FAMILY AND INTIMATE PARTNER VIOLENCE

Fatality Review Team Protocol

2nd Edition

Virginia Department of Health

Office of the Chief Medical Examiner

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PREFACE TO THE FIRST EDITION

Virginia recognizes that family and intimate partner violence is the ultimate interpersonal betrayal and represents at least one third of all homicides. In 1999, 145 men, women and children lost their lives to family and intimate partner violence in Virginia. Previous studies also show intimate partner violence as a serious threat to women both nationally and within our own state. As more studies are conducted, society begins to recognize that family and intimate partner violence is a public health and community problem and not just a criminal justice concern. Ultimately, we must realize family and intimate partner violence deaths should and can be prevented.

Virginia has begun a proactive response toward ending this violence. In 1999, Section 32.1-283.3 of the *Code of Virginia* was enacted, which gives cities and counties the authority to conduct family violence fatality review teams to better understand why and how such deaths occur. This process enables cities and counties to identify points of intervention and to develop strategies to prevent future deaths.

With this vision, knowledge and commitment, the Office of the Chief Medical Examiner's Family Violence Fatality Review Team Advisory Group has created a model protocol for cities and counties to use as they begin the process of conducting fatality review. Simply stated, a common theme shared by Advisory Group members was that victims of fatal family and intimate partner violence should not have died in vain. The fatality review process will give communities an opportunity to learn from these tragic events and to work together to reduce violence between intimates.

Fatality review is a relatively new process. States vary as how to address and incorporate this process into their structure. Proudly, Virginia is on the forefront as it is only one of a handful of states that has adopted legislation to support family violence fatality reviews. The model protocol will serve as a how-to guide for cities and counties as they begin their team development. A successful fatality review team needs the acceptance, cooperation and participation of local government throughout the process.

The Office of the Chief Medical Examiner takes great pride in presenting this model protocol to the localities of the Commonwealth and will offer ongoing assistance to cities and counties as they begin and continue the process of conducting family and intimate partner fatality reviews.

Marcella F. Fierro, MD
Chief Medical Examiner
Virginia Department of Health

PREFACE TO THE SECOND EDITION

Intimate partner and family violence account for a third of all homicides in Virginia every year. Since the first edition of this protocol was published, several communities across Virginia have convened fatality review teams and a number of others are organizing review teams. I am deeply gratified that so many Virginians are taking this important step to identify intervention and prevention strategies to save lives. Fatality review increases cooperation, collaboration and communication among the agencies that provide services to victims and perpetrators of domestic violence. Fatality review is not about blame, it is about making something good come out of the tragedy of violent death at the hands of someone who purportedly loved the victim. The Office of the Chief Medical Examiner is committed to this process and will continue to provide technical assistance and consultation to communities as you implement fatality review.

Marcella F. Fierro, MD
Chief Medical Examiner

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I. INTRODUCTION

VA CODE § 32.1-283.3 (A) *The Chief Medical Examiner shall develop a model protocol for the development and implementation of local family violence fatality review teams, which shall include relevant procedures for conducting reviews of fatal family violence incidents…The Chief Medical Examiner shall provide technical assistance to the local teams and serve as a clearinghouse for information.*

(B) *The Chief Medical Examiner shall provide ongoing surveillance of the fatal family violence occurrences and promulgate an annual report based on accumulated data.*

PURPOSE OF DOCUMENT

The Virginia General Assembly requested that the Office of the Chief Medical Examiner develop a model protocol to assist communities that choose to conduct reviews of fatal family or intimate partner violence. The protocol presented in this document is designed as a best practice guide for the development of family or intimate partner fatality review teams. It is based on a review of domestic violence and child fatality review protocols and models from other states and was developed with input and advice from a multidisciplinary advisory group of key stakeholders convened by the Chief Medical Examiner.

BACKGROUND

In 1998, the Virginia Commission on Family Violence Prevention convened a task group to assess the need for family or intimate partner violence fatality reviews in Virginia. The Commission's task group concluded that legislation was needed to provide authority to conduct the reviews and to ensure confidentiality. As a result of the task group's work, the Commission requested the introduction of legislation (HB 2185/SB1035) relating to family or intimate partner violence fatality review teams and family or intimate partner violence fatality surveillance.

In 1999, the General Assembly enacted § 32.1-283.3 of the Code of Virginia. Along with the development of a model protocol, this statute provides for the establishment of local/regional family violence fatality review teams and the creation of a surveillance system for the detection and analysis of family violence homicides. **(See Appendix A for Code § 32.1-283.3.)** It also directs the Office of the Chief Medical Examiner to serve as a clearinghouse of information and to provide technical assistance to localities that choose to review family or intimate partner violence fatalities.

PURPOSE OF FATALITY REVIEW

The purpose of fatality review is to reduce the incidence of family or intimate partner violence fatalities. The process provides a means to analyze system responses to family or intimate violence by the relevant agencies, institutions, and organizations within a community. Fatality review is a nonjudgmental evaluation of the events leading up to the family or intimate partner violence fatality, and it is not to be utilized as an avenue to find fault or place blame. Expected benefits of fatality review include:

- Greater understanding of these events.
- Greater understanding of policies, procedures and roles of the participants.
- Enhanced cooperation among the participants.
- System reform based on review findings.

SELECTING FATALITIES FOR REVIEW

> **VA Code § 32.1-283.3 (A)** *a "fatal family violence incident" means any fatality, whether homicide or suicide, occurring as a result of abuse between family members or intimate partners.*

Teams may use a broad definition of family or intimate partner violence. The Code of Virginia provides a framework that allows a review of any fatality, homicide, murder/suicide or suicide that occurred as a result of violence between family members or intimate partners. It is recommended that review teams focus their efforts first on fatalities of intimate partners, then on family members, and lastly on other fatalities associated with family or intimate violence.

Intimate partners include the following relationships regardless of whether they lived together: current or former spouses, opposite sex co-habitating partners, same-sex co-habitating partners, girlfriends/boyfriends, ex-girlfriends/boyfriends, adult/teen dating relationships, same sex partners, ex-same sex partners, and persons having a child in common.

Family members include people related by blood or marriage.

Other associated fatalities may include co-workers, neighbors, or law enforcement officers who are on the scene of a family or intimate partner conflict.

In addition, selection of cases to review may vary by locality. For example, in those areas where a child fatality review team is already reviewing deaths of children due to abuse and neglect, it would be redundant for the family or intimate partner team to review the same type of case.

II. ORGANIZING A LOCAL/REGIONAL TEAM

VA Code § 32.1-283.3 (C) *Any county or city, or combination of counties, cities or counties and cities may establish a family violence fatality review team to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities. The team shall have the authority to review the facts and circumstances of all fatal family violence incidents that occur within its designated geographic area.*

Teams are created through individual efforts and the voluntary cooperation of agencies involved with family violence deaths. Communities vary based on population, demographics, culture and economics. As a result, fatality review teams may vary in composition, size and structure. This model protocol provides communities with a outline for creating teams and conducting reviews that can be adapted throughout the state.

DESIGN STEPS

Step 1. Team Development

> **VA Code § 32.1-283.3 (C)** *…The team shall have the authority to review the facts and circumstances of all fatal family violence incidents that occur within its designated geographic area.*

Anyone may initiate a fatality review. Two or more persons who share a common interest in convening a fatality review may meet to begin this process. The person or persons getting the team started need to:

- Contact representatives from relevant agencies and ask them to participate. **(See Appendix B for suggested team membership and Appendix C for examples of letters seeking participation or support.)**
- Hold a meeting to present basic information about the purpose and benefits of fatality reviews.
- Develop a mission statement. The mission statement of a family or intimate partner violence fatality review team communicates the team's purpose. It will offer guidance as the team develops goals, selects and reviews cases and develops recommendations. **(See Appendix D for sample mission statements.)**
- Develop a strategy to obtain approval from the city or county government.

The team should be diverse with respect to ethnicity and race, include people in a position to facilitate policy and procedural change, and include people with family violence expertise.

Step 2. City/County Endorsement

> **VA Code § 32.1-283.3 (C)***…Any county or city, or combination of counties, cities or counties and cities may establish a family violence fatality review team to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities.*

In order to conduct a fatality review within the guidelines of the Code, the city or county government or combination of counties or cities must establish the review team. Team organizers should approach local government officials after having 1) obtained participation from the key agencies, institutions, and agencies in the community and 2) developed a mission statement.

The city or county manager is the chief administrative officer of local government and should be able to establish the fatality review team or to provide assistance if approval from elected officials is needed.

A meeting should be arranged with the city or county manager to ask for his or her assistance to establish a fatality review team. One should be prepared to:

- Inform the official about the provisions of § 32.1-283.3 of the Code of Virginia.
- Explain the purpose of fatality review.
- Demonstrate widespread agency and community support for the team.
- Present the team's mission and goals.
- Describe benefits of the review for the community.

If the city or county manager determines that the local elected officials should adopt a resolution, the manager should be asked to patron the resolution. **(See Appendix E for resolution samples.)** If the vote of local government must be obtained, it is recommended that delegates from the group meet individually with members of the council or board to request their support for the resolution. If the locality has a public hearing on items before the governing body, prominent community players should speak in favor of the resolution at the public hearing.

If a team is combined or regional, authorization must be obtained from each of the participating localities.

Step 3. Organizational Meetings

> **VA CODE § 32.1-283.3 (E)** *Each team shall establish local rules and procedures to govern the review process prior to the first fatal family violence incident review conducted.*

The organizational process will involve a series of important meetings prior to actually beginning a review. The following action steps are designed to guide teams through the organizational phase of team development. The planning process should result in the development of rules and procedures by which the review will be conducted. At a minimum, rules and procedures should cover membership, team structure, confidentiality and scope of the review. **(See Appendix F on how to establish an effective working team.)**

Membership

> **VA CODE § 32.1-283.3 (D)** *Membership in the team may include, but shall not be limited to: health care professionals, representatives from the local bar, attorneys for the Commonwealth, judges, law enforcement officials, criminologists, the medical examiner, other experts in forensic medicine and pathology, family violence victim advocates, health department professionals, probation and parole professionals, adult and child protective services professionals and representatives of family violence local coordinating councils.*

Since fatality review involves frank and open discussion regarding a number of confidential matters, it is critical that the team develops and maintains trust among its members. A core group is recommended to help teams achieve cohesion and continuity. The core group should include at a minimum representatives from the following disciplines:

- Law Enforcement
- Medical Examiner
- Public Health
- Probation and Parole
- Mental Health
- Social Services
- Domestic Violence Program
- Commonwealth's Attorney

Other disciplines may be included on the team at the discretion of the core group. **(See Appendix B.)** In addition, other individuals may be asked to present information about a particular fatality on a case-by-case basis.

Team Structure

> **VA CODE § 32.1-283.3 (C)** *The team shall have the authority to review the facts and circumstances of all fatal family violence incidents that occur within its designated geographic area.*

Once the core group is established, teams need to identify the geographic area from which cases will be selected for review and appoint a chair or co-chairs who will take responsibility for coordinating the fatality reviews. Some administrative costs are associated with fatality review teams. These costs include production of minutes, mailing meeting notices, and time needed by the chair to prepare for a review. Usually, these administrative costs are assigned to the chair's agency.

Confidentiality

> **VA CODE § 32.1283.3 (F)** *All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision A 54 of § 2.2-3705. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed.*
>
> *…Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals.*
>
> *All team members, persons attending closed team meetings…shall execute a sworn statement to honor the confidentiality…*
>
> *Violations of this subsection shall be punishable as a Class 3 misdemeanor.*

One of the goals of fatality review is to review the facts and circumstances surrounding the violent death of an intimate partner or family member. All of the information discussed in a fatality review is confidential either by statute or practice. By design, the Code provides extraordinary confidentiality protection to the review process in order to facilitate frank discussion that can lead to insights and interventions that might prevent these fatalities in the future.

The following procedures are recommended to protect confidentiality:

- The Chair will be the keeper of any confidential document produced by the team during a review and ensure that it is promptly destroyed at the conclusion of the review.
- Each member will execute a sworn statement of confidentiality when joining the team. The chair will keep a file of the confidentiality statements.
- At the beginning of each review, the confidentiality of the review will be reiterated and each person attending the review will sign a statement of confidentiality. **(See Appendices G and H for sample Memorandum and Confidentiality Agreements.)**

The Code of Virginia specifically outlines that information obtained during a fatality review cannot be disclosed to anyone outside the review and any violations of confidentiality are punishable as a Class 3 misdemeanor.

Scope of the Review

VA CODE § 32.1-283.3 (E) *Each team shall establish local rules and procedures to govern the review process prior to the first fatal family violence incident review conducted. The review of a death shall be delayed until any criminal investigations or prosecutions connected with the death are completed.*

Teams are to develop procedures for:

- Confidentiality and destruction of confidential documents.
- Decision making within the group.
- Selection and identification of cases for review. Sources could include newspaper articles and referrals from participating members, community agencies and institutions, the Office of the Chief Medical Examiner and other sources. Cases may not be reviewed until all criminal investigation or prosecution connected with the death is completed.
- Cases that involve multiple jurisdictions.
- Cases that may overlap with local child fatality review. **(See Appendix I for existing child fatality review teams.)**
- Appointing and training new members.
- Notification of team members of cases for review and what information is needed for the review.
- Ground rules for meetings.
- Recording interventions and prevention strategies identified in the review. An assessment form or other tool may be useful. **(See Appendix J for sample form.)**
- Considering how to include surviving family members in the review process. **(Appendix K discusses ways to include survivors.)**
- Communicating recommendations to agencies, institutions, and local government.
- Resigning from the review team.
- Taking care of the group (debriefing counseling).
- Media relations. **(See Appendix L for media guidelines and sample press release.)**

Copies of rules, procedures, reports and recommendations should be sent to the Office of the Chief Medical Examiner.

III. CONDUCTING A REVIEW

The following steps should be taken when conducting a fatality review:

- Welcome members and review mission, goals and objectives of the review.
- Execute confidentiality statement.
- Present facts and circumstances of the case. This information may include:
  - ✓ Basic demographics.
  - ✓ Circumstances of the event.
  - ✓ Personal histories of the parties including: medical, mental health, financial, legal (civil and criminal complaints, specifically the existence of past or present protective orders), services obtained by the victim, perpetrator and family prior to the fatal incident and services rendered after the fatality to family members and/or other affected persons.
- Consider creating a timeline of the events that lead to the death.

The following questions are suggested to guide the discussion:

BACKGROUND

What was the nature and history of the violence and abuse in relationships between the victim, perpetrator and children?

Who knew of or suspected family or intimate partner violence, including families, agencies and collaterals to include neighbors, friends and co-workers? How did they know?

What actions were taken or not taken as a result of those contacts or awareness/suspicions of family or intimate partner violence?

What information was available to each agency involved in the case?

What risks and/or lethality indicators were present for the victim, perpetrator and children? **(See Appendix M for a list of lethality indicators.)**

What is the victim's medical/behavioral history?

What is the perpetrator's medical/behavioral history?

What is the victim/perpetrator history for substance abuse?

AGENCIES INVOLVED

Which agencies had contact with the victim and perpetrators in the case?

Which agencies had contact with the children, co-workers, and others affected in the case?

Did any criminal justice or civil agency have contact with the victims or perpetrators? Were there any contacts for assistance and protection (victim, perpetrator, other family members or concerned individuals)? Detail circumstances: 911, hotline and requests for services.

What was the extent of involvement (if any) of the parties involved with the legal system and other related community services agencies?

What interagency communication/collaboration was initiated in response to the case?

POLICIES AND PROTOCOLS

What do reviews of various agency policies, protocols, trainings, records, and practices reveal? Are written policies and procedures in place?

Were all the current written policies and procedures followed?

What are the "best practice" procedures? How do these compare with those developed by other communities?

Are current policies and protocols adequate? If not, how could they be improved?

Were relevant statutes regarding family abuse, protective orders, stalking, firearms, etc., enforced?

SERVICES PROVIDED

What services were offered/provided/declined?

When did services and interventions occur?

What does the event timeline tell the team?

What other services could have been utilized, i.e., substance abuse services?

OUTCOMES

What were the barriers to obtaining services for the victim, perpetrator and children?

What were institutional barriers (e.g., language, cultural, and social costs)?

Were statutes a barrier to assistance or prevention?

What were the barriers to interagency communications?

What specific interventions could have resulted in better outcomes?

What kind of prevention strategies flow from the interventions identified?

Were there any other significant recommendations?

Did the review team have all pertinent information it needed to complete the review?

IV. REPORTS AND RECOMMENDATIONS

Fatality reviews provide a unique perspective on the circumstances of violent death that may generate specific recommendations to change practices or policy or that may identify more broad-based prevention strategies. It is recommended that fatality review teams plan to release recommendations or strategies for prevention to community agencies, institutions and government. **(See Appendix N for examples of review team recommendations.)**

Guidelines for reports and recommendations:

- Never publish or release case specific information that could identify victims or families. Timing should be considered prior to the release of recommendations.
- Target recommendations to agencies, institutions, or other entities that have the power to make the changes recommended.
- Adopt recommendations by consensus to make a powerful statement to the community.

V. EVALUATION

Evaluation is critical. Teams should evaluate both process and outcomes of the fatality review.

Process

Team members should complete evaluations on an ongoing basis to provide feedback on the review process and make recommendations for improvements.

An evaluation tool should be completed at the conclusion of the review and include no more than five questions based on a Likert Scale using the following statements:

	Don't Agree				Agree
I am satisfied with participation.	1	2	3	4	5
There was enough time.	1	2	3	4	5
I am satisfied with the recommendations.	1	2	3	4	5
The assessment tool is useful.	1	2	3	4	5

Comments:

Evaluation tools need also to include space for comments such as suggestions for future reviews, recommendations for membership, and general feedback.

Outcome

Teams should establish a method of follow-up on their recommendations. They should assess how recommendations have had an impact on the relevant agencies, institutions, and organizations within a community. Teams are also encouraged to track any trends, positive or negative, with each new review process. Several ways to complete a comprehensive outcome evaluation include surveys, interviews, and focus groups.

VI. SUMMARY

A successful fatality review involves commitment from its participating members and agencies to ensure the purpose is understood, confidentiality is maintained, and goals are achieved. With improved understanding of the circumstances leading up to the fatality, team members develop recommendations to improve safety and services for victims, their families, and communities.

Teams are advised to avoid the pitfalls that interfere with a successful review. People will have normal emotional responses to violent death, including guilt, anger and frustration. Sometimes this is expressed as the urge to know more details, seeking to place blame and starting side conversations. It is important to maintain the team's focus on prevention and to identify ways to improve the community response to family and intimate partner violence.

The following outline of this model protocol can be used as a checklist to help teams ensure a review is successful.

OUTLINE OF MODEL PROTOCOL

I. Purpose

- Fatality review is a mechanism to create safer communities by establishing a multidisciplinary review team that will work to reduce future family and intimate partner violence fatalities.
- Fatality review identifies needed services and points of intervention and develops strategies for prevention.
- Fatality review is a powerful tool for responding to - not just reacting to - family or intimate partner fatalities.

II. Organization

- Teams are to be multidisciplinary and should consist of members who can create change and influence policy.
- Teams should focus on their mission and periodically review their goals.
- Teams must have the endorsement of local officials.
- Teams are to develop:

    a) Purpose and functions.

    b) Membership/Attendance.

    c) Team chair or co-chair responsibilities and term of office.

    d) Confidentiality.

    e) Ground rules:

        - Upholding confidentiality.
        - Monitoring "air time".
        - Respecting all opinions.
        - Avoiding victim blaming.
        - Maintaining a nonjudgmental process of fact-finding and information sharing.
        - Focusing on how it happened, not why it happened.

- Team members are encouraged to candidly assess their own ability to participate and to withdraw if appropriate.
- Teams should provide different debriefing opportunities for the team.

III. Reports and Recommendations

- Recommendations are best reached by using a consensus decision-making process.
- Reports are to include aggregate information only.
- Recommendations should be directed to those who have the power to influence change.
- Send reports and recommendations to:

Family Violence Surveillance Coordinator
Office of the Chief Medical Examiner
400 E. Jackson Street
Richmond, VA 23219

phone: 804-786-6044
fax: 804-371-8595

IV. Evaluation

- Teams should evaluate the review process on an ongoing basis.
- Teams are to follow up on recommendations.
- Team members should share information with their agency directors.
- Members are to make suggestions for the next review.

VII. FREQUENTLY ASKED QUESTIONS

1. What are the most important tasks that teams need to accomplish before reviewing deaths?

- Clarity about the mission of the review team. Reviewing violent death is difficult. By keeping the focus on prevention and improving services, teams are more productive.
- Establish decision-making procedures.
- Establish confidentiality procedures.
- Decide how the team will document review findings and recommendations.
- Decide how information and recommendations will be released from the team.

2. How do teams identify deaths to review?

Teams may identify cases through their law enforcement agencies, the Commonwealth's Attorney office, newspaper articles or the Office of the Chief Medical Examiner.

3. Do teams review every fatality? Which deaths should teams review?

While teams may select any death related to family or intimate partner violence, the OCME recommends that teams focus on intimate partner violence that results in homicide or suicide.

4. Why do teams have to wait until prosecution is complete to review a death?

Section 32.1-283.3 states "The review of a death shall be delayed until any criminal investigations or prosecutions are complete." Remember that the purpose of fatality review is prevention not investigation.

5. How much time does it take to review a death?

The amount of time it takes to review a death depends upon how much information is available, the circumstances of the death and the history of agency involvement with the victim and perpetrator. It is not unusual to spend an hour or more to review a death.

6. How often do teams need to meet for fatality reviews?

Frequency of meetings depends upon the number of deaths appropriate for review in a given time period.

VIII. APPENDICES

THE VIRGINIA STATUTE RELATING TO FAMILY VIOLENCE FATALITY REVIEW TEAMS

§ 32.1-283.3

Family violence fatality review teams established; model protocol and data management; membership; authority; confidentiality, etc

A. The Chief Medical Examiner shall develop a model protocol for the development and implementation of local family violence fatality review teams (hereinafter teams) which shall include relevant procedures for conducting reviews of fatal family violence incidents. A "fatal family violence incident" means any fatality, whether homicide or suicide, occurring as a result of abuse between family members or intimate partners. The Chief Medical Examiner shall provide technical assistance to the local teams and serve as a clearinghouse for information.

B. Subject to available funding, the Chief Medical Examiner shall provide ongoing surveillance of fatal family violence occurrences and promulgate an annual report based on accumulated data.

C. Any county or city, or combination of counties, cities or counties and cities may establish a family violence fatality review team to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities. The team shall have the authority to review the facts and circumstances of all fatal family violence incidents that occur within its designated geographic area.

D. Membership in the team may include, but shall not be limited to: health care professionals, representatives from the local bar, attorneys for the Commonwealth, judges, law enforcement officials, criminologists, the medical examiner, other experts in forensic medicine and pathology, family violence victim advocates, health department professionals, probation and parole professionals, adult and child protective services professionals, and representatives of family violence local coordinating councils.

E. Each team shall establish local rules and procedures to govern the review process prior to the first fatal family violence incident review conducted. The review of a death shall be delayed until any criminal investigations or prosecutions connected with the death are completed.

F. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision A 54 of § 2.2-3705. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the review nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 22 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

G. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a family violence fatality review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports or records to review teams as part of such review, shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

APPENDIX B:

MEMBERSHIP

When developing a **Core Group**, consideration should be given to the Code. Membership specified in § 32.1-283.3 (D) lists suggestions for membership but does not limit a team to the list. Best practices suggest that review teams should consist of the following **minimum core group** members:

Commonwealth Attorneys	Law Enforcement Officials
Domestic Violence Program Professionals	Medical Examiners
Mental Health Professionals	Probation and Parole Professionals
Health Department Professionals	Adult and Child Protective Services Professionals

In addition to the minimum core group listed above, **other core group membership** may include but is not limited to:

Criminologists	Forensic/Pathology Experts	Criminal Defense/Public Defender Attorneys
Judges	Health Care Professionals	Victim Witness Professionals
Domestic Violence Coordinating Council Members	Magistrates	Batterer Intervention Professionals
	Substance Abuse Counselors	

OTHER POSSIBLE PARTICIPANTS

The following are **other possible group participants** who may serve as key informants and attend a meeting to fulfill a specific purpose. These other possible participants may or may not be permitted to participate in the entire review process, but will be informed of any recommendations offered by the team.

Animal Control Officers	CASA representatives	Private Counselors/Therapists
Court Service's Unit Intake/ Probation Officers	Emergency Medical Services Professionals	Public Housing Tenant Services Specialists
City/County Manager or Board of Supervisor Representatives	Housing/Shelter Services Advocates	Local Employment Assistance Program Specialists
Clergy	School Officials	Sexual Assault Advocates
Business supervisors	Military Officials	Education Representatives
	Private Attorneys	

APPENDIX C:

SAMPLE LETTER TO PROSPECTIVE MEMBERS

[Date]

[Address]

Dear [ ]:

Pursuant to Section 32.1-283.3 of the Code of Virginia, the [ ] is in the process of establishing a local Family Violence Fatality Review Team. Please find enclosed a copy of this statute and the Virginia Department of Health's *Family or Intimate Partner Violence Fatality Review Team Protocol*.

I invite you, as a concerned person in the community response to domestic violence, to participate in [City/County]'s Family Violence Fatality Review Team. An organizational meeting is scheduled for [date] from [time] at the [location]. This review process will involve close collaboration among the following agencies, [list core member participating agencies]. Together, we can strive to find solutions to prevent further tragedies.

The purpose of the family violence fatality review is to take a thoughtful, nonjudgmental look at the events leading up to a family violence fatality. Fatality reviews can also be an important tool for identifying gaps in a system response to family violence, identifying critical points of intervention and providing a forum for increasing communication and collaboration among those involved in a coordinated community response to family or intimate partner violence. The fatality review model is not intended to assign blame to individuals, agencies or institutions. The team will operate under the assumption that all persons and agencies involved care deeply about preventing violence within the family and operate in good faith, using the best judgment and information available at the time.

I hope that the team can count on your involvement. Please let [name] know by [date] if you will be able to participate. [name] can also answer any questions you might have about the process.

Sincerely,

[ ]

Used with permission from the State of Wisconsin, Domestic Violence Intervention Project.

LETTER TO REVIEW TEAM/OTHER POSSIBLE GROUP PARTICIPANT

[Date]

[Address]

Dear [ ]:

I would like to invite you or a member of your agency, as a concerned participant in the community response to domestic violence, to present your agency's information to the [City/County] Fatality Review Team regarding [Case Name]. The review is scheduled for [date] from [time] at the [location].

The purpose of the family violence fatality review is to take a thoughtful, nonjudgmental look at the events leading up to a family violence fatality. Fatality reviews can also be an important tool for identifying gaps in a system response to family violence, identifying critical points of intervention, and providing a forum for increasing communication and collaboration among those involved in a coordinated community response to family or intimate partner violence. The fatality review model is not intended to assign blame to individuals, agencies or institutions. We operate under the assumption that all persons and agencies involved care deeply about preventing violence within the family and operate in good faith, using the best judgment and information available at the time.

I hope that we can count on your involvement for this review. Please let [name] know by [date] if you will be able to present. [name] can also answer any questions you might have about the process.

Sincerely,

[ ]

LETTER OF SUPPORT FROM GOVERNMENT OFFICIAL

[Date]

[Address]

Dear Domestic Violence Coordinating Council:

Pursuant to §32.1-283.3 of the *Code of Virginia*, I endorse/authorize the formation of a family violence fatality review team for the [City/County] and designate _____as a participating agency.

The purpose of the family violence fatality review is to take a thoughtful, nonjudgmental look at the events leading up to a family violence fatality. Fatality review engages the agencies, organizations, and systems that provide services to victims and perpetrators in a process designed to identify gaps in a system response to family violence. Fatality review also identifies critical points of intervention and provides a forum for increasing communication and collaboration among those involved in a coordinated community response to family or intimate partner violence. The ultimate purpose of fatality review is to reduce the incidence of fatal family or intimate partner violence and create a safer community in which to live.

All information and records obtained or created during the review of a fatality shall be excluded from the Virginia Freedom of Information Act (§2.1-340 et seq.) pursuant to subdivision 59 of subsection B of §2.1-342. Violations of this confidentiality shall be punishable as a Class 3 misdemeanor.

Sincerely,

[City/County] Manager

APPENDIX D:

SAMPLE MISSION STATEMENTS

Delaware State Domestic Violence Fatal Incident Review Panel:

The mission of this panel is to review domestic violence fatalities to decrease the incidence of such deaths. By conducting audits of state agencies and private organizations, which had contact with the deceased individual or the alleged perpetrator, the system's response to domestic violence may be improved. Prevention of future deaths includes changing individual organization's policies and procedures and generation of information for intervention, prevention, public policy development and education.

Project Safeguard–Denver, Colorado Domestic Violence Fatality Review Committee:

The purpose of this committee is to investigate domestic violence related fatalities. Information will be collected, correlated and disseminated to create better understanding and education in the dynamics of domestic violence related fatalities, for future prevention. It is recognized that the perpetrators of domestic violence are ultimately responsible for the death of victims. Thus, the goal of this committee is not to place blame but rather to better understand the dynamics of domestic violence when death is involved and thereby diminish the possibilities of future fatalities.

Hamilton County, Ohio Domestic Violence Death Review Panel:

The mission of the Hamilton County Domestic Violence Death Review Panel is to prevent domestic violence cases from escalating into murder by constructively examining the circumstances of past and future deaths by domestic violence, by making recommendations arising out of these death reviews, and by increasing coordination and communication between agency and systems.

Project Watch–Minneapolis, Minnesota Domestic Fatality Review:

Representatives from the criminal justice system, the medical community, and the advocacy community… will work to identify the circumstances that lead to the death and determine indicators that could prompt early identification, intervention and prevention efforts in similar cases. The purpose of this project is not to lay blame, but rather to actively improve all systems that serve persons involved with domestic abuse, and to prevent violence and fatalities in the future.

Used with permission from the *Delaware State Domestic Violence Fatal Incident Review Panel, Project Safeguard, Hamilton County Domestic Violence Death Review Panel and Project Watch.*

APPENDIX E:

SAMPLE RESOLUTIONS

Example A:

SUBMITTED TO: Local Governing Body

SUBJECT: Establish Family and Intimate Partner Violence Fatality Review Teams

PROPOSED BY: City or County Manager

The City Council,

Concerned by the devastation family and intimate partner violence has upon individuals within our city; and

Understanding that fatality review will yield results to help prevent similar tragedies from recurring; and

Seeking a thoughtful and nonjudgmental method of evaluating the events that lead to family and intimate partner violence fatalities:

Recommends that the City Domestic Violence Coordinating Council establish a Family and Intimate Partner Fatality Review Team to:

a. Engage agencies, organizations and systems which provide services to victims and perpetrators to identify gaps in system responses and provide for increased communication and collaboration amongst the agencies involved; and

b. Operate under the assumption that all persons and agencies involved care deeply about preventing violence within the family and operate in good faith, using best judgment and information available at the time; and be it further resolved

c. Offer recommendations that will benefit our community and improve our public safety.

Example B:

SUBMITTED TO: Local Governing Body

SUBJECT: Establish a Family and Intimate Partner Violence Fatality Review Team

PROPOSED BY: City Manager

The City Council,

Whereas, family and intimate partner violence has destructive consequences upon individuals and families within our city; and

Whereas, careful examination of family and intimate partner violence fatalities will yield results to help prevent similar tragedies from recurring; and

Whereas, a thoughtful and nonjudgmental method of evaluating the events that lead to family and intimate partner violence fatalities will create a safer community; therefore be it

Resolved, that the Domestic Violence Coordinating Council will engage agencies, organizations and systems which provide services to victims and perpetrators to identify gaps in system responses and provide for increased communication and collaboration amongst the agencies involved; and

Resolved, that the Domestic Violence Coordinating Council will operate under the assumption that all persons and agencies involved care deeply about preventing violence within the family and operate in good faith, using the best judgment and information available at the time; and

Resolved, that the Domestic Violence Coordinating Council will offer recommendations to benefit our community and improve our public safety; and be it further

Resolved, that the Domestic Violence Coordinating Council will establish a Family and Intimate Partner Fatality Review Team.

Example C:

RESOLUTION TO ESTABLISH THE CHESTERFIELD COUNTY INTIMATE PARTNER AND FAMILY VIOLENCE FATALITY REVIEW TEAM FOR THE PURPOSES OF INDENTIFYING AND DESCRIBING TRENDS AND PATTERNS OF DOMESTIC VIOLENCE RELATED DEATHS IN THE COUNTY; INCREASING COORDINATION AND COMMUNICATION BETWEEN AGENCIES PROVIDING SERVICES TO FAMILIES EXPERIENCING DOMESTIC VIOLENCE; AND INDENTIFYING INTERVENTIONS AIMED AT SYSTEM IMPROVEMENTS

WHEREAS, family and intimate partner violence has destructive consequences upon individuals and families within our County; and

WHEREAS, the General Assembly enacted Section 32.1-283.3 of the Code of Virginia, 1950, as amended, to permit Chesterfield County to establish a family violence fatality review team to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities:

and

WHEREAS, careful examination of family and intimate partner violence fatalities will yield results to help prevent similar tragedies from recurring; and

WHEREAS, a thoughtful and nonjudgmental method of evaluating the events that lead to family and intimate partner violence fatalities will create a safer community.

NOW, THEREFORE BE IT RESOLVED, that the Chesterfield County Fatality Review Team will identify gaps in system responses and work to provide increased communication and collaboration amongst the agencies involved.

AND, BE IT FURTHER RESOLVED, that the Chesterfield County Fatality Review Team will operate under the assumption that all persons and agencies involved care deeply about preventing violence within the family and operate in good faith, using the best judgment and information available at the time.

AND, BE IT FURTHER RESOLVED, that the Chesterfield County Fatality Review Team will offer recommendations to Chesterfield County service providers which benefit our community and improve our public safety.

AND, BE IT FURTHER RESOLVED, that Chesterfield County Board of Supervisors will establish an Intimate Partner Family Violence Review Team the Team shall establish local rules and procedures to govern the review process.

AND, BE IT FURTHER RESOLVED, that the Chesterfield County Intimate Partner Fatality Review Team be established and that the following individuals may serve on the Team pursuant to Section 32.1-283.3 (D) of the Code of Virginia:

The Chief Judge of the 12th Judicial Juvenile and Domestic Relations Court, or another Juvenile and Domestic Relations Court Judge designated by the Chief Judge

The Commonwealth Attorney of the County of Chesterfield or designee

The Sheriff for the County of Chesterfield or designee

The Chief Magistrate for the County of Chesterfield or designee

The Chief of Police for the County of Chesterfield or designee

The Director of Chesterfield-Colonial Heights Community Corrections Services or designee

The Director of Chesterfield Community Services Board or designee

The Director Chesterfield Victim Witness Assistance Program or designee

The Director of Chesterfield-Colonial Heights Health Department or designee

The Director of Chesterfield-Colonial Heights Department of Social Services or designee

The coordinator of the Chesterfield County Domestic Violence Resource Center

The Chesterfield County Criminal Justice Planner

A representative from a local Batterer Intervention Program

The Director of the YWCA or designee

Other disciplines/members may serve on the team at the discretion of the team.

AND, BE IT FURTHER RESOLVED, that this action provide that the Chesterfield County Domestic Violence Resource Center will serve as staff support for the Fatality Review Team and shall work with a core team of county domestic violence and criminal justice staff to support the organization and maintenance of the Fatality Review Team.

Adopted 12/19/01.

Example D:

RESOLUTION NO. 10071-01

A[N] RESOLUTION ESTABLISHING A FAMILY AND INTIMATE PARTNER FATALITY REVIEW TEAM FOR THE CITY OF NEWPORT NEWS

WHEREAS, the Virginia General Assembly, upon the request of a task force of the Virginia Commission on Family Violence Prevention, adopted legislation designed to address family or intimate partner violence fatalities; and

WHEREAS, this legislation, found at Virginia Code §32.1-283.3, authorizes localities to establish family violence fatality teams "to examine fatal family violence incidents and to create a body of information to help prevent family violence fatalities"; and

WHEREAS, the Commonwealth's Attorney has requested and the City Manager has recommended that the Council of the City of Newport News (the "Council") establish a family violence fatality review team (the "Review Team") for the City of Newport News; and

WHEREAS, the Council agrees that establishment of such a Review Team would serve an important public purpose and therefore wishes to establish such a team for the City of Newport News.

NOW, THEREFORE, BE IT RESOLVED by the Council for the City of Newport News, Virginia, that:

1. The Newport News Family and Intimate Partner Fatality Review Team (the "Review Team") is hereby created.

2. The purposes of this Review Team shall be the following:

   a. To engage agencies, organizations and systems which provide services to victims and perpetrators to identify gaps in system responses and provide for increased communication and collaboration amongst the agencies involved; and

   b. To operate under the assumption that all persons and agencies involved care deeply about preventing violence within the family and operate in good faith, using best judgment and information available at the time; and

   c. To evaluate events that lead to family and intimate partner violence fatalities; and

   d. To offer recommendations that will benefit the community and improve public safety.

3. The Review Team shall have the authority to review the facts and circumstances of all fatal family violence incidents that occur within the City of Newport News. All information and records obtained or created regarding the review of fatality shall be considered confidential and shall be excluded from the Virginia of Information Act.

4. The Review Team shall consist of the following:

   a. A representative from the Newport News Commonwealth's Attorney's Office designated by the Commonwealth's Attorney.

   b. A representative from the Newport News Police Department designated by the Chief of Police.

c. A representative from the State Medical Examiner's Office.

d. A representative from the Newport News Department of Social Services.

e. A domestic violence program professional.

f. A representative from the Newport News Community Corrections Division.

g. A representative from Hampton-Newport News Community Services Board.

h. Other representatives from organizations or other professionals as defined in the protocol developed by Virginia's Chief Medical Examiner.

5. The members of the Review Team shall elect a Chairman and Vice-Chairman. The Review Team may organize itself into subgroups in order to facilitate the accomplishment of its work.

a. The Commonwealth's Attorney's representative shall be responsible to organize the Review Team's initial meeting at which the Chairman and Vice-Chairman will be selected and the Team will establish its operating procedures.

b. The Review Team should refer to and use the protocol developed by Virginia's Chief Medical Examiner as a means to organize itself and conduct its activities.

6. The Review Team's activities will be governed by the provisions of Virginia Code §32.1-283.3 as it may be amended from time to time.

7. The members of the Review Team shall serve as such without compensation.

8. The Review Team shall submit an annual report to the City Council in order for the Council to evaluate the continued need for the Review Team and its activities.

PASSED BY THE CITY COUNCIL OF THE CITY OF NEWPORT NEWS OCTOBER 23, 2001.

Example E:

A RESOLUTION 2001-R157-148

To establish the Richmond Family Violence Review Team for the purposes of examining fatal family violence incidents, creating a body of information to help prevent future family violence fatalities, and reviewing the facts and circumstances of fatal family violence incidents that occur within the city of Richmond.

Whereas, family violence has destructive consequences upon individuals and families within the city of Richmond;

Whereas, care examination of family violence fatalities can help prevent similar tragedies from recurring;

Whereas, a thoughtful and non-judgmental method of evaluating the events that lead to family violence fatalities can create a safer community; and

Whereas the General Assembly enacted section 32.1-283.3 of the Code of Virginia (1950), as amended, to permit the City of Richmond to establish a family violence fatality review team to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities; NOW, THEREFORE, BE IT RESOLVED BY THE COUNCIL OF THE CITY OF RICHMOND:

That the Richmond Family Violence Fatality Review Team is hereby established pursuant to section 32.1-283.3 of the Code of Virginia (1950), as amended.

BE IT FURTHER RESOLVED BY THE COUNCIL OF THE CITY OF RICHMOND:

That a representative of the Richmond Commonwealth's Attorney's Office shall serve as chairperson of the Richmond Family Violence Fatality Review Team and shall appoint members of the team pursuant to section 32.1-283.3 of the Code of Virginia (1950), as amended.

BE IT FURTHER RESOLVED BY THE COUNCIL OF THE CITY OF RICHMOND:

That the Richmond Family Violence Fatality Review Team shall examine family violence incidents, shall create a body of information to help prevent future family violence fatalities, and shall have the authority to review the facts and circumstances of all fatal family violence incidents that occur within the city of Richmond.

BE IT FURTHER RESOLVED BY THE COUNCIL OF THE CITY OF RICHMOND:

That the Richmond Family Violence Fatality Review Team shall establish rules and procedures to govern the review process prior to the first family violence incident review that it conducts.

BE IT FURTHER RESOLVED BY THE COUNCIL OF THE CITY OF RICHMOND:

That the Council of the City of Richmond encourages the Richmond Family Violence Fatality Review Team to also review child fatalities resulting from violence and to engage agencies, organizations and systems that provide services to victims and perpetrators of violence against children in order to identify gaps in system responses and in order to improve coordination among the agencies involved.

APPENDIX F:

EFFECTIVE WORKING TEAMS

The Virginia Commission on Family Violence Prevention identified issues that may arise during the development and life-course of a local domestic violence coordinating council. These same issues apply to the development of a family or intimate partner violence fatality review team. The Commission recommended that members consciously address the following issues to improve a council's/team's effectiveness in responding to the needs of the community.

Maintaining Membership, Involvement and Investment

- Ensure relevant agencies and groups are continuously represented
- Encourage attendance and involvement in the team's work
- Determine whether other agencies/members should be invited to participate
- Facilitate meeting logistics (e.g., notice, place, time, frequency, amenities during meetings)
- Ensure members are receiving expected benefits
- Encourage and distribute leadership opportunities
- Emphasize routine information exchange and updates from key players
- Ensure meetings begin and end on time

Revising Change

- Periodically reexamine mission statement, goals and objectives for relevance
- Be flexible to meet changing community needs, team composition and procedure

Documentation

- Mission Statement/Goals and Objectives
- Products
  - Endorsement of local government/ Resolution
  - Recommendations
  - Press releases and media materials
  - Protocols
  - Report aggregate data only

Evaluating Progress

- Review action plans – have goals and objectives been met?
- Review data for trends and changes in
  - Victim services
  - Caseload and dispositions
  - Batterer programs
  - Substance Abuse Services
  - Training
  - Educational programs
  - Law enforcement reports, other agency records
- Perceptions of satisfaction of team members

Used with permission from the Virginia Commission on Family Violence Prevention.

APPENDIX G:

SAMPLE MEMORANDUM OF AGREEMENTS

Hamilton County, Ohio Domestic Violence Death Review Panel

I agree for my organization to be a full participant of the Hamilton County Domestic Violence Death Review Panel. This participation will include providing an ongoing representative to participate on a regular basis as a member of the panel and providing the necessary data to support its operations as described in the Domestic Violence Death Review Panel's Operating Guidelines.

I understand that the mission of the Hamilton County Domestic Violence Death Review Panel is to prevent domestic violence cases from escalating into murder by constructively examining the circumstances of past and future deaths by domestic violence, by making recommendations arising out of these deaths' reviews, and by increasing coordination and communication between agencies and systems. Operating guidelines and confidentiality procedures that govern the Panel are those described in the Hamilton County Domestic Violence Death Review Panel Operating Guidelines.

This agreement will be in effect as of _____. I can request a revision or review of this agreement within thirty (30) days of written notice. Notice of revision or termination of this Memorandum of Agreement will be sent to all members of the Hamilton County Domestic Violence Death Review Panel.

_____ _____

Signed **Date**

WASHINGTON STATE DOMESTIC VIOLENCE FATALITY REVIEW PROJECT
INTERAGENCY CONFIDENTIALITY AND COOPERATION AGREEMENT

To be signed by a representative of each agency agreeing to participate in Family or Intimate Partner Violence Fatality Review Team

Organization:_____

Represented by:_____

This cooperative agreement is made this _____day of _____, _____ between _____ and all agencies and individuals who serve on the _____Family or Intimate Partner Violence Fatality Review Team.

On behalf of _____, I indicate our support of the objectives of the _____Family or Intimate Partner Violence Fatality Review Team:

Through the process of conducting a formal review of selected fatalities in which family violence or intimate partner violence is considered a significant factor, the _____Family or Intimate Partner Violence Fatality Review will:

1. Identify and describe trends and patterns in family or intimate partner violence related fatalities by:
   a) documenting trends and patterns in periodic reports which present the aggregated findings of the domestic violence fatality reviews conducted throughout the state.
2. Increase safety for victims and accountability for perpetrators of family or intimate partner violence by:
   a) promoting cooperation and communication among agencies investigating and intervening in family or intimate partner violence.
   b) identifying gaps in services and accountability structures and formulating recommendations for policies, services and resources to fill those gaps.
3. Formulate recommendations for collaboration on family or intimate partner violence investigation, intervention and prevention.

_____agrees that membership of _____Family or Intimate Partner Violence Fatality Review Team should be comprised of (but not limited to) the following disciplines: domestic violence victim advocates; law enforcement; judiciary; medical; public health; social services; medical examiners; prosecution; probation; child protective services; batterer's treatment.

This participation will include providing an ongoing primary representative and alternate representative on a regular basis as the member of the Review Team and providing necessary information to support the Family or Intimate Partner Violence Fatality Review Team's operations.

I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigation materials and information may result in criminal liability.

Because the review process may involve case specific sharing of information, and confidentiality is inherent in many of the involved reports, each member of the Family or Intimate Partner Violence Fatality Review Team will take clear

measures to understand the limits of what they may reveal in their capacity as an agency representative. All members will sign a confidentiality agreement that prohibits any unauthorized dissemination of information related to the review process. No material may be used for reasons other than which was intended.

_____ agrees that no one associated with this agency will represent the views of the Family or Intimate Partner Violence Fatality Review Team to the media.

In my capacity as its authoritative representative, I commit _____ 's participation, support and assistance to the _____Family or Intimate Partner Violence Fatality Review Team.

This agreement will be in effect on the date below. I can request a revision or review of this agreement within thirty (30) days of written notice. Notice of revision or termination of this Agreement will be sent to all members of the _____Family or Intimate Partner Violence Fatality Review Team.

Signature _____

Title _____

Date _____

APPENDIX H:

SAMPLE CONFIDENTIALITY AGREEMENTS

FAMILY AND INTIMATE PARTNER FATALITY REVIEW

The purpose of the Family or Intimate Partner Violence Fatality Review Team is to conduct a complete retrospective analysis of family or intimate partner violence death incidents. I, the undersigned, as a representative of

_____

swear that I shall not divulge any information, records, discussions and opinions disclosed during any closed meeting to review a specific death. Such information, records, discussions and opinions shall remain confidential and shall not be used for reasons other than those required under § 32.1-283.3 of the *Code of Virginia*. **Violation of this agreement is a Class 3 Misdemeanor.**

_____

Print Name

_____ Date _____

Signature

WASHINGTON STATE DOMESTIC VIOLENCE FATALITY REVIEW PROJECT

AGREEMENT TO MAINTAIN CONFIDENTIALITY

To be signed by each person in attendance at each Family or Intimate Partner Violence Fatality Review Team meeting

By signing this form, I do hereby acknowledge and agree to the following:

I agree to serve as a member of the _____Family or Intimate Partner Violence Fatality Review Team. I acknowledge that the effectiveness of the fatality review process is dependent on the quality of trust and honesty team members bring to it. Thus, I agree that I will not use any material or information obtained during the Family or Intimate Partner Violence Fatality Review Team meeting for any reason other than that which it was intended.

I further agree to safeguard the records, reports, investigation material, and information I receive from unauthorized disclosure. I will not take any case identifying material from a meeting other than that which originated in the agency I represent. Thus, I will not make copies or otherwise document/record material made available in these reviews, including electronically. I will return all material shared by others at the end of each meeting.

I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigation materials and information may result in civil or criminal liability and exclusion from the Family or Intimate Partner Violence Fatality Review Team.

I agree to refrain from representing the views of Family or Intimate Partner Violence Fatality Review Team to the media.

Printed Name	Signature	Date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

APPENDIX I:

CHILD FATALITY REVIEW

The process of developing a Domestic Violence Fatality Review Team and Child Fatality Review Team is quite similar. Both teams need to have clearly defined goals, membership, confidentiality requirements, and procedures for offering recommendations to decrease deaths. When a fatality involves a child because of domestic violence, collaboration between the two teams is recommended.

The investigation and prevention of childhood fatalities are responsibilities shared by the community and agencies that serve that community. Therefore, local Child Fatality Teams allow a community to assess and address the issues that surround the deaths of their children. Virginia currently has three local or regional child fatality teams.

Piedmont Region Child Fatality Review Team

The Piedmont Regional Child Fatality Review Team was organized in 1994 under the guidance of the regional office of the Department of Social Services and the Child Abuse Prevention Council of the Roanoke Valley. The Team serves the geographic area corresponding to region six of the Virginia Department of Social Services and the staff from the regional office in Roanoke serves as the main contact agency for the review team. The team serves the following localities: Alleghany, Amelia, Amherst, Appomattox, Augusta, Bath, Bedford, Botetourt, Brunswick, Buckingham, Campbell, Charlotte, Clifton Forge, Covington, Craig, Cumberland, Danville, Franklin, Halifax, Henry, Highland, Lunenburg, Martinsville, Mecklenburg, Patrick, Nelson, Nottoway, Pittsylvania, Prince Edward, Roanoke, Rockbridge, Staunton and Waynesboro.

For more information, contact:

Teresa Biggs,
Child Fatality Review Team Coordinator

Commonwealth Building, Suite 100
210 Church Ave., S.W.
Roanoke, VA 24011

540-857-7867
Email: tcb996@piedmont.dss.state.va.us

Fairfax County Child Fatality Prevention Team

The Fairfax County Child Fatality Prevention Team was established in 1994. The Fairfax County Team is one of the few in the country to review all child deaths including accidental and natural deaths. The Fairfax Team reviews all fatalities for children under the age of 18 who were either residents of the County or died in Fairfax County, including the cities of Fairfax and Falls Church. The Team also serves as a consultant to neighboring jurisdictions when requested.

For more information, contact:

Jim Pope,
Child Fatality Review Team Coordinator

12011 Government Center Parkway, Suite 200
Fairfax, VA 22035

703-324-7415
Email: jpope2@co.fairfax.va.us

Hampton Roads Child Fatality Review Team

The Hampton Roads Regional Child Fatality Review Team began in August 1994. The meeting was convened by the Hampton Roads Committee to Prevent Child Abuse and Children's Hospital of The King's Daughters with the purpose of establishing a local response to the problem of child fatalities. The Hampton Roads Team serves a large and diverse geographic area. It includes the cities of Hampton, Chesapeake, Newport News, Williamsburg, Norfolk, Portsmouth, Virginia Beach, Suffolk, and Franklin as well as the counties of Accomack, Brunswick, Isle of Wight, Surry, Southampton, Northampton, Gloucester, Mathews, James City and York/Poquoson.

For more information, contact:

Gail Heath,
Child Fatality Review Team Coordinator

State Department of Social Services
Pembroke 4, Suite 300
Virginia Beach, Virginia 23462

757-491-3987
Email: geh993@eastern.dss.state.va.us

APPENDIX J:

SAMPLE ASSESSMENT FORM

Intervention

1. List the agencies and individuals involved in this fatality.
2. Identify the agencies that offered interventions.
3. Identify the agencies that might have provided interventions but did not.
4. Describe the interventions that worked and how those interventions can be expanded or improved.
5. List specific interventions, coordinated efforts and collaborative approaches that could have resulted in better outcomes.
6. Discuss how prevention strategies flow from the interventions identified.

Information

7. Identify the barriers encountered by:
    a. the victim, perpetrator and children to obtain services (e.g., language, cultural, social, and institutional)
    b. the agencies involved and not involved in the fatality
    c. the fatality review team
8. Outline ways to overcome these barriers.

APPENDIX K:

FAMILY INVOLVEMENT

It is recommended that teams consider two specific ways to include surviving family members in the fatality review process. Teams may decide to include a representative from a survivor advocacy group or victims of crime group. This person would serve as a member of the team and bring the perspective of victim's families to the review of fatalities. In addition, teams may choose to request interviews with surviving family members to obtain information about the victim's experiences. Family members are often valuable sources of information about events and issues that may not be documented in an official record. However, family survivors may not be ready to participate in a process that revisits the violent death of their loved one. Teams that choose to involve family members must ensure the following:

- Family members understand the fatality review process, and that its goal is prevention and not placing blame.
- Expectations are clear and defined for both family and team members.
- Family members are interviewed separately and not during a formal review.
- Interviews are conducted by one or two team members who are experienced in crisis intervention or grief counseling.
- Privacy and confidentiality is maintained for family members throughout the interview and the review process.
- Resources and referrals are made available to family members.
- Published reports and recommendations are shared with family informants.

APPENDIX L:

MEDIA RELATIONS

Teams may decide to release their recommendations to the public. In doing so, teams should discuss who, what, when, where, why and how to do this successfully. Teams that become familiar with the protocols of local media are more likely to have editors and reporters take notice. Careful consideration must be given to what the team wants to share and the message the team wants to convey.

- Who is the target audience?
- What information should be included?
- What is the tone of the release?
- What are the possible problems that could arise from the release and how can they be avoided?
- What is the end result or what does the team want to accomplish with the release?

Teams may want to consider releasing recommendations during Domestic Violence Awareness Month in October. The release must be factual, honest, well written and concise. Teams should consider their media sources carefully and may need to make more than one effort to catch the attention of a media source.

PRESS RELEASE FORMAT:

For Immediate Release
Date

For More Information Contact:
Name, (phone) (pager)

Title

(City, State)- Text

For more information on (title), log on to the (name of agency) website at www: _____, and click on "(title)".

###

SAMPLE PRESS RELEASE:

FOR IMMEDIATE RELEASE

Media Contacts:
George Stinnett,
Children's Hospital of The King's Daughters
(757) 668-7424

Betty Wade Coyle,
Hampton Roads Committee to Prevent Child Abuse
(757) 625-3182/440-2749

Hampton Roads Child Fatality Review Team to Release Local Child Fatality Statistics

The Hampton Roads Child Fatality Review Team will release information and statistics on child fatalities in the region at a press conference scheduled for Friday, April 28, 2000 at 2:00 p.m. at Children's Hospital of The King's Daughters (CHKD). Members of the press are invited to attend.

The Hampton Roads Child Fatality Review Team is an organization of child service and health professionals who meet monthly to review and discuss child fatalities that are referred to the local Child Protective Service (CPS) agencies for investigation as occurring from possible abuse or neglect.

As a result of these reviews, the Regional Child Fatality Review Team has been keeping statistics for the past four years and has complied data to educate the public in the trends in child fatalities and how these fatalities can be prevented.

The Virginia Department of Social Services statistics for 1998 indicate that 20 of the state's 36 fatalities, or 56%, caused by abuse or neglect attributed to a caretaker occurred in Hampton Roads. Moreover, the region's fatalities doubled from a total of 10 in 1997 to a total of 20 in 1998. (Please note: all statistics have been compiled by fiscal years, which are calculated from July 1st of one year to June 30th of the next.) The state has not yet released the 1999 statistics. The 1999 regional total for fatalities due to abuse or neglect fell from 20 to 11. Even though the numbers have decreased, the circumstances of these fatalities raise a number of concerns for the community.

Speakers at the press conference will include Dr. Leah Bush, Chief Medical Examiner for the Tidewater Region; a spokesman for the CHKD Children's Advocacy Center, and Betty Wade Coyle, Executive Director of the Hampton Roads Committee to Prevent Child Abuse who authored the regional report. Other members of the team representing the Children's Hospital of The King's Daughters, local police departments, Commonwealth Attorney's offices, and social service agencies will be present to answer questions after the presentation.

Used with permission from the Hampton Roads Child Fatality Review Team.

APPENDIX M:

RISK AND LETHALITY INDICATORS

The following are primary indicators in evaluating whether a batterer will kill his/her partner, other family members and/or him/herself. These indicators are not ranked; however, the more indicators present in a relationship, the higher the victim's risk that future violence or death may occur.

Threats of homicide or suicide	Stalking
Previous episodes of violence	Fantasies of homicide or suicide
Separation	Firearms
Rage	Access to victim
Public display of violence toward victim	Sexual violence
Timing, fear of losing a partner	Hostage taking
Drug or alcohol consumption	Depression
Prior calls to the police	Pet abuse
Sense of ownership of the victim by the batterer	Abuser's lack of respect for the law
Obsessiveness about partner or family	Intimidation/Threats
Isolation of victim, perpetrator or both	Acute mental health problems
Destruction of property	Cultural influences

APPENDIX N:

SAMPLE RECOMMENDATIONS

Hamilton County Domestic Violence Fatality Report

Education

The Team submits several recommendations for implementation by various professionals in the community. Education is a key theme of these recommendations with suggested educational efforts focused on the victim, friends and family of the victim and the general community. The Team also recommends educational efforts be made with court personnel and the medical community. The specific recommendations are as follows:

Victim

- ✓ Education concerning stalking: what it is, how to get help and how to develop a Safety Plan.
- ✓ Develop outreach programs for men with concerns about domestic violence.
- ✓ Education concerning development of Safety Plan.

Friends and Family of Victim

- ✓ Education for those people who are aware of abuse about interventions and resources for victims of domestic violence.
- ✓ Education concerning development of a Safety Plan.
- ✓ Education about separation assault.

Community

General Education:

- ✓ Education about a loaded gun in the house related to domestic violence.
- ✓ Education about use of alcohol and/or drugs and incidence of domestic abuse.
- ✓ Education about separation assault.
- ✓ Public education about verbal violence as a precursor of later physical violence.
- ✓ Education of community about reoccurring patterns of abuse and escalation of violence.

Courts:

- ✓ Education of courts about long-term batterers' treatment.
- ✓ Education of judges about reluctance and fear as lethal red flags.

Medical Community:

- ✓ Continued education of medical community about domestic violence.
- ✓ Education to encourage recognition of abuse during pregnancy.

Used with permission from the Hamilton County Domestic Violence Fatality Report.

HAMPTON ROADS REGIONAL CHILD FATALITY REVIEW TEAM: FY99

As a result of the case reviews and findings, the Team has made recommendations and initiated programs and projects to help prevent future fatalities.

The Team has continued to improve record keeping and has recommended better processes to facilitate communications between the various agencies in order to enhance the collection of more complete, timely, and legally relevant information. A current project of the Team is the development of suggested best practice protocols for child fatalities. Data collection methodology is being revised to generate more detailed information and to be a part of other similar data collection projects.

Many new strategies to better educate parents and the public regarding child safety and health issues have been explored and implemented. Because of the high percentage of deaths and children left in vegetative or disabled states from being shaken, an ongoing Shaken Baby Awareness Campaign has been instituted. Videos have been purchased and placed in physicians' offices, departments of social services, hospitals and libraries to help people understand the seriousness of this type of injury. Drowning prevention is also an education priority and a number of Team agencies have been working to get these messages out to their customers as well as the public at large. This year, The Children's Hospital of The King's Daughters (CHKD), through the Way to Grow program, is introducing a series of informational cards for caretakers that address a number of safety concerns identified by the Team.

Collaborations with a number of community groups and agencies such as CHKD, the United States Navy, Health Families Hampton Roads, Child Abuse Prevention Services, the Children's Advocacy Center, the Suburban Junior Women's Club, Chesapeake General Hospital and Prevention Child Abuse Hampton Roads have helped to enhance this effort.

In April 1999, a daylong conference sponsored by the CHKD Children's Advocacy Center addressed prevention issues for the 300 attending professionals. Team members conduct lectures and trainings for professionals, parents, and the community on an ongoing basis.

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SANTA CLARA COUNTY DEATH REVIEW COMMITTEE FINAL REPORT OCTOBER 1998-DECEMBER 1999

We the members of Santa Clara County Domestic Violence Death Review Committee recommend as follows:

1. The Domestic Violence Council continues its efforts to educate the public on domestic violence, including the release of this report to the public.
2. That our community stands up and reports domestic violence when it is observed. Ignoring the problem is not the answer to solving the problem.
3. The Workplace Violence Committee continues to educate employers about the issue of workplace violence as it relates to domestic violence.
4. All local school districts develop a curriculum, which addresses the issues of domestic violence and dating violence.
5. Continue to promote the idea that victims of domestic violence should get restraining orders.
6. The Domestic Violence Council examines and reports on the availability of mental health care for low/middle income families.
7. Encourage the media to report on the availability of assistance for domestic violence victims, so that victims, family members and others can have the information needed to assist victims.
8. Insure that all domestic violence related educational information is culturally competent and take into account that domestic violence also occurs in the elder, gay and lesbian community.
9. Encourage family law attorneys to question divorce/separation clients about prior domestic violence and get the appropriate protections in place.
10. Encourage better policies for handgun rental at those businesses.
11. Promote education on the issue of domestic violence, which will encourage psychiatrists and batterer treatment programs to obtain releases from perpetrators so that information can be shared.
12. Encourage the use of assessments for substance abuse and encourage substance abuse counseling in domestic violence cases.
13. Encourage utilization of available monies for mental health services for children exposed to domestic violence.
14. Encourage parents to get parenting classes, which discuss the impact of domestic violence on children.
15. Encourage victims to access available support services.

Respectfully submitted, The Death Review Committee–1999, Santa Clara County Domestic Violence Council

VIRGINIA STATE CHILD FATALITY REVIEW TEAM

Recommendations from Review of Firearm Fatalities, 1998

In 1994, 63 children and youth under the age of 18 died as a result of a firearm injury. The State Child Fatality Review Team examined firearm fatalities to gain an understanding of the circumstances surrounding child and adolescent firearm fatality in order to make recommendations to reduce firearm injury and fatality among children in Virginia.

Ways to Improve Child and Adolescent Death Investigation

We recommend that the Medical Examiner request and that the Department of Criminal Justice Services, Forensic Science Division perform full toxicology screens, including marijuana, amphetamines, and inhalants on all sudden, unexplained or violent deaths in children under the age of 18 years old.

We recommend that in all child and adolescent deaths due to firearms, law enforcement personnel conduct an investigation to determine the ownership and storage of those firearms to support prosecution under §18.2-56.2 regarding access to firearms by children.

Provide Training for Law Enforcement and School Personnel

We recommend that the Department of Criminal Justice Services encourage local law enforcement training academies to utilize the model lesson plan Objective 9.0 regarding Mentally Ill/Abnormal Behavior and to expand training to include adolescent development issues and protocols for crisis response to suicidal children and youth.

We recommend that the Virginia Department of Education offer grants to provide training to regular classroom teachers and school administrators on the psychopathology of children so that they may more effectively address child psychopathology in education settings.

Early Intervention, Strengthening Families and Access to Mental Health Services

We recommend continued support for the Supreme Court of Virginia's Court Improvement Project to improve permanency planning for children.

We recommend that the General Assembly increase funding for prevention and early intervention services such as Healthy Families, Resource Mothers, and Family Resource Centers to strengthen families before problems become severe.

We recommend that additional resources be made available to all youth in the juvenile justice system to insure equal access to a wide range of mental health services.

Prevention of Firearm Injury through Education

We recommend that the Virginia Department of Health's Injury Prevention Program make firearm safety a priority.

We recommend that each school division insure that that the content of its elementary, middle and secondary school curricula covers effective firearm safety practices.

Suicide Prevention

We recommend that the Virginia Department of Education develop a model protocol for school personnel to identify and respond to a potential suicide among members of the student body.

We recommend that each school division include suicide prevention in its elementary, middle and secondary school curricula.

We recommend that health assessments by medical professionals for children and adolescents include risk assessments for depression, suicide and availability of firearms in the home.

Prevention through Legislation

We recommend that legislation be enacted to require that all new firearms sold in Virginia include safety trigger locks.

We recommend that legislation be enacted to require that all firearm dealers provide firearm safety information to purchasers of firearms.

APPENDIX O:

DOMESTIC VIOLENCE RESOURCES

AGENCY	PHONE	EMAIL	WEB ADDRESS
Virginians Against Domestic Violence (VADV) 2850 Sandy Bay Road, Suite 101 Williamsburg, VA 23219	**757.221.0990**	**vadv@tni.net**	**http://www.vadv.org**
Virginia Department of Criminal Justice Services 805 East Broad Street Richmond, VA 23219	**804.786.4000**	**webmaster@dcjs.state.va.us**	**http://www.dcjs.state.va.us**
Virginia Department of Social Services 730 East Broad Street Richmond, VA 23219	**804.692.1900**	**comm@email1.dss.state.va.us**	**http://www.dss.state.va.us**
Virginians Aligned Against Sexual Assault 508 Dale Ave., Suite B Charlottesville, VA 22903	**804.979.9002**	**vaasa@rlc.net**	**http://www.vaasa.org**
Virginia Poverty Law Center, Inc. 201 West Broad Street, Suite 302 Richmond, VA 23220	**804.782.9430**	**info@vplc.org**	**http://www.vplc.org**
Center for Injury and Violence Prevention Virginia Department of Health 1500 E. Main Street, Room 105 Richmond, VA 23219	**804.692.0104**	**civp@vdh.state.va.us**	**http://www.vahealth.org/civp/**
Office of the Chief Medical Examiner Virginia Department of Health 400 E. Jackson Street Richmond, VA 23219	**804.786.6044**	**tbarr@vdh.state.va.us**	**http://www.vdh.state.va.us/medexam**

APPENDIX P:

DEFINITIONS:

Critical Incident Stress Debriefing (CISD)

Magellan Behavioral Health defines CISD as a crisis intervention response aimed at helping people cope with a traumatic event in order to lessen any long-term negative effects. CISD provides support and stabilization by a trained professional counselor, allows an outlet for emotional expression, restores normal coping skills and helps people regain a sense of control.

In order to determine if a CISD is called for in your workplace situation, assess the following factors relating to the incident:

Degree of danger
Level of disruption
Duration of the trauma
Immediacy of the event

Susan Berger, MFT, Psychotherapist, states that holding a CISD can play an important role in preventing the development of Post-Traumatic Stress Disorder by providing an immediate sense of safety, group cohesion, mutual support and education, as well as an opportunity for venting feelings and normalization of symptoms, and creating a plan for further action.

Domestic Violence a pattern of assaultive and coercive behavior including physical, sexual and psychological attacks, as well as economic coercion, that adults or children use to gain power and control over their intimate partner.

Family Abuse Section 16.1-228 of the Code of Virginia defines Family Abuse as follows:

"Family abuse" means any act involving violence, force, or threat including any forceful detention, which results in physical injury or places one in reasonable apprehension of serious bodily injury and which is committed by a person against such person's family or household member.

"Family or household member" means (i) the person's spouse, whether or not he or she resides in the same home with the person, (ii) the person's former spouse, whether or not he or she resides in the same home with the person, (iii) the person's parents, stepparents, children, stepchildren, brothers, sisters, grandparents and grandchildren, regardless of whether such persons reside in the same home with the person, (iv) the person's mother-in-law, father-in-law, sons-in-law, daughters-in-law, brothers-in-law and sisters-in-law who reside in the same home with the person, (v) any individual who has a child in common with the person, whether or not the person and that individual have been married or have resided together at any time, or (vi) any individual who cohabits or who, within the previous twelve months, cohabited with the person, and any children of either of them then residing in the same home with the person.

Fatal Family Violence

any fatality, whether homicide or suicide, occurring as a result of abuse between family members or intimate partners.

Homicide *(Definitions from "Reviewing Domestic Violence Fatalities: Summarizing National Developments")*

Intimate Partner	Murder or non-negligent manslaughter of a person by her/his intimate or former intimate partner.
Family	The willful killing of someone by a victim's relative by blood or marriage.
Multiple Domestic	Involves various permutations and combinations of victims including intimate partners, competitors or love-triangle antagonists, family members including children and the perpetrator him/herself.
Homicide-Suicide	The killing of one or more persons followed soon after by the suicide of the perpetrator.

Likert Scale The Likert technique presents a set of attitude statements. Subjects are asked to express agreement or disagreement on a five-point scale. Each degree of agreement is given a numerical value from one to five. Thus, a total numerical value can be calculated from all the responses.

Preventable Death one in which with retrospective analysis, the Team determines that a reasonable intervention might have prevented the death. Reasonable is defined by taking into consideration the condition, circumstances or resources available.

Relationship

	Intimate	**Other Family**
National Crime Victim's Survey (Offender's relationship to victim)	Spouse Ex-Spouse Boyfriend/Girlfriend Ex-Boyfriend/Girlfriend	Parent/Stepparent Child/Stepchild Siblings Other relatives
FBI's National Incident-Based Reporting System (NIBRS) (Victim's relationship to the offender)	Spouse Common-law Spouse Ex-Spouse Boyfriend/Girlfriend Homosexual Relationship	Parent/Stepparent Child/Stepchild Sibling/Stepsibling Grandparent Grandchild In-law Other family

Surveillance the ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in the planning, implementation, and evaluation of public health practice.

Teen Violence violence that occurs by or to teens between the ages of 12-19 years.

APPENDIX Q:

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NOTES

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NOTES

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