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FAMILY AND INTIMATE PARTNER VIOLENCE FATALITY REVIEW

TEAM PROTOCOL & RESOURCE MANUAL

FOURTH EDITION

VIRGINIA DEPARTMENT OF HEALTH

OFFICE OF THE CHIEF MEDICAL EXAMINER

VDH VIRGINIA DEPARTMENT OF HEALTH

To protect the health and promote the well-being of all people in Virginia.

Family and Intimate Partner Violence Fatality Review

Team Protocol & Resource Manual

Fourth Edition

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The Virginia Department of Health, Office of the Medical Examiner (OCME) acknowledges the commitment of Domestic Violence Fatality Review Team participants who devote their time, energy, and expertise to work towards creating safer communities throughout Virginia.

The aim of this report is to support the establishment of new and developing teams and assist teams currently reviewing cases in continuing their invaluable work. Our focus is primarily on Virginia teams, but draws from national resources, research, and practice. We hope it serves as a comprehensive, practical, and useful "how-to" resource guide.

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Dedication

This manual is dedicated to those who have lost their lives to domestic violence and to their family members, friends, and surviving children. It is our goal to learn from these tragedies and implement changes in communities across Virginia to prevent future domestic violence-related deaths from occurring.

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Introduction

In 2019, Virginia's domestic violence fatality review teams celebrated their twentieth anniversary of working to save lives in communities throughout Virginia. Since their inception, research has identified new, evidence-based risk factors, institutional reforms have supported increased service provision for domestic violence survivors, and the advent of new technologies and social media have created emerging threats and opportunities for domestic violence service providers. To remain responsive, this, the fourth edition of the Family and Intimate Partner Violence Fatality Review Team Protocol and Resource Manual, builds upon lessons learned over the past two decades and incorporates strategies to address and respond to the changing landscape of domestic violence in communities across Virginia.

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 (hereafter referred to as domestic violence fatality review teams) and the creation of the Family and Intimate Partner Violence Surveillance Project, which is a surveillance system for the detection and analysis of family violence homicides in Virginia. Since 1999, twenty-two teams have been established in all four regions of the OCME.

Mission and Purpose of Fatality Review

The mission of fatality review is focused on prevention, and the purpose of fatality review is to save lives. The process is evidence-based and utilizes a public health approach to violence prevention, providing a means to analyze system responses to family or intimate violence by agencies, institutions, and organizations within a community. While the practice is centered on an in-depth evaluation of the system response, maintaining a nonjudgmental evaluative technique is critical to a successful review, not an avenue to find fault or place blame. If implemented appropriately, 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.

By conducting detailed reviews of the tragic deaths of victims, teams prepare, publish, and disseminate data findings and action-oriented recommendations. These recommendations identify gaps in system responses and critical points for intervention and prevention, and improve the quality and coordination of their community response to domestic violence by providing a forum for

stakeholder collaboration and evaluation. Overall, fatality review plays a critical role in improving the overall community awareness, education, health, and safety.

CORNERSTONES OF FATALITY REVIEW

Domestic violence fatality review provides a systematic way of reviewing incidents of fatal domestic violence through a lens of prevention and accountability. To conduct effective reviews, teams should uphold the five cornerstones of fatality review:

- Multidisciplinary: Given the complexity of the cases reviewed by DVFRTs, team membership should represent a diverse set of disciplines, knowledge, and perspectives. During the review process, team members will share their expertise and opinions, and the process will also teach members ways their own agency and/or profession can play a positive role in prevention and intervention efforts. Multidisciplinary membership is essential to evaluate the system response and contributing factors, and ultimately strengthen the community's capacity to prevent these deaths. Additionally, having multiple disciplines in team meetings will also improve the recommendation development process as interdisciplinary discussion creates more effective and feasible prevention recommendations, and makes team members more apt to champion recommendations within their agencies if invested in the team's process.

  Members act as interpreters for their respective agencies. They are expected to explain and contextualize their agency's unique role, strengths, and challenges. The capacity to exchange information among multidisciplinary team members is invaluable in building team knowledge and trust.

- Local: While the specific agencies involved will depend on the jurisdiction of the team, all agencies and representatives should be local and existing members of the community. In being part of the community, these members will have a strong understanding of the local composition and functionality of the existing community response system, and will improve the validity and utility of team recommendations, as often, local community advocates and providers already know from experience where there are opportunities for improvement. Additionally, having members with a strong knowledge of the opinions and trends in the approval process in your community for policies and procedures is an asset, as it might help drive the implementation strategy of your recommendations, or help you identify a local champion for a particular recommendation as it goes through the approval process.

  Retrospective: Cases selected for review should be closed and with no further criminal investigation or prosecution pending. This allows for a more thorough review of cases and their outcomes, and provides teams with the benefit of hindsight. During an investigation, agencies often receive fragmented, piecemeal information, which can be difficult to uncover the true story. Since all records are available at once for fatality review teams, it is easier to identify risk factors and patterns associated with specific causes of fatal domestic violence. The information garnered from reviews can then be used to guide and inform policy and practice among investigative agencies to more easily and quickly detect red flags in real time.

- **Confidential:** Maintaining confidentiality is arguably the most critical component of a successful review. While the *Code of Virginia* specifies how to maintain confidentiality throughout the review process, individual members must also reconcile their own agency's confidentiality policies with the protected process of fatality review.

- **"No blame, no shame":** Reviews are not meant to re-investigate a case or to place blame on any particular agency or person. While the team may identify early intervention opportunities that were missed, the team must remember that the perpetrator is responsible for the violence, not the responding agencies. In conducting a non-judgmental analysis of the strengths and challenges of a community's response to domestic violence, the weight of the work is on the community as a whole, instead of a few specific agencies.

UPDATES TO § 32.1-283.3 OF THE *CODE OF VIRGINIA*

Effective July 1, 2016, the language of the statute that provides a legal framework for the practice of domestic violence fatality review was updated to broaden the scope of fatalities that are eligible for review by DVFRTs. With this update, teams may now review a range of fatalities beyond homicides and suicides, and gives teams latitude to examine fatal domestic violence however it manifests in their communities.

While "family members" and "intimate partners" are not clearly defined in this or any other statutes, the closest reference is to "family and household members" in *Code of Virginia* § 16.1-228, which include the following:

- Current or former spouses;
- Parents, stepparents, children, step-children, brothers, sisters, half-brothers, half-sisters, grandparents, grandchildren, and in-laws;
- Any individual who has a child in common with the person;
- Any individual who cohabits or who, within the previous 12 months, cohabited with the person, and any children of either of them.

These categories are not exhaustive of the relationships that can be and are impacted by domestic violence in Virginia. Other relationships involving domestic violence include but are not limited to dating partners; boyfriends and girlfriends; non-family caretakers of children or dependent adults; same-sex partners; foster family members; and stalking perpetrators (where an offender is pursuing or perceives a romantic relationship with the victim). The spirit of the law, therefore, is to cast a wide net that extends beyond statutory definitions to encompass all possible aspects of domestic violence that impact Virginia communities. The OCME recommends DVFRTs use this broader definition.

This will help teams to identify and address the full breadth and scope of fatal domestic violence in their communities. With this in mind, the following types of deaths may be reviewed by Virginia DVFRTs:

- **Homicides:** From 2003-2017, nearly one in three homicides is a result of family or intimate partner violence in Virginia.[1] These include cases where a person is killed by an intimate partner or family members, or in the crossfire or while trying to intervene in a domestic violence incident. Family and intimate partner violence associated homicides may also involve persons outside the family or intimate partner relationship to whom the violence is directed, such as in cases of jealousy toward a new intimate partner.

- **Suicides:** Nearly a third of intimate partner homicides in Virginia are followed within one week by the suicide of the alleged offender.[1] Many teams include homicide-suicides in their reviews, although less information may be available due to limited criminal investigation and the inability to prosecute the offender. Other suicides that may be related to domestic violence include those that involve an attempted homicide of a family members or intimate partner, or a problem or conflict involving such a relationship. From 2003-2017, 32.7% of suicides in Virginia were known to be precipitated by a problem or conflict with an intimate partner.[1] Few teams include suicides in their review, but there is growing interest in understanding the role of suicide in domestic violence.

- **Other Manners of Death:** "Any fatality" may also include other manners of death, namely natural, accidental, and undetermined deaths. With these manners of death are eligible for review, sometimes determining the context within which the person's life ended can be challenging without a criminal investigation and prosecution. However, given that fatality review is grounded in the prevention of future deaths, domestic violence can sometimes be a relevant factor in these fatalities. It is the responsibility of the team to determine this context, and to decide if the availability or coordination of community services (for victims and perpetrators of domestic violence) was found to contribute to the cause of death, such that a reasonable intervention might have prevented the death, then these case are eligible to be reviewed under Virginia law. As the team's focus is on the full spectrum of domestic violence in their community, the question of preventability is centered on whether and how service providers may have interacted with the involved parties. If teams do choose to review these manners of death, the team may also need to broaden their understanding of what makes up the domestic violence response system in their community and adjust their members accordingly.

While many cases come under the jurisdiction of the OCME as sudden or unexpected, the OCME does not conduct routine surveillance of natural, accidental, or undetermined deaths for the involvement of family or intimate partner violence. For these reasons, the process of identifying cases such as these for review will require input and insight from local agencies, team members, or community members who have knowledge of a context of domestic violence surrounding the death. This can include a history of calls for service or death cases involving Child or Adult Protective Services.

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1. Virginia Office of the Chief Medical Examiner. (2018). *Virginia Violent Death Reporting System.*

SECTION

1

ESTABLISHING A TEAM

Establishing a local domestic violence fatality review team (DVFRT) begins with community-defined interest in the practice of domestic violence fatality review as a means to save lives, and better serve the community by improving the quality and coordinator of the local domestic violence response.

Determine Jurisdiction

With a demonstrated commitment to the evidence-based practice of fatality review, the first question community stakeholders must answer is, will the team be local, representing one-city or county jurisdiction, or will it be regional, representing two or more jurisdictions? In considering team jurisdiction, teams must acknowledge that domestic violence has no boundaries. Just as it crosses borders of age, race, ethnicity, religion, sexual orientation, and socioeconomic status, it also crosses those boundaries of jurisdiction. In confronting the borderless and widespread nature of domestic violence, some communities will find that it makes sense to combine efforts with others. This may be especially true for localities where resources are scarce or populations and fatality numbers are low. Pooling efforts can better utilize people and resources, and better integrate services across jurisdictional lines. Conversely, a locality with a high number of fatalities, a large population, many service providers, and adequate resources may want to focus their efforts within their own jurisdiction. They may find that their team gets too big or cumbersome, or has too many cases to review, if they combine efforts with other cities or counties. Many factors may affect a team's decision regarding jurisdiction, including those of community:

- **Size and location**: What is the population? What geographic area is covered by the jurisdiction? Are there special geographic considerations (e.g., adjacent county borders or an independent city within county borders) that might encourage or discourage cooperation among local stakeholders?

- **Resources**: Does the locality have sufficient will, time, and personnel to establish and maintain a fatality review team? While actual operating costs are generally minimal, and can be kept low and absorbed by member agencies (e.g., use free meeting space, minimize copying and supply costs, utilize donated equipment or administrative help), finding experienced professionals willing and able to commit to the work of fatality review can be challenging, but is critical to the team's success. Team leadership must be transparent about the requirements and responsibilities for new members, ensuring all team members and their respective agencies understand the resource allocations necessary to participate and be an active and engaged team member.

- **Fatality statistics**: How common is domestic violence homicide and/or suicide in the locality or in neighboring localities? If the number is low, it often makes sense to combine jurisdictional efforts.

- **Overlapping services**: Are there neighboring jurisdictions that share critical services, such as a domestic violence shelter that serves multiple counties? Are there efforts or systems already in place to integrate services across jurisdictional lines, such as cooperation on serving and enforcing orders of protection?

Develop Core Team

Once the jurisdiction of the team is determined, community stakeholders should identify the *Team Coordinator*. This individual generally takes the lead in identifying and contacting the agencies and representatives most relevant in establishing a team, and ultimately, in reviewing cases. These individuals will become the *Core Group* of the fatality review team. The *Core Group* is generally a smaller, focused, and committed group of multidisciplinary domestic violence stakeholders. They are the steering committee that identifies potential community membership and moves the process of team development forward. We recommend teams start with a core group and expand to a *Full Team* as the process gains focus, approval, and momentum.

Develop Mission Statement

Once the *Core Group* is established, members begin to develop a *Mission Statement*. The *Mission Statement* serves two critical roles: it clarifies the team's purpose and communicates that purpose to outside agencies and organizations. The *Mission Statement*, along with the endorsement of the core group members, agencies, and organizations, serves as the foundation for obtaining critical governmental endorsements.

Teams define themselves in different ways through their *Mission Statement*, but there are some clear commonalities in their goals. A national review of DVFRT mission statements revealed the following themes:

- Change system and individual responses
- Coordinate/integrate local, state efforts
- Identify trends and patterns
- Identify high risk factors
- Improve early community interventions
- Recommend changes in laws, policies, rules and procedures
- Identify gaps in community systems, particularly related to traditionally underserved populations
- Develop a process for change and improvement
- Educate the public, policy makers, and funders

When developing the *Mission Statement*, while it should reflect the goals and objectives of the team, teams should consult existing teams' mission statements, and not feel the need to reinvent the wheel. Further, teams should recognize that *Mission Statements* are not static, and they are likely to change over time as the team evolves. We recommend teams revisit their *Mission Statement* periodically to be sure it is consistent with the goals and objectives of the team.

Finally, in order to streamline the approval process, it is recommended that teams solicit feedback for the *Mission Statement* from key governmental officials prior to adoption and endorsement. Further, regional teams are encouraged to vet the *Mission Statement* through each jurisdiction represented.

Obtain Governmental Endorsement

While the *Code of Virginia* §32.1-283.3 provides for the establishment of DVFRTs, obtaining an official authorization from local city or county governments is critical, as it confirms the importance of the team's work and gives authority for reviews to begin. This authorization also serves as a powerful tool in recruiting the full team, as well as in getting all prospective members and agencies to fully participate in the review process.

Building Support for a Governmental Resolution

The *Core Group* has a wealth of knowledge regarding the political landscape of their community, and their experience within the community can be vital in shepherding a resolution through official channels. They are in the best position to know or find out about potential areas of support or resistance within the community, which should be discussed and planned for prior to seeking official authorization from the local city or county government.

Utilizing the knowledge of the *Core Group*, there are many strategies for building support to facilitate formal governmental authorization. First, teams may want to consider obtaining a letter of support from an influential governmental official or agency. This letter endorses the team's formation and goals. Additionally, it can be beneficial to make an educational presentation to community or governmental agencies. Though there are many compelling reasons to do fatality review, some people may be unfamiliar with its theory and practice. The team organizer or core group, therefore, must educate others about the principles and benefits of fatality review, including:

- Domestic violence fatalities are preventable, and the purpose of fatality review is to save lives.
- Every year, in Virginia, domestic violence accounts for a third of all homicides. These deaths are a public health and safety challenge, as well as a criminal justice concern.
- The *Code of Virginia* §32.1-283.3 encourages the formation of domestic violence fatality review teams, and gives statutory confidentiality protection to DVFRT work.
- Fatality review is a case-specific, multidisciplinary evaluation of the events leading up to a fatal domestic violence death. It does not seek to reinvestigate a case, nor to place blame.
- Fatality review brings community members together. Multidisciplinary teams work together to identify the strengths and challenges of the domestic violence response system in their community.
- In the process of reviewing cases and analyzing system responses, team members gain a better understanding of the roles, policies, and practices of other community agencies and organizations. This enhances the understanding, collaboration, and cooperation among domestic violence service providers.
- In developing recommendations to improve the community's domestic violence response, fatality review enhances victim safety and perpetrator accountability, and keeps communities safer.

Obtaining Passage of a Governmental Resolution

The process of obtaining a formal resolution, as well as the wording of the resolution itself, varies greatly. Generally, initial contact is made with the city or county manager. In some areas, it may be necessary to get an action item or agenda item on a governmental meeting schedule.

Prior to formal submission of the team's resolution, we recommend vetting a final draft with important stakeholders or governmental officials. Like vetting the *Mission Statement*, this gives the team outside feedback and support before seeking formal approval. Regional teams are encouraged to seek the approval of critical stakeholders from each jurisdiction— especially if there is any existing friction between localities.

DEVELOP TEAM PROTOCOL

The *Team Protocol* is a collection of policies and procedures that provide guidelines for case review, as well as overall team functioning. While the breadth of these policies and procedures varies between teams, it is important that these policies and procedures are developed in a thoughtful and thorough manner, as they will direct how the team is to work, and establish working principles for all team members.

A team's policies and procedures, like its *Mission Statement*, need not be static. As the team gains experience, the needs and goals may change, and we recommend DVFRTs periodically review and re-evaluate all aspects of team functioning, including membership, orientation/training, case selection, data collection forms, group dynamics). Regional teams, who may have more members and therefore more potential for turnover or change, might find this review process especially useful.

The following outline summarizes the basic structure of the team protocol, as well as some of the important issues a team must address in developing their team protocol.

I. Mission Statement
II. Purpose Statement
III. Team Membership
    - What structure do we want for our team (e.g. chairperson, co-chair, recorder, and facilitator)?
    - What roles and functions do we need in order to accomplish our reviews?
    - Who facilitates the meetings?
    - Who coordinates record collection?
    - Who coordinates the administrative function and other work of the team?
IV. Membership Rules and Responsibilities
    - Will there be membership terms for team members?
    - What are the attendance requirements for team members?
    - What if a member resigns or has to be removed?
V. Case Identification and Selection
    - How are cases identified?
    - Who/what guides the selection of appropriate cases?
    - What is our case selection criteria (e.g., homicide, homicide-suicides, suicides, associated homicides)?
VI. Notification, Record Collection and Case Review Preparation
    - How do we notify team members of upcoming cases for review?
    - How do we obtain the documents we need?
    - How will case information be summarized/prepared for team meetings?
VII. Team Case Review
    - How do team members present relevant information?
    - What are case timelines and how will the team develop timelines?
    - How will the team complete system assessments?
    - What information will we record for each case?

VIII. Case Review Confidentiality
- How will we ensure each team member is aware of his or her individual and agency responsibilities regarding confidentiality?
- Who stores the records and how are they kept confidential?
- What are statutory requirements and protections for team members and their agencies?
- How do we encourage reluctant team members to share case-specific information?

IX. Team Recommendation Process
- How will the team develop the recommendations?
- Will the team develop a recommendation-development subcommittee?

X. Data Development and Promulgation
- How often will the team plan to release reports?
- How will the team publish and distribute the findings and recommendations for our reviews?
- What is the team's media strategy for releasing reports?
- Who represents the team to the community and/or the media?

XI. Reporting Requirements
- What are the statutory requirements for reporting team findings?

Invite Full Team

Identifying appropriate team members is a critical task for the *Team Coordinator* and *Core Group*. With a solid knowledge of community systems and politics, the *Core Group* should be able to select—and enlist the early support of—the agencies most directly involved with domestic violence fatality cases. Local law enforcement and the Office of the Commonwealth's Attorney are generally prominent and powerful community agencies. They are also the agencies most directly involved with the investigation of death events, and can therefore guide the team in identifying which cases to review. In all cases of homicide, law enforcement conducts an investigation into the circumstances of the fatal event. In most cases, the Commonwealth's Attorney will pursue prosecution and compile additional critical information such as a psychological evaluation, presentence report, witness testimony, and victim impact testimony. All of this information is vital to successful case selection and review. Many teams report that having the early support and participation of at least one of these agencies is critical to successful team formation and case review.

INVITE FULL TEAM

We recommend that the larger *Full Team* be multidisciplinary, and inclusive of all systems involved with both victims and perpetrators, and diverse with respect to ethnicity, race, and gender. Ideal team members are seasoned, mature professionals with a solid background in domestic violence who can best facilitate policy and procedural change. Each team member will become the spokesperson for—and potential agent of change within—their own agency. Understanding their agency's general policies and procedures, as well as its involvement in case-specific facts, is vital. Some key considerations when selecting the right team members include:

- **Able to commit to meeting times**: Consistent member participation is a hallmark for building trust among team members. Meeting times should be consistent and agency representatives should commit to regular attendance, in writing, upon joining the team.

- **Non-defensive**: An open-minded, non-defensive approach to case review promotes the free flow of information and creates an atmosphere for team members to analyze and question agency responses.

- **Experience on the front line**: First-hand experience will provide a needed critical eye toward the availability, consistency, and effectiveness of agency services. These team members will also have knowledge of how agency practice may diverge from agency policy.

- **Able to influence agency policy**: A team member's ability to implement agency changes based on recommendations from the case review (or to garner the attention of decision makers who can) is critical for success in local fatality review.

Be flexible about the composition of your *Core Group* and *Full Team*. Virginia law provides suggestions for, but does not mandate, team membership. We recommend that a team includes professionals from local:

- Adult and Child Protective Services
- Law Enforcement
- Commonwealth's Attorneys
- Community Corrections
- Medical Examiners
- Domestic Violence Programs
- Mental Health
- Health Departments
- Probation and Parole
- Victim/Witness Programs

Best practice suggests that inclusivity be a guiding principle in team formation. Any agencies or organizations that are important to a coordinated community response to domestic violence should be included. Additional group members may include professionals from local:

- Batterer Intervention Programs
- Healthcare/Forensic Nurse Examiners
- Court Clerks/Court Service Units
- Judges/Magistrates
- Criminal Defense/Public Defenders Attorneys
- Substance Abuse Counseling
- Criminologists
- DV Coordinating Councils
- Schools
- Forensic/Pathology
- Faith Leaders

Once the core group identifies prospective agencies or organizations they want to serve on the team, an agency representative is invited through a *Letter of Invitation*. Important elements of the DVFRT letter of invitation include:

- Brief outline of the purpose, principles, and benefits of fatality review
- Brief summary of community domestic violence facts and/or perceived community need
- Reference to any applicable state laws or local ordinances
- Team mission statement
- List of agencies involved (at this point, probably the core group)
- Specific meeting time, place, and purpose

After receiving responses from the *Letters of Invitation*, the *Team Coordinator* and *Core Group* hosts a meeting for team members. This meeting allows members to meet and make introductions, review the status of team formation, and discuss plans for further team and process development. If the *Core Group* has prepared a draft of the team's policies and procedures, these might also be distributed or discussed at this meeting. Formal memorandums of agreement (MOAs) and/or Cooperation and Confidentiality Agreements should be distributed to all team members, to be reviewed and executed by each agency or organization. These agreements can vary in complexity, but should include:

- Agency endorsement of the domestic violence fatality review process and the team *Mission Statement*
- Agency designation of a representative(s) to the team
- Agency agreement to fully participate in the case review process, through regular attendance at meetings and provision of case-specific documentation
- Agency understanding of the rights and responsibilities regarding confidentiality, including applicable state or local law (specific confidentiality agreements are generally executed with individual members in addition to the MOA)

It is important to remember that the representation of different disciplines in the team members will enhance the effectiveness of the team; each member will bring a unique perspective on domestic violence. A wide range of factors such as education, race, gender, religion, socioeconomic status, and sexual orientation can affect these professional and personal perspectives. However, for team members to work together effectively, they must respect each other's differences and find a common ground.

To do this, teams should allocate time to build a solid foundation in the fundamentals of domestic violence, including but not limited the following:

- Local and national domestic violence demographics
- Local and national domestic violence laws
- Local and national domestic violence agencies/resources
- Multicultural competencies
- Lethality Risk Assessment
- Victim Sensitivity
- Perpetrator Accountability
- The Power and Control Wheel

"TO KNOW IS NOT ENOUGH. WE WILL END THE VIOLENCE NOT JUST BY UNDERSTANDING THE EXPERIENCES OF VICTIMS, BUT BY LETTING THAT UNDERSTANDING TRANSFORM OUR WORK AND OUR LIVES. WHEN OUR KNOWLEDGE IS MET WITH COMPASSION FOR VICTIMS' LIVES AND A POWERFUL SENSE OF OUR COLLECTIVE RESPONSIBILITY, WE CAN TRANSFORM THE CONDITIONS THAT ALLOW ABUSE TO THRIVE."

– WASHINGTON STATE COALITION AGAINST DOMESTIC VIOLENCE

TEAM ROLES AND TITLES

While the agencies or organizations that comprise a team are often similar, the structure of DVFRTs varies tremendously depending on the locality. Each team should work with their own unique community resources, considerations, and needs to develop their team structure. Listed below is a summary of common titles and roles in a fatality review team:

- CHAIR: The Chair is often an influential, powerful community domestic violence stakeholder. They may be an honorary member who enhances the credibility, prestige or effectiveness of the team, but may not be actively involved in the day-to-day team functioning. Alternatively, the Chair may be the person who leads the team in many senses of the word: guiding and inspiring members, running meetings, selecting cases to review, handling correspondence, and speaking to the media.

  If two members wish to share responsibilities, the team may appoint both as Co-Chairs. A Co-Chair structure can work well for single or multijurisdictional teams. Regional teams, who represent multiple jurisdictions, might find that Co-Chairs who represent different jurisdictions might give the team an even greater sense of unity.

- CO-CHAIR: The Co-Chair is the partner of the Chair and shares responsibilities. Their division of labor may be based on many issues such as schedules and availability, personality and/or professional strengths, or team rapport. Sometimes the Co-Chair serves as a back up to the Chair, filling in when s/he is not available or when the workload increases. If both Chair and co-Chair are serving in an honorary capacity, a strong Coordinator will be needed to keep the team running smoothly.

- **COORDINATOR**: The Team Coordinator organizes and orchestrates the meeting-to-meeting functioning of the team. If the Chair does not have a hands-on administrative approach, then the Coordinator usually serves in this capacity. They might manage everything from team correspondence to case selection. If the Chair handles some but not all of the administrative duties of the team, the coordinator might serve as a back-up or have designated duties such as handling team correspondence or compiling case information prior to team review.

  In some cases, the Coordinator might be the true "heart" of the team. They may have been the driving force in forming the team, but for practical and/or political purposes, an honorary Chair (s) was appointed. In this sense, depending on the commitment of the Chair(s), the Coordinator might also be the team leader, encouraging and motivating team participation with the blessing of the Chair.

- **RECORDER**: A fatality review team brings together people, facts, and documents in their case review process. It is recommended to have a dedicated Recorder, as having one person designated for this function tends to make data collection more efficient and organized, and allows other team members to focus on discussing and synthesizing the case rather than on note-taking. A Recorder may be responsible for keeping team attendance records, for recording case review facts during a meeting, for creating case timeline documentation, and/or for keeping minutes of team meetings.

- **SPOKESPERSON/COMMUNICATIONS COORDINATOR**: As a change agent in Virginia, teams are responsible for sharing their findings with the community. To do so, teams should appoint one or two members to serve as press contacts, and be responsible for actively engaging with local media. While the team can collectively develop key messaging and talking points, the individual in this role should be familiar and comfortable working with both traditional and social media.

- **MEMBER**: Fatality review team members are part of a challenging and dynamic process. Everyone is asked to participate—to contribute relevant case facts when possible, to help clarify case circumstances, to educate the team about agency roles, to participate in group discussions and consensus, and to help develop team findings and recommendations. There are often two types of members: permanent members, and ad-hoc or case-specific members.

  - *Permanent members* join the team for a specified period of time outlined in the policies and procedures. These members, and/or the agency they represent, sign a team MOA and/or Confidentiality Agreement and are considered a permanent— and vital—part of the team.

  - *Ad-hoc or Case-Specific members* are temporary visiting members of the team. They are professionals who are asked to attend a team meeting(s) because of their particular expertise and/or because they have had direct involvement with a case under review. Like permanent members, ad-hoc members must sign a confidentiality agreement and follow the general guidelines of the team's case review process.

Team structure is not static and will likely evolve over time. Appropriate team roles may change due to many factors: changing personnel/membership, division of labor, personality issues, political considerations, etc. Teams should decide if, like other policies and procedures, team structure and roles are open to membership review, feedback, and possible change. Best practices suggest teams perform periodic evaluations of all aspects of their team functioning—including team structure, policies and procedures, member satisfaction, and the efficacy of their findings and recommendations.

MEMBERSHIP RULES AND RESPONSIBILITIES

Teams should be clear in their expectations about membership. The Team Protocol should specify the rules and responsibilities of each team member, and each member should review and agree to these policies. Key responsibilities outlined in the Team Protocol should include the following:

- **Terms**: Membership rules and responsibilities address how long a member is expected to serve on the team. Some teams require that members serve a minimum one year term; others two years or more. Some teams have staggered terms, especially for *Core Team* members, to ensure continuity of leadership and institutional memory.

- **Attendance and substitution**: Members are expected to attend all case review meetings. In the event that a member cannot make a meeting, rules should be in place regarding notification requirements. Chronic absenteeism can disrupt the cohesion and productivity of a team. Teams should specify rules regarding absenteeism.

- **Training**: Members—especially new members—need training on the process of fatality review; teams should plan and provide for this, and the OCME can provide additional training and technical assistance. The following is a suggested summary of what to include in member orientation:
    - Introduction to other team members/agencies
    - Team's written policies and procedures
    - Background information on local/state domestic violence issues
    - Background information on local/state fatality review, including pertinent sections from the *Code of Virginia*
    - Confidentiality information including the relevant *Code of Virginia* and team policies/ documents
    - Examples of other localities' or states' domestic violence fatality review findings and recommendations and/or final reports
    - Notification of relevant community/professional training seminars
    - Systems Assessment paradigm

CONFIDENTIALITY

Confidentiality is the assurance that sensitive information is never shared beyond the team, and is truly one of the cornerstones of fatality review. Meeting participants should maintain confidentiality both inside and outside of team meetings, including all information shared by presenters and all team discussions related to case review. Upholding confidentiality fosters trust among team members, which allows for more candid and informative discussions.

There are multiple levels of confidentiality to be respected and maintained at all times:

- **Team Confidentiality**: All team activities (including discussions and sharing of documents) related to case review are strictly confidential and cannot be discussed with anyone outside the team. The only exception is in the dissemination of team findings, which must be published in aggregate or other form that protects the identity of individuals.
- **Agency Confidentiality**: All agency/organization facts and documents relevant to a case review are to be kept strictly confidential. Upon the conclusion of case review, all case-specific documents are returned to the originating agency or destroyed. While fatality review is a protected process in Virginia, team members are each responsible for understanding and following their agency-specific confidentiality rules when gathering or presenting relevant case documents and histories.
- **Member Confidentiality**: Team members cannot share or discuss confidential information with anyone outside DVFRT meetings. Many teams require members to sign a continuing confidentiality statement at each meeting. This serves as a useful reminder of the full confidentiality agreements already executed, and helps to ensure that all members (including visitors or ad-hoc members) are participating under current agreements.

  For some team members, in addition to agency confidentiality rules, they have professional confidentiality privileges. In such cases, team members should seek agency counsel to determine their ability to share case information.

To support and facilitate this process, the Virginia legislature enacted §32.1-283.3 of the *Code of Virginia*. This statutory framework outlines the confidentiality protections—and responsibilities—of a DVFRT. Team members and agencies must understand and honor these provisions, as well as those outlined in team-specific policies and procedures. Virginia law requires the execution of a sworn statement to honor confidentiality for all persons attending a closed team meeting. Each individual team member, as a representative of their agency/organization, must sign confidentiality agreements. Additionally, at the beginning of each case review and/or each meeting, we recommend team members sign an additional confidentiality agreement. This serves as a reaffirmation of each member's confidentiality responsibilities.

FOUNDATIONS OF HIGH-PERFORMING TEAMS

While there is no single way to ensure a team will be successful, developing a process built on mutual respect, shared valued, and transparency is essential. Regardless of the type of team, common themes of successful teams include:

- Shared vision, mission, and values
- Realistic goals that are tied to achievable outcomes
- Established ways of working and expectations
- Defined roles and responsibilities of each member
- Invested and motivated team members
- Purposeful leaders who actively listen and are willing to adapt and change when necessary

SECTION

2

CONDUCTING CASE REVIEW

Case review is a powerful process because it brings together case-specific facts and experienced domestic violence stakeholders who can contextualize and effectively analyze those facts. This process creates a unified forum for shared ideas and critical thinking, and is a vital link in improving a community's coordinated response to domestic violence.

This section details the process of case review. It is important to note that the process and practice of case review will vary among teams. Depending on their needs, goals, and resources, each team will decide what specific documents and procedures work best for them. There are many commonalities, however, in the basic principles, process, and chronology of case review.

- Case identification and selection
- Case notification and information request
- Collection of case facts
- Organization of case facts
- Collective team discussion, analysis, and documentation

Case Identification and Selection

While the expansion of the statute enabling fatality review allows teams to review any manner of death, teams should consider their capacity and resources, as well as the characteristics of their community when determining which types of cases to review. Virginia DVFRTs have the responsibility to identify and respond to the problem of domestic violence in whichever way that manifests in their community. Ideally, each DVFRT conducts an exhaustive review of all deaths related to domestic violence in their community; however, many teams face limited time and resources. To maximize the ability of DVFRTs to provide insights and improvements to the local response system, teams may consider the following ways to focus their review.

- **How Many?** The number of domestic violence related deaths occurring in the team's jurisdiction every year may help determine your Team's scope of review. Data on family and intimate partner homicides and suicides specific to a locality or region are available by request from the OCME. These data from the Family and Intimate Partner Homicide Surveillance Project and the Virginia Violent Death Reporting System can assist communities in getting a more complete portrait of their unique experience of fatal violence.

  For a community with relatively few deaths each year, it may be feasible for even a small team that meets quarterly to review every eligible death as it occurs. For a community with especially small numbers, the team may be convened as needed when a case becomes available for review.

  If a community experiences a large number of fatalities, or the team is small and/or meets infrequently, it may not be practical to review all eligible cases. In this case, the team should make a strategic decision about which cases are reviewed by the team.

- **What are your priorities?** Many Virginia DVFRTs limit their review to intimate partner homicides. This is a logical place to begin a review, since intimate partner homicides accounted for roughly half of all domestic violence related homicides in Virginia. Some teams also choose to focus on fatalities involving intimate partner violence because that issue is a priority to their community stakeholders and/or because there are existing systems and services which can respond to team findings and recommendations. The greater availability of domestic violence resources, services, and research that are specific to intimate partner violence creates an opportunity for DVFRTs focusing on intimate partner violence-related deaths to guide how such resources and information are used in their community for the greatest impact.

  Most teams also prioritize fatal violence that occurs directly between family members or intimate partners before extending their review to associated violence that may involve bystanders and other victims who are third parties to the relationship. Similar to the availability of resources specific to intimate partner violence, prevention and response mechanisms tend more often to focus directly on interpersonal violence than on bystander safety or other issues that are unique to domestic violence associated fatalities. Teams may also prioritize violent death cases before reviewing cases involving natural, accidental, or undetermined causes, especially if identifying such cases proves difficult for the team.

- **Where and when to start?** An understanding of current law and procedure impacting the community response to domestic violence and how those have changed or been updated over time may also help your team narrow its focus or find its starting place. For example, some teams have chosen to limit their review to cases that occurred after mandatory arrest laws were passed in Virginia.

  Often, a prominent case will spark the formation of a new team and serve as the catalyst for determining the team's focus. Wherever your team may start, consider how far back in time the review should reach. The most important consideration in retrospective case review is the relevance of the team's recommendations when they are based on events from the past.

Whichever criteria your Team uses to determine the types of cases it will review, the relevance of your team's findings and recommendations will be impacted by any apparent bias in your case selection strategy. To avoid "cherry picking" cases, such as those that received a lot of media attention or were prosecuted, choose a time period and case type(s) that are relevant and manageable for your team then review all eligible cases that fit those criteria.

Case Notification and Information Request

Team members are notified in writing of case selection. For privacy purposes many teams recommend that notification be made by U.S. mail or hand-delivered. Team members should be provided with critical case identifiers such as the names of the victim and perpetrator (including aliases), birth dates, date of death, as well as a brief description of the fatal event. This process will be the same for both permanent and ad-hoc team members.

Collection of Case Facts

Case review involves the careful examination of events that led to a domestic violence fatality. It begins with the collection of case facts gathered from all relevant community agencies and organizations, such as:

- Demographic information for the victim and perpetrator (e.g., age, gender, race, employment status, education, and income level)
- Location of the fatal event
- Relationship of the parties involved in the fatal event
- Cause of death
- Lethality indicators
- Community services requested, received or refused by the victim or perpetrator

Well-researched case facts enable the team to create a comprehensive picture of the fatal event. Members are responsible for gathering all pertinent facts, documents, and background information from their respective agencies. Their efforts in this regard can make or break a successful case review. The following, adapted from an information source list compiled by the National Council of Juvenile and Family Court Judges,[2] are useful information sources for team review.

- Adoption records
- Animal control reports
- Autopsy/Medical Examiner reports
- Batterer Intervention Program reports
- Child Protective Services records
- Child support records
- Court files: all cases including criminal, civil, family and juvenile
- Court advocate records
- Domestic violence/shelter service records
- Employment records
- Faith community interviews
- Family history genograms: including family violence
- Former intimate partner interviews
- Housing/landlord records: including maintenance records, neighbor complaints
- Insurance policies
- Juvenile records
- Law enforcement reports- all incident reports and call history, 911 tapes
- Marriage counseling records
- Medical/dental records: including photographs, diagrams if available
- Medical provider interviews
- Mental health records
- Military records
- National Crime Information Center (NCIC) or criminal history records

2. McHardy, L.W., Hofford, M. (1999). *Domestic Violence Fatality Review: Recommendations from a National Summit.*

- Pre-trial service records
- Prosecution record
- School records
- Security guard interviews
- Service records from other communities
- Social Media (Facebook, Instagram, Twitter, etc.)
- Social service records
- Suicide intervention reports
- Victim advocate records
- Weapons records

In addition to providing an agency's case-specific facts, members are expected to provide the team with a contextual understanding of this data. They are responsible for interpreting for the team, as thoroughly as possible, the actions of their agency or organization. Without this information, a team cannot create—or effectively analyze—a comprehensive picture of the fatality.

Organization of Case Facts

In order to effectively evaluate the community's coordinated response and develop recommendations, the case review process should include the development of a case chronology or timeline. Timelines are an effective way of organizing case facts from various agencies and organizations. A timeline is a summarized listing of the events leading up to a fatality, including the date, agency, and incident. While the timeline should detail any known agency involvement, it should not identify individual service providers who interacted with the victim.

Collective Team Discussion and Analysis

Once the team has presented, reconciled, and compiled all case facts, the collective work of discussing and analyzing the case begins. Using the timeline developed by the team, the team will review each incident and identify where the community could have stepped in and how the system response could have been stronger. Additionally, the team will document their findings and preliminary recommendations in a team-specific case review information tool. With a strong, multidisciplinary team, members are able to provide various perspectives, which can identify an array of gaps in services and offer unique, meaningful solutions to filling these gaps.

Guiding team discussions

Each agency or organization brings to the table key case information from a wide range of disciplines. While the information they bring is vital, so too is the coming together of the service providers themselves. This joining of information and stakeholders creates the most comprehensive picture possible of the life and death of a domestic violence victim. Through this process, teams have the unique opportunity to apply critical thinking to examine the complexities of domestic violence and of their system response. At the heart of the discussion, teams will identify issues and answer the question, "*Why did this individual(s) die?"*

Below are further questions to consider in guiding the team's discussion and analysis:

- **Was the depth and breadth of the death investigation appropriate?**
  - Discuss what steps each investigating agency took during their investigation.
  - Did case records include an appropriate amount of information?
  - Was the death investigation collaborative?
  - Was the death investigation thorough?

- **What were the gaps in services and system response?**
  - Did the individual and relevant family members receive necessary services prior to this death? If not, what services should have been offered?
  - Were culturally responsive and inclusive services available to the individual or family prior to this death? If not, what culturally responsive and inclusive services should have been offered?
  - What services are lacking in our community?
  - Was there adequate collaboration and communication among agencies?

- **What could improve the response in order to prevent another fatality?**
  - What changes in behaviors, technologies, agency systems and/or laws could minimize the identified risk factors and prevent another death?
  - Do agencies need to provide trainings on specific topics for staff to better address the community's needs?
  - Did mandated reporters operate as required?
  - Would awareness and education for community members have improved the outcome?

GUIDING TEAM DISCUSSIONS

- **Who should have engaged with this individual/family along the way but did not?**
  - Did this individual and family receive appropriate referrals?
  - Were there barriers to receiving services for the child or family?

- **What recommendations could ensure a more robust domestic violence safety net?**
  - What are our best recommendations to address the identified gaps?
  - Who should take the lead on implementing each recommendation?
  - Are there evidence-based interventions that could have been effective in this situation that were not available?

PREVENTABILITY

After case review is complete, the team should collectively discuss and answer the question:

With the benefit of retrospective analysis, could a reasonable intervention have prevented this death? If yes, how? If no, why not?

This discussion is critical to successful fatality review because it generates potential interventions that might have altered the outcome. Again, the variety of professionals on the team will and should see the answer to these questions in different ways. The team's determination of preventability is determined using a consensus decision-making process rather than a vote.

CONSENSUS PROCESS

Why is a consensus process preferable for fatality review teams?

While voting creates winners and losers and emphasizes a quantitative rather than a qualitative method of decision-making, consensus decision-making encourages group members to discuss and work through differences to reach a mutually agreed upon position. Voting can destabilize and undermine the integrity of a group decision. People leave the meeting not accepting the group decision and are less apt to support the recommendation. Voting can generate lobbying and coalition building among group members instead of fostering collaboration.

In contrast, a consensus process allows for full and complete discussion. Consensus does not assume that all persons in the group hold the same opinion or reach complete agreement, but it does assume the fundamental right for all group members to express themselves in their own words. Members must take responsibility to listen and genuinely hear what others say. This allows the team to speak with one voice. This back-and-forth dialogue is also important when developing recommendations.

Avoid immediately going with the majority, but instead attempt to get the members in the minority to be comfortable agreeing with the others. If the team cannot reach a consensus, choose the "Team could not determine" option on the data collection tool.

Interventions

Using a consensus-decision making process, if the team determines the death was preventable,

Discuss:

- What data-informed interventions existed that if accessed could have prevented this death?
- Are effective interventions currently in place that could expand to serve a larger population?
- What interventions should exist that could prevent future deaths?
- What else could save an individual in similar circumstances?

Identify:

- Strengths and weaknesses in current systems that did or did not respond.
- Evidence-based programs that would address gaps in services and system response.
- Could legislative or policy change address any of the areas noted to need improvement?

At the end of the case review, the *Team Recorder* should read back the ideas for intervention and prevention that they captured during discussion.

- Did the recorder capture all team members' ideas?
- Do any members wish to elaborate or provide additional details for intervention/prevention?

These ideas for intervention and prevention will later become the basis for developing the Team's recommendations.

Completion of a Case Review Information Tool

Throughout the rich team analysis of the case facts and evaluation of the system response, the *Team Recorder* will be documenting the case review process in the team's case review information tool. Completing a case review information tool is a critical element in the analysis and documentation of a case. While each team should work to develop their jurisdiction-specific tool, generally, the tool should include two sections: case facts and systems assessment.

The case facts portion of the tool documents detailed information about the victim and perpetrator, about the fatal event, and about relevant case histories. It serves as a critical baseline for the team's quantitative case review reporting. We recommend that this form be as specific and close-ended as possible, especially for a newer team less familiar with the case review process.

The systems assessment portion of the tool, evaluates a variety of individual and community-level factors that may have directly or indirectly contributed to mortality, as well as a space where teams record case-specific recommendations and areas for improvement in the systems response. As such, this portion of the tool is qualitative, and captures team member's responses to the discussion questions highlighted above. While the information tool can serve as record keeping and data collection tool, it can also help streamline the findings and recommendations process, where the aggregate information is tabulated and analyzed.

GUIDANCE FOR CONDUCTING VIRTUAL CASE REVIEW

In exceptional circumstances, including pandemics and natural disasters, that make it difficult to convene meetings in-person, virtual meeting platforms may be considered. Although it may be different than in-person meetings, there are advantages to conducting meetings virtually, such as geographic flexibility and cost-effectiveness.

Many virtual platform options exist that can be utilized to conduct review meetings, such as Zoom, WebEx, Microsoft Teams, or Google Meet. The choice of platform can be left up to the team leaders to decide; however, there are best practices to consider to effectively implement and to preserve the confidentiality of conducting virtual review meetings.

- **Pre-registration & Password.** Consider having your team members pre-register for the meeting, rather than creating a public link to the meeting. This adds an extra layer of security, and lets the hosts know who will be able to attend the meeting, so that only attending participants will receive meeting materials.
- **Waiting room**. Having a waiting room for participants prevents them from joining the meeting before the host is able to start the meeting. This will allow the host to see who has joined to let them into the meeting individually.
- **Using 'mute'**. Have participants muted upon entry to help control people from speaking over each other at the outset of the meeting. Reminding everyone to keep their audio muted except to speak will also prevent participants from speaking over each other.
- **Webcam etiquette**. Given that many participants may join the meeting from their home, it is not necessary to mandate participants to turn on their webcams. Be mindful of everyone's privacy and allow participants to be comfortable in sharing their video or not.
- **Disabling chat**. When dealing with many participants in a meeting, it may be harder to monitor the chat. Consider disabling the chat feature, and instead use hand-raising feature, if available, to help facilitate the conversation and prevent participants from talking over each other.
- **Breakout rooms.** If the virtual platform allows and depending how cases are normally discussed, you might consider using breakout rooms to split the team to discuss the case and bringing everyone back to the larger group for feedback and consensus-building. Using breakout rooms may make the discussion manageable and allow all team members the opportunity to speak within a virtual environment.
- **Polls**. Because it is important to build consensus within the team when reviewing a case, you may consider setting up anonymous polls for each case. This allows the facilitator to gauge the thought process of the team, and allow members who did not have a chance to speak to provide their opinions.
- **Confidentiality**. As confidentiality is a cornerstone of fatality reviews due to sensitive and confidential materials related to the victim, it is important that confidentiality is maintained in a virtual environment. As such, be sure to remind participants to join the meeting in a secure space where the screen is not left for other viewers to see. In addition, be mindful of which case files can be shared with participants. Unfortunately, this may mean being unable to share files or photos that you would have been able to present in an in-person meeting.

SECTION

3

DEVELOPING RECOMMENDATIONS

A team's findings and recommendations are the critical link between their confidential process of case review and the de-identified sharing of results from that process with the community. Findings and recommendations together represent the collective analysis and wisdom of the team. This section will reinforce what recommendations are, their structure, and how to develop them.

Organization and Standardization of Aggregate Data

While the team will develop individual case findings and recommendations during every review, the aggregate form will serve as the basis for team recommendations. Teams may choose to organize their case-specific facts into aggregate form after reviewing a certain number of cases (e.g. ten cases), or after a predetermined length of time (e.g. one year). In order to streamline the process, teams should maintain a centralized database, through either Excel, Access, REDCap, or SPSS, which mirrors the variables from the team's case review information tool, and acts as a master list for all fatal incidents reviewed. The specific types of analyses the team is able to run will depend on the variables included in the case review tool; however, all teams should be able to capture summary counts with percentage breakdowns for any quantitative variables. Analysis of the number and percentage of occurrences described in the aggregate form will provide answers to the following questions:

- What types of fatal domestic violence is the local community experiencing?
- What are the sociodemographic (age, gender, race, marital status) profiles of the victims and perpetrators?
- What types of fatal agents (e.g. firearm, knife, body part) was used in the fatal incident?
- What risk factors were present prior to the fatal incident?
- What services were requested, received, or refused by the victim or perpetrator?
- What agencies were not involved but needed to be?

Additionally, teams should work together to identify intra-community challenges and themes and observations during the review, which will provide qualitative information.[3] Examination of all aggregate data provides information on trends and patterns contributing to mortality. Analyzing which factors are present and which are absent is critical. Further, teams can then assess which group of factors was cited most frequently as contributing to mortality, and which individual factor within that group was most often a contributing factor.

Writing Effective Recommendations

By developing data-driven and supported recommendations, teams can develop a robust and relevant action plan to address critical challenges and weakness identified in the review process. Further, effective recommendations should target direct and indirect contributors to mortality, and challenge team members to think outside the limits of current agency practices, as the team's recommendations are ideas for change. Remember that the team has identified gaps in the current system so do not be afraid to offer recommendations that improve upon current practice.

3. Maryland State Child Fatality Review Team. (2012). *Guidelines for Local Case Review.*

KEY QUESTIONS FOR DEVELOPING RECOMMENDATIONS

The purpose of team recommendations is to make a discernible improvement in the local community response to domestic violence, so ask the following questions when developing team recommendations:

- Will the recommendation be effective in reducing the identified risks?
- Are potential improvements roughly proportional to the impact of the change required?
- Is the recommendation objective, balanced, and free from judgement?
- Is the recommendation evidence-based and data-driven?
- Is the recommendation reasonably practical?
- Does the recommendation introduce risks in another area, or could it have unintended consequences?
- Is the recommendation sustainable?

WRITING S.M.A.R.T.I.E. RECOMMENDATIONS

S.M.A.R.T.I.E.[4] is an acronym that guides the development of measurable goals. While traditionally referred to as S.M.A.R.T. goals, as teams serve as local agents of change, it is critical that equity and inclusion are core values of the team, and are included in the work of the team. To assess if recommendations are S.M.A.R.T.I.E, teams should consider:

- **Specific** – *Who? (Target population and Activity Implementers) and What? (The Action or Activity)*
  - The recommendation should provide the 'who' and 'what' of the change, you want to see in your community.
  - The recommendation should be simplistically written and clearly define what you are going to do, and who will be responsible for the implementation.
  - Use only one action verb, and make sure they are clearly measurable, avoiding ambiguous verbs like "know" or "understand."
- **Measureable** – *How much change is expected?*
  - The recommendations should quantify the amount of change expected.
  - Used for planning and evaluation purposes, and provides tangible evidence that you have accomplished the goal.
- **Achievable** – *Can the desired outcome be accomplished given the available resources?*
  - The recommendations should feel challenging, but defined well enough so that it is achievable.
  - Constraints (time, funding, available resources, staff capacity) should be taken into consideration, and recommendations should be set accordingly.
- **Relevant** – *Is the desired outcome realistic and achievable, but also consistent with the findings from the team's review?*
  - Consider if and how completing an objective will be relevant to achieving the overall goal.
  - Recommendations are more effective when they accurately address the scope of the problem in the community, and have defined steps that can be implemented within a specific period.
- **Time-bound** – *By when will the desired outcome be met?*
  - Creates a sense of urgency and a timeline for completion and evaluation.
- **Inclusive** – *Does your desired outcome include all persons, particularly those who are traditionally marginalized?*
  - Brings traditionally marginalized people—particularly those most impacted—into processes, activities, and decision/policy-making in a way that shares power.

4. The Management Center. (2019). *SMARTIE Goals Worksheet.*

- **Equitable** – *Does your desired outcome address systemic injustice and inequities?*
  - It includes an element of fairness or justice that seeks to address systemic injustice, inequity, or oppression.

Focus on Prevention

While recommendations will focus on both internal changes within individual agencies, as well as external changes addressing system-wide challenges, all recommendations should be prevention-focused, with the overall goal of reducing future fatal domestic violence. To this end, recommendations should address all levels of prevention: primary, secondary and tertiary.

- **Primary** — Primary prevention is any action, strategy, or policy that prevents domestic violence from initially occurring. It goes beyond awareness raising and works to promote behaviors we want to see adopted. Further, primary prevention seeks to reduce the overall likelihood that anyone in the general population would ever become a victim or perpetrator by creating conditions that make violence less likely to occur.
  - EXAMPLE: Implementation of the Center for Disease Control's teen dating violence prevention program, DatingMatters®.

- **Secondary** — Secondary prevention is intervening and responding to violence that has already occurred in order to stop repeat violence.
  - EXAMPLE: Shelter, counseling, legal and medical advocacy, safety planning, Protective Orders.

- **Tertiary** — Tertiary prevention aims to lessen the long-term consequences of domestic violence, and focuses on ongoing support to victims and ongoing accountability for perpetrators.
  - EXAMPLE: Support groups for survivors, Batterer Intervention Programs

While recommendations will call for improved intervention services for individuals and families currently experiencing domestic violence, teams should also implement prevention-focused recommendations to address the root causes and conditions that make domestic violence possible in our communities.

"A person experiencing domestic violence today needs help now. Yet without prevention, today's children are at risk of becoming tomorrow's victims."

– Rhode Island Coalition against Domestic Violence

AIMING RECOMMENDATIONS AT MULTIPLE LEVELS

While the promotion of prevention activities is an essential step to supporting the public health mission of fatality review, it is also critical that teams aim their recommendations at multiple levels within the community. To do this, teams should use the Social Ecological Model (SEM), which is a framework used to identify the various social and environmental levels that influence an individual's actions. The SEM Model, as seen in Figure 1, holds that there are multiple factors that influence a person's likelihood to be victims of or perpetrate domestic violence. These four levels are the individual, relationship, community, and societal, and recommendations should target each of these levels.

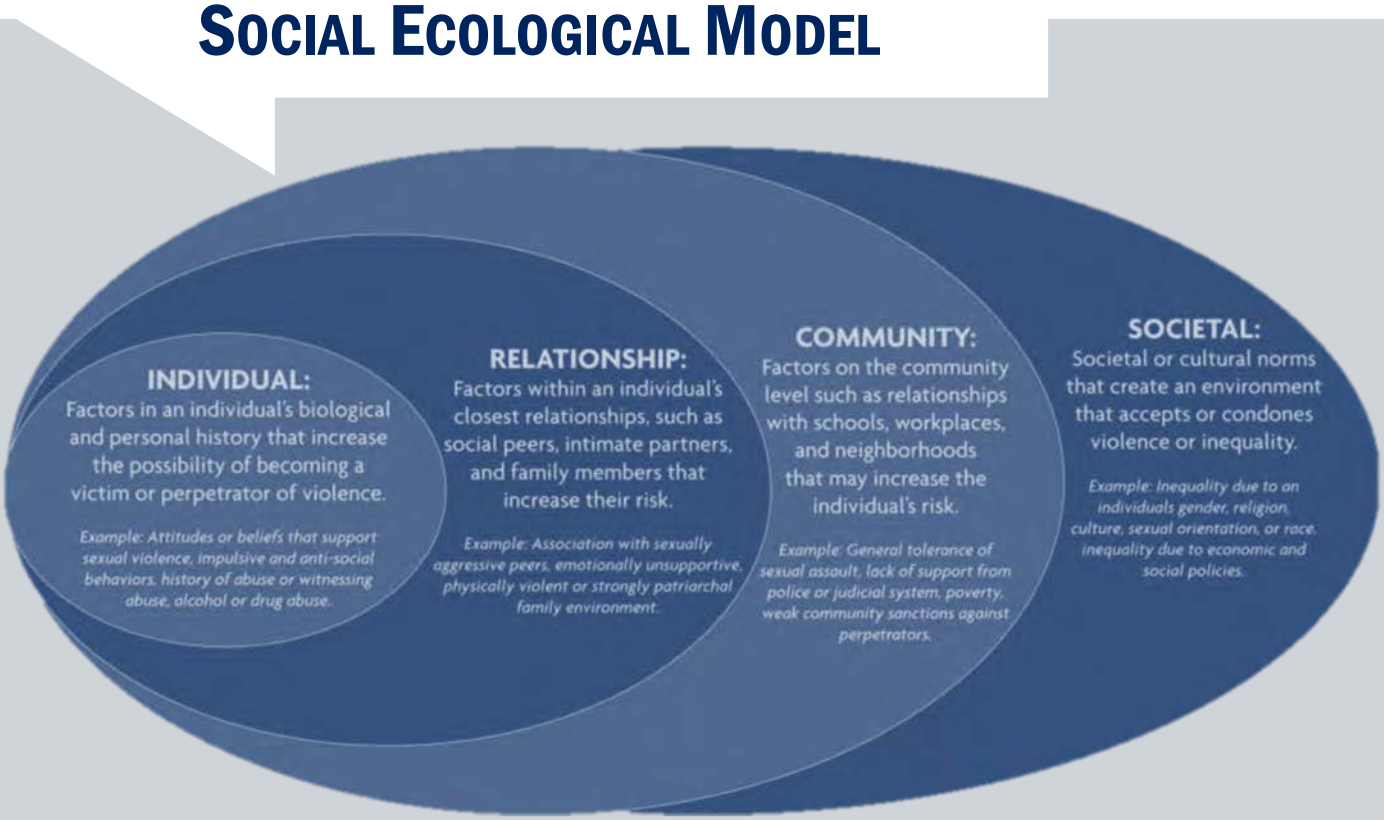

Figure 1: Social Ecological Model Framework Diagram[34]

Examples of prevention activities, aimed at building protective factors include:

- **Individual** – Mentoring and skill-building programs geared towards individuals
- **Relationship** – Family-focused programs: parenting classes, home visitation programs
- **Community** – Community-wide, open dialogues about sexual violence and healthy relationships; Affordable and easy access to resources; Equal opportunity employment; Affordable and equitable housing
- **Societal** – Programs/campaigns aimed at reducing health disparities, inequities, and inequalities; Active bystander response; Practice and respect of affirmative consent; Perpetrator accountability and strong criminal justice system

5. Abuse Counseling & Treatment, Inc. (2018). Prevention.
6. Dahlberg, L.L., Krug, E.G. Violence—A Global Health Problem. In: Krug, E., Dahlberg, L.L., Mercy, J.A., Zwi, A.B., Lozano, R., eds. (2002). *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization: 1-56.

MONITORING AND EVALUATING THE IMPLEMENTATION OF TEAM RECOMMENDATIONS

Monitoring and evaluation (M&E) is widely recognized as an essential element of managing policy improvements and ensuring accountability. While it occurs independently of management processes, implementation of M&E tools can help teams determine the impact they are having in the lives of survivors and at-risk individuals. Additionally, data gathered from M&E activities can provide support for funding requests, including expansion of existing services or development of new services.

There are two types of evaluation that will be useful for teams to implement – process and outcome evaluation. Process evaluation assesses the degree to which your program is operating as intended. While this is often a type of evaluation used by program managers, teams can periodically conduct process evaluations to assess their overall team functionality, and explore ways to improve.

After the team releases their recommendations, outcome evaluation assesses the proximal impact of these recommendations, and looks at what occurred as a result of the recommendations. To conduct this objective-based evaluation method, during the recommendation development stage, teams will create a framework (logic model/logframe, program theory model, and theoretical roadmap) for the recommendation design. This framework will map out the key steps needed to achieve the desired goal, and identify the appropriate indicators that can measure change. While outcome evaluation is an involved process, teams are uniquely poised to conduct this type of critical evaluation given their in-depth knowledge of the recommendation design, and it is the most appropriate evaluation method to assess team impact.

Additionally, we recommend that each time new recommendations are released to the public, the team should also report on the current status of the previous years' recommendations. In doing so, the team reaffirms its commitment to the community and highlights the work already being done by team member agencies and other community organizations. This creates an accountable feedback mechanism, and provides recognition for the transformative impact the team has on the community response to domestic violence.

After the team develops its list of data-driven, prevention-focused recommendations, the focus should be on disseminating the recommendations to the community or communities served by the team's members. These team products can take a variety of forms, but should serve to educate and motivate local stakeholders, and will lead to improvements in the community's coordinated response to domestic violence. These reports, while vital at the local level, also contribute to work done at the state and national level.

SECTION

4

CREATING TEAM PRODUCTS

Planning team Products

In beginning to develop a team product, teams must first decide the purpose and audience of the product. Does the team want to release an annual report for local lawmakers, or an infographic for community members? The team may develop a number of products, in different formats, for different sets of stakeholders, and can include a variety of written materials and presentation materials. Example possible products include:

- Annual Reports
- Interim Reports
- Infographics
- Press releases on team activities
- Newsletters
- Social media campaign
- Conference Presentations
- Website (either through independent webpage or team members' websites
- Posters
- Webinars
- Videos
- Community-wide presentations
- News features (local media stations, newspapers)
- Brochures

Once the purpose and audience of the product is determined, the team should work collectively to develop a concept map of the product, detailing its organization and content. A content map is a visual representation of the substance of the product, with the inter-related components outlined. In creating a visual representation of the product, all team members are able to understand the report on a whole and can easily draft sections independently.

While the type of product will depend on team and community goals and resources, teams must abide by the statutory requirement that no reports disclose the identity of individuals involved in the case. Additionally, each product will want to answer four critical questions:

- *Who is at risk in the community?*
- *What is known about the characteristics of the violence and the relationship of those involved? What are the red flags for domestic violence in our community?*
- *What did the team—in their collective, multidisciplinary wisdom and with the benefit of retrospective review—think and conclude about these deaths?*
- *From these conclusions, how does the team propose to prevent future domestic violence fatalities?*

Writing Collaboratively

Once the team has agreed upon the type and content of the product, teams should consider developing subgroups to write individual sections. Smaller groups can help divide the workload, and ensure the appropriate subject matter experts write the sections of the product. If the team does divide the writing into subgroups, be mindful that all groups are using the same terminology and publication guidelines, and maintaining version control. While teams should trust their subject matter experts, make sure to be mindful of the audience's knowledge and understanding of particular subjects, and push back when groups add unnecessary layers of complexity and threaten to confuse the people with whom you are trying to communicate. Additionally, if using subgroups, each subgroup should keep the full team informed of their progress, and build in time for feedback.

Assign a final editor, who will be responsible for ensuring the product is cohesive and coherent. This editor should be a strong writer, and will have the final approval on language and substance. Given the collaborative nature of this process, conflicts can arise if it is unclear who is in control of this process; thus, assigning editorial control at the onset of the writing process is critical to fostering a strong, collaborative writing process.

The key to successful collaborative writing is determining and planning the content and audience of the product, capturing its substance in a concept map, letting the appropriate team members write specific sections, and giving one-person editorial control. In this way, the team can collectively produce informative and useful products.

Disseminating team products

While the type and audience of team products will vary, for all team products, teams should develop a dissemination plan. This plan will ensure the product reaches the intended audience in an organized and timely manner. While teams have traditionally either mailed their report to lawmakers and policy directors, or distributed printed copies to specific agencies, teams should consider using social media and other online means to distribute their products, thereby, increasing the number of people with access to the team's products.

As part of the dissemination plan, the team should develop and implement a media strategy. While the team's spokesperson will liaise directly with the media and other external stakeholders, the team should work together to develop key talking points and other messaging. The talking points should be clear, concise, and targeted. While the media can be an ally for teams, sometimes data is incorrectly interpreted and reported, and can lead to perpetuation of myths and stereotypes about domestic violence. This can be avoided by building ongoing relationships with local members of the media, educating the media on appropriate ways to discuss and report on domestic violence incidents, and serving a resource for media on local statistics related to domestic violence.

General Tips for Making Team Products Appealing and Accessible

While the purpose of the team products are to share your team's findings and recommendations, they should also illustrate what fatal family violence looks like in the local community, and how the team is actively working to reduce future deaths. If done effectively, this should inspire community stakeholders and change agents to implement the team's recommendations, and catalyze future community action. The following tips will ensure your team's products paint an informative and inspiring picture of the team's hard work and dedication.

1. *Consider all types of readers*

   The way each person will use the team's products will vary, so will the type of content that will speak to each reader – some prefer words and narrative descriptions, and others prefer graphics and images. Accommodate both types of readers by using appropriate fonts and a balanced combination of narrative and graphics.

2. *Reduce your content*

   While each case review will generate a wealth of information, not every piece should be included in the team products. Being concise and succinct will improve readability and understanding. Too much content is confusing and causes readers to lose focus of the recommendations. If your team has a significant amount of data, all of which the team feels is appropriate to share, consider breaking up the data thematically and releasing a series of products. Generally, when the team finishes drafting the product, a rule of thumb is to reduce the content by at least 25% during the copy writing and editing process.

3. *White space is OK*

   Just as too much content included in the entire report can overwhelm the reader, so too can too much content on one page. With a crowded page, there is no focal point for the reader, or no visual map of the change the team is trying to evoke. When this happens, readers skim and miss key points. Having white space on a page is good, as it reduces clutter and draws readers to the most salient points of the team's work.

4. *Avoid standard layouts*

   For your team product to get noticed, be creative and avoid standard 8 ½" x 11" layouts. Use design to make the product's purpose clear, including incorporating informative headings and subheadings and utilizing different typography elements. Headings can serve both the writer and the reader – for the writer, headings can organize your thoughts, and for readers, headings can make it easier for the reader to read and identify the most applicable portions to their needs. Additionally, font, color, and font sizes are all elements of typography, and help highlight the most important points for the reader. Avoiding default fonts can add character to a document, but avoid using more than three fonts as this can be distracting, instead of engaging.

General Tips for Making Team Products Appealing and Accessible

5. *Turn paragraphs into graphics*

   It is important to present team findings in a way that resonates with readers, and often graphics offer a more engaging, memorable, and understandable rather than written data summaries. Depending on what you are trying to convey, different visuals are appropriate. Graphs, charts, infographics, and maps are helpful in illustrating data described in the narrative, and tables are best when trying to convey relationships between two sets of information. Using different chart types can provide variety and make each visual engaging. For all visuals, make sure to include a description of the visual element to provide readers context, and consider annotating charts to provide a deeper understanding of particular points. This is especially helpful if your data has any outliers.

   Additionally, use icons to illustrate and emphasize key statistics within your team's products. Icons are simple vector visuals that convey concepts, and can reinforce statistics in your infographic. Make sure icons are appropriate for the theme of the report or data element, and consider using a contrasting color to for the icon or text to emphasize the particular point.

SECTION

5

SUSTAINING STRONG TEAMS

As with any team project or initiative, fostering a positive and supportive culture amongst team members is essential to ensuring its longevity. A team works most effectively when its team members trust, respect, and feel comfortable with each other. This rapport does not happen overnight, nor is it automatic. It is part of an evolving process that takes effort and nurturing process. While the specific ways teams work through this process, we recommend teams consider the following strategies.

Team Evaluation

There are many strategies to foster a healthy team, but in order to correctly identify needs and areas for improvement; teams must have an evaluation system or feedback process. In doing so, teams should regularly ask, 'how are we doing?' and take time to reflect on progress and learn from what the team is doing. Team members must have the opportunity to voice their ideas and concerns regarding all aspects of team functioning. Allowing time for members to periodically evaluate the team process gives members a strong sense of ownership in the team, encourages honest and valuable group discussion, and may lead to positive changes in policies and procedures. While there are numerous evaluation tools, teams should collectively decide what type of tool or methodology will be most useful for the specific needs of the team, and will continue to foster trust and openness within the team.

Stress management

By its nature, fatality review is difficult work. Case review entails a thorough examination of a fatality and may chronicle a history of violence, conflict, neglect, and abuse. This can be difficult to deal with, especially for individuals who have chosen careers devoted to serving and protecting community members, and can cause secondary traumatic stress or compassion fatigue. To deal with the emotional stress team members may feel teams should have formal policies to support positive coping mechanisms and facilitated, structured opportunities to share emotional reactions. These policies and opportunities should integrate the following:

- Providing continuous awareness of what compassion fatigue is and how to periodically self-assess for it;
- Routinely debrief as a team and "talk out your stress";
- Promote self-care amongst team members, which include healthy eating, regular exercise, and adequate relaxation and sleep;
- Identify local professional resources available to team members needing extra assistance.

Celebrate achievements

Given that participation on a fatality review team is most often voluntary, is it important to take time to acknowledge each members' dedication to the team and community, and to let them know their hard work is appreciated. A letter of thanks, a certificate or award, or publicity that recognizes members' efforts can both motivate and strengthen the team. Additionally, teams should consider holding social functions and special outings (i.e. end of the year celebration) to both thank the team for their work and strengthen team relationships and trust.

Cultural Responsiveness

With the growing diversity of Virginia's communities, it is essential that services for victims of domestic violence are appropriate, accessible, and effective for everyone—regardless of gender, age, ability, sexual orientation, language, race, or ethnicity. Fatality review provides a space to identify and evaluate the influence of cultural factors on the fatal event, and then, develop culturally responsive recommendations. But how can a team be sure they identify and understand the cultural factors relevant in a case?

As with any other organization, a fatality review team can be assessed on whether their practices are culturally responsive and their reviews consider the victim's cultural experiences. There are many tools available to assist an organization in conducting a self-assessment for cultural responsiveness, but none specific to domestic violence fatality review. The *Virginia Domestic Violence Fatality Review Cultural Responsiveness Self-Assessment Tool* provides a series of items allowing team members to consider and discuss the various aspects of their team's capacity for culturally responsive reviews.

The Tool contains 32 items on the above five core team functions (Policies and Procedures; Team Structure and Capacity; Case Review Process; Findings and Recommendations; and Reports and Community Action), and should take no more than 30 minutes to complete. Each team member either on their own time or at a meeting designated for the assessment process should fill out the Tool individually. Team members are not required to put their name on their assessment, providing the opportunity for honest observations about the team.

The Tool can be completed by itself, or along with other assessment strategies such as focus groups, community surveys, and key-informant interviews. The results are collected and shared in a nonjudgmental way, carried out in the spirit of providing feedback for improving capacity for culturally responsive services to their community.

Cultural responsiveness is an ongoing process that requires commitment and continued self-assessment. This self-assessment process can be repeated as needed. Ideally, your team will re-visit the tool and the process as you learn about community needs through review, data collection, and discussion. Routine reflection on the cultural issues relevant to your community and to your team will improve team functioning, and ultimately the effectiveness of your work to prevent fatal domestic violence.

Maintaining a Team in a Virtual Setting

If using a virtual environment to conduct reviews (See Section 2), an important aspect of review meetings is to maintain a positive and supportive culture among team members. Distance from each other presents its own challenges, as it may affect the ability to build off each other, or observe nuances in body language, which may hinder the team from focusing on the victim's experience and circumstances leading to the fatal injury. Reiterating the goal of the team and adequate facilitation will be important in a virtual setting. For existing teams that are transferring to the virtual setting, if existing foundations of the review practice are in place, adaptation to a different medium should become relatively straightforward.

Another aspect to keep in mind is to try and incorporate team building activities to maintain trust among members. For example, one idea may be to schedule time for team-building before the meeting occurs, offering a casual setting to help familiarize with each other, 'break the ice', and build rapport. Additionally, ensuring there are mechanisms for feedback loops will also be essential. Check-in with other members to see how the online medium is working and reassess practices if there are aspects of the virtual meeting to be improved, which can be done using post-meeting surveys.

For additional resources, please visit the National Domestic Violence Fatality Review Initiative (NDVFRI) at https://ndvfri.org/.

SECTION

6

REFERENCES AND RESOURCES

Fatality Review

National Domestic Violence Fatality Review Initiative. (2016). *FAQs – National Domestic Violence Fatality Review Initiative*. Retrieved from https://ndvfri.org/about/faqs/.

The National Center for Fatality Review and Prevention. (2018). Retrieved from: https://www.ncfrp.org/

Thompson, Robin H., National Domestic Violence Fatality Review Initiative (2006, Spring). *Evoking Social Change: How Domestic Violence Fatality Team Recommendations Can Make A Difference, Part I*. Fatality Review Bulletin, 1-4. Retrieved from http://www.baylor.edu/content/services/document.php/29501.pdf.

Virginia Department of Health Office of the Chief Medical Examiner. (2009). *Family and Intimate Partner Violence Fatality Review – Team Protocol and Resource Manual – 3rd Edition December 2009.* Retrieved from: http://www.vdh.virginia.gov/content/uploads/sites/18/2016/07/RM-Final-12-23-09.pdf.

Graphic Design and Reporting

BetterEvaluation. (2013). *Report and Support Use of Findings*. Retrieved from: https://www.betterevaluation.org/sites/default/files/Report%20-%20Compact.pdf.

Health Service Executive. (2017). *Developing Recommendations: Guidance for Consultation.* Retrieved from: https://www.hse.ie/eng/about/qavd/protected-disclosures/incident-management-framework/developing-recommendations-guidance.pdf.

Mcguire, Sara, Venngage. (2018). *17 Statistical Infographic Templates to Help You Make an Impact on Readers*. Retrieved from: https://venngage.com/blog/statistical-infographic-templates/.

Schloesser, Elissa, Evergreen Data. (2013). *Guest Post: 5 Tips for Creating Effective Visual Summaries for your Reports.* Retrieved from: http://stephanieevergreen.com/guest-post-5-tips-for-creating-effective-visual-summaries-for-your-reports/.

United States Department for Health and Human Services, Agency for Healthcare Research and Quality. (2016). *General Tips for Making Your Report Appealing and Easy to Skim.* Retrieved from: https://www.ahrq.gov/professionals/quality-patient safety/talkingquality/resources/design/generaltips.html.

WilliamsWittle. (2003). *10 Tips on Nonprofit Annual Report Writing & Design*. Retrieved from: http://www.williamswhittle.com/wordpress/wp-content/uploads/2013/04/Williams-Whittles-10-Tips-on-Nonprofit-Annual-Report-Writing1.pdf.

Monitoring and Evaluation

Overseas Development Institute. (2011). *Background Note: A guide to monitoring and evaluating policy influence.* Retrieved from: https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/6453.pdf.

Sullivan, Cris M., Pennsylvania Coalition against Domestic Violence. (1998). *A Practical Guide: Outcome Evaluation Strategies for Domestic Violence Programs*. Retrieved from: https://www.dvevidenceproject.org/wp-content/uploads/PCADV-Sullivan_Outcome_Manual.pdf.

Primary Prevention and Public Health Approaches

Abuse Counseling and Treatment, Inc. (2015). *Social Ecological Model*. Retrieved from: http://www.actabuse.com/services/community-education/prevention/.

Centers for Disease Control and Prevention. (2010). *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report.* Retrieved from: https://www.cdc.gov/violenceprevention/pdf/NISVS_Report2010-a.pdf.

Centers for Disease Control and Prevention. (2015). *The Public Health Approach to Violence Prevention.* Retrieved from: https://www.cdc.gov/ViolencePrevention/overview/publichealthapproach.html.

Florida Coalition against Domestic Violence. (2018). *Primary Prevention Toolkit*. Retrieved from: https://www.fcadv.org/projects-programs/primary-prevention-toolkit#skip-link

Pennsylvania Coalition against Domestic Violence. (2018). *Adopting a New Public Health Approach: Primary Prevention*. Retrieved from: http://www.pcadv.org/Learn-More/Prevention/.

Rhode Island Coalition against Domestic Violence. (2018). *What is primary prevention?* Retrieved from: http://www.ricadv.org/en/what-we-do/prevention/what-is-primary-prevention.

The Management Center (N.D). *SMARTE Goals Worksheet?* Retrieved from: http://www.managementcenter.org/resources/smartie-goals-worksheet/.

Teamwork Skills

American Bar Association. (2018). *Compassion Fatigue.* Retrieved from: https://www.americanbar.org/groups/lawyer_assistance/resources/compassion_fatigue.html

Government of New Zealand, Department of Conservation. (2018). *Work well as a group*. Retrieved from: https://www.doc.govt.nz/get-involved/run-a-project/community-project-guidelines/work-well-as-a-group/.

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