Domestic Violence Fatality Review as a Strategic & Evaluative Tool for Social Change

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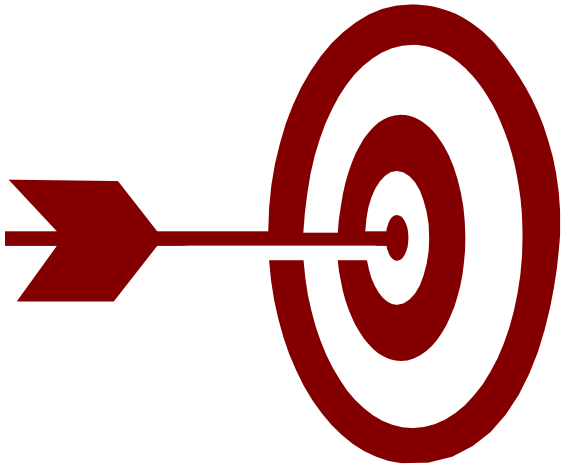
What is Strategic Fatality Review?

Specific focus on the domestic violence dynamics and characteristics in YOUR community



- Who is your typical victim? Perpetrator?
- Do they seek assistance? If so, where? If not, why not?
- How can you provide services that fit the needs?
- How can you improve your services for the people who need them?

What is Evaluative Fatality Review?

Critical examination of 3 areas:

- Agency response
- Systemic or multi-agency response
- Fatality review team's policy, procedure, and response

AGENCY SCOPE	DVFRT SCOPE	SYSTEMIC SCOPE
In what areas can your agency improve policy and practice?	How can your team improve domestic violence prevention? (Concrete DVFRT goals)	How can the team and other groups collaborate to reduce DV incidents and fatalities?
Revise risk/danger /other assessment tools	Reduce in # of DV fatalities	Establish CCR
Provide DV dynamic training for staff	Increase in # of calls for service or assistance	Educate faith-based leaders, employers on DV dynamics
Hire bilingual and culturally competent staff	Increase # of protective orders	Challenge insensitive or inaccurate images/language in media (RI, FL, WA)

5 Advanced Practices to Implement Strategic and Evaluative Fatality Review

- Identify victim and perpetrator barriers to help
- Seek input from surviving family and friends
- Link findings, solutions, and recommendations to case review
- Publicize data, reports, and recommendations
- Improve policy and procedures of the fatality review team, each agency, and the system

Identify Victim and Perpetrator Barriers to Help

- Identify your community's DV profile
  - What does DV look like? Racial/age/sexual orientation disparities?

- Barriers?
  - English proficiency
  - Varying cultural beliefs/values
  - Education
  - Employment, income, transportation

- Utilize and revise your DVFRT's data collection tool so they address your DV profile, any disparities and/or barriers.

Seek Input from Surviving Family and Friends

- For case background and during report/recommendations phase
- Team members trained in crisis intervention should interview (DV shelter/local program, Victim/Witness)
- Provide written testimony
- Make sure to ask: *How could the system have better served the decedent and/or perpetrator?*

Link Findings, Solutions, and Recommendations to Case Review

- Aggregate, statistical and/or non-identifying format only, 32.1-283.3, 1999

- Chesterfield example (2006):

  ***Finding**: In 64% of the cases, the perpetrators had prior arrests. Almost half of these arrest records involved domestic violence arrests.*

  ***Recommendation**: Identify repeat offenders and assess for increased services and/or supervision needs, i.e. specialized probation services, safety planning for victims, outreach services for family members and stricter sentencing recommendations.*

- Norfolk example (2011, draft):

  ***Finding**: In two cases, the victims were part of a closed community, in which English was a second language.*

  ***Solution:** Agencies such as the Norfolk Community Services Board and the YWCA continue to educate and expand community outreach to communities of non-mainstream nationalities.*

  Since 2010, the YWCA has educated 3,862 community members on sexual assault, risk reduction, and domestic violence.

Publicize Data, Reports, and Recommendations

- Aggregate data, recommendations, suggested & enacted implementations, & impact of the DVFRT over time
- Stress system & agency accountability
- Work with media
  - Media Ambassadors
  - Post reports on all agency websites
- Forward reports to Board of Supervisors, City Counsel and other local authorities

Improve Policy and Procedures of the DVFRT, Agencies, & the System

- Review/revise your protocol and membership regularly
  - After dissemination of each report; annually, every 24 months, etc…
  - Use findings and recommendations when revising

- Hold agencies accountable for implementing recognized policy & practices improvements
  - Progress checks

- Suggest input or revise assessments and tools used by agencies
  - Danger Assessments (law enforcement, pretrial, probation)
  - Risk Assessments (local DV programs, BIP)
  - Various data collection tools
  - Revising MOUs, interagency agreements

References

- Chesterfield County Intimate Partner and Family Violence Fatality Review Team. (July 2006). “How Many More?: Findings & Recommendations.”

- Norfolk Domestic Violence Fatality Review Team. (October 2011). “Initial Report: Review of Domestic Violence Fatalities, Norfolk, Virginia 2005-2008 (Draft).”

- Thompson, Robin. (2006, Spring). "Evoking social change: how domestic violence fatality team recommendations can make a difference." Part 1.*Fatality Review Bulletin*, Spring,1-4.

- Thompson, Robin. (2006, Spring/Summer). "Evoking social change: how domestic violence fatality team recommendations can make a difference." Part 2.*Fatality Review Bulletin*, Spring/Summer,1-4.

Stay Informed

- Communicate with other DVFRTs
- **Participate in the upcoming VA DVFRTs Meet & Greet *(date January or Feb 2012 @ OMCE)***
- Community-Defined Solutions to Violence Against Women Website: http://communitysolutionsva.org
- VA DVFRT Website: http://www.vdh.virginia.gov/medExam/Violence.htm
- National DV Fatality Review Initiative Website: http://www.ndvfri.org/
- VAWnet Special Collection on Intimate Partner Violence Homicide Prevention: http://www.vawnet.org/special-collections/DVHomicide.php
- Contact Avina for technical assistance

Contact Information

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Open Discussion---Q/A

An Introduction: Domestic Violence Fatality Review in Virginia

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What is Fatality Review?

- ***Public health approach*** to keep citizens safe and communities violent-free
- ***Retrospective and confidential*** examination of a fatal event
- ***Prospective*** objective to diminish the likelihood of future fatalities
- ***Collaboration*** between a ***multidisciplinary*** team of local stakeholders

About Domestic Violence Fatality Review

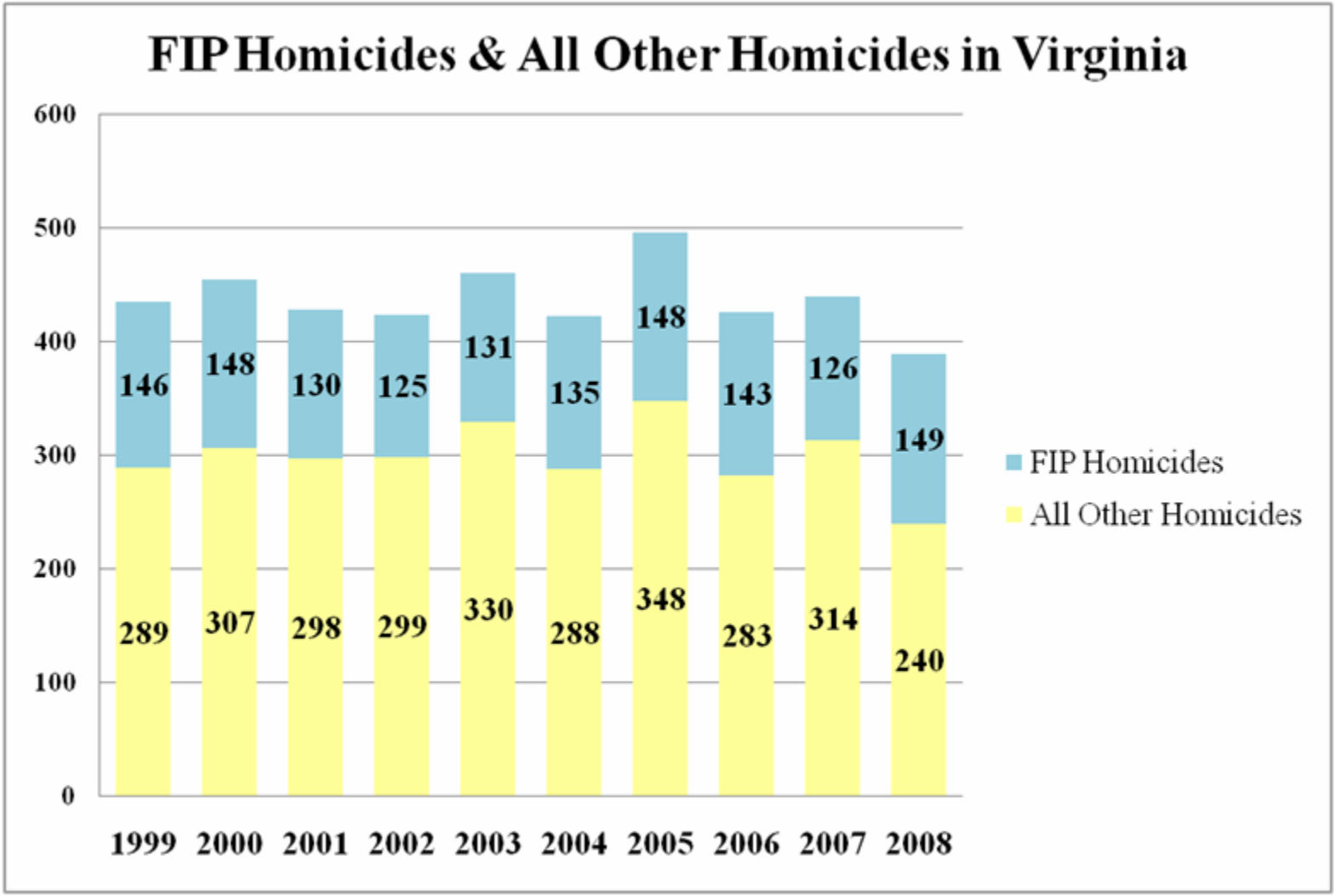
- Endorsed and authorized by Code of Virginia, § 32.1-283.3, 1999
  - Provides confidentiality protections for case review
- No blame- No shame process
  - Non judgmental analysis of strengths/challenges to DV community response
  - Does not seek to find fault, place blame or reinvestigate a case
  - DVFRTs review CLOSED CASES only

What Takes Place During Review?

Team of community DV stakeholders comes together to:

1. Review circumstances of fatal event
2. Analyze strengths and weaknesses in community response
3. Address findings and recommendations based on case-specific information
4. Identify areas for improvement and prevention

Why Are DVFRTs Important?



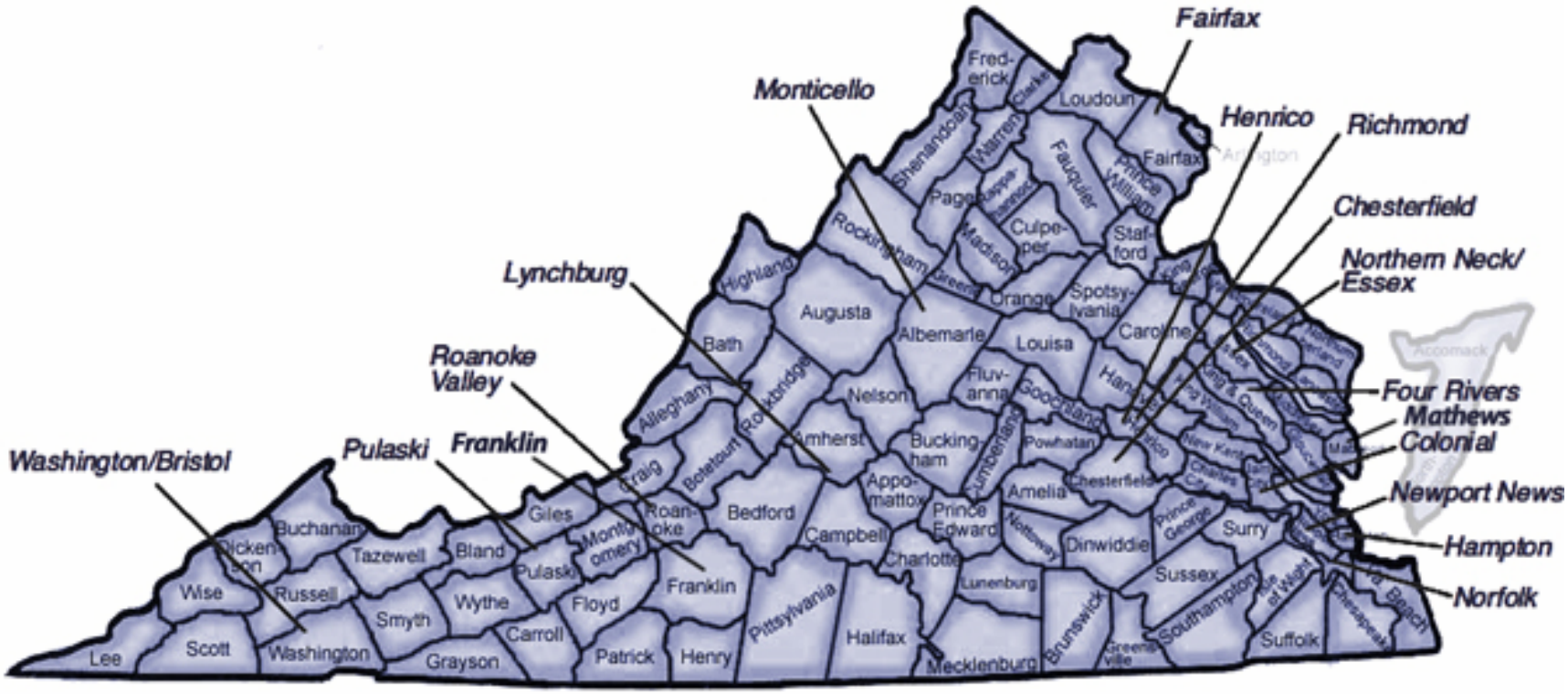
Numbers of FIP Homicide Compared to all other Homicides, 1999-2008 (N=4,377)

Benefits to Fatality Review

1. Demonstrates community's commitment to preventing domestic violence
2. Provides enhanced understanding of family & intimate partner fatalities
3. Creates improved awareness of policies, procedures & roles of all community service providers
4. Enhances cooperation & collaboration among community service providers
5. Supports public health & safety through case-specific recommendations for system improvement

Virginia DVFRTs

- 17 Government Endorsed DVFRTs!



Key DVFRT Representatives

- Commonwealth's Attorney's
- Law Enforcement
- Domestic Violence/Crisis Programs
- Health Department
- Mental Health
- Social Services
- Community Corrections
- Victim/Witness

Other Key Representatives

- Batterer Intervention Programs
- Court Clerks/Court Service Units
- Domestic Violence Shelters
- Criminal Defense/Public Defender
- Domestic Violence Coordinating Councils
- Healthcare/Forensic Nurse Examiners
- Immigrant Community Based Service Providers
- Children's Centers
- State Police
- Ethnic/Cultural Human Service Groups
- Judges
- Magistrates
- Medical Examiners
- Substance Abuse Counseling
- School Officials
- Community Service Boards
- Faith-based groups
- Various Women's Groups
- Homeless Shelters
- Other Family Service Providers

Steps to Form a Team

1. Community Interest
2. Choose an organizer and invite key DV stakeholders to participate in core group
3. Draft mission statement
4. Seek governmental enforcement
5. Generate policies & procedures
6. Identify other stakeholders to participate in full team
7. Initial meeting, MOAs/Confidentiality agreements
8. Begin case review

Questions or Comments?

For more information:

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http://www.vdh.virginia.gov/medExam/Violence.htm

Document 24: Case Facts Data Collection Form (A)

(Adapted and used with permission from the Henrico, Virginia and Florida DVFRTs)

Case Facts Data Collection Form

1. **Case Number**_____ 2. **Date(s) of Review** _____

3. **Demographic Information**

	Victim	Perpetrator
Gender		
Age at time of death		
Race		
Employment status		
Education		
Income level		

4. **Victim's Place of Injury/Fatality** (Select one):

___Victim's residence
___Perpetrator's residence
___Victim/Perpetrator joint home
___Other home/private residence
___Residential institution (jail, dormitory, shelter)
___Victim's worksite
___Perpetrator's worksite
___Public Building
___Street/highway
___Sports, athletic, nature area
___Parking lot/garage
___Other:_____
_____

5. **Relationship of Parties** (Select one):

___Spouse
___Ex-spouse
___Parent
___Step-parent
___Child
___Step-child
___Boyfriend
___Ex-boyfriend
___Brother/sister
___In-law
___Co-habitant
___Girlfriend
___Ex-girlfriend
___Other:_____
_____

6. **Circumstances that apply to decedent's and perpetrator's relationship** (Select one):

___They lived together at some point
___They lived together at the time of the fatality
___They were intimate prior to the fatality
___They had a child(ren) in common

___They had child(ren) in household, but not in common

___They always maintained separate dwellings

7. **Incident Information: Date of death**:_____

Death caused by:	___Gunshot ___Stabbing ___Asphyxiation ___Beating ___Strangulation ___Other:_____
Weapon used:	___Yes ___No
Type of weapon:	___Firearm ___Knife or sharp object ___Blunt object ___Car/vehicle ___Rope ___Personal weapon (hand, foot) ___Other:_____
If firearm, what type:	___Handgun ___Rifle ___Shotgun ___Automatic ___Semi Automatic ___Revolver ___Other firearm:_____
How was firearm acquired?	
Did perpetrator have other weapons?	___Yes ___No

Number of children present during incident:_____

Did the children witness the incident: _____Yes _____No

Number of other collateral victims: _____

Relationship to victim/perpetrator_____

_____

8. **Relationship Factors**

	Yes	No	Unknown
Decedent and perpetrator in process of separation at time of fatality			
Decedent and perpetrator had separated			
Perpetrator served with divorce papers			
Decedent and perpetrator had divorce finalized			
Decedent pregnant at time of fatality Perpetrator the father Other party the father			
Decedent had started a new relationship			
Perpetrator had started a new relationship			
TOTAL			

9. **Criminal Justice Interaction Factors**

Domestic Violence: Current/Fatal Event	**Yes**	**No**	**Unknown**
Decedent had filed an injunction on the perpetrator			
Perpetrator had been served with a Protective Order			
Criminal charges were pending against perpetrator or victim			
Court order was in effect at time of fatality			
Domestic Violence: Past History	**Yes/ # of times**	**No**	**Unknown**
Perpetrator arrested for Domestic Violence against decedent			
Perpetrator was arrested for domestic violence on another partner			
Previous protective orders on decedent			
Violated by perpetrator			
Effort made by decedent to remove or withdraw an order			

10. **Substance Abuse, Health, Mental Health Factors**

At the time of the fatal incident:	Decedent			Perpetrator		
	Yes	No	Unk	Yes	No	Unk
Abused drugs						
Abused alcohol						
Took nonprescription medication						
Had been prescribed medication						
Took prescribed medication						
Took psychiatric medication						
Had prior attempts to commit suicide						

11. **Employment/Monetary Factors**

	Yes	No	Unknown
Perpetrator had loss of employment recently			
Perpetrator had loss of income recently			

12. **Lethality Indicators**

Were any of these factors known to be present in the life of the perpetrator?	Yes	No
Emotional/Mental Deterioration		
Suicidal		
Homicidal		
Loss of day to day functions		
History of psychiatric problems		
Poor compliance with taking medications		
Depression		
Economic loss		
Loss of family support		
Ownership/Control of Decedent by Perpetrator		
Obsessiveness about partner or family		
Extreme jealousy		
Access to victim and/or family members		
Rage and/or depression over separation		
Perceived betrayal		
Perceived rejection after attempts to reconcile		

Antisocial behavior	Yes	No
History of domestic violence		
History of assaults on others		
History of criminal activity		
History of stalking		
History of substance abuse		
Possession of weapons		
History of abusing children (physically or sexually)		
History of childhood abuse or witnessing abuse		
Failure of Community Control		
Violation(s) of restraining order		
Violation(s) of probation		
Arrest(s) for domestic violence		
Failure to complete Batterer's Intervention Program		
Failure to complete Substance Abuse Treatment		
Failure to complete Anger Management Program		
Severity of Violence		
Used a weapon		
Death threat		
Strangulation		
Hurt Pet		
Severe injury		
Sadistic/threatening act		
Partner expressed concerns that she/he would be killed		
TOTAL		

13. **Signs of Escalating Circumstances**

Did the decedent:	Yes	No
Express fear of physical danger to self or children		
Express fear of losing custody of children		
Isolate themselves from family and/or friends		
Have evidence of physical injury		
Exhibit signs of depression, anger, low self esteem, suicidal thoughts		
Express fear of involvement in the criminal justice system		
Show guilty feelings about the failed relationship		
Show or express signs of sleeping difficulties		
Show or express history of family abuse		
Express fear of being alone		
Express fear of making a great life change		

Express belief that partner would change and/or stop abuse		
Did the perpetrator:	**Yes**	**No**
Abuse the decedent in public		
Keep tabs on or stalk the decedent		
Put down the decedent's family and friends		
Told the decedent that jealousy is a sign of love		
Made all the decisions in the relationship		
Blamed the decedent for the abuse		
Used intimidation by instilling fear in looks/gestures		
Told the decedent that fears about the relationship were not important		
Smashed objects and destroyed property		
TOTAL		

List all entities that had knowledge of or suspected violence based on "yes" answers above: What services were offered, provided, declined?

14. **Services Requested, Referrals Made, Services Received or Refused by the Victim or Perpetrator in the Six Months Prior to the Fatality**

Service	**Requested by Victim/ Perpetrator**	**Referred by Agency**	**Service Received**	**Refused by Victim or Perpetrator**
Domestic Violence Services:				
Counseling services				
Center				
Religious community/church				
Children services				
Supervised visitation center				
Other:				
Law Enforcement				
Legal Assistance				
County Attorney				
Court/Judges				
Family Court				
Probation/Parole				
Other:				

Health Care Provider	**Requested By Victim/ Perpetrator**	**Referred by Agency**	**Service Received**	**Refused by Victim/ Perpetrator**
EMT/Paramedics				
Ambulance				
Emergency Room				
Physician				
Mental Health Clinic				
Mental Health Program				
Other:				
Children's Services				
Dept. of Social Services				
School Involvement				
Other:				

Number of prior calls for services to Domestic Violence Centers:____
Number of prior calls for service to Law Enforcement:_____
Number of prior calls for service concerning Child Abuse:_____

Number of times program was attended:

Anger Management Program:
Perpetrator _____ Victim_____
Completed:_____ Completed:_____

Batterer Intervention:
Perpetrator _____ Victim_____
Completed:_____ Completed:_____

Substance Abuse Treatment:
Perpetrator _____ Victim_____
Completed:_____ Completed:_____

Other Court ordered program:_____
Perpetrator _____ Victim_____
Completed:_____ Completed:_____

15. What agencies were not involved but needed to be:
_____
_____
_____

Document 26: Questions to Guide Case Review Discussion

QUESTIONS TO GUIDE CASE REVIEW DISCUSSION

BACKGROUND

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

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

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

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

What risks and/or lethality indicators were present for the victim, perpetrator and children?

What is the victim's medical/behavioral history?

What is the perpetrator's medical/behavioral history?

What is the victim/perpetrator history for substance abuse?

AGENCIES INVOLVED

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

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

Did any criminal justice or civil agency have contact with the victims or perpetrators? Were there any contacts for assistance and protection (victim, perpetrator, other family members or concerned individuals)?

Detail circumstances: 911, hotline and requests for services.

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

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

POLICIES AND PROTOCOLS

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

Were all current written policies and procedures followed?

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

Are current policies and protocols adequate? If no, how could they be improved?

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

SERVICES PROVIDED

What services were offered/provided/declined?

When did services and interventions occur?

What does the event timeline tell the team?

What other services could have been utilized?

OUTCOMES

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

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

Were statutes a barrier to assistance or prevention?

What were the barriers to interagency communications?

What specific interventions could have resulted in better outcomes?

What kind of prevention strategies flow from the interventions identified?

Were there any other significant recommendations?

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

Document 27: Systems Assessment Data Collection Form

CASE #_____ DATE OF REVIEW(S)_____

FACTOR	DIRECTLY CONTRIBUTED TO MORTALITY	PRESENT IN CASE BUT DID NOT DIRECTLY CONTRIBUTE TO MORTALITY	NOT RELEVANT IN CASE
COMMUNITY FACTORS			
Lack of affordable housing			
Insufficient transportation services			
Insufficient child care services			
Lack of emergency shelter			
Insufficient legal services			
Lack of coordination of services			
Other:			
TOTAL			
VICTIM FACTORS			
Delay or failure to seek services			
Mental illness			
Substance Abuse			
Mental retardation/cognitive impairment			
Physical disability			
Lack of income			
Noncompliant with court orders			
Age (very old/young)			
Isolation from family/friends			
No/limited transportation			
Literacy			
Health issues			
Immigration/Citizenship			
Language barrier			
Pregnancy			
History of sexual abuse			
Violence in family of origin			
Other			
TOTAL			
PERPETRATOR FACTORS			
Delay or failure to seek services			
Mental illness			
Substance Abuse			
Mental retardation/cognitive impairment			
Physical disability			
Employment problems			
Lack of income			

FACTOR	DIRECTLY CONTRIBUTED TO MORTALITY	PRESENT IN CASE BUT DID NOT DIRECTLY CONTRIBUTE TO MORTALITY	NOT RELEVANT IN CASE
Immigration/Citizenship			
Non-compliant with court orders			
Literacy			
Health issues			
Pregnancy			
History of sexual abuse			
Violence in family of origin			
Possessed a firearm			
Possessed a firearm illegally			
Other			
TOTAL			
SERVICE AGENCY/FACILITY FACTORS			
Policies delayed or resulted in inadequate response			
Policies were not followed			
Inadequate policies			
Lack of screening			
Did not refer or seek consultation			
Inadequately trained personnel			
Insufficient follow-up			
Insufficient interagency communication/collaboration			
Other			
TOTAL			
LAW ENFORCEMENT FACTORS			
Policies delayed or resulted in inadequate response			
Policies were not followed			
Inadequate policies			
Inadequate training			
Information not provided on community resources			
Delay in service of Protective Order			
Other			
TOTAL			
Judicial Factors – Magistrate, Prosecution, Court			
Lack of training			
Information not provided on community resources			
Issues related to Orders of Protection			
Other			
TOTAL			

1. Of the interventions that worked, what needed to be expanded and improved?

2. What interventions, coordinated efforts, and/or collaborative efforts could have resulted in a better outcome?

3. What gaps in services were identified?

4. What prevention strategies could be identified from the interventions identified?

5. List recommendations for improvements identified through review of this case:

Document 28: Aggregate Case Facts Data Collection Form

Aggregate Case Facts Data Collection Form

Time Period of Review_____ Total Number of Cases Reviewed _____

	Total Number of Cases With Yes	Percent of Cases With Yes
Victim Demographic Information		
Gender		
Male		
Female		
Age		
<18		
18 to 25		
26 to 30		
31 to 35		
36 to 40		
41 to 45		
46 to 50		
51 to 55		
56 to 60		
61 to 65		
> 65		
Race		
White		
Black		
Asian		
American Indian		
Other		
Victim was Hispanic		
Employment Status		
Full Time		
Parttime		
Unemployed		
Education		
< High School		
Completed High School or GED		
Some College		

	Total Number of Cases With Yes	Percent of Cases With Yes
College Graduate		
Advanced Degree		
Income Level		
<10,000		
10,000-20,000		
21,000 – 30,000		
31,000 – 40,000		
41,000 – 50,000		
>51,000		
Perpetrator Demographic Information		
Gender		
Male		
Female		
Age		
<18		
18 to 25		
26 to 30		
31 to 35		
36 to 40		
41 to 45		
46 to 50		
51 to 55		
56 to 60		
61 to 65		
> 65		
Race		
White		
Black		
Asian		
American Indian		
Other		
Perpetrator was Hispanic		
Employment Status		
Full Time		
Parttime		
Unemployed		
Education		
< High School		
Completed High School or GED		
Some College		
College Graduate		
Advanced Degree		
Income Level		

	Total Number of Cases With Yes	Percent of Cases With Yes
<10,000		
10,000-20,000		
21,000 – 30,000		
31,000 – 40,000		
41,000 – 50,000		
>51,000		
Place of Injury		
Victim's residence		
Perpetrator's residence		
Victim/Perpetrator joint home		
Other home/private residence		
Residential institution		
Victim's worksite		
Perpetrators worksite		
Public building		
Street/highway		
Sports, athletic, nature		
Parking lot/garage		
Other		
Victim's Relationship to Perpetrator		
Spouse		
Ex-spouse		
Parent		
Step-parent		
Child		
Step-child		
Boyfriend		
Ex-boyfriend		
Brother/sister		
In-law		
Co-habitant		
Girlfriend		
Ex-girlfriend		
Other		
Circumstances of Relationship		
Lived together at some point		
Lived together at time of fatality		
Intimate prior to fatality		
Had child(ren) in common		
Had child(ren) in household but not in common		
Always maintained separate dwellings		

	Total Number of Cases With Yes	Percent of Cases With Yes
Incident Information		
Death caused by:		
Gunshot		
Stabbed		
Asphyxiation		
Beating		
Strangulation		
Other		
Weapon was used		
Type of weapon		
Firearm		
Knife or sharp object		
Blunt object		
Car/vehicle		
Rope		
Personal weapon		
Other		
If firearm, what type		
Handgun		
Rifle		
Shotgun		
Automatic		
Semi-automatic		
Revolver		
Other firearm		
Perpetrator had other weapons		
Children present during incident		
Children witnessed incident		
Other victims/witnesses during incident		
Relationship Factors		
In process of separation		
Had separated		
Perpetrator served with divorce papers		
Divorce finalized		
Decedent pregnant at time of fatality		
Perpetrator was the father		
Other party was the father		
Decedent had started a new relationship		
Perpetrator had started a new relationship		
Criminal Justice Interaction Factors		

	Total Number of Cases With Yes	Percent of Cases With Yes
Decedent had filed an injunction for protection from the perpetrator		
Perpetrator had been served with a Protective Order		
Criminal charges were pending against perpetrator or victim		
Court order was in effect at time of fatality		
History of Previous Domestic Violence		
Perpetrator arrested for Domestic Violence against decedent		
Perpetrator was arrested for domestic violence on another partner		
Previous protective orders on decedent		
Violated by perpetrator		
Effort made by decedent to remove or withdraw an order		
Substance Abuse, Health, Mental Health Factors		
Victim: At the time of the fatal incident		
Abused drugs		
Abused alcohol		
Took nonprescription medication		
Had been prescribed medication		
Took prescribed medication		
Took psychiatric medication		
Had prior attempts to commit suicide		
Perpetrator: At the time of the fatal incident		
Abused drugs		
Abused alcohol		
Took nonprescription medication		
Had been prescribed medication		
Took prescribed medication		
Took psychiatric medication		
Had prior attempts to commit suicide		
Employment/Monetary Factors		
Perpetrator had loss of employment recently		
Perpetrator had loss of income recently		
Perpetrator Lethality Indicators		
Emotional/Mental Deterioration		
Suicidal		
Homicidal		
Loss of day to day functions		
History of psychiatric problems		
Poor compliance with taking medications		

	Total Number of Cases With Yes	Percent of Cases With Yes
Depression		
Economic loss		
Loss of family support		
Ownership/Control of Victim by Perpetrator		
Obsessiveness about partner or family		
Extreme jealousy		
Access to victim and/or family members		
Rage and/or depression over separation		
Perceived betrayal		
Perceived rejection after attempts to reconcile		
Antisocial behavior		
History of domestic violence		
History of assaults on others		
History of criminal activity		
History of stalking		
History of substance abuse		
Possession of weapons		
History of abusing children (physically or sexually)		
History of childhood abuse or witnessing abuse		
Failure of Community Control		
Violation(s) of restraining order		
Violation(s) of probation		
Arrest(s) for domestic violence		
Failure to complete Batterer's Intervention Program		
Failure to complete Substance Abuse Treatment		
Failure to complete Anger Management Program		
Severity of Violence		
Used a weapon		
Death threat		
Strangulation		
Hurt Pet		
Severe injury		
Sadistic/threatening act		
Partner expressed concerns that she/he would be killed		
TOTAL		
Signs of Escalating Circumstances		
Did the Victim:		

	Total Number of Cases With Yes	Percent of Cases With Yes
Express fear of physical danger to self or children		
Express fear of losing custody of children		
Isolate themselves from family and/or friends		
Have evidence of physical injury		
Exhibit signs of depression, anger, low self esteem, suicidal thoughts		
Express fear of involvement in the criminal justice system		
Show guilty feelings about the failed relationship		
Show or express signs of sleeping difficulties		
Show or express history of family abuse		
Express fear of being alone		
Express fear of making a great life change		
Express belief that partner would change and/or stop abuse		
Did the perpetrator:		
Abuse the decedent in public		
Keep tabs on or stalk the decedent		
Put down the decedent's family and friends		
Told the decedent that jealousy is a sign of love		
Made all the decisions in the relationship		
Blamed the decedent for the abuse		
Used intimidation by instilling fear in looks/gestures		
Told the decedent that fears about the relationship were not important		
Smashed objects and destroyed property		
TOTAL		

Services	**Requested by Victim/ Perpetrator**		**Referred by Agency**		**Service Received**		**Refused by Victim or Perpetrator**	
	No.	**Percent**	**No.**	**Percent**	**No.**	**Percent**	**No.**	**Percent**
Domestic Violence Services								
Counseling services								
Center								
Religious community/church								
Children services								
Supervised visitation center								
Other								
Law Enforcement								
Legal Assistance								
County Attorney								

Court/Judges								
Family Court								
Probation/Parole								
Other								
Health Care Provider								
EMT/Paramedics								
Ambulance								
Emergency Room								
Physician								
Mental Health Clinic								
Mental Health Program								
Other								
Children's Services								
Dept. of Social Services								
School Involvement								
Other								

Median number of prior calls for services to Domestic Violence Centers:____
Median number of prior calls for service to Law Enforcement:_____
Median number of prior calls for service concerning Child Abuse:_____

Median number of times program was attended:

Anger Management Program:
Perpetrator _____ Victim_____
Completed:_____ Completed:_____

Batterer Intervention:
Perpetrator _____ Victim_____
Completed:_____ Completed:_____

Substance Abuse Treatment:
Perpetrator _____ Victim_____
Completed:_____ Completed:_____

Other Court ordered program:_____
Perpetrator _____ Victim_____
Completed:_____ Completed:_____

List agencies that were not involved but needed to be and the number of times the agency was listed:

_____
_____
_____
_____
_____

Document 30: Aggregate Systems Assessment Form

Aggregate Systems Assessment Form

TIME PERIOD OF REVIEW:_____ TOTAL NUMBER OF CASES REVIEWED_____

FACTOR	TOTAL NUMBER OF YES RESPONSES	PERCENT OF CASES IN WHICH THIS FACTOR CONTRIBUTED TO MORTALITY
COMMUNITY FACTORS		
Lack of affordable housing		
Insufficient transportation services		
Insufficient child care services		
Lack of emergency shelter		
Insufficient legal services		
Lack of coordination of services		
Other:		
TOTAL		
VICTIM FACTORS		
Delay or failure to seek services		
Mental illness		
Substance Abuse		
Mental retardation/cognitive impairment		
Physical disability		
Lack of income		
Age (very old/young)		
Isolation from family/friends		
No/limited transportation		
Literacy		
Health issues		
Immigration/Citizenship		
Language barrier		
Pregnancy		
History of sexual abuse		
Violence in family of origin		
TOTAL		
PERPETRATOR FACTORS		
Delay or failure to seek services		
Mental illness		
Substance abuse		
Mental retardation/cognitive impairment		
Physical disability		
Employment problems		
Lack of income		
Immigration/Citizenship		

FACTOR	TOTAL NUMBER OF YES RESPONSES	PERCENT OF CASES IN WHICH THIS FACTOR CONTRIBUTED TO MORTALITY
Non-compliant with court orders		
Literacy		
Health issues		
Pregnancy		
History of sexual abuse		
Violence in family of origin		
Possessed a firearm		
Possessed a firearm illegally		
TOTAL		
SERVICE AGENCY/FACILITY FACTORS		
Policies delayed or resulted in inadequate response		
Policies were not followed		
Inadequate policies		
Lack of screening		
Did not refer or seek consultation		
Inadequately trained personnel		
Insufficient follow-up		
Insufficient interagency communication/collaboration		
TOTAL		
LAW ENFORCEMENT FACTORS		
Policies delayed or resulted in inadequate response		
Policies were not followed		
Inadequate policies		
Inadequate training		
Information not provided on community resources		
Delay in service of Protective Order		
TOTAL		
Judicial Factors – Magistrate, Prosecution, Court		
Lack of training		
Information not provided on community resources		
Issues related to Orders of Protection		
TOTAL		

Consolidate all responses to each question from all case reviews. If a single response was repeated multiple times, list the item once and indicate the frequency of occurrence.

1. Of the interventions that worked, what needed to be expanded and improved?

2. What interventions, coordinated efforts, and/or collaborative efforts could have resulted in a better outcome?

3. What gaps in services were identified?

4. What prevention strategies could be identified from the interventions identified?

5. List recommendations for improvements identified through review of this case:

Norfolk Domestic Violence Fatality Review Team
Executive Summary
Final Report (2005-2008)
(Draft Only)

Between 2005 and 2008, the Norfolk Domestic Violence Fatality Review Team conducted a comprehensive analysis of eighteen family or intimate partner violence fatalities in an effort to prevent future domestic violence related deaths. The Team defines "family or intimate partner" or "family our household member" as defined in Virginia Code Section 16.1-228.

Demographics 2005 - 2008 Adult Domestic Violence Fatalities Information[1]

Demographic/Person	Gender		Race / Ethnicity			Age			
	Male	Female	Black	White	Other	18 - 24	25 - 44	45 - 64	65 +
Victim	7	10	13	3	1	3	7	5	2
Defendant	12	5	13	3	1	3	7	6	1

Relationship Between Victim and Defendant	Child	Acquaintance	Family of Intimate Partner (e.g. in-law)	Immediate Family Member	Current / Former Intimate Partner	Other
	0	0	2	2	13	1

Top four contributors to domestic violence fatalities:

1. Delay/Failure to Seek Services: In thirteen fatalities, the delay or failure to seek services on the part of the victim or perpetrator directly contributed to the death.
2. Substance Abuse: In nine fatalities, serious substance abuse issues on the part of the victim or perpetrator directly contributed to the death.
3. Mental Health Issues: In nine fatalities, serious mental health issues on the part of the victim or perpetrator directly contributed to the death.
4. Access to a Firearm: In nine fatalities, access to a handgun directly contributed to the death.

[1] Please note: that although the number of fatalities reviewed was 18, the number of victims stands at a total of 17 being that one of the victims was counted as his own defendant and not a victim (his death was a result of his own actions). Additionally, the number of defendants also stands at 17 being that one defendant was responsible for two victims although he has only been counted once.

Gaps in services:

1. Erratic dissemination of "No Contact Orders"
2. Need for Increased Supervision of Probationers
3. Need for Greater Domestic Violence Education Outreach in Socially Isolated Communities
4. Lack of Availability of long term counseling for child victims and witnesses
5. Church authorities inappropriately attempting o remedy domestic violence through marriage counseling through church authorities
6. Unwillingness of others to get the authorities or service providers involved
7. System inability to monitor perpetrator and/or victim delay or failure to seek services

Team Recommendations:

1. Increase the use of Norfolk DCJS for both pre-trial supervision of alleged offenders pending trial and post-trial monitoring of defendants convicted of crimes.
2. Further outreach and education to address lack of awareness in tight-knit or socially isolated communities.
3. Further outreach and education to the African American community to foster and promote faith in the criminal justice system.
4. Address the disproportionate number of domestic violence fatalities in the African-American community by: (a) forming a city committee to examine and propose solutions; and (b) hiring a long-term or short-term specialist to work within the Norfolk Department of Human Services.
5. Ensure identification and advocacy of children in need of services. Obtain quality resources for long-term counseling and therapy for surviving children.
6. Implement a pragmatic, useable, danger assessment protocol for first responders

For more detailed information on our findings and recommendations, please contact:
Linda Bryant, Deputy Commonwealth Attorney for City of Norfolk.

[1] Please note: that although the number of fatalities reviewed was 18, the number of victims stands at a total of 17 being that one of the victims was counted as his own defendant and not a victim (his death was a result of his own actions). Additionally, the number of defendants also stands at 17 being that one defendant was responsible for two victims although he has only been counted once.