Nearly every day in Ohio, television stations and newspapers carry reports about homicides related to intimate partner violence (IPV). Murder-suicides and other awful events—often involving children—horrify the public and make news for extended periods as cases are investigated and prosecuted. For people and agencies who work regularly to prevent family violence, these incidents are profoundly disturbing. Yet they also offer opportunities to gain public interest in the issue and prompt stakeholders to reflect on what they can do to keep such events from happening again.

Domestic violence fatality reviews (DVFRs) provide a reflective process that generates realistic, locally-tailored recommendations to prevent and curtail IPV. This document briefly reviews DVFRs, how they currently operate in Ohio, and what policy changes might improve their work.

What is a domestic violence fatality review? A DVFR engages community stakeholders in a systematic process to learn as much as possible from a local death related to IPV. Agency representatives and other stakeholders work together to collect and review data to understand the circumstances of the victim and perpetrator prior to death. This often involves constructing lifespan timelines, identifying key events, red flags, and actual as well as missed opportunities for prevention and intervention from various systems (e.g., family, health care providers, criminal justice, schools, and many others). The process does not begin until the prosecution is completed and a case is closed.

DVFRs recognize that the entire community is accountable, and so do not seek to shame or blame any specific individuals or agencies. Rather, the goal is to engage a wide range of community stakeholders to work collaboratively to create safer systems. The team then develops action plans for implementing the recommendations generated through the review process.

When done well, DVFRs strengthen relationships among different systems and agencies that interact with people experiencing IPV. And they do so while respecting the dignity of survivors and their

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1 Although the term “domestic violence” is more familiar to the public, the term “intimate partner violence” (IPV) is more precise and preferred by researchers and policy makers. Intimate partner violence involves physical, sexual, and/or emotional violence that occurs in the context of a current or former relationship. The most serious injuries and adverse consequences of intimate partner violence are disproportionately experienced by women.

families, creating opportunities for them to participate in the process. Through this work they also frame the public’s understanding of the causes and consequences of domestic violence.³

A common barrier to creating DVFRs involves potential exposure to liability for individuals and agencies. If a review finds, for example, that errors were made by a domestic violence advocate, the person or their office might fear being sued or punished. Without clear legal protection, many agencies would be understandably reluctant to participate. Similarly, local agencies may be unsure whether federal and state regulations permit them to share information about a murdered victim in a DVFR. Lastly, cost is another common barrier, especially the staff time that agencies must devote to participating.

**How do DVFRs operate in Ohio?** Ohio currently has six local DVFRs that have reviewed hundreds of IPV-related fatalities over the past decade. The following table lists the location of, and contact person for each DVFR active as of January 2015.

<table>
<thead>
<tr>
<th>County</th>
<th>Contact person</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuyahoga</td>
<td>Dean Jenkins</td>
<td><a href="mailto:jenkinsd@cmcoh.org">jenkinsd@cmcoh.org</a></td>
</tr>
<tr>
<td>Hamilton</td>
<td>Kendall Fisher</td>
<td><a href="mailto:kendall@womenhelpingwomen.org">kendall@womenhelpingwomen.org</a></td>
</tr>
<tr>
<td>Lucas</td>
<td>Cassandra Durfey</td>
<td><a href="mailto:cdurfey@fcapc.org">cdurfey@fcapc.org</a></td>
</tr>
<tr>
<td>Montgomery</td>
<td>Susan Gottschalk</td>
<td><a href="mailto:susang@artemiscenter.org">susang@artemiscenter.org</a></td>
</tr>
<tr>
<td>Summit</td>
<td>Terri Heckman</td>
<td><a href="mailto:TerriH@scmcbw.org">TerriH@scmcbw.org</a></td>
</tr>
<tr>
<td>Wood</td>
<td>Kathy Mull</td>
<td><a href="mailto:k.mull@cocoonshef.org">k.mull@cocoonshef.org</a></td>
</tr>
</tbody>
</table>

DVFRs in other counties are no longer active (e.g., Franklin, Trumbull), or are in the process of organizing (e.g., Lorain), but this list above is the most current one available.⁴ It is noteworthy that five of the six are located in core metropolitan counties where the large number of IPV-related homicides warrants regular meetings.

Rather than investigate each death separately, DVFRs in Ohio review a number of murders that accumulate over time. They consider factors like perpetrators’ previous contact with the criminal justice system, as well as safety strategies that the victims may have used. The team members then look for common patterns across the cases and summarize their findings in a written report. This approach has the benefit of being more efficient and less burdensome to participants.

Representatives from active DVFRs consistently support their continuation. Even without dedicated funding, participating agencies have maintained DVFRs through grant funding or in-kind donations. Their experience had increased community awareness of IPV, improved collaboration among stakeholders and led to concrete changes in practices. In one county, for example, the sheriff now

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⁴ Revealingly, most contacts could only identify one or two other counties in Ohio that had a DVFR. This brief, along with statewide organizations like the Ohio Domestic Violence Network, can play a key role in facilitating collaboration.
routinely shares information on a suspect’s criminal history at booking, so that all information is available at the time of a bond hearing.

Yet while encouraging the growth of DVFRs, existing coordinators discouraged mandating new requirements that would require them to change the models that have already been working effectively. They also noted that each community has a particular dynamic relations among systems and agencies, so statewide or multi-county DVFRs that encompass a large area may be less helpful.

**What might Ohio consider doing?** In 2012, 92 homicides in Ohio were known to be related to intimate partner violence, 54 of which occurred in counties currently without a DVFR.\(^5\) Thus, there is a clear opportunity for Ohio to expand the number of communities that have one. It may be most productive to focus efforts on those counties that already record at least 10 homicides per year. In descending order of population, these include Franklin, Stark, Butler, Mahoning and Trumbull.

Statewide actions that Ohio can pursue to facilitate the creation of local DVFRs include the following:

*Clarify policies that discourage agencies from participating in DVFRs.* State and federal agencies, for example, could specify under what circumstances health care providers, child protective services, VAWA-funded agencies and others may share protected data within a DVFR process. In addition, Ohio could provide a defined level of protection from liability for individuals, prosecutor’s offices and other agencies for information discovered during their participation in a DVFR.

Thirty-five other states already have statutes or executive orders establishing (or providing guidance for local communities to establish) DVFRs.\(^6\) Resources are available through the Ohio Domestic Violence Network and the National Domestic Violence Fatality Review Initiative – a US Department of Justice-funded project that provides free resources and a network of contacts with local and statewide DVFRs.

An improved policy environment may be particularly helpful for enabling smaller counties to organize *ad hoc* DVFRs, following an IPV-related homicide in their area. Because less populous counties usually experience one such murder only every few years, it may be unrealistic to maintain a standing committee. Instead domestic violence coalitions can work with local stakeholders to consider a DVFR as an appropriate response the next time an IPV-related murder occurs.

*Encourage collaboration among local DVFRs and the Ohio Violent Death Reporting System.* Ohio is one of 32 states to systematically investigate and record the circumstances surrounding, as well as the victim and perpetrator characteristics of each violent death.\(^7\) Because OH-VDRS uses a standardized module for IPV-related deaths, findings from their data can help put into context findings from local DVFRs. Utah has already benefited from fostering a strong partnership between that state’s violent death reporting system and their Domestic Violence Fatality Review Committee.\(^8\)

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Personal communication, Mbabasi Kariisa, Violence and Injury Prevention Program, Ohio Department of Health, 1/26/15.


For more information about intimate partner violence and domestic violence fatality reviews:

National Domestic Violence Fatality Review Initiative
www.ndvfri.org (928) 523-9205

Ohio Domestic Violence Network
www.odvn.org (800) 934-9840

For local data on intimate partner violence in Ohio, visit:

Ohio Family Violence Prevention Project
http://grc.osu.edu/familyviolenceprevention

This policy brief was authored by Kenneth Steinman for the Ohio Family Violence Prevention Project. The document benefitted from comments by Linda Baer Bigley, Cassandra Durfey, Kendall Fisher, Susan Gottschalk, Terri Heckman, Dean Jenkins, Kathy Mull, Christine Mulvin, Nancy Neylon, Diana Ramos-Reardon, Alexandria Rudin, Tim Sahr, Debra Seltzer and Jo Simonsen. Thank you for your help!