



Justice for Victims of Violence

## Fatality Review: A Tool to Save Lives

Global Rights for Women (GRW) works with leaders from around the world to improve communities' responses to violence against women. **Through a process called Fatality Review, we can help mobilize your community to end femicide.**

Femicide constitutes the most serious form of violence against women, taking the lives of about 87,000 women in the world each year. Worldwide, more than half of murdered women are killed by a family member, and more than a third are killed by an intimate partner. Each day, 137 women are killed by intimate partners.<sup>1</sup>

Femicide has been recognized as a critical human rights challenge by the current and former United Nations Special Rapporteurs on violence against women, its causes and consequences (SRVAW).

In 2012, former SRVAW Rashida Manjoo described femicide as the end result of “an extended and ignored continuum of violence” against women. Current SRVAW Dubravka Simonovic has prioritized the elimination of femicide, calling on all states to establish a “femicide watch,” and to collect and publish data to illuminate the patterns underlying these killings and the states' response.<sup>2</sup> Human rights advocates in Latin America, in particular, have mobilized in response to this call, creating the Latin American Model Protocol for the investigation of gender-related killings of women (femicide/feminicide).

Fatality Review is a unique tool for analyzing fatalities in the context of a system's response to violence against women and girls, in order to develop recommendations that will improve law enforcement and legal systems' protections for women. It is a powerful response to the United Nations' call to action to end femicide.

### What is a Fatality Review?

After a woman is murdered, her community is often paralyzed with grief and an overwhelming sense of helplessness. Police, prosecutors, judges and women's advocates may all blame each other - undermining multi-sectoral efforts to protect women and hold offenders accountable.

Fatality Review helps to prevent deaths by improving a system's response to violence against

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<sup>1</sup> UNODC, “Global Study on Homicide: Gender-related killing of women and girls,” Vienna: 2018, 10, available at [https://www.unodc.org/documents/data-and-analysis/GSH2018/GSH18\\_Gender-related\\_killing\\_of\\_women\\_and\\_girls.pdf](https://www.unodc.org/documents/data-and-analysis/GSH2018/GSH18_Gender-related_killing_of_women_and_girls.pdf).

<sup>2</sup> A/71/398

women. The purpose of a Fatality Review is to assess specific femicides in order to develop recommendations for changes to policies, protocols, practices, resource allocation, and coordination to reduce and eliminate violence against women and resulting fatalities. The focus is not on the job performance of individual practitioners, but rather on the functioning and coordination of agencies and the system as a whole.

### **Systemic Problem Solving Approach**

Global Rights for Women's approach to systems change reflects several key principles:

- We centralize victim safety, autonomy and well-being. When victims' needs are not at the center, workers analyzing problems will drift toward increasing the system's efficiency rather than its effectiveness.
- We develop a strong knowledge base. We don't assume that anecdotes are evidence-based.
- Advice from individuals, personal experiences or statistics may not reveal the whole picture. We use data and research to find out:
  - The circumstances victims face.
  - Institutional responses and their outcomes.
  - How workers are organized to act on cases.
  - Best practices from other countries and communities.
  - Opinions of experts on the topic.
- We use a systemic and social change analysis, by:
  - Exposing systemic problems, not shaming individuals.
  - Examining weaknesses in case processing, which requires knowledge of how institutions standardize their responses.
  - Examining the eight methods of how workers are organized to do their work:
    - Administrative practices
    - Rules and regulations
    - Linkages
    - Resources
    - Education and training
    - Concepts and theories
    - Mission, purpose and function
    - Accountability
- We use a model of constructive engagement:
  - Being respectful.
  - Acknowledging that problem-solving rarely works in an atmosphere of criticism.
  - Assuming that practitioners can and will help.
  - Building relationships and trust.

- Understanding that judgment and blame among practitioners can undermine victim safety

### **Why focus on domestic violence fatalities?**

Unlike other homicides, domestic violence fatalities are usually the culmination of a relationship characterized by repeated acts of violence, coercion, and intimidation. Criminal investigations of domestic violence fatalities often focus on the homicide as a single act of violence. However, practitioners who intervene in domestic violence cases should understand that each act of domestic violence is usually part of a patterned use of coercion, intimidation, and the use or threat of violence.

A Fatality Review analyzes not only the killing itself, but the dynamics of the relationship and the pattern of intervention by agencies in the community. By reviewing 911 calls, police reports, medical records and other documentary evidence, a Fatality Review Team analyzes the information that was gathered prior to the homicide to document the pattern of domestic violence.

Examining patterns of violence and intervention allows the Fatality Review Team to identify risk indicators that arose prior to the homicide, and to identify opportunities for the system to disrupt the pattern of violence, rather than just responding to single incidents. Fatality Review Teams can then create recommendations for systemic changes that will both respond to each act of violence, and stop the pattern violence before it becomes lethal.

Analysing the pattern of domestic violence leading to homicides also helps to identify which type of domestic violence is occurring, and which kind typically leads to lethal violence.

Domestic violence can be categorized into three different types: coercive controlling violence, resistive violence, and domestic violence unrelated to coercive control.

- 1) Coercive Controlling Violence (also commonly referred to as “battering”)** is the ongoing patterned use of intimidation, coercion, and violence, as well as other tactics of control to establish and maintain a relationship of dominance over an intimate partner.

Perpetrators who use coercive controlling violence believe they are entitled to control the actions, thinking, and behaviors of their partner and children. Coercive controlling violence and abuse is distinguished by physical violence, sexual violence, and dominating and demeaning conduct.

It creates fear in the victim and a significant power gap between the perpetrator and the victim. The victim has little or no autonomy in this type of relationship and often feels trapped.

- 2) **Resistive Violence** includes both legal and illegal use of force, which is used by victims to control the abuser's use of coercive and controlling tactics, or in reaction to other men's violence against them as women.

Most victims of coercive controlling violence and abuse use many other tactics to try to stay safe before using violence to resist the oppression and violence they live with. Victims will often appeal to family and friends, try to negotiate with their abuser, appease them, or separate from them before resorting to this type of domestic violence.

- 3) **Violence Unrelated to Coercive Control** is used by one intimate partner against the other and is neither an ongoing attempt to exert coercive control, nor a response to coercive control. It encompasses all other acts of domestic violence, and includes:

***situational violence***, in which one or both parties uses violence, but it is not part of an on-going pattern of coercion and intimidation.

***pathological violence***, in which ending, or controlling the pathology would end the violence (mental illness, drug and alcohol addiction with no pattern of coercion and entrapment of the partner, brain damage).

***anomie***, violence associated with a breakdown in social order. Examples include the increase in rape and abuse of women by their partners in desperate social conditions, such as those experienced during war, natural disasters and in refugees camps.

Fatality Review can help to identify which type of domestic violence led to each homicide, and can inform new interventions or methods of coordination to prevent future deaths.

### **Risk factors for lethality**

One key task of a Fatality Review Team is to assess each domestic violence homicide to determine what risk factors for lethal violence were present leading up to the homicide. Often, intervening parties such as police, hospitals and clinics, advocates, or even family members or friends have information about the domestic violence that could indicate a high risk of lethal violence.

Risk assessment tools have been developed to help police and other criminal justice agencies to identify risk factors when responding to domestic violence. Fatality Review Teams can use similar factors to determine whether risk indicators were present - or even identified by interveners - before the homicide. If so, Fatality Review Teams can recommend strategies or protocols that will help make the risk visible to all parties who intervene in cases of domestic violence.

## **Why focus on systemic gaps, rather than identifying “poor performers”?**

Analyzing systemic gaps in response to domestic violence allows a Fatality Review Team to improve coordination among agencies that intervene in domestic violence. Addressing systemic issues and developing system-wide solutions can lead to sustainable change.

Coordination across and within responding agencies is essential to effectively protecting victims. The action of one practitioner is strengthened by the cumulative effect of coordinated actions across the criminal justice system. Interagency coordination is strengthened when information is organized around common risk markers that are uniformly collected, analyzed and shared.

A criminal justice intervention that leads to an end to the violence requires inter-agency coordination across and among the many practitioners involved, as well as a strong system of accountability to each other. It requires practitioners who are committed to the mission, function, and goals of their respective agencies through an interagency approach that is simultaneously accountable to the victim on whose behalf they intervene, and to the offender with whom they intervene.

In the context of Fatality Review, focusing on gaps in coordination and agency intervention allows the Fatality Review Team to develop recommendations that will last beyond the participation of individual practitioners. For example, they may recommend new protocols for coordination and information sharing among agencies, or the implementation of a risk assessment tool that will allow police to gather information about the context of the domestic violence and to share that information with prosecutors, the court, and probation officers. Developing and implementing recommendations as a team also creates a system of interagency accountability for effective intervention in domestic violence.

Global Rights for Women staff bring years of experience analyzing institutional responses to violence against women and helping to create effective, coordinated interventions to reduce and eliminate domestic violence.

## **Who is involved in Fatality Review?**

A Fatality Review Team typically includes representatives from the judiciary, the prosecutor’s office, law enforcement, and women’s NGOs, and can also include the medical examiner, public defender, probation, corrections, and others responsible for intervening in cases of domestic violence. Ideally, the Fatality Review Team includes representatives of every agency that is responsible for intervening on behalf of victims of domestic violence, as well as advocates who work directly with victims. A Project Director should be selected, who will coordinate the Fatality Review Team.

## **Guiding Characteristics of a Fatality Review Team**

It is important for Fatality Review Teams to develop a shared understanding of the team's goals and its guiding principles. Each team will develop guiding principles based on their local context. Global Rights for Women can help to facilitate this process. For example, the Fatality Review Team in Hennepin County, Minnesota, USA agreed to the following guiding principles:

- 1) The team agrees that the perpetrator is solely responsible for the homicide.
- 2) The team reviews specific homicides, and makes its findings based on the information available about those particular homicides, rather than relying on broader experience or anecdotes.
- 3) The team only reviews closed cases, because more documentation is available and because the passage of time allows for emotions and tensions to dissipate. Each Fatality Review Team must decide the scope of its particular review.
- 4) The team seeks to reach consensus on every recommendation.
- 5) The team recognizes that there is no way to know for sure whether different responses or interventions would have prevented the homicide.
- 6) The conversations of the team are confidential. Team members sign a confidentiality agreement.

To see the annual reports of the Fatality Review Team in Hennepin County, Minnesota, USA, go to <http://www.amatteroflifeanddeath.org>.

### **Sample Fatality Review Work Plan**

1. Select a case or cases for the Fatality Team Review.
2. The Project Director sends requests for agencies to provide documents and reviews the information.
3. The Project Director reviews the records to develop a chronology of the case. The chronology is a step-by-step account of the lives of the victim and perpetrator, their relationship, incidents of domestic violence, events that occurred immediately prior to the homicide and the homicide. Names of police, prosecutors, social workers, doctors, or other professionals involved in the case are not used. The danger in the person's life will be identified through clusters of risk markers.
4. A designated person from the team contacts members of the family of the victim to inform them that the Fatality Review Team is reviewing the case and to see if they are willing and interested in providing information and reflection.
5. A chronology is sent to the Fatality Review Team members prior to the case review meeting, and documents from the police records, prosecution records and, typically, medical records are also sent. Two team members are assigned to review each of these records, one member from the agency that provided the information and one with an outside perspective.
6. Each Fatality Review Team meeting begins with members signing a confidentiality agreement. At the meeting, individuals who reviewed the case report their findings. The team then develops a series of observations related to the case, and asks questions, like, "How do we know what we know?" "Where are our knowledge gaps?"

7. The Fatality Review Team conducts a “Red Flag Analysis.” How we carry out risk assessment is as important as what we ask. Fatality Reviews can illuminate how we gather risk marker information.
8. The Fatality Review Team analyzes agency and community engagement in the case. Which agencies and community members were involved? Where was their communication and coordination between the agencies and community members? In many Fatality Reviews across the world, there was very little systems involvement and very little information sharing. What is getting in the way of increased communication and coordination?
9. Small groups of Team members use these observations to identify opportunities for intervention that may have prevented the homicide. The small groups then present their findings to the full Review Team, which discusses the issues and opportunities. The Review Team records key issues, observations and opportunities for intervention related to each case.
10. Now that gaps have been identified, what changes can realistically be made? Note: Recommendations that are not implemented leave agencies vulnerable in the future.

### **Where can I learn more?**

For more information on how Global Rights for Women can help your community develop a Fatality Review Team, or to schedule a training, please contact Melissa Scaia, Director of International Training, at [mscaia@grwomen.org](mailto:mscaia@grwomen.org) or Laura Wilson, Staff Attorney, [lwilson@grwomen.org](mailto:lwilson@grwomen.org).