What Virginia's Domestic Violence Fatality Review Teams are saying...

"With all the funding cutbacks, fatality review is especially important because it helps us better utiltize community systems, and get the most out of the resources we've got." *-Norfolk Domestic Violence Fatality Review Team*

"A fatality review team is a critical component in coordinating a community's response to domestic violence. The focus on the needs endemic to the community will result in strengthened victim services." *-Washington/ Bristol Domestic Violence Fatality Review Team*

"The work we have accomplished through our fatality review team is significant. We have had an excellent opportunity to examine real circumstances and systems responses, and have enhanced our ability to implement positive change that ultimately serves to maintain the safety, autonomy, and integrity of domestic violence victims." *-Lynchburg Domestic Violence Fatality Review Team*

"Establishing a domestic violence fatality review team in our county has enhanced communication and coordination among key stakeholders that interact with victims and perpetrators. More specifically, the case review process has enabled practitioners in our community to better understand their individual and collective roles in responding to domestic violence." *-Fairfax Domestic Violence Fatality Review Team*

For more information about domestic violence fatality review, visit the Office of the Chief Medical Examiner (OCME) website: http://www.vdh.state.va.us/MedExam/violence.htm

This site includes:
Overview of OCME role in Virginia's effort to prevent domestic violence

Code of Virginia § 32.1-283.3 relevant to domestic violence fatality review teams

Listing of Virginia's local and regional domestic violence fatality review teams

OCME Annual Family and Intimate Partner Homicide Reports

Family and Intimate Partner Violence Fatality Review: Team Protocol and Resource Manual (3rd Edition- December, 2009)

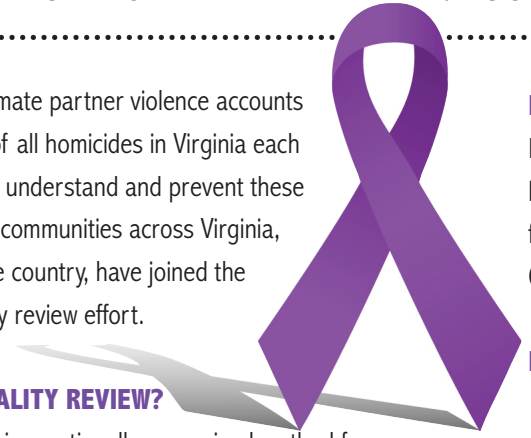
VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Domestic Violence Fatality Review

Helping communities save lives and improve systems of public health and safety

DOMESTIC VIOLENCE FATALITY REVIEW: LOCAL TEAMS WORKING TO SAVE LIVES AND IMPROVE PUBLIC HEALTH AND SAFETY

Family and intimate partner violence accounts for one-third of all homicides in Virginia each year. To better understand and prevent these tragic deaths, communities across Virginia, and across the country, have joined the growing fatality review effort.



WHAT IS FATALITY REVIEW?

Fatality review is a nationally recognized method for understanding how and why people die--the goal of which is to reduce those deaths. Domestic violence fatality review teams (DVFRTs) are made up of mutidisciplinary stakeholders who come together to review cases of fatal violence. This process is *confidential* and *retrospective*, and is protected by Virginia law. Case review does *not* seek to place blame or reinvestigate deaths; it seeks to enhance community collaboration and safety.

WHAT ARE THE BENEFITS OF FATALITY REVIEW?

-Demonstrates community commitment to the prevention of family and intimate partner violence.
-Provides enhanced understanding of fatal domestic violence and lethality risk factors.
-Motivates community awareness and action through data-driven team findings and recommendations.
-Promotes positive collaboration and cooperation among local domestic violence service providers.
-Strengthens community systems promoting victim safety and perpetrator accountability.

HOW IS FATALITY REVIEW AUTHORIZED?

DVFRTs are endorsed by local government, and authorized by the *Code of Virginia* § 32.1-283.3. There are currently fifteen established local and regional teams across the Commonwealth.

HOW IS A FATALITY REVIEW TEAM FORMED?

A team is a voluntary, community-based group of domestic violence stakeholders. Generally, a team organizer invites the participation of all agencies involved in the local domestic violence response. A detailed description for establishing and running a team is included in the *Family and Intimate Partner Violence Fatality Review: Team Protocol and Resource Manual* available on the Office of the Chief Medical Examiner (OCME) website.

WHO ARE TEAM MEMBERS?

Virginia law recommends but does not mandate team membership. Recommended representation includes: Commonwealth's Attorneys, law enforcement officers, domestic violence program providers, judges, probation and parole officers, magistrates, victim/witness and legal advocates, batterer intervention providers, school officials, medical examiners, court personnel, and social service program providers.

WHAT ABOUT CONFIDENTIALITY?

Confidentiality is a cornerstone of fatality review. The *Code of Virginia* § 32.1-283.3 supports and protects confidential team case review. Statutory highlights include:

-All team members and agencies sign confidentiality agreements which protect the information, records, discussions and opinions shared during case review. Violations are punishable as a Class 3 misdemeanor.
-Only closed cases (those with no further criminal investigations or prosecutions) may be reviewed.
-All case review information is excluded from the Virginia Freedom of Information Act.
-Published team findings must *not* identify individuals; they can be published only in statistical or other form which protects privacy.

WHERE CAN WE FIND OUT MORE?

In Virginia, the OCME provides training, technical assistance and resources to developing and established DVFRTs. The Commonwealth has been on the forefront of domestic violence fatality review, and our teams' work has had a positive impact in many local communities. Team findings and recommendations have also contributed to domestic violence work being done at the state and national levels. The OCME looks forward to continuing its support of Virginia's DVFRTs in this crucial public health and safety effort.

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