former intimate male partners killed 91 women in Washington State. During the same period of time two police officers lost their lives intervening in domestic cases.

Implications for Law Enforcement Agencies

A question law enforcement agencies commonly ask about fatality reviews is, Are we more likely to be sued if the review reveals mistakes in the way we responded to a particular case? In Florida and other states that have legislation that shields deliberations from discovery or introduction into evidence in any civil action or disciplinary proceeding by an employer, the answer is No. States without legislation typically conduct "public record" reviews. They often start by examining homicide-suicide cases where they know there are no pending civil issues. In states without enabling legislation, reviewers only examine information available to the public and the media.

Greater awareness of the events in relationships and communities that precede domestic homicides can improve police policies, inform police intervention, and lessen the likelihood of officer injury and death.

Even with public record information, extremely thorough and detailed fatality reviews can be conducted that identify problems with the delivery of services. In other words, reviews undertaken without protection of legislation can identify all kinds of systems breakdowns, regardless of whether law enforcement officers or any other professionals participate in the process. The question for law enforcement then becomes Do we want a representative at the table to either present or respond to information regarding the handling of a case or set of cases? Given that controversial cases might be reviewed in the media anyway, it may be prudent to have representatives from law enforcement agencies present for these public-record reviews. Attending such reviews may provide a learning experience for all and improve communication and coordination with other agencies and individuals.

Police have received some negative press over the years for their performance

in domestic cases. The negligence award to Tracy Thurman in Torrington, Connecticut, stands as one landmark example of mishandling, but there are many others. In Thurman, the city of Torrington, Connecticut, was found negligent for not taking reasonable action to prevent Tracy Thurman from being viciously assaulted by her husband, leaving her paralyzed below the neck.[20] As jurisdictions turn to review cases, more instances of questionable police handling of domestic conflicts will likely emerge. Reviews guided by state domestic violence coalitions using public record data have the potential for uncovering negligence, failures to follow protocol, and malfeasance.

Identifying police agencies as weak links in a chain of professional responders to domestic violence is one thing. But blaming police agencies, or worse still, individual officers, for serious injuries or deaths is more problematic. Domestic violence cases and the multiagency response to them are extremely complicated. In the final analysis, the perpetrator bears ultimate responsibility. Singling out a single agency for criticism downplays the complexity of these cases.

By coming to the table to participate in the review process police agencies can reinforce community trust that departments are open and responsive while ensuring that complicated technical information from the public record can be communicated to an array of professionals in the most effective manner. In addition, attendance and participation in death reviews-whether public record reviews or those shielded by confidentiality legislation-will enhance communication between agencies and create greater accountability on the part of law enforcement. Improving communication between agencies will likely strengthen protections for battered women and their children.

Greater awareness of the events in relationships and communities that precede domestic homicides can improve police policies, inform police intervention, and lessen the likelihood of officer injury and death. A glance at some of the practical recommendations for law enforcement that have emerged from death reviews serves to bolster the argument for law enforcement participation.

Recommendations for Law Enforcement

The findings of fatality review teams and the research into domestic homicide provide much information about what happens before a death occurs. All those involved in serving victims of domestic violence can benefit from this information. Triaging is a central aspect of police work. Line officers not only decide whether to make an arrest in a particular instance: they also sense the level of danger in particular cases. Recently, some police agencies have begun to use formal "risk/lethality/danger assessment" instruments to identify cases with a high risk of serious violence. The more we learn about the complex antecedents to domestic homicide, the more we can educate our communities, agencies, and officers about the dynamics of these cases. Identifying and understanding these dynamics can form the basis for further training designed to foster safer environments for family members and police officers alike.

Since so many of the cases that result in domestic fatalities have similar characteristics to domestic violence cases that have not escalated to lethal proportions, the value of these risk assessment instruments is limited.[21] However, risk assessment tools based upon systematic research into domestic homicide will be more powerful if used in tandem with local knowledge about systems' interventions. Their usefulness to police departments will likely increase significantly if

officers themselves serve on death review teams and provide feedback to departments on the use of such instruments in light of individual or aggregate deaths in their jurisdictions.

Some death review teams have argued for the use of risk assessment tools as an integral part of coordinated community responses to domestic violence cases. For example, in New Hampshire from January 1990 until October 31, 2000, 47 percent of the 224 homicides were domestic violence-related. In a recent report, the review team recommended that "domestic violence should be a topic included among continuing professional education requirements for all relevant disciplines . . . including law enforcement."[22] The report goes on to state that "all professionals working on cases involving domestic violence should conduct an ongoing risk assessment. The results of that risk assessment will be shared with other providers to the extent allowable by their profession's ethical guidelines."[23]

In Florida, the Pinellas County team believes that death reviews have sharpened existing coordinated community responses to domestic violence. From its discussions with local law enforcement, the Pinellas team identified an approach to educate men who commit domestic violence. These discussions led to the installation of a VCR at the sheriff's holding cell where perpetrators are shown videos on domestic violence. The Pinellas team is now moving toward creating a tracking system to monitor perpetrators more carefully. In the past, if perpetrators were ordered to probation and re-offended before the order was put into the computer, the perpetrator was typically not charged with a violation of probation. Through its work with probation, the courts, and the police, the team is working to close this loophole.

In Washoe County, Nevada, the death review team recommended that police reports of domestic violence contain information on prior domestic calls to the residence involving the same victim and perpetrator. In Maine, review recommendations include increased instruction on evidence collection at domestic violence crime scenes, better preparation on the use of 911 tapes, and improvement in the way officers conduct interviews. The Hamilton County, Ohio, death reviews recommended stronger enforcement of violations of protection orders and parole conditions.

Most review teams across the country have called for greater education in the dynamics of domestic violence for law enforcement and other agencies working with battered women and their families. Some recommendations call for recognizing the significance of specific warning signs. For example, in Washington State, reviewers noted the dangers posed by suicidal abusers and recommended that "officers should routinely ask victims about the abuser's history of making homicidal or suicidal threats." If such threats have been made, officers should "urge the victim to call a domestic violence program for help with safety planning."[24] The report also recommends expanding the sections of the Washington Association of Sheriffs and Police Chiefs Model Operating Procedures on "screening for suicide and responding to suicidal abusers."[25]

A number of statewide reviews recognize the urgent need for translation services in cases of domestic violence involving victims and perpetrators whose first language is not English.[26] The Washington State report recommends that "Institutions such as law enforcement, hospitals, domestic violence programs, and Temporary Aid to Needy Families (TANF) offices should create collaborative relationships with grassroots organizations based in limited English-speaking communities."[27] The report continues: "Consistent with our state law, law enforcement agencies should conduct investigations of do-

IACP's advisory team on domestic violence fatality review.

IACP Takes on Domestic Violence Fatality Review

In March the IACP's Police Response to Violence Against Women Project convened the first meeting of advisors chosen to help develop a model protocol for law enforcement on domestic violence fatality review. The meeting, held in Santa Fe, New Mexico, brought together experts in the fields of social science research, law enforcement, and victim advocacy. Under a grant from the Department of Justice's Violence Against Women Office, the advisory team will guide the development of a *Training Key* on danger assessment, gather information through visits to communities engaged in fatality reviews, and draft protocols to direct law enforcement's participation in the review process. Site visits to Florida and Delaware have been completed. Visits to Tennessee, Colorado, and Maine are planned for this summer.

IACP's Police Response to Violence Against Women Project is pleased to be working with this distinguished team of advisors: Chief James Roberts, Shreveport, Louisiana, Police Department; Lt. (Retired) Mark Wynn, Nashville; Captain Randy Lockmiller, Knoxville Police Department; Phyllis Sharps, George Washington University, Washington, D.C.; Neil Websdale, Northern Arizona University; Bryon Johnson and Heather Moss, University of Pennsylvania; Jackie Campbell, Johns Hopkins University; Judge Susan Carbon; Rhonda Martinson, Battered Women's Justice Project; David Adams, EMERGE; and advocates Margaret Hobart, Felicia Collins Correia, S. E. Chase, and Robin Hassler Thompson.

At the 108th Annual IACP Conference later this year in Toronto, two of our advisors, Dr. Websdale and Dr. Johnson, will facilitate a roundtable discussion on domestic violence fatality review. Please look for the roundtable in the conference schedule and join us for an exciting and challenging exchange.

Chief of Police

St. Cloud, Minnesota

St. Cloud (population 59,107) is located in central Minnesota approximately 60 miles northwest of the Minneapolis/St. Paul metropolitan area. The department consists of 90 sworn personnel and 20 civilians and has an annual budget of $8.3 million.

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mestic violence crimes with qualified interpreters."[28] In one domestic homicide case in Washington State "a law enforcement officer asked a six-year-old child to translate for the family member on the scene who had discovered the bodies of the two victims."[29] In another case "a hostage situation went on for at least an hour, and because no translator was present, the young hostage had to provide translation while the murderer held a gun to her head."[30]

In addition to the potentially traumatizing effects on nonprofessional on-scene translators, the use of imprecise translators may also impede the subsequent case investigation in both domestic homicides and non-lethal domestics. The report concludes that the use of the AT&T translation service is a "compromise step" that may be "awkward" or uncomfortable for some battered women "but [is] preferable to using children or neighbors or not seeking out translation at all." Hobart goes on to note that "some departments have officers tape the entire conversation, even while using translation, so that the opportunity to transcribe and obtain professional translation services exists in the future."[31]

The problems regarding translation services in domestic violence cases echo much broader issues involving services for communities of color, especially in the inner city. Many African American battered women living in inner-city housing projects display a deep suspicion of police. So too, do their communities. The community and certain members therein might label a battered woman a "snitch" if she calls to seek protection for herself or her children. Community policing and its emphasis on greater and more varied forms of surveillance seems to make little difference on domestic violence crimes in these acutely disadvantaged areas. Given that the domestic homicide rate is many times higher among inner-city blacks than it is among whites, fatality reviews offer the potential for enhancing dialogue between inner-city minority citizens and the police. This dialogue might include discussion of the management of the war on drugs, public housing rules and regulations, welfare-to-work initiatives, and other policies that limit battered women's ability to leave dangerous intimate relationships.

Conclusion

Domestic violence and the thousands of deaths that stem from it utilize large proportions of police department budgets, result in a significant number of liability claims against departments each year, and directly result in the death and injury of responding officers. Fatality reviews, when conducted carefully and appropriately, can

- improve the response of police to these cases;
- enhance collaboration, communication, and cooperation between and among police and other involved agencies;
- reduce liability; and
- save lives and extend protections to battered women and their families.

The deliberations from domestic violence fatality reviews can augment community education about this persistent social and criminal justice problem. At the same, time law enforcement agencies can engage in deeper and more meaningful discussions about issues that affect the ability of women to escape these dangerous relationships. As the practice spreads and the sophistication of these reviews grows across the country, we urge leaders in the law enforcement community to embrace this opportunity to enhance their agency's response and improve the lives of many American families. ❖

[1] Male intimates killed 1,600 women in 1976 and 1,218 in 1999 (Bureau of Justice Statistics, 2001). See

also James Fox and Marianne Zawitz, *Homicide Trends in the United States* (Washington, D.C.: Government Printing Office).

[2] From our work-in-progress survey of 44 states, the following have some form of domestic violence death reviews. The letter L in parentheses after a state denotes the presence of legislation that supports the review process: Alaska, Arizona, California (L), Colorado, Delaware (L), District of Columbia, Florida (L), Illinois, Iowa (L), Kansas, Kentucky, Maine (L), Michigan, Minnesota (one county with a team, local legislation), Nevada (L), New Hampshire (executive order), New Jersey (executive order), New Mexico, North Carolina, Ohio, Oklahoma Oregon, Pennsylvania, Tennessee (L), Virginia (L), Washington (L).

[3] Barbara Hart, Legal Committee, "Domestic Violence Death Review," National Council of Juvenile and Family Court Justices, February 9, 1995.

[4] Evan Stark and Anne Flitcraft, "Killing the Beast Within: Woman Battering and the Female Suicidality," *International Journal of Health Services* 25, no. 1 (1995): 55.

[5] Stark and Flitcraft, "Killing the Beast Within," 46.

[6] These authors investigated the medical records of women who came to the emergency room at Yale-New Haven Hospital as attempted suicides over a one-year period. They identified 176 such women who had attempted suicide at least once during the study year (see Stark and Flitcraft, "Killing the Beast Within," 48).

[7] Stark and Flitcraft, "Killing the Beast Within," 53.

[8] The 1999 report by the New Mexico Female Intimate Partner Violence Death Review Team, titled "Getting Away with Murder," notes that the law enforcement investigation of intimate partner homicides "may lack vigor and consistency, especially homicides in which the perpetrator then commits suicide" (19).

[9] Charles Patrick Ewing, *Fatal Families: The Dynamics of Intrafamilial Homicide* (Thousand Oaks, Calif.: Sage, 1997), 143.

[10] Cited in Ewing, *Fatal Families*, 143.

[11] N. Websdale and B. Johnson, "Battered Women's Vulnerability to HIV Infection," *Justice Professional* 10, no. 4 (1997): 183-198.

[12] Joan Zorza, "Woman Battering: A Major Cause of Homelessness," *Clearinghouse Review* 25, no. 4 (1991).

[13] *Report*, 7.

[14] See L.L. Leape, "Error in Medicine," *Journal of the American Medical Association* 272 (1994): 1851-1857.

[15] This includes deaths classified as homicides, suicides, unintentional injury, undetermined cause, those with inadequate certificates, and peculiar circumstances (asthma, AIDS). This is not to suggest that the deaths of women over 60 are not due to domestic violence. For example, "suicide pacts" where elderly men kill their female partners and then themselves cannot be assumed to be free of a history of domestic violence. Indeed, gerontologist Donna Cohen found that homicide-suicides involving elderly women in west central Florida from 1988 from 1994 doubled. In all, such homicides accounted for 20 percent of the total homicides of people aged over 55. Cohen also notes that while the health of half of women had deteriorated, two-thirds had expressed "no desire to die." Evidence that women killed in so-called suicide pacts had expressed "no desire to die" may suggest they were being battered before their demise (Cited in Charles Ewing, *Fatal Families*, 143).

[16] See Neil Websdale, *Understanding Domestic Homicide* (Boston, Mass.: Northeastern University Press, 1999). For the most recent statement on the status of the Florida fatality review teams, see Neil Websdale and Byron Johnson, "Implementing and Monitoring New Fatality Review Teams" (available from the Florida Department of Children and Families, Tallahassee, Florida, 2001).

[17] Florida Statutes 741.3165 s. 1(2).

[18] Florida Statutes 741.316 s. 1 (4).

[19] M. Hobart, "Honoring Their Lives, Learning from their Deaths: Findings and Recommendations from the Washington State Domestic Violence Fatality Review," Washington State Coalition Against Domestic Violence (2000).

[20] *Thurman* v. *City of Torrington, Connecticut*, 595 F. Supp. 1521 (Dist. Conn. 1984). See also *Bruno* v. *Codd*, 396 N.Y.S.2d 974 (1977).

[21] See Neil Websdale, "Lethality Assessment Tools: A Critical Analysis," VAWNET Violence Against Women Grants Office Applied Research Series (2000).

[22] New Hampshire Governor's Commission on Domestic and Sexual Violence, Nashua, New Hampshire, (November 2000): 7.

[23] New Hampshire Governor's Commission on Domestic and Sexual Violence, Nashua, New Hampshire, (November 2000): 7.

[24] Hobart, "Honoring Their Lives," 12.

[25] Hobart, "Honoring Their Lives," 11. The report recommends that law enforcement officers immediately call in mental health professionals when batterers threaten suicide (35).

[26] New Hampshire Governor's Commission on Domestic and Sexual Violence, Nashua, New Hampshire, (November 2000): 16. Santa Clara County Death Review Committee, *Final Report, October 1993-September 1997*, 13. *Charan Investigation*, 6. Hobart, "Honoring Their Lives," 47-51.

[27] Hobart, "Honoring Their Lives," 9.

[28] Hobart, "Honoring Their Lives," 9.

[29] Hobart, "Honoring Their Lives," 48.

[30] Hobart, "Honoring Their Lives," 49.

[31] Hobart, "Honoring Their Lives," 50.