

Team Protocol and Resource Manual

3rd Edition- December 2009



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Family and Intimate Partner Violence Fatality Review Team Protocol and Resource Manual



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Preface to the Third Edition

I am pleased to share this Protocol and Resource Manual that supports the development of local and regional domestic violence fatality review teams in Virginia. The resources and materials included here provide directions on death review in the area of domestic violence homicides.

Why should you consider a fatality review team in your community? What profit or good comes from a death review process? Simply put, fatality review is a nationally recognized method for understanding how and why people die—the goal of which is to reduce those deaths. Child death review teams operate in nearly all 50 states. The Centers for Disease Control and Prevention encourages development of maternal mortality review teams, which are underway in many states. An emerging area for death review is elder abuse and other vulnerable adult populations.

Fatality review:

- recognizes that violent death is a premature and preventable community crisis
- convenes a multidisciplinary team of stakeholders who understand the problems of community violence and are committed to solutions
- involves a confidential and retrospective process that is endorsed and protected by the *Code of Virginia*
- offers solutions that strengthen our systems of public health, public safety, and public protections
- uses agency involvement and death investigation records to understand the strengths, challenges, and gaps in a community's response to violence
- makes recommendations to enhance that community response by highlighting areas of improvement such as training, funding, coordination of services, or changes to policy and procedures

My thanks to the members of the Domestic Violence Fatality Review Advisory Committee, and to all participants/members of Virginia's state and local fatality review teams. Each shared his/her experiences and resources to include in this manual. Their wisdom and direction have been so valuable as we completed this project.

As Chief Medical Examiner, I believe in the power of fatality review. Never easy, fatality review is a courageous and worthwhile process that can help us reduce violence in our communities. My staff and I look forward to working with you in the development of your community fatality review team.



Leah L.E. Bush, M.S., M.D. Chief Medical Examiner Virginia Department of Health, Office of the Chief Medical Examiner

Author's Introduction

The Virginia Department of Health, Office of the Chief Medical Examiner (OCME) is pleased to present this *Family and Intimate Partner Violence Fatality Review Team Protocol and Resource Manual*. We hope it will contribute to the important fatality review work being done here in Virginia and across the country.

The ultimate goal of fatality review is to save lives. By examining the tragic deaths of victims, teams learn how to better serve their community by improving the quality and coordination of their domestic violence response. Fatality review plays a critical role in improving community health, education, and safety. As a nurse and educator, working on this project has been especially gratifying for me. I feel privileged to have joined forces with so many caring and committed people, especially our Domestic Violence Fatality Review Advisory Committee members and our dedicated Virginia teams. And a special thanks goes to Kimberly Ludlow whose final editing assistance and moral support was invaluable.

The goal of this work is to help new and existing domestic violence fatality review teams better understand the principles and practice of fatality review. Our focus is primarily on Virginia teams, but we drew from national as well as statewide resources, research, and practice. We hope this Protocol and Resource Manual will serve as a useful "how-to" guide— instructing and inspiring the work of fatality review teams. We designed it to be as comprehensive, practical, and user-friendly as possible. The following summarizes some of its content and navigation features:

The Protocol and Resource Manual is divided into four main areas:

<u>Main Text Section</u> includes Chapters 1-10. Each chapter focuses on a particular topic (e.g., establishing a team, obtaining governmental endorsement). Chapter text describes the basic principles and practice relevant to that particular topic, and includes tips and quotes from experienced professionals. It also guides you to related documents and resources, which are referenced numerically and can be found in the Document Resource Section and the General Resource Section.

General Index lists alphabetically all topics, teams, documents and resources.

<u>Document Resource Section</u> provides teams with ready-to-use (or adapt) word documents. Fatality review teams don't need to reinvent the wheel; these documents provide practical solutions and ideas, and can save valuable time and energy.

<u>General Resource Section</u> provides teams with other relevant information—including links to fatality review resources and reports, articles, sample team protocols and guidelines, and domestic violence fatality review training materials.

This Protocol and Resource Manual is an updated and expanded version of the OCME's 2002 Family and Intimate Partner Violence Fatality Review Team Protocol. For the sake of brevity, we refer to this edition throughout the text as the "Manual." We have endeavored to make this 3rd Edition Manual as complete and accurate as possible. During its development, vast amounts of information and resources were compiled, and critical review was provided by many individuals—particularly by members of our Advisory Committee. The OCME, however, is responsible for the content of this Manual, and is the voice represented by the editorial use of "we."

Lastly, a note on our use of the term "domestic violence" which is used throughout the chapters, documents, and resources. Overall, we felt it was the best term to fit both common *and* legal meanings. Section 32.1-283.3 of the *Code of Virginia* gives statutory authority for "conducting reviews of fatal family violence incidents", which is defined as "any fatality, whether homicide or suicide, occurring as a result of abuse between family members or intimate partners.¹" For the sake of clarity and brevity we chose the umbrella term "domestic violence."

We welcome your feedback, criticism, or suggestions regarding any aspect of this Manual.

-Meg Norling, R.N., B.S.N., State Coordinator
Domestic Violence Fatality Review
Virginia Department of Health, Office of the Chief Medical Examiner
December 2009

Virginia Domestic Violence Fatality Review Advisory Committee

The Office of the Chief Medical Examiner wishes to thank the past and present members of the Virginia Domestic Violence Fatality Review Advisory Committee. We sincerely appreciate the time and wisdom they generously shared with us in the development of this Protocol and Resource Manual:

Eileen M. Addison

Colonial Area Family and Intimate Partner Violence Fatality Review Team

Marjorie Arrington

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Beth C. Bonniwell, M.S.W.

Henrico County Family Violence Fatality Review Team

Susan W. Clark

Lynchburg City Family Violence Fatality Review Team

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Virginia Maternal Mortality Review Team

Synetheia N. Newby

Newport News Domestic Violence Fatality Review Team

Bridgette Roseman

Newport News Domestic Violence Fatality Review Team and Hampton Family Violence Fatality Review Team

Gregory D. Underwood

Norfolk Domestic Violence Fatality Review Team

Seema Z. Zeya

Fairfax County Domestic Violence Fatality Review Team

Jon R. Zug

Monticello Area Domestic Violence Fatality Review Team

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Virginia Domestic Violence Fatality Review Teams

A complete and current listing of team contact information can be found on the website for the Office of the Chief Medical Examiner at http://www.vdh.state.va.us/medExam/Violence.htm

Chesterfield County Intimate Partner & Family Violence Fatality Review Team

Colonial Area Family and Intimate Partner Violence Fatality Review Team (James City County, York County, City of Poquoson, City of Williamsburg)

Fairfax County Domestic Violence Fatality Review

Four Rivers Regional Fatality Review Partnership
(New Kent County, Charles City County, King William County,
King and Queen County, and the town of West Point)

Hampton Family Violence Fatality Review Team

Henrico County Family Violence Fatality Review Team

Lynchburg Family Violence Fatality Review Team

Monticello Area Domestic Violence Fatality Review Team (Albemarle County and City of Charlottesville)

Newport News Fatality and Intimate Partner Violence Fatality Review Team

Norfolk Family Violence Fatality Review Team

Northern Neck/Essex Domestic Violence Fatality Review Team (Counties of Essex, Lancaster, Northumberland, Richmond, Westmoreland)

Richmond Child and Family Violence Fatality Review Team

Statewide Coordinator:

Domestic Violence Fatality Review Coordinator
Virginia Department of Health, Office of the Chief Medical Examiner
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CHAPTER 1: ESTABLISHING A TEAM



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

Local domestic violence fatality review teams (DVFRTs) are created through individual efforts and the voluntary cooperation of agencies involved with family violence. Anyone may initiate the establishment of a fatality review team. This *team organizer* 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 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.

Identifying appropriate team members is a critical task for the team organizer 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.

We recommend that the core group and larger full team be multidisciplinary 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. Choose wisely. Each team member will become the spokesperson for—and potential agent of change within—his or her own agency. Understanding their agency's general policies and procedures, as well as its involvement in case-specific facts, is vital. Members act as interpreters for

"Pick team members who have the power to make change within their agency!"

-Amy Jacobson, Colonial Area, Virginia DVFRT

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.

SELECTING THE RIGHT TEAM MEMBERS				
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.			

Figure 1: Selecting the Right Team Members

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 be established which 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/

-Court Clerks Forensic Nurse Examiners

-Court Service Units -Judges

-Criminal Defense/Public Defender Attorneys -Magistrates

-Substance Abuse Counseling -Criminologists

-DV Coordinating Councils -Schools

-Forensics/Pathology -State Police

The full text of the *Code of Virginia* relevant to domestic violence fatality review teams is included in the Resource Section of this Manual.



See Resource 1: Code of Virginia §32.1-283.3

Communities vary based on population, culture, and economics. As a result, fatality review teams may vary in composition, size, and structure. Included in the Resource Section of this Manual is a chart which summarizes team composition among a sample of Virginia DVFRTs.



See Resource 2: Team Composition Chart

A critical issue for developing DVFRTs is team jurisdiction. Will the team be *local*, representing one city or county jurisdiction only, or will it be *regional*, representing two or more jurisdictions?

In considering team jurisdiction, keep in mind 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 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 (e.g., rural areas). Pooling efforts can better utilize people and resources, and better integrate services across jurisdictional lines. In the case of a regional team, the whole may truly be greater than the sum of its parts.

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? Finding experienced professionals willing and able to commit to the work of fatality review is critical. Tough economic times—when reduced city, county, and state budgets have created greater workloads for many service providers—can make this more challenging. Actual operating costs of a DVFRT are generally minimal. Out-of-pocket costs such as paper, supplies, and postage 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).
- 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?

"Cooperation and collaboration are the keys to a successful multijurisdictional fatality review team, but occasionally using what we call 'persuasion through guilt' can be a successful tactic at bringing necessary participants to the table."

-Jon Zug, Monticello Area, Virginia DVFRT If a team decides a regional approach is best, it should consider full (i.e., multiple) representation from critical agencies or disciplines. For example, if a team is comprised of three counties, a representative from *each* Commonwealth's Attorney's Office—a total of three—would be included. Due to their critical involvement with domestic violence cases, we recommend that teams consider full representation from the following agencies/disciplines: Commonwealth's Attorney's Office, law enforcement, victim/witness programs, domestic violence service providers, community corrections, and probation/parole.

Whether a DVFRT decides their jurisdiction should be local or regional, the next step in team formation is sending out *letters of invitation*. Members of the core group identify and invite prospective agencies or organizations they want to participate on the team. Having

buy-in at the highest levels of your community is a powerful tool in rallying support. Keep this in mind as you consider which agency representatives to invite, as well as which core group member(s) signs the 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

A sample letter of invitation is included in the Document Resource Section.



See Document 1: Letter of Invitation

After letters of invitation are sent and responses received, the team organizer and core group hosts a meeting for prospective team members. This meeting allows members to meet and make introductions, review the current 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) 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)

A sample memorandum of agreement and an interagency cooperation and confidentiality agreement are included in the Document Resource Section

"It helped that we already had a group of collaborative partners to respond to instances of domestic violence in our county. Building on an established foundation and preexisting working relationships makes team development easier."

-Patricia Jones-Turner, Chesterfield, Virginia DVFRT



See Document 2: Memorandum of Agreement
See Document 3: Interagency Cooperation/Confidentiality Agreement

To help summarize and clarify all the events described in this chapter related to the establishment of a DVFRT, we have included an introductory flowchart in the Document Resource Section. Teams may find this chart useful when educating potential members—as well as the community at large—about fatality review. It can be used as is, or adapted to fit the needs of each community.



See Document 4: Establishing a Domestic Violence Fatality Review Team: Summary

CHAPTER 2:

DEVELOPING A MISSION STATEMENT

Once the core group has been 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:

- Learn how to reduce and prevent domestic violence
- Change system and individual responses
- Coordinate/integrate local, state efforts
- Decrease domestic violence deaths
- Identify trends and patterns
- Identify high risk factors
- Improve community interventions
- Recommend changes in laws, policies, rules and procedures
- Enhance cooperation between public and private entities (to reduce deaths)
- Review facts/perform research (to prevent deaths)
- Develop a process for change and improvement
- Educate the public, policy makers, and funders²

Other commonly cited themes include:

- Raise awareness of domestic violence in the community
- Bring new stakeholders to the table, and forge new alliances
- Open lines of communication within and between agencies
- Identify domestic violence-related deaths
- Identify gaps in community systems, particularly related to those groups traditionally underserved
- Coordinate community information
- Improve early intervention
- Provide accurate information to elected officials, the media, and the community

We recommend that teams submit for review a draft of their mission statement to stakeholders or governmental officials who are critical to the successful establishment of the team. DVFRT members, who are experienced domestic violence professionals, should be aware of the political landscape and key players in their community. Vetting the mission statement with these key officials gives a team outside feedback, and may streamline the formal approval process. Regional teams are encouraged to vet the mission statement through *each* jurisdiction represented. For example, if a team is comprised of one independent city and one county, relevant city *and* county officials should be consulted.

Mission statements are not static. Indeed, 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 work and goals of the team. When developing policies and procedures, it is a good idea to include plans for a periodic (re)evaluation of all aspects of team functioning—including the mission statement.

Become familiar with the work of other teams. Reading other mission statements, policies and procedures, findings and recommendations, and reports will inspire new ideas and can save time and energy. Teams don't need to reinvent the wheel. An extensive body of domestic violence fatality review literature has been developed over the years—teams should take advantage of and learn from it.

The following sample mission statements come from Virginia domestic violence fatality review teams:

County of Chesterfield

The mission of the Chesterfield County Fatality Review Team is to conduct reviews of intimate partner and family violence fatalities to prevent future family violence related deaths. The team also works to support Chesterfield County's strategic goal of being the safest and most secure community of its size in the USA. Objectives:

- -To identify and describe trends and patterns of domestic violence related deaths in the county.
- -To increase coordination and communication between agencies providing services to families experiencing domestic violence.
- -To identify interventions aimed toward system improvements and change.³

City of Hampton

The mission of the Hampton Domestic Violence Fatality Review Team is to reduce the incidence of family violence fatalities.

The Hampton Domestic Violence Fatality Review Team will work to identify the circumstances that lead to the death and determine indicators that could prompt early identification, intervention, and prevention efforts in similar cases.

It is recognized that the perpetrators of domestic violence are ultimately responsible for the death of victims. Thus, the goal of this committee is not to place blame but rather to better understand the dynamics of domestic violence when death is involved and thereby diminish the possibilities of future fatalities.⁴

County of Henrico

The mission of the Henrico County Family Violence Fatality Review Team is to prevent abuse between family members and intimate partners from escalating into homicide or suicide by constructively examining the circumstances of past and future family violence fatalities, by making recommendations arising out of these fatality reviews and by increasing coordination and communication among agencies, departments, and systems.

The Henrico County Family Violence Fatality Review Team feels strongly that a successful fatality review involves commitment from its participating members and agencies to ensure the purpose is understood, confidentiality is maintained and goals are achieved. With improved understanding of the circumstances leading up to the fatality, team members develop recommendations to improve safety and services for victims, their families and communities.⁵

City of Newport News

Domestic Violence Fatality Review Committee shall review deaths associated with domestic violence that occur in Newport News, focusing on decedents age 18 and above who fall within the criteria established by this committee.

We recognize the responsibility for responding to and preventing domestic violence fatalities lies with the community not with any single agency or entity. We recognize that promoting more accurate identification and reporting of domestic violence fatalities will result in the development of prevention strategies for all domestic violence injuries in the Commonwealth of Virginia.

Finally, we recognize the implementation of domestic violence fatality panels will lead to improved coordination and services for families and children at the local level.⁶

Counties of Northern Neck and Essex

The mission of the Northern Neck/Essex Domestic Violence Fatality Review Team is to prevent domestic violence cases from escalating into murder by constructively examining the circumstances of past and future adult and children deaths by domestic violence, by making recommendations arising out of these death reviews, and by increasing coordination and communication between agency and system. Thus the goal of this team is not to place blame but rather to understand better the dynamics of domestic violence deaths and diminish the possibility of future fatalities.⁷

CHAPTER 3:

OBTAINING GOVERNMENTAL ENDORSEMENT



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

After the core group has been identified and the mission statement drafted, a DVFRT must obtain a *governmental resolution* from their local city or county government. Obtaining this formal resolution is critical: 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.

The core group has a wealth of knowledge regarding the political landscape of their community. They are in the best position to know or find out about potential areas of support or resistance within the community. These issues should be discussed and planned for prior to seeking official authorization. The core group's experience within the community can be vital in shepherding a resolution through official channels.

"Don't underestimate the value of having supportive governmental resolutions.

Be very public about having the endorsement of your local authorities. It may be the closest thing to 'getting a big stick' the team may have."

-Becky Lee, Richmond, Virginia DVFRT

BUILDING SUPPORT FOR A GOVERNMENTAL RESOLUTION

There are many strategies for building support to facilitate formal governmental authorization. Teams may want to consider obtaining a *letter of support* from a powerful governmental official or agency. This letter endorses the team's formation and goals. A sample governmental letter of support is included in the Document Resource Section of this Manual.



See Document 5: Letter of Support from Governmental Official

Additionally, it may 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:

- The purpose of fatality review is to save lives. Domestic violence accounts for a third of all homicides in Virginia every year.
- Domestic violence fatalities can and should be prevented. These deaths are a public health and safety problem, as well as a criminal justice concern.
- Victims of domestic violence homicide should not have died in vain. Every domestic
 violence death is a shocking and tragic event in a community. Fatality review seeks
 to transform these tragedies into opportunities to improve a community's response to
 domestic violence.
- Fatality review brings community members together. Multidisciplinary teams work together to identify the strengths and challenges of the domestic violence network 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.
- 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.
- 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.

While fatality review has gained acceptance and momentum in the past decades, it is still a relatively new concept to many people. Be sure your audience, whether it is one person or an entire Board of Supervisors, understands the concept of and need for fatality review. The following are suggested elements for an educational presentation promoting domestic violence fatality review:

- Brief background on the issue of domestic violence, and how it has negatively impacted your community (include demographics and statistics)
- Brief background on domestic violence fatality review—what it is, why it is done, and how it can positively impact your community by supporting public health and safety
- Code of Virginia §32.1-283.3—Virginia's statutes are clear in their endorsement of fatality review, and in the confidentiality protections they afford all team members and agencies
- Identification of the core group: their professional knowledge, agency affiliations, experience, and commitment to the prevention of domestic violence
- Team mission statement

The Virginia Department of Health, Office of the Chief Medical Examiner, which provides training, technical assistance, and resources to DVFRTs across the state, has developed an educational PowerPoint presentation that outlines the basic principles and benefits of fatality review. This presentation can be adapted to fit the needs of individual communities, and is included in the Document Resource Section.



See Document 6: Learning from Loss: How Domestic Violence Fatality Review Improves Community Health and Safety (PowerPoint)

Be sure to communicate to your audience that establishing a fatality review team sends a powerful message about your community's commitment to preventing domestic violence. Working together as a team, the stakeholders most directly involved in responding to domestic violence will review case-specific facts, identify system strengths and challenges, and develop recommendations to improve their community's domestic violence network. This process can enhance victim safety and perpetrator accountability, and keep 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. A sample city council agenda item summary is included in the Document Resource Section.



See Document 7: City Council Agenda Item Summary

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, legal advice, 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. Early feedback from critical stakeholders, particularly city or county attorneys, can help streamline the formal approval process. For example, a regional Virginia team discovered during vetting that one jurisdiction's city attorney preferred similar wording for *each* resolution to be submitted by *each* jurisdiction. Addressing this issue before draft resolutions were finalized and submitted for formal approval saved each jurisdiction time and energy. Sample city and county endorsement/resolutions are included in the Document Resource Section.



See Document 8: County Endorsement/Resolution

See Document 9: City Endorsement/Resolution

If a team is regional, authorization should be obtained from *each* of the participating jurisdictions. Samples from Colonial Area, Virginia, where two localities obtained approval for a multijurisdictional effort, are included in the Document Resource Section.



See Document 10: Multijurisdictional City/County Resolution: City

See Document 11: Multijurisdictional City/County Resolution: County

CHAPTER 4:

FRAMING POLICIES AND PROCEDURES



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

Once the core group is formed, the mission statement is developed, and the process of obtaining a governmental resolution is underway, the team is ready to draft their *policies and procedures* (also referred to as the *team protocol*). This includes guidelines for case review as well as overall team functioning. Some teams begin this basic drafting process early on, during the initial core group stage. Others wait until their full team is developed. An advantage of early drafting with a smaller group is that it can

streamline the decision-making process. It also enables the core group to present prospective team members with a beginning framework of team process. A possible disadvantage of early drafting is that it frontloads some of the work for the core group. In either case, the full team needs time to review—and provide feedback on—the team's policies and procedures before they are finalized.

Establishing policies and procedures is a timeconsuming but critical step in team development. Welldeveloped policies and procedures are worth your time and effort because they cover all aspects of team functioning and case review. We recommend reading protocols from existing teams. This will give the team a good sense of issues to consider and provide members with a solid framework from which to adapt their own unique policies. A sampling of team protocols is included in the Resource Section of this Manual. "Be thoughtful and thorough when designing policies and procedures. They will not only direct and focus the work of the team, they can also reduce conflict and establish working principles. They depersonalize the actions of individuals and keep you focused on outcomes."

-Becky Lee, Richmond, Virginia DVFRT



See Resource 3: Sample DVFRT Protocol: Chesterfield, Virginia See Resource 4: Sample DVFRT Protocol: Fairfax, Virginia

Drafting policies and procedures need not drain the energy and momentum of the team. An article in the Maryland Domestic Violence Fatality Review Newsletter recommends a timely drafting of policies and procedures. Their recommendations, quoted verbatim, follow:

...We encourage teams to develop their protocol quickly in order to get to the business of reviewing cases. Developing the protocol over a protracted period can become an impediment to the team's objective of reviewing cases. Some suggestions:

- Create a subcommittee of 4-6 team members.
- **Appoint** a drafter.
- **Complete** the task within a very short period of time- perhaps one month.
- Do homework! Have the subcommittee
 members read the (sample or model) protocol
 ahead of time and be ready with initial
 comments at the first meeting.
- Don't wordsmith the model. Either accept or change the concepts conveyed in each section.
- Draft changes promptly in order to meet your deadline.
- Focus on completing the protocol. Agree to make additional changes once the team becomes fully operational. You will already have the foundation in place.
 - -Maryland Network Against Domestic Violence Fatality Review Newsletter, Winter/Spring 2008⁸

"We benefited from networking with other Virginia teams. It helped to gather advice and resources from people already doing the work. Each team needs to develop policies and procedures that fit their particular community, but learning about the evolution and practical experiences of other teams can move the process forward. We, in turn, have been pleased to share some of our team's work with other developing teams."

-Seema Zeya, Fairfax, Virginia DVFRT A team's policies and procedures, like its mission statement, need not be static. As it gains experience, the needs and goals of a team may change. We recommend DVFRTs periodically review and re-evaluate all aspects of team functioning (e.g., 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. For example, one regional Virginia team worded their policies and procedures to allow for the possible addition of other jurisdictions. They recognized early on that, given shared services and close geographic proximity, they might want to further expand their team membership. Revisiting all team processes periodically—and updating policies and procedures if needed—can help keep the team vital.

The following outline summarizes some of the important issues a team must address in developing their policies and procedures. Each of the topics listed (e.g., shaping team structure) corresponds to a fully developed chapter in this Manual. The full chapters follow in order, and contain detailed information as well as relevant documents and resources.

DVFRT POLICY AND PROCEDURE: QUESTIONS TO CONSIDER

Chapter 5: Shaping Team Structure

Roles and Titles

- What structure do we want for our team (e.g., chairperson, co-chairs, recorder, 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 functions and other work of the team?
- Should our team include a member from the survivor community?

Membership Rules/Responsibilities

- How long will I serve on the team?
- What if I can't make a meeting?
- What if a member resigns or has to be removed?

Chapter 6: Building Team Capacity

Domestic Violence Training

- Do we have a common understanding of "domestic violence"?
- What are the state and federal laws regarding domestic violence?
- Are we aware of and sensitive to issues of victim-blaming?

Fatality Review Training

- Are we familiar with the concept and practice of fatality review?
- What are the guiding principles of fatality review?
- What training do team members need before they begin case review? Who provides it?

Systems Assessment Training

- What is systems assessment? How does it differ from a focus on individuals?
- How do I learn about and profile my community? What resources are available?
- What exactly do all the service providers in my community do, and how do they interact with each other?
- How do we improve our coordinated community response (CCR) to domestic violence?

Group Dynamics Training

- What qualities are important in a team leader?
- What is consensus decision-making and why is it important to a DVFRT?
- How do we encourage feedback on team structure and functioning?
- How do we deal with the possible emotional stress of fatality review?

Chapter 7: Protecting Confidentiality

- What are my 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?
- What is the "no blame, no shame" concept of fatality review?
- How do we contact and network with other teams?

Chapter 8: Reviewing Fatalities

- How are cases identified?
- Who/what guides the selection of appropriate cases?
- What is our case selection criteria (i.e., do we include homicides, homicide-suicides, suicides)?
- How do we obtain the documents we need?
- What are case facts?

- How do team members present relevant information?
- How will case information be summarized/prepared for team meetings?
- What are case timelines and how are they used?
- What is systems assessment?
- What information will we record for each case?
- Do we involve the family/survivor in the case review process?

Chapter 9: Developing Findings and Recommendations

- What is a finding?
- How do we turn individual case information into aggregate case information?
- Do we need special software or personnel to compile aggregate case information?
- How will we use the findings to develop recommendations?
- What are the elements of an effective recommendation?

Chapter 10: Preparing Team Reports

- What are the statutory requirements for reporting team findings?
- How will we publish and distribute the findings and recommendations of our reviews?
- Where can I find samples of other teams' reports?
- What are some important issues to consider before report-writing?
- How do I write a press release?
- Do we need a media kit that includes information on domestic violence and the fatality review process?
- Where can we find reliable statistics and resources regarding domestic violence?
- Who represents the team to the community and/or the media?

CHAPTER 5: SHAPING TEAM STRUCTURE

Across Virginia and the United States, the structure of DVFRTs varies tremendously. Working with their own unique community resources and considerations, each team crafts a structure that suits its particular needs.

TEAM ROLES AND TITLES

Team structure refers to the number of team members chosen, the titles a team wishes to use, and the distribution of duties/responsibilities among the members. Ideally, each team will have certain duties and responsibilities fulfilled in order to operate effectively (e.g., contacting members, facilitating meetings, storing documents). We refer to these duties and responsibilities as **roles**.

Titles are the formal designations given to certain team members. In general, the following are some of the most commonly used titles:

- Chair
- Co-Chair
- Coordinator
- Facilitator
- Recorder
- Member
- Ad-Hoc Member

Which titles a team chooses, and how they wish to distribute the duties and responsibilities among members, will vary widely. Not all teams use these exact titles, and they distribute roles in very different ways. Listed below is a summary of the range of titles and roles:

CHAIR: The chair is often an influential, powerful community domestic violence stakeholder. S/he 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. Or, 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. The following graphic gives an example of the functional spectrum of the chair's involvement with his/her fatality review team:

Honorary Involvement	Partial Involvement	Full Involvement
Not involved in	Runs meetings	Handles all meeting,
day-to-day work	but not administrative	administrative, and
or team meetings.	functions.	leadership functions.

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 day-to-day (or 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. S/he 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. S/he 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.

FACILITATOR: The role of facilitator is not necessarily synonymous with team leader (whether that leader is the chair, co-chair, coordinator, or some other role). If the

team leader is a strong participant with good social and leadership skills, s/he may handle the facilitation of team meetings. If, however, the team leader is unsuited to this role (due to personality, organizational skills, or schedule demands) then it might be advisable to appoint a facilitator to run meetings and keep the team's work on track.

A facilitator may be drawn from the team membership or from outside resources. Professionally trained facilitators are available in most communities. The Henrico, Virginia team uses the services of a county human resources representative "to participate in fatality review to provide meeting and process management."

Whether drawn from inside or outside resources, a facilitator should have good people, process, and organizational skills. A facilitator can be seen as the team's guide, making the work of the team easier and more productive. One of the keys to productive team work is cooperation. Ideally, the group facilitator will enhance team cooperation by promoting important values such as active participation, consensus decision-making, power-sharing, mutual respect, inclusiveness, and equality.

Like all team members, the facilitator needs training and orientation in the process of fatality review (see *Chapter 6: Building Team Capacity*). S/he must pay special attention to issues of group dynamics, consensus decision-making, and confidentiality.

RECORDER: A fatality review team brings together people, facts, and documents in their case review process. Some teams have a designated recorder to help organize and document the case review process. Those that do not will fulfill this role by volunteer and/or rotating team member participation.

A recorder may be responsible for keeping team attendance records, for recording case review facts during a meeting, for creating case timeline documentation (see *Chapter 8: Reviewing Fatalities*) and/or for keeping minutes of team meetings. Virginia teams that use a dedicated recorder recommend it. 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. The Hampton, Virginia DVFRT also designates their recorder as the person responsible for "collecting and shredding confidential member papers at the end of each meeting, and assisting the chair in writing reports."¹⁰

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. **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 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.

To illustrate the diversity of team structures, we have included in the Resource Section verbatim descriptions of roles and titles from the protocols of two Virginia teams.



See Resource 5: Sample DVFRT Role and Title Designations

INCLUSION OF "NON-SYSTEM" MEMBERS IN THE TEAM PROCESS

An important membership issue being considered within the fatality review community is whether teams should include *representation from "non-system" members*—groups not traditionally identified as part of the domestic violence response system, such as members of the survivor advocacy or crime victims' rights group, and/ or family members who have lost a loved one to domestic violence. In either case, this person brings a first-hand, personal experience of domestic violence to the team, and can speak directly to the challenges faced by victims and their families.

Survivors or family members could work with the DVFRT in a number of ways. One would be to serve as a permanent member of the team. Another would be to participate as an ad-hoc member, consulting with the team on an as-needed basis. Family members of victims or perpetrators could also contribute to the work of the team by sharing information in a case review interview. The many ways survivors or family members could participate in the work of a DVFRT makes this important issue relevant to both team membership and case review. A more detailed discussion of whether and how to include these individuals follows.

Should teams include survivors as members?

Neil Websdale, co-founder of the National Domestic Violence Fatality Review Initiative, met with Maryland DVFRTs in May 2006. One of the important topics discussed was the inclusion of survivors as DVFRT members. The following was reported in the July 2006 Fatality Review Newsletter:

Dr. Websdale explained why he endorses the inclusion of domestic violence survivors as DVFRT members. Teams with survivors learn more and have more useful recommendations. Survivors have unique experiences and insights other team members cannot fathom. They can help other team members "texturize" the victim's life and her experiences.

Dr. Websdale pointed out that criteria for selection of survivor members should be like the criteria applied to other team members—limited to whether they will contribute to the team and will not use the team as a soapbox or a forum for finger-pointing. He mentioned that teams could consider additional methods of incorporating survivors, such as by asking a group of survivors for feedback on the team's recommendations." -Maryland Domestic Violence Fatality Review Newsletter, July 2006¹¹

INCLUSION OF FAMILY/FRIENDS IN THE CASE REVIEW PROCESS

Whether and how to include victim's families and friends in the fatality review process is a team decision. Family members are often valuable sources of information about events and issues that led to a death but might not be documented in official records. Teams may choose to request interviews with surviving family members to obtain this personal, unofficial information about the victim's experiences.

Be sensitive to the needs and emotional state of family survivors. They may not be ready to participate in a process that revisits the violent death of their loved one. Teams that choose to involve family members should ensure the following:

- Family members understand the fatality review process and that its goal is prevention and not placing blame.
- Expectations are clear and defined for both family and team members.
- Family members are generally interviewed separately and *not* during a team case review meeting. A DVFRT may make an exception and decide to interview a

friend/family member *during* a case review meeting if members reach a consensus decision that this is appropriate. One Virginia team, for example, interviewed a victim's friend *during* a team case review meeting because a number of team members had a good rapport with this person and s/he was willing and comfortable speaking to the team as a whole.

- Interviews are conducted by one or two team members who are experienced in crisis intervention or grief counseling.
- Privacy and confidentiality are maintained for family members throughout the interview and review process.
- Resources and referrals are made available to family members.
- Published reports and recommendations are shared with family members.

A sample Family Interview Questionnaire from San Diego, California is included in the Document Resource Section.



See Document 12: Family Interview Questionnaire

The issue of family and other survivor involvement in the fatality review process was discussed at length at a National Summit hosted by the Family Violence Department of the National Council of Juvenile and Family Court Judges and the Governor's Task Force on Domestic and Sexual Violence, Florida Department of

"Our team has firsthand experience interviewing a victim's friend or family member during a team meeting. With proper guidelines, this can be a powerful tool to humanize the case review process."

Susan Clark, Lynchburg, Virginia DVFRT.

Community Affairs. Consensus about best practices in this area was not reached, but a comprehensive list of suggestions was assembled and is included in the Resource Section.



See Resource 6: Family/Survivor Involvement in DVFRTs: Recommendations from a National Summit.

Suggestions for survivor member interviews are included in the Resource Section of this Manual.



See Resource 7: Suggestions for Survivor Member Interviews

MEMBERSHIP RULES AND RESPONSIBILITIES

Teams should be clear in their expectations about membership. Rules and responsibilities should be spelled out in the policies and procedures and be reviewed and agreed to by all prospective team members

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. For example, the Fairfax, Virginia team protocol requires core team members to notify the coordinator "at least three days in advance of a meeting to be missed." Additionally, the protocol addresses the important issue of sending a replacement, requesting that the member who can not attend "send an alternate representative from their respective agency to participate in Team review. The alternate representative is expected to fully brief the Core Team member on issues discussed at the review."

Chronic absenteeism can disrupt the cohesion and productivity of a team. Teams should specify rules regarding absenteeism. For example, the Fairfax, Virginia team protocol states that "if a Core Team member misses more than three meetings in a year, the Team Co-Chairs and the DV Coordinator may revisit that person's membership to determine whether s/he may need to resign from the Team."¹⁴

"Fatality review teams should be a community effort, not just composed of members who represent the system. We continue to advocate for teams to provide for community representation by including, for example, survivors of domestic violence and members of the clergy. Why? In the case of survivors, who better understands the issue we are trying to tackle? In the case of the clergy, that's who victims speak with. One study found that of 400 victims, 2% had reported their situation to a domestic violence program; yet a resounding 70% had spoken with a clergyman about the abuse! Consider how these additions might improve your team's review process."

 Maryland Domestic Violence Fatality Review Newsletter, Summer/Fall 2008¹⁵ **Resignation:** Teams should address resignation procedures. If a member is no longer willing or able to participate on the team, timing for notification requirements and replacement procedures should be outlined. In addressing resignations, the Hampton, Virginia team requires a member to "notify the chair in writing. Members who resign from the team should be replaced within 60 days of the chair receiving notification of the resignation. New members will be appointed by the chair based on recommendations from the team."¹⁶

Training: Members—especially new members—need training on the process of fatality review; teams should plan and provide for this. Recommendations for training are covered in detail in *Chapter 6: Building Team Capacity*. 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
- Family and Intimate Partner Violence Fatality Review Team Protocol and Resource Manual- 3rd Edition, December 2009 (relevant selections and/or the complete manual)
- 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

There are some basic guiding principles for members (both permanent and ad-hoc) that are common to many, if not all, fatality review teams. The following member guidelines are from the Hennepin, Minnesota team:

- 1. Actively participate in all discussions.
- 2. Keep the goal of systemic improvements and prevention in mind.
- 3. Work toward collective understanding without laying blame. No personal attacks.

- 4. Use "I" statements.
- 5. Actively listen. Seek first to understand.
- 6. Maintain confidentiality. What is discussed in the Team stays in the Team.
- 7. Respect the participation of others and the process used.
- 8. Practice inclusiveness and equality in Team meetings.
- 9. Use conflict as an opportunity to build relationships.
- 10. Use self-care strategies.
- 11. Be on time and stay for the duration of the meeting. Advise the contact person if you will not be attending the meeting.
- 12. Avoid getting into the politics of a particular role or political stance.
- 13. Disclose any personal connections to the case being reviewed prior to the start of the meeting.
- 14. Avoid the use of acronyms. (Hennepin, MN^{17})

Other resources which explore the responsibilities of a fatality review team member are included in the Resource Section.



See Resource 8: Guiding Principles and Themes in Domestic Violence Fatality Review

See Resource 9: Working Assumptions and Group Agreement in Domestic Violence Fatality Review

CHAPTER 6:

BUILDING TEAM CAPACITY

A DVFRT works most effectively when its team members share knowledge, skills and trust. These critical qualities enhance the productivity and capability of the team and are referred to as *team capacity*. Because case review is new to many community stakeholders, team chairs or coordinators should facilitate training in the following areas before case review begins:

- Domestic violence: awareness of and sensitivity to the dynamics of domestic violence
- **Fatality review:** clear understanding of the theory and practice of fatality review
- Systems assessment: shift in focus from individuals to community networks
- **Team-building:** fostering positive group dynamics

"It is important that professionals develop a sophisticated understanding of domestic violence. This is especially important when that person has the potential to greatly affect the life of a person experiencing abuse."

-Hennepin, Minnesota Domestic Violence Fatality Review Team¹⁸

DOMESTIC VIOLENCE TRAINING

In order to effectively review cases and develop meaningful findings and recommendations, teams need a shared appreciation of the dynamics of domestic violence. This may seem self-evident, but it is important to remember that fatality review team members represent a variety of professions and disciplines, each with their unique perspective on domestic violence. These professional *and* personal perspectives can be affected by a wide range of factors such as education, race, gender, religion, socioeconomic status, and sexual orientation. For team members to work together effectively, they must respect each other's differences and find common ground.

A solid foundation in the fundamentals of domestic violence builds the sensitivity that team members need to effectively review and analyze cases. Substantive training information might include:

- Local and national domestic violence demographics
- Domestic violence fundamentals (including dynamics and safety planning)
- Local and national domestic violence laws
- Local and national domestic violence agencies/resources
- Multicultural competencies
- Lethality risk assessment
- Victim sensitivity
- Perpetrator accountability

A resource list of domestic violence educational materials is included in the Resource Section of this Manual. This list includes suggestions from local domestic violence agencies and provides a starting point for discussion and education about domestic violence. Also included in the Resource Section are two basic and well-known frameworks for understanding the societal context of domestic violence: the Social-Ecological Model and the

domestic violence: the Social-Ecological Model and t Power and Control Wheel.

> See Resource 10: Educational Materials Resource List



See Resource 11: Social-Ecological Model: A Framework for Prevention

See Resource 12: Power and Control Wheel

A listing of Virginia-specific domestic violence laws, as well as Federal and State Uniform Statutes, are included in the Resource Section.



See Resource 13: Virginia Domestic Violence Laws

See Resource 14: Federal and State Uniform Statutes

"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 Violence¹⁹

FATALITY REVIEW TRAINING

In order to effectively review cases, team members need to be versed in fatality review theory and practice. Domestic violence fatality review is a relatively new field, and may even be new to seasoned domestic violence professionals. *Team orientation* includes training and information on the *general* practices of fatality review, as well as the *specific* practices of your team. These materials might include:

- Team mission statement
- Team policies and procedures
- Code of Virginia sections referring fatality review
- Family and Intimate Partner Violence Fatality Review Team Protocol and Resource Manual- 3rd Edition, December 2009
- Team reports from other localities/states
- Other training/educational materials as determined by the team

Included in the Resource Section is a listing of online information resources about fatality review and domestic violence.



See Resource 15: Links to Information Sources about Fatality Review and Domestic Violence

The team orientation process should also familiarize team members with the commonly accepted *guiding principles* of fatality review. Some of the principles and benefits of fatality review, particularly useful in a community education presentation, were outlined in *Chapter 3: Governmental Endorsement*. A more comprehensive list as it relates to the fatality review process is included here:

- No-blame, no-shame: The goal of fatality review is to save lives and improve a community's coordinated response to domestic violence. To this end, multidisciplinary professionals carefully examine and analyze the circumstances of a death. Fatality review does not seek to assign blame to any agency or individual, nor does it seek to reinvestigate a case.
- Confidentiality: Successful case review hinges on team members honoring the rights and responsibilities of confidentiality. A detailed discussion of this topic can be found in *Chapter 7: Protecting Confidentiality*.

- Member participation: Case review, by its nature, requires that all involved agencies gather, present, and contextualize case-specific facts. The absence of relevant information can compromise the process and results of case review.
- Perpetrator Accountability: The perpetrator is responsible for the violence. Fatality review teams work to improve system response to violence, but abusers, not systems, are the cause of the problem.
- Victim sensitivity: Even experienced teams can fall into the unproductive trap of blaming the victim. As a team, work to shift focus away from the responses of victims and to the actions of abusers and the community response to domestic violence.
- Consensus decision-making: Fatality review is truly a group effort where members *together* analyze cases and develop findings and recommendations. The decision-making model most consistent with this group process is the consensus model, detailed in the team-building section of this chapter.

"Women were devastated by the personal betrayal of their abusers but perhaps equally harmed by the seemingly endless ways that police officers, clergy, welfare workers, judges, family members, landlords, attorneys, and therapists found to blame them for their partners' violence."

-Ellen Pence, Co-founder, Duluth Domestic Abuse Intervention Project²⁰

SYSTEMS ASSESSMENT TRAINING

Although fatality review is rooted in case-specific facts, teams have the unique opportunity—and responsibility—to analyze the big picture of a community's response to domestic violence. Members of a DVFRT, within their respective agencies, focus on improving the lives of individuals every day. The work of a fatality review team, however, requires a shift and widening of this focus, from *individuals* to *systems*. *Systems* assessment engages multidisciplinary members in a collective analysis of the strengths, gaps and challenges of the systems within a community.

The coming together of team members and facts is one of the most powerful aspects of fatality review. Working together, team members analyze their local domestic violence response efforts and capacities. Knowing your community is essential

"When I advocate for an individual woman, I am trying to help her overcome the many obstacles on her path to effectively using the courts and police to protect her. When I do systems advocacy, I am trying to build a new path. I come to understand what I need to do in systems advocacy by my work with individual women."

Ellen Pence,
 Co-founder,
 Duluth Domestic
 Abuse Intervention
 Project²¹

to effective systems assessment. This includes a profile and assessment of your overall community (e.g., local demographics, government, housing, and employment) as well as an examination of the specific roles and relationships among domestic violence agency responders.

Creating a community profile and assessment:

Examining your community enables the team to understand the local context in which domestic violence takes place. To do this, members compile and analyze information including population, economics, employment, housing, education, transportation, crime, and local services (general and domestic violencespecific). Identifying services that currently exist and the utilization patterns of those services allows for appraisal of resources, exposure of hidden resources which may be under-utilized, and identification of gaps in services. This information can then be used as a guide for comprehensive strategic planning. A listing of links to online community profile information sources is included in the Resource Section. Two community profile forms that can be adapted to fit the needs of your community are included in the Document Resource Section



See Resource 16: Links to Online Community Profile Resources



See Document 13: Community Profile: Demographics

See Document 14: Community Profile: Services and Utilization Patterns

Coordinated community response (CCR): Understanding the concept and practicalities of a *coordinated community response* (CCR) goes hand-in-hand with systems assessment. The goal of a CCR is to identify, integrate, and improve domestic violence services and networks within a community. This concept originated with the Domestic Abuse Intervention Project in Duluth, Minnesota and is described in detail in *Coordinating Community Responses to Domestic Violence: Lessons from Duluth and Beyond*²². This is one of many texts recommended on the educational materials list found in the Resource Section.



See Resource 10: Educational Materials Resource List

There are many ways to adapt the principles and practice of CCR to your community. One example is an assessment tool developed by the Virginia Sexual and Domestic Violence Action Alliance. This tool focuses on the effectiveness of protective orders as they relate to a community's overall CCR. Although this tool focuses on protective orders, it can be expanded or adapted to fit the needs of any community. A copy of this assessment tool is included in the Document Resource Section.



See Document 15: Ensuring the Effectiveness of Protective Orders in Virginia: Community Assessment Tool

Understanding the roles and relationships of agencies: It is critical to effective systems assessment that team members understand the services of—and the connections or gaps between—existing community domestic violence agencies and organizations. Although team members are experienced professionals with a good working knowledge of their own agency and discipline, they may not know about *other* agencies and disciplines. As a multidisciplinary team, they have a unique opportunity to educate each

other about their respective agency, services, policies, and procedures. This education process is valuable for all teams. Single jurisdiction teams learn about domestic violence services within their own jurisdiction. Multijurisdictional teams learn about those *within* and *among* all participating localities.

We recommend that teams engage in this agency education process *before* case review begins, although it also happens organically during team discussions. Members may find that this process enriches their ability to ask informed questions during case review, and enhances their capacity to identify and analyze gaps, overlaps, and challenges in the coordination of services. It also increases their sense of team cohesion.

Educating members about the roles and relationships of all domestic violence agencies can be encouraged and facilitated by the team. For example, before they began case review, the Lynchburg, Virginia DVFRT took the time for

"Our team took
the time to be sure
members had a
good understanding
of the roles and
relationships of all
involved agencies
and organizations
before we reviewed
our first case...it was
an invaluable tool in
building group trust
and cohesion"

–Susan Clark, Lynchburg, Virginia DVFRT

members to introduce themselves and their respective disciplines, agencies and services. They report that this process was an excellent tool in building team education, trust and cohesion. Their agency education suggestions follow.

Suggested elements for the agency education process

- Agency's enacting legislation and powers
- Functions of the agency
- Population the agency serves (children, elderly, non-English speaking, etc.)
- Location and hours of agency services (main office, satellite offices)
- Process for receiving agency services
- Cost of services
- Eligibility requirements for receiving agency services
- Ways the agency interacts with other agencies and service providers
- Services offered to person(s) involved in domestic violence (e.g., victims, family members, perpetrators)
- Examples of forms used, brochures, and other handouts
- Questions and answers from team members (Lynchburg, VA DVFRT²³)

Systems Matrix: Another framework for exploring the roles and relationships of system providers can be found by developing a Systems Matrix. The excerpt shown below was adapted from a chart used by the Humboldt County, California District Attorney's Interagency Domestic Violence Protocol Task Force, to clarify the roles and relationships of community service providers²⁴:

	Victim	Shelter Victim Advocate	Medical Provider	Police Officer	Victim- Witness Advocate	Social Services
Victim						
Shelter Victim Advocate						
Medical Provider						
Police Officer						
Victim- Witness Advocate						

Figure 2: Sample Systems Matrix

The chart is a depiction of all community agencies/disciplines involved in domestic violence (including the victim) along x and y axes, forming a graphic matrix or "relationship grid." Completing this chart may help team members to better visualize and understand the roles and vital relationships among domestic violence service providers. Team members complete the matrix by looking at points of intersection and answering the following questions:

- How do these two agencies (for example, law enforcement and domestic violence services) communicate when they have a domestic violence case in common?
- How do they coordinate responses to domestic violence events?
- What laws, policies and procedures govern, permit, prohibit, and shape this communication and coordination?
- What mechanisms exist for identifying and correcting problems in this relationship?

Moving across and through this matrix leads the team to a comprehensive picture of their community response to domestic violence. Completing the matrix provides the team with a baseline understanding of professional relationships, as well as opportunities for better coordination. Even before case reviews begin, this exercise can alert teams to potential strengths,

"Teams should remain mindful of their mission: to create systemic change. How does this case help you to see how gaps in the system can be plugged or how system improvements can be made? The findings of the particular case should result in recommendations that can be applied to the system."

Maryland Domestic
 Violence Fatality
 Review Newsletter,
 Summer/Fall
 2008.²⁵

challenges, and gaps that will be identified in specific case review. A sample blank matrix, which can be adapted to your community systems and needs, is included in the Document Resource Section.



See Document 16: Systems Matrix

TEAM-BUILDING TRAINING

A DVFRT 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. Following are some of the critical elements in fostering positive group dynamics, covered in detail in this section:

- Strong team leadership
- Consensus decision-making
- Team evaluations
- Stress management
- Team appreciation

Strong team leadership: The importance of strong team leadership cannot be overstated. DVFRT structures vary, but leadership most often comes from the chair/co-chair and/or the team coordinator. These

"Every team needs a 'maniac with a mission' to make sure the team happens! Strong committed leadership is critical to the establishment and longevity of a team."

Betty Wade Coyle,
 Norfolk Virginia
 DVFRT

members are most responsible for setting the tone of the meetings, establishing team policies and procedures, educating and encouraging team members, and monitoring the smooth meeting-to-meeting functioning of the team.

Effective leadership inspires a team and helps facilitate the development of trust and cohesion. It extends into every aspect of the team's functioning, including seemingly simple things like leading meetings. Tips for leading/facilitating group meetings are included in the Resource Section.



See Resource 17: Tips for Leading/Facilitating Group Meetings

A team leader should have good social skills and know the basics of group facilitation. These skills come more easily to some people than others, but can always be learned and improved upon. The Resource Section contains two articles written on leadership and coalition-building. *The Tension of Turf* article is especially relevant for regional teams who bring together a greater number or diversity of members, agencies, and jurisdictions.



See Resource 18: Creating an Atmosphere Where Everyone Participates
See Resource 19: The Tension of Turf: Making it Work for the Coalition

Consensus decision-making: Fatality review is truly a group effort; working together, members review cases and develop findings and recommendations. The decision-making model most consistent with the spirit of group process is *consensus decision-making*.

Consensus means that all team members agree that the decision is the best one for the group as a whole. It does not mean that all members share the same opinion. Consensus decision-making requires a unity of purpose and group commitment that voting does not. Voting creates winners and losers. It emphasizes a quantitative, rather than qualitative method, and can undermine the integrity of a group decision. Consensus can take longer but the time is worth spending because it is a synthesis of everyone's perspectives and intelligence. The decision that emerges out of consensus represents the whole and everyone takes responsibility to carry it out.

In the consensus decision-making model, there is a continuum of consensus that can be reached, from strongest agreement to strongest disagreement or blocking. The terms used in different models may vary slightly, but the following chart summarizes the basic spectrum:

YES!	<u>OK</u>	NON-SUPPORT	NO! (BLOCK)
(Unqualified Yes)	(Acceptable)	(Standing Aside)	(Unqualified No)
"I strongly agree with the decision."	"I can live with the decision; I find it	"I don't fully agree with the decision, but I am willing to support it because	"I strongly disagree with the decision and choose to block it."
	acceptable."	I trust the wisdom of the group."	olova II.

Consensus decision-making is considered so important that it has been incorporated by some teams into their written policies and procedures. An example of a consensus decision-making summary from the Chesterfield, Virginia DVFRT is included in the Resource Section.



See Resource 20: Consensus Decision-Making

Team evaluations: Another key tool in building a strong team is the evaluation/ feedback process. Team members should be given 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 stronger sense of ownership in the team, encourages honest and valuable group discussion, and may lead to positive changes in policies and procedures. This feedback can be given verbally or in written form. Written feedback can be given anonymously, which might encourage more candid comments, especially from members who are less likely to speak their mind. Two sample team evaluation tools are included in the Document Resource Section.



See Document 17: Team Evaluation Form (A)

See Document 18: Team Evaluation Form (B)

If the evaluation process is anonymous, regional teams might find it useful to identify feedback by jurisdiction. Asking respondents to name the locality they represent will preserve anonymity, but can help track possible jurisdiction-specific issues. For example, if evaluations indicate that certain jurisdictions are dissatisfied with an aspect of team functioning, the group as a whole needs to find a consensus solution. All teams need to assure members that their voices will be heard and counted equally. This is especially true for regional teams where collaboration can be more challenging due to a greater number or diversity of members, agencies, and localities.

Stress management: By its nature, fatality review can be 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 hard to deal with, especially for individuals who have chosen careers devoted to serving and protecting community members. As seasoned professionals, team members are familiar with concepts of professional boundaries, but this work can still have an emotional impact on individuals or on the group as a whole. Teams should consider how to deal with the emotional stress they might feel.

Talk to other teams about positive coping mechanisms. Many DVFRTs do not have formal policies in this area, but may have helpful ideas, resources, or strategies to share. For example, one Virginia team leader reports that she always ends a case review meeting by thanking her members for their work and allowing them time for comments or general discussion. Another Virginia team made the conscious decision *not* to have their case review meetings on Friday in order to better separate case review and weekend time.

We encourage team leaders to seek professional advice and/or become familiar with some of the research relating to the possible emotional stress resulting from case review. There is a wealth of literature relating to professional stress, fatigue and burnout; the topics of *compassion fatigue* and *secondary traumatic stress* are particularly relevant to the work of DVFRTs.

Team appreciation: Team members appreciate being acknowledged for their hard work. Thanking members is a basic but important practice that is sometimes overlooked. DVFRT members are busy professionals who voluntarily take time from their personal or professional lives to commit to the work of the team. Their dedication to the team and the community deserves respect and gratitude.

Selection of appropriate team members: A

team lays the foundation for positive group dynamics early on. As outlined in *Chapter 1: Establishing A Team*, the selection of appropriate members is an important part of building a good team. Ideally, team members are seasoned, mature professionals who are committed to improving their community's response to domestic violence. They should be open-minded, non-defensive, and willing to commit to the schedule and goals of the team. Members who are most likely to foster a sense of trust and commitment are those who attend meetings consistently and participate fully in the work of the team.

Development of policies and procedures:

Another key to building a good team is the development of comprehensive and appropriate team policies and procedures. Members need to know the ground rules of the team, including how the team will be run, what is "Have great
leadership, preferably
as the team leader...
This person should
be able to act as
champion for the
team. The leader
should have influence,
care passionately for
death review and DV,
be well-respected in
the community, and
have an ability to
listen to people."

-Susan Gottschalk, Montgomery, Ohio DVFRT

expected of them, and how cases are selected and reviewed. Give team members time to review and provide feedback on these policies and procedures before they are finalized. Giving members the opportunity to participate in the framing of the team encourages a sense of ownership.

CHAPTER 7:

PROTECTING CONFIDENTIALITY



CODE OF VIRGINIA § 32.1-283.3 (F) All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act...All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum or discovery or be admissible in

any criminal or civil proceeding. ...No person who participated in the review nor any member of the team shall be required to make any statements as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals...All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

(G) Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a family violence fatality review, unless such act or omission was the result of gross negligence or willful misconduct...

Confidentiality, the assurance that sensitive information is never shared beyond the team, is truly one of the cornerstones of fatality review. Candid discussions about specific events and interventions are vital to successful case review. 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.

A DVFRT lays the groundwork for confidentiality long before any specific agreements are signed. From its inception, a team educates all stakeholders—the core group, local governmental agencies, and prospective members—about the rights and responsibilities of confidentiality. These principles are expressed in many elements of team planning and development, including:

- Letters of invitation to prospective team members
- Formation of the team's mission statement
- Presentations to government officials
- Development of team policies and procedures
- Orientation/training of new team members

Virginia Freedom of Information Act (FOIA) and Confidentiality

The Virginia Freedom of Information Act (FOIA) gives the public access to records maintained by government entities.

In order to protect DVFRT confidentiality, the *Code of Virginia* §2.2-3705.5 (9) excludes "information and records acquired...(ii) during a review of any death conducted by a family violence fatality review team to the extent made confidential by §32.1-283.3..."

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 may be published in statistical 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. Agency employees or representatives are encouraged to reacquaint themselves with the confidentiality rules specific to their agency 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.

The *Code of Virginia* endorses and protects both single and multijurisdictional teams. A legal framework of trust begins with statutory protections and is enhanced by team confidentiality agreements. Virginia law requires the execution of a sworn statement to honor confidentiality for all persons attending a closed team meeting. Confidentiality agreements must be signed by each individual team member as a representative of their agency/organization. Sample confidentiality agreements are included in the Document Resource Section of this Manual.



See Document 19: Affidavit of Confidentiality

See Document 20: Confidentiality Agreement (A)

See Document 21: Confidentiality Agreement (B)

We recommend team members sign an additional confidentiality agreement at the beginning of each case review and/or each meeting. This abbreviated statement serves as a reaffirmation of each member's confidentiality responsibilities. Some teams include this reminder statement at the top of each meeting sign-in sheet, as shown in the sample agreement to maintain confidentiality, included in the Document Resource Section.



See Document 22: Agreement to Maintain Confidentiality

Despite the encouragement and protection of statutory guidelines, some individuals or agencies may be reluctant to engage in the fatality review process. This is often due to a fear of blame and exposure. Regional teams—where members share information with peers both *within* and *outside* their jurisdiction—may find this especially challenging. There are a number of ways to foster trust among team members:

- Agency education process: Team members educate their colleagues about the unique services, laws, and ethics of their specific agency or profession. Of particular relevance to confidentiality issues is the discussion of the unique considerations each member faces regarding information and record sharing (e.g., privilege issues). For a more detailed discussion of team education, see *Chapter 6: Building Team Capacity*.
- **Team Leadership:** Leadership is vital to the education and maintenance of team confidentiality. DVFRT structures vary, but it is often the coordinator or chairperson who plays an important role in training on and monitoring of team confidentiality. Consideration of confidentiality is built into most aspects of team functioning, including the framing of policies and procedures, the review of fatalities, and the building of team capacity. For a more detailed discussion on team leadership, see *Chapter 6: Building Team Capacity*.
- No blame, no shame: Fatality review is a confidential, nonjudgmental evaluation of the events leading up to a fatal incident. It is *not* an avenue to find fault, place blame, or reinvestigate a case. An accepted principle of fatality review is that the *perpetrator* is responsible for the violence; it is not the failure of an individual service provider or agency. This is referred to as the "no blame, no shame" concept of fatality review. Prospective and/or reluctant members need education on this concept, as well as on statutory and team confidentiality protections.

Many teams grapple with confidentiality concerns, and can benefit from the experience of other teams. We recommend that teams familiarize themselves with relevant and current DVFRT information, such as DVFRT final reports, newsletters, articles, and conference materials. Networking with other teams can also be useful. The Office of the Chief Medical Examiner provides a listing of Virginia DVFRTs, available online at http://www.vdh.state.va.us/medExam/Violence.htm.

CHAPTER 8:

REVIEWING FATALITIES



CODE OF VIRGINIA §32.1283.3 (A) The Chief Medical Examiner shall develop a model protocol for the development and implementation of local family violence fatality review teams (hereinafter teams) which shall include relevant procedures for conducting reviews of fatal family violence incidents. A "fatal family violence incident" means any fatality, whether homicide or suicide, occurring as a result of abuse between family members or intimate partners... (E) The review of a death shall be delayed until any criminal investigations or prosecutions connected with the death are completed.

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 chapter 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. These common elements are outlined below, and follow in order through this chapter:

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

BEFORE YOU BEGIN CASE REVIEW...

As outlined in Chapter 6 - Building Team Capacity, we recommend DVFRTs facilitate basic training and team-building before case review begins. Supporting a shared knowledge and sense of unity among members will enhance the productivity and effectiveness of the team.

We strongly recommend teams read the final reports of other DVFRTs before they begin case review. Familiarizing members with the work of other teams will help you better plan for your own team's case review process, findings and recommendations, and final report.

CASE IDENTIFICATION and SELECTION

In identifying and selecting appropriate cases to review, the *Code of Virginia* provides a broad framework that allows a review of any homicide, homicide-suicide or suicide that occurred as a result of violence between family members or intimate partners.

The Code requires that teams review only closed cases where no further criminal investigations or prosecutions are pending. It is advisable to discuss the identification of appropriate cases with your Commonwealth's Attorney. Regional teams should check with the Commonwealth's Attorneys of all relevant jurisdictions. In general, the members of the team most closely involved with the case—usually Commonwealth's Attorneys or law enforcement—are an excellent resource in selecting cases that fit Virginia's statutory criteria. In Virginia, DVFRTs generally focus their efforts first on fatalities of intimate partners, then on family members, and lastly on other fatalities associated with family or intimate partner violence.

The number and types of cases reviewed depends on many factors, including the number of local domestic violence fatalities and the goals and capacity of the team. Teams should attempt to review as broad or objective a range of cases

"We decided to review suicide cases when it became apparent that in many instances the decedent was involved with several community resources, and was known to law enforcement and mental health professionals before his/ her death. This awareness kept the team focused on the importance of effective communication between the different disciplines and the need for immediate referral for services."

-Amy Jacobson, Colonial Area, Virginia DVFRT

as possible. Avoid selectively picking cases. Instead, choose a designated period of time (for example, the year 2005, or the five year period from 2003-2007) and review all relevant cases that occurred during that time. This method will provide an inclusive and representative overview of a locality's fatal domestic violence cases.

When new DVFRTs choose their initial case(s) for review, they should start with cases that are relatively simple to review. While there are no easy cases, there are those that are better documented, less controversial, or more readily available for review (e.g., a homicide/suicide with no pending criminal investigation or prosecution).

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

"If the case to be reviewed also involves a jurisdiction outside of Hampton, the chairman shall invite participation by the appropriate representatives of the involved jurisdiction."

-Hampton, Virginia DVFRT Protocol²⁶ 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 Judges²⁷ 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
- Newspaper articles/media accounts

- Pre-trial service records
- Prosecution records
- School records
- Security guard interviews
- Service records from other communities
- Social services records
- Suicide intervention reports
- Victim advocate records
- Weapons records
- Witness/neighbor/family member interviews*

*The possible inclusion of information and/or representation from "non-system" members (e.g., family and friends of victims or members of the survivor advocacy community) is an important issue for teams to consider. More information on this topic is included in Chapter 5: Shaping Team Structure.

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.

ORGANIZING CASE FACTS

Compiling case facts: Once case facts are collected by members from their respective agencies, this information is compiled and organized. Teams can do this *prior to* the first case review meeting or *during* the meeting. Either method is acceptable, and depends on the energy and staffing of the team. Generally,

the compilation of case information prior to the team meeting requires a designated recorder or coordinator. S/he gathers, organizes, and sometimes summarizes case information so it is ready when the team comes together at the case review meeting.

If case facts are *not* compiled prior to the team meeting, this task is done during the case review meeting by either a volunteer or designated recorder. A designated

"Start with facts not emotions. Establish communication, build trust, and the rest will come."

-Betty Wade Coyle, Norfolk, Virginia DVFRT recorder is not necessary, but makes data compilation and reporting more organized and efficient. It also allows other team members to focus on case discussion and synthesis rather than on taking notes.

Creating a case timeline: Timelines have been found to be an effective way of organizing case facts from various agencies and organizations. A timeline is a summarized listing of events leading up to a fatality. It describes each discrete event (such as an arrest, or request for services) in a simple format identifying the date, agency, and incident. An example adapted from the Hennepin, Minnesota case chronology form²⁸ follows:

Date	Agency	Event(s)	Additional information, opportunities for intervention, recommendations, or comments
April 4, 2007	Police	911 hang-up from residence. Return call attempted. No answer. Dispatch sent officer to investigate. Jane and John Doe denied needing assistance.	(This is generally completed as the team collectively discusses and analyzes the case facts)
April 21, 2007	Child Protective Services	Anonymous phone call received with concern for children's safety. Caller reportedly saw John Doe repeatedly hit his 3-year old child Mary Doe in the face.	
April 27, 2007	Court	Emergency Protective Order sought by Jane Doe.	

Figure 3: Sample Case Review Timeline

As shown in the example above, timelines refer to agency involvement, and do not identify the names of individual service providers. Timeline chronology can begin with the fatal event and work backwards, or begin with the earliest contact and work forward to the time of death. Timelines may be created prior to or during the team's case review meeting(s). The last column is generally completed with the collective input of all members.

One Virginia team uses PowerPoint to create its timeline during the case review meeting(s). A member/recorder makes timeline entries on a computer that then projects the entries on a screen. This way, all team members can easily view and discuss the timeline. A timeline form (with instructions) can be found in the Document Resource Section.



See Document 23: Case Review Timeline

Completing a case facts data collection

form: Completing a case facts data collection form is a critical element in the analysis and documentation of a case. This document is completed during the case review meeting through the contribution of all team members. A detailed discussion is included in the "Collective Team Discussion" section that follows.

Completing a systems assessment data collection form: Completing a systems assessment data form is another critical element in the analysis and documentation of a case. This form is also completed during the case review meeting through the contribution of all team members. A detailed discussion is included in the "Collective Team Discussion" section that follows.

"Written timelines have been a significant part of protocol development since we have begun fatality review in Maryland. Teams that use timelines know how helpful they are to case review. They organize reviews, simplify case presentation, efficiently include all the important case information, and minimize distracting questions during reviews. A sample timeline is on the MNADV website."

-Maryland Fatality Review Newsletter, Summer/Fall 2008²⁹

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. There are multiple elements involved in the case review process. All are critical. Not all teams use the same terminology for this process, nor do they all use the same data collection or analysis methods. Likewise, there is no prescribed order to these functions; they are often done simultaneously and/or throughout the entire case review process.

CASE FACTS

Discussion and analysis: Fatality review is truly a multidisciplinary process. Case information from a wide range of disciplines is brought to the table for discussion and analysis. Equally important 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 examine the complexities of domestic violence

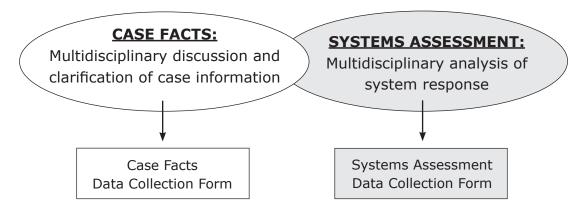


Figure 4: Elements of a DVFRT's Collective Case Review Process

and of their system response. As mentioned earlier, the sharing of multidisciplinary information and perspectives is critical to effective case review and systems assessment. A team member is responsible for bringing their agency's information to the table, for understanding that information, and for being able to contextualize that information for other team members—for example, by explaining his/her agency's policies and procedures, professional guidelines, resource limitations, etc. It is through this multidisciplinary education and discussion that team members are able to better understand the realities—and identify strengths and gaps—in their community's response to domestic violence.

Documentation: Teams should complete some kind of comprehensive data collection form. This form 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. This encourages the collection and reporting of case information that is more easily adapted to the next—and more complex—level(s) of case review which is systems assessment. Sample case facts data collection forms, ranging from more closed-ended to more open-ended, are included in the Document Resource Section.

"It is extremely important to have a data collection tool that will capture all the case information you need to assist your team in making findings and recommendations, and that works for your particular jurisdiction. We've reviewed many cases, and have refined and improved our data collection process—and forms—over time."

-Susan Clark, Lynchburg, Virginia DVFRT



See Document 24: Case Facts Data Collection Form (A)

See Document 25: Case Facts Data Collection Form (B)

See Document 26: Questions to Guide Case Review Discussion

Data collection forms and procedures are not static and may evolve over time. We encourage teams to periodically review and revise their processes and forms. This may be especially valuable for multijurisdictional teams, where existing protocols for domestic violence response and reporting may vary among jurisdictions.

SYSTEMS ASSESSMENT

Discussion and analysis: This is probably the most complex and critical level of case review. After all the facts and circumstances have been presented, the team synthesizes and analyzes this information. This process, which is the heart of multidisciplinary review, is detailed in *Chapter 6: Building Team Capacity*. As individuals and as a team, members apply critical thinking to the system responses identified in the case. This is not necessarily a separate step of case review. It may be happening on an individual or team basis throughout the entire review process.

Experienced teams report that this level of analysis improves and becomes easier with time, especially if the team has an effective, systematic method of case review in place.

Documentation: Like the case facts data collection form, the systems assessment data collection form serves multiple functions. It encourages discussion and analysis at the systems level. It also serves as a record-keeping and data collection tool which can help streamline the findings and recommendations process (where aggregate case review information is tabulated and analyzed). New teams, especially, may resist the filling out of forms. But experienced teams have found that these documents encourage higher-level critical thinking and make their work easier when they begin developing findings and recommendations. A sample systems assessment data collection form is included in the Document Resource Section.

"I want to be sure we ask the hard questions about each case before we finish it...I would suggest that we have not really faced the difficult systemic issues. I think we have identified many of the issues this case has raised about what the victim did or did not do, but we have not truly turned the mirror around to try to examine how each of our agencies could have done a better job."

Baltimore Chairperson
Dorothy Lennig, in a letter
to her team, quoted in
the Maryland Domestic
Violence Fatality Review
Newsletter, June 2007³⁰



See Document 27: Systems Assessment Data Collection Form

Case review will be different for every team but shares many basic elements. Using the descriptions and experiences of other teams, a DVFRT will find the process—and the data collection tools—that work for them. We recommend that teams familiarize themselves with the case review guidelines, as well as the protocols and reports, of other teams. Sample DVFRT case review guidelines are included in the Resource Section.



See Resource 21: Sample DVFRT Case Review Guidelines

Fatality review is a complex process, and a team's work will grow more efficient and sophisticated over time. As with other aspect of DVFRT functioning, we recommend teams network with and learn from other teams whenever possible. We have included the following chart to summarize the case review process outlined in this chapter.

CASE REVIEW SUMMARY

Prior to the case review meeting: individual members prepare case information

- 1. Case identification and selection
- 2. Case notification and information request
- 3. Collection of case facts by individual team members
- 4. Possible early compilation of case facts *before* first case review meeting (by team recorder or coordinator)

During the case review meeting: collective, multidisciplinary case review begins

- 5. Case facts:
 - a. Discussion/reconciliation
 - b. Documentation
 - i. Team may create timeline
 - ii. Team completes case facts data form
- 6. Systems Assessment:
 - a. Discussion/analysis
 - b. Documentation
 - i. Team completes systems assessment data form

CHAPTER 9:

DEVELOPING FINDINGS AND RECOMMENDATIONS



CODE OF VIRGINIA §32.1-283.3 "Upon the conclusion of the fatality review...the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals."

A team's findings and recommendations are the crucial link between their confidential process of case review and the de-identified sharing of results from that process with the community. A *finding* summarizes the aggregate body of information compiled and analyzed during case reviews. A *recommendation*, based on the team's data-driven findings, is a concrete call to action that tells a community how to intervene and prevent future fatalities. Findings and recommendations together represent the collective analysis and wisdom of a team. The following is an excerpt from the Henrico, Virginia DVFRT's 2008 findings and recommendations:

Finding: A biological or stepfather murdered all of the child victims. Sixty-seven percent of the child victims were of elementary school age and 33 percent were under the age of 13 months.

Recommendation: (1.2) Law enforcement officers, health care professionals, daycare providers, teachers, school administrators, administrators of after-school programs, coaches, leaders, volunteers and agency employees working with elementary school children should have mandatory training on the impact of domestic violence on children.³¹

"Make the process of case review as systematic as possible...
This improves the data collection and analysis process, and better prepares the team for the findings and recommendations process."

-Beth Bonniwell, Henrico, Virginia DVFRT

FINDINGS

After each case review is completed, teams will have a new body of information upon which to build their findings and recommendations. DVFRTs will find this process is made easier if, as recommended in *Chapter 8: Reviewing Fatalities*, they have gathered and reported data in a systematic way. By standardizing data collection, aggregate quantitative analysis is made more efficient and reliable.

Aggregate data is the sum total of case facts from multiple reviews. By examining this aggregate data, a team begins to identify important factors and trends. For example, if a firearm was used in a homicide being reviewed, the *individual* case data collection form documents this. The aggregate data collection form would then document how many cases involved the use of a firearm, and what percentage of total cases that number represents. The following graphic represents the relationship of an individual case fact (e.g., use of firearm as documented in one case) to the aggregate total data.

"We have found it helpful to identify preliminary findings as each case review is completed. We do this in addition to filling out our case review documents and find it helps us recall and analyze case details."

Susan Clark, Lynchburg, Virginia DVFRT

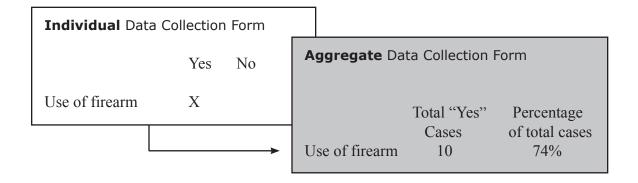


Figure 5: Relationship of Individual to Aggregate Data Collection Forms

Whatever *individual* data collection form is used, we recommend the team use a corresponding *aggregate* form. The following graphic illustrates the overall flow of *individual* case information (and documents) into *aggregate* case information (and documents).

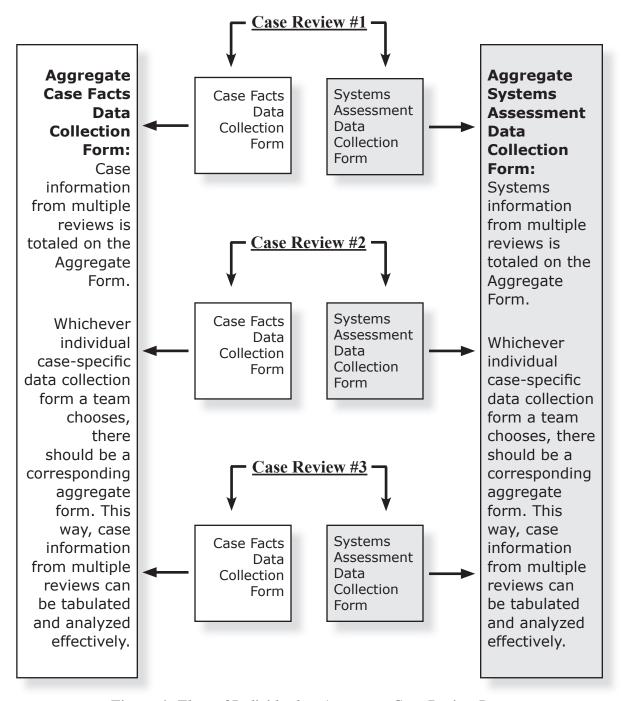


Figure 6: Flow of Individual to Aggregate Case Review Data

Information collection and tabulation is important to case review, and need not be overly time-consuming or complex. Some teams use readily available software such as Excel or Access to do this work. Others are lucky enough to have a skilled member(s) willing to do this work. Outside help can also be utilized. For example, one Virginia team uses an intern from a local college to help them process case information.

DVFRTs may choose to organize findings after reviewing a certain number of cases (e.g., ten cases) or after a predetermined time period (e.g., one year). Some experienced teams report that they organize findings and brainstorm preliminary recommendations after each individual case review. In either case, the data presented in aggregate form will serve as the basis for team recommendations. Analysis of the number and percentage of occurrences described in the Aggregate Case Facts data will provide answers to the following questions:

- Who is being affected by the problem?
- What methods are used to perpetrate the violence?
- In what circumstances does the problem exist?
- What specific problems arise from those circumstances?
- How are domestic violence victims and perpetrators affected by the problems?
- What signs were present prior to the incident?
- What services were requested, received, or refused by the victim or perpetrator?
- What agencies were not involved but needed to be?

Examination of all aggregate data (i.e., Aggregate Case Facts and Aggregate Systems Assessment) provides information on trends and patterns contributing to mortality. Analyzing which factors are present and which are absent is critical. 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. Samples of aggregate forms are included in the Document Resource Section of this Manual.



See Document 28: Aggregate Case Facts Data Collection Form See Document 29: Aggregate Case Facts Data Spreadsheet See Document 30: Aggregate Systems Assessment Form

RECOMMENDATIONS

Effective team findings—drawn from careful compilation and analyses of case facts—will lead to effective recommendations. Important elements include:

- Explanation of the problem/finding
- Clear connection to the case(s)
- Action required
- Clear target (topic area and stakeholder)

There are many possible areas of action that a recommendation can address:

- Education
- Training
- Policy
- Practice
- Networks or collaborations
- Resources
- Funding
- Services
- Legislation

"Teams should understand that making recommendations and seeking change is their reason for being... (They) should develop a sense of empowerment to take actions they believe are necessary in order to get a fair hearing for their recommendations and to, ultimately, evoke social change."

-Maryland DVFR Newsletter, June 2007³²

Recommendations can take many forms. They can be wide-ranging and multidisciplinary or discipline-specific. In their 2006 DVFRT Report, Washington State listed key recommendations which they described as meriting priority because "they relate to issues identified repeatedly in reviewed domestic violence fatality cases and speak to a range of professional disciplines."³³

- (1) Mental health professionals, suicide specialists, and domestic violence programs should collaborate to provide cross-training to each other and to increase their ability to provide the appropriate range of services to domestic violence victims who are suicidal or have other mental health concerns.
- ...(3) Domestic violence programs and task forces should engage community informants, such as friends and family of domestic violence victims, to learn how to increase visibility of the range of services available. Such efforts should address the distinct opportunities and challenges for rural and remote communities and for marginalized populations.³⁴

In the same report, Washington State also made recommendations that were discipline-specific, such as the following recommendations addressed to civil attorneys, judges and civil courts:

(6.4) Courts should have domestic violence resource information available throughout the courthouse (e.g., in bathrooms, waiting areas, clerks' offices, Protection Order offices).

(6.8) All attorneys practicing family law should receive training on how to identify when domestic violence is an issue and what factors indicate an increased risk for serious injury or lethality.³⁵

Shifting gears from reviewing cases to writing findings and recommendations is difficult for some teams. So is sorting through fatality review documentation for multiple cases. This is another reason why many teams recommend the use of systematic data-collection forms and documentation as individual cases are being reviewed. It makes the findings and recommendations processes much easier.

The following tips on developing recommendations are from Chesterfield County, Virginia, a single jurisdiction team, but apply to multijurisdictional teams as well. An additional consideration for regional teams is whether their recommendations will be general (covering all jurisdictions) or locality-specific if necessary.

Take time: The recommendation process took us three times longer than we thought it would!

Consider work groups: We formed smaller subgroups of 6 or less people to begin work on the recommendations, which were then presented to the larger group. This was efficient, but may have slowed down the larger group's motivation.

Information synthesis: This was challenging; there was a lot to process since we'd reviewed over 15 cases

Prioritize issues: Our team decided to focus only on issues that were present in at least 50% of the cases. We searched for trends, then identified specific issues.

"Make sure your recommendations are tied directly to your case findings. Recommendations should be specific and data-driven, not just general recommendations without validation."

Susan Clark, Lynchburg, Virginia DVFRT **Create a working chart:** As risk factors were identified, they were posted on a chart. As cases materials and risk factors were reviewed, this helped keep us organized.

-Sharon Lindsay, Chesterfield, Virginia DVFRT³⁶

As teams develop recommendations—determining what action should be taken to address domestic violence problems in their community—they might utilize a guide such as the Spectrum of Prevention. This framework provides definitions and concrete examples of prevention strategies. It can be accessed through The National Online Resource Center on Violence Against Women at www.vawnet.org. A copy is included in the Resource Section.



See Resource 22: Spectrum of Prevention (from A Prevention Primer for Domestic Violence: Terminology, Tools, and the Public Health Approach)

Teams structure their findings and recommendations in a variety of ways. We recommend DVFRTs review the findings and recommendations of other teams. We have included several sample findings and recommendations from Virginia teams in the Resource Section.



See Resource 23: Sample Virginia DVFRT Findings and Recommendations

"The success of our multijurisdictional team in identifying cases to review, attending and coming prepared to meetings, and making sound recommendations is largely because our key stakeholders—law enforcement and prosecutors—have a proactive and progressive interest in interrupting the cycle of violence and any ineffective response to domestic violence."

-Amy Jacobson, Colonial Area, Virginia
DVFRT

CHAPTER 10: PREPARING TEAM REPORTS



CODE OF VIRGINIA §32.1-283.3 "Upon the conclusion of the fatality review...the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals."

DVFRTs owe it to their communities to develop meaningful findings and recommendations, and to summarize and report their conclusions. A team's report(s) raises community awareness about the dynamics and prevention of fatal domestic violence. It serves to educate and motivate local stakeholders, and can lead to improvements in a community's coordinated response to domestic violence. These reports, while vital at the local level, also contribute to work being done at the state and national level.

PLANNING TEAM REPORTS

Depending on community goals and resources, team reports can vary widely in format, complexity, and cost. We recommend reading the reports of other teams to

help you decide on the structure and content of your own report. A DVFRT report can be a simple letter outlining findings and recommendations or a complex multi-page document with charts, photographs, and statistical summaries. In Virginia, the statutory requirements specify only that the report *not* disclose the identity of any individuals involved in the case. Included in the Resource Section of this Manual is a summary of elements commonly found in DVFRT reports, as well as links to online reports.

"As members of a team we have the opportunity to bring about social change in our own county through a true coordinated community response. What power, if used appropriately! Simply organizing and meeting just to say you have a team is not only a waste of everyone's valuable time, but sells the community— particularly victims of the community—short. Teams should gather with a clear view of the shared power they hold and the responsibility they have undertaken...."

Maryland DVFR Newsletter, Winter/
 Spring 2008³⁷



See Resource 24: Elements Commonly Found in DVFRT Reports

See Resource 25: Links to DVFRT Reports

The following are questions to consider before a team begins planning for the development and publication of their report:

- What form will the report take (e.g., letter, brochure, PowerPoint)?
- How will we publish it (e.g., printed, electronic)?
- Who is our audience?
- Who will write the report?
- How will we organize the case review data (e.g., by county/region, magisterial districts)?
- Who will handle the graphics?
- Do we need a professional printer (or can we self-publish)?
- Who funds the report, and what is our budget?
- Who will review and edit the report (e.g., team members, professional editor)?
- Do we need to vet the report (e.g., community leaders, survivors, government officials)?
- How do we get the report publicized (e.g., press release, press conference, mailing)?
- Are there political considerations regarding the release of this report? Who will deal with them?
- Who is our designated media spokesperson(s)?

Whatever report format a team chooses, the critical essence of that report should address:

Who is at risk in our community? This includes a description/demographic profile of victims, families at risk, and perpetrators, including age, race/ethnicity, gender, and area of county or city.

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? This includes discussion of circumstances surrounding domestic violence deaths such as lethality and other factors present in the intimate partner and/or family relationship, nature of intimate partner relationship and/or conflict, precipitating fatal violence, and the degree to which children witnessed violence.

What did the team—in their collective, multidisciplinary wisdom, and with the benefit of retrospective review—think and conclude about these deaths? This includes team conclusions about services, gaps, resources, and training in the community's response to domestic violence.

The heart of a team's final report is their findings and recommendations. The statistical information provided in the report should clearly substantiate the problems that the recommendations are intended to address. Substantiated findings provide support and leverage for implementation of the team's recommendations.

The Chesterfield, Virginia team structured their recommendations using statistical facts drawn directly from aggregate case review, and followed that with their conclusion, recommendation, target group and a general discussion of the issue. An example from their 2004 report follows:

Fact: In the cases reviewed, 55% of victims were recently separated or planning to separate from the perpetrator.

Conclusion: Victims who have either recently separated or plan to separate from a violent partner are at greater risk of harm and/or serious injury.

Recommendation: Increase awareness of lethality risk factors including those associated with separation. If targeted audiences can perform lethality risk assessments that include questions about separation or be aware of the risk associated with separating, victim safety may be enhanced.

Targeted groups: Divorce attorneys, court intake workers, DSS staff, general public, family and friends of families experiencing domestic violence.

Discussion: Separation is a risk factor that is usually connected with lethal intimate partner violence. Separation can include anything from filing for divorce to verbal statements to friends and family members about leaving an abusive relationship. In 2002, the Office of the Chief Medical Examiner found that 28 of 43 intimate partner homicides in Virginia were associated with a relationship that had ended or was ending. Of those 28 cases, there

were 2 divorces filed, 7 separations, 10 break-ups, and 9 cases in which the victims planned to end the relationship. Most of our Chesterfield County domestic homicides involved victims who were planning to leave their abuser.³⁸

Effective DVFRT reports can lead to positive social change—including improved funding, training, legislation, and coordination of domestic violence services. Writing for the National Domestic Violence Fatality Review Initiative (NDVFRI), Robin H.Thompson summarizes 12 ways teams can help effect social change:

- 1. Trumpet the differences you have made.
- 2. Communicate in clear, simple, straightforward and user-friendly ways.
- 3. Prioritize and limit recommendations.
- 4. Be rigorous in stressing accountability.
- 5. Follow-up regularly on recommendations.
- 6. Make the report and other products useful to the field.
- 7. Work with the media: establish credibility and relationships.
- 8. Ground the work in reality—talk to community (victims) and incorporate their voices.
- 9. Have a long-term vision—this won't happen overnight.
- 10. Link findings and recommendations to reviewed cases.
- 11. Designate "ambassadors" for talking to the media, doing training and technical assistance (both to state and to members' constituent groups).
- 12. Be informed by the work of other fatality review teams.³⁹

The full text of these recommendations can be found in the Resource Section.



See Resource 26: "Evoking Social Change: How Domestic Violence Fatality Review Team Recommendations Can Make A Difference, Part 2."

"Transitioning to developing recommendations and writing a report can be difficult. Our team went on a report-writing retreat! This helped us to focus, be productive, and think outside the box."

Beth Bonniwell, Henrico, Virginia DVFRT Report writing is a challenging process for many teams. It can be difficult to transition from case review to report writing (similarly, it can be difficult to transition from case review to developing findings and recommendations). Teams may want to consider forming a subgroup(s) to begin drafting the report. This divides the workload among multiple members/groups and may encourage more varied and creative input. Consider members' motivation, availability, teamwork, and writing skills as you form these groups.

If report writing is divided among multiple members or groups, be sure they are using the same data and terminology. Avoid using unfamiliar or technical jargon. Have

all writers follow one designated set of publication guidelines, such as those of the *American Psychological Association (APA)* or the *Chicago Manual of Style*. Keep in mind that you will need to reconcile different perspectives or writing styles. Designating one person to edit and/or write the final version can improve continuity, but may be overwhelming for one person.

Establish goals and deadlines, as well as a communication/review process with the full team. If a subgroup(s) is doing the bulk of the writing, they should keep the full team informed of their progress and build in time for team feedback. Try to keep the non-writing members invested in the team process during report-writing. One solution might be to have the other team members work on another project during this time. For example, the Henrico, Virginia team identified the need for a PowerPoint presentation to use as a community education tool. Team members who were not involved in report-writing worked on the PowerPoint while the others finished drafting the team report. This way, everyone was involved and productive.

"Don't underestimate the power of your team's report to educate and create change.
The findings and recommendations of Virginia DVFRTs have had a positive impact at the local level, and also feed into important work being done at the state and national levels."

Meg Norling,
State Coordinator,
Domestic Violence
Fatality Review,
Virginia Department
of Health, Office of
the Chief Medical
Examiner

DISSEMINATING TEAM REPORTS

The team's report is a powerful tool for education, advocacy and social change. Publication of a team's report can take many forms:

• Letter to a governmental agency, community partners, and/or general public (this can be mailed, emailed, or presented in person at a public forum)

- Printed report, to be distributed to specific agencies and/or the general public
- Electronic posting of information on a designated website
- Link to electronic posting of portable document format (pdf) file
- Press release to the media

WORKING WITH THE MEDIA

The media can be an invaluable partner in raising community awareness and publicizing the work of the team. Your team may have access to an experienced media person through one of the member agencies. Law enforcement agencies, for example, often have a designated media contact. A brief summary of important points regarding the media follows:

- **Know your media options**: They include TV news and talk shows, radio news and talk shows, press conferences, newspaper or magazine articles, columns, editorials, letters to the editor, websites, online journals, proclamations, calendar announcements and community bulletin boards.
- Create a media list: Know the names and contact information for your media options. Keep the list current.
- **Designate a team media spokesperson:** Each DVFRT should have one (or more) person(s) responsible for speaking on behalf of the team. The media spokesperson for a regional team should be clear that s/he is speaking on behalf of their team which represents *multiple* jurisdictions. For example, a spokesperson for a three-county team, identified as representing an agency

in County 1, should be clear to mention that s/he speaks on behalf of the team representing Counties 1, 2, and 3. This way, all team members and localities feel fully represented.

- Build media relations: Introduce your team spokesperson(s) to local media and public relations professionals. This provides networking opportunities and establishes the spokesperson as a valuable expert resource.
- **Prepare your message:** Develop talking points. These are key points that should be clearly stated, and are especially important to use during interviews.

"There are times when you will want media support for advocacy work you're doing. If you develop good relationships with key reporters they can help to support your efforts..."

-Amazons Olivella, Committee Member, National Domestic Violence Awareness Month Project⁴⁰

- **Be clear and concise:** Stay on message with any communications. "Less is more" when dealing with the media. Targeted, clear information is more likely to be reported or interpreted correctly.
- Use your report to educate the community: A DVFRT's findings and recommendations are important educational tools for the community. Use them!

There are many guides and resources available to teams to help them become more media-savvy. The National Domestic Violence Fatality Review Initiative (NDVFRI) has compiled an extensive list of media tips, which is included in the Resource Section.



See Resource 27: Working with the Media

The National Resource Center on Domestic Violence has published *Media Outreach Made Easy: An Advocate's Guide to Working with the Press.* It can be accessed at http://new.vawnet.org/Assoc_Files_VAWnet/NRC_media.pdf. Two sample media releases are included in the Resource Section.



See Resource 28: Sample Media Release (A) See Resource 29: Sample Media Release (B)

In addition to providing the media with your report, we recommend including fact sheets or background information about domestic violence and fatality review. Like the general public, journalists may not be knowledgable about these topics. Providing this information helps fill potential gaps and avoids misreporting.

Another benefit of providing background information is that it puts domestic violence homicides in context. Your community's fatalities are not isolated occurrences. They are part of a larger social, criminal, public health, and safety crisis. This is a critical concept about which the media and general public should be

"By accurately covering domestic violence homicides and avoiding sources, questions and language that perpetuate myths, journalists can make a significant difference in helping the community understand how domestic violence can go unchecked to the point of murder."

-Kelly Starr, Washington State Coalition Against Domestic Violence⁴¹ educated. There are a number of respected sources for information, statistics and resources regarding domestic violence. These include:

Virginia Department of Health, Office of the Chief Medical

Examiner- Family and Intimate Partner Violence Homicide

Surveillance and Fatality Review

www.vdh.state.va.us/MedExam/violence.htm

Virginia Sexual and Domestic Violence Action Alliance

www.vadv.org

National Family Violence Prevention Fund

www.endabuse.org

National Online Resource Center on Violence Against Women

www.vawnet.org

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