Domestic Violence Fatality Review

A Guide for Florida's Domestic Violence Fatality Review Teams

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CONTENTS

INTRODUCTION

Domestic violence fatality review (DVFR) teams identify and analyze homicides, suicides and other deaths caused by or related to domestic violence. Some DVFR teams explore basic demographic information about victims and perpetrators and provide brief details about the involvement of community agencies and stakeholders. Other teams gather more comprehensive information about the lives of victims and perpetrators, their families, and their social networks to examine the extent of agency and community interaction with the perpetrator and/or victim. All DVFR teams utilize the review to propose interventions designed to close gaps in agency and systems coordination, collaboration and communication and enhance community responses to domestic violence. Often system enhancements include training to ensure providers are sensitive to the complex lives of victims and understanding their role in holding perpetrators accountable.

Although domestic violence fatality review has been in existence for more than two decades, reviewing the fundamentals of the DVFR team model is important to stay current with emerging practices. Teams regularly invite new members or sometimes lose seasoned members. New teams also periodically come into existence. The purpose of this guide is to provide DVFR teams with basic information on conducting a domestic violence fatality review from a contextual framework that considers the experiences of domestic violence victims and the choices made by perpetrators. The use of comprehensive processes and protocols that examine the lives and deaths of victims of intimate partner homicide and their perpetrators can lead to improved safety for domestic violence survivors and their children, and provide insight into meaningful and constructive ways to hold perpetrators accountable for their violent behavior.

Information on the history of fatality review and emerging practices for new and continuing teams is also included in this guide. No matter how long a team has been operating, there is always opportunity to consider new elements in a review and to learn more about effectively preventing domestic violence homicides.

OVERVIEW OF DOMESTIC VIOLENCE FATALITY REVIEW

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Beginning in the early 1990's, frustration with the high levels of violence against women in America coincided with an emerging model of reviewing fatalities in the medical, aviation and nuclear fuel industries. This new model used multidisciplinary teams to focus on prevention rather than blaming various individuals or organizations for these tragic deaths. Professionals working toward the reduction of domestic violence crimes utilized the social momentum in the field and applied the practices of other fields to domestic violence intimate partner homicide.

The Violence Against Women Act (VAWA), which was first passed in 1994, provided funding and credibility to the efforts of those working to reduce the death rate of women in violent relationships. Domestic violence fatality review expanded quickly and increased to approximately 190 permanent teams in 44 states within a decade after the passage of VAWA. In sparsely populated states such as Montana, New Mexico, Kansas, Iowa and Oklahoma, statewide teams work with local communities where deaths occur. More populated states have a larger number of teams; Maryland and California each have at least 20 teams and there are 13 teams in Arizona.[1]

[1]Dr. Neil Websdale, Director, National Domestic Violence Fatality Review Initiative, phone interview, March 2017.

Florida was the first heavily populated state to develop both a statewide domestic violence fatality review team and a network of community-based teams. There are currently 25 local fatality review teams that review domestic violence homicides in rural and urban communities throughout the state. Florida's approach of one statewide team in addition to local teams is a model now used in nine other states. Florida's teams follow a solution-oriented *no blame, no shame* philosophy that focuses on communities working together to prevent domestic violence homicides. All teams comply with Florida statutory mandates to maintain the confidentiality and public records exemptions when reviewing fatality related information.[2]

Local teams in Florida began to review intimate partner homicides between 1996 and 1999, prior to the Florida Legislature providing teams with confidentiality protections in 2000.[3] In 2008, the Florida Coalition Against Domestic Violence (FCADV) implemented the Statewide Fatality Review Steering Committee, comprised of key representatives from state and local agencies with the purpose of addressing local DVFR team challenges to conducting fatality reviews. In 2009, FCADV and the Florida Office of the Attorney General implemented the Florida Attorney General's Statewide Domestic Violence Fatality Review Team after a dramatic rise in statewide domestic violence homicides demanded additional attention toward these tragic deaths. Florida's Statewide Domestic Violence Fatality Review Team convenes at least four times each year to conduct a comprehensive review of a domestic violence homicide that occurred in a community that does not have a local DVFR team, with the goal of enhancing Florida systems and preventing fatalities.

In addition to the cases reviewed by the the Statewide Domestic Violence Fatality Review Team, local teams conduct reviews in their respective communities. Teams use a uniform data collection tool to gather and report information identified about the characteristics of the victim and the perpetrator, including known domestic violence histories, criminal records and a range of observable evidence-based risk factors. The statewide team analyzes this data to produce the annual *Faces of Fatality Report*.

[2]See s. 741.316 and s 741.3165, F.S. in Appendix B

[3]Dr. Neil Websdale, Director, National Domestic Violence Fatality Review Initiative, phone interview, March 2017.

Recognizing that these deaths constituted both community and criminal justice problems, many teams increased the number and type of groups from which they gathered information, including relatives, co-workers, friends and neighbors of the victims or perpetrators, faith–based communities, school counselors, animal control officers, drug and alcohol counselors, mental health professionals, physicians, nurses and many others. These community members and professionals often had a diverse sense of the dangers and difficulties survivors of domestic violence faced before they were killed.

Since the year 2000, surviving family members and those close to victims and perpetrators have become more involved in the review process, contributing to the understanding of the complex lives of the victims and perpetrators. This evolution in many teams reflects an influence of a number of social factors, including the decision of surviving family members to have input in the review process. The involvement by family members and friends has enriched the review process and brought the work of the fatality review teams into closer contact with those directly impacted by these horrible murders.

ORGANIZING A DOMESTIC VIOLENCE FATALITY REVIEW TEAM

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Local communities often form a DVFR team after an intimate partner homicide prompts community partners to explore interventions that could help to prevent future deaths. A local community leader such as the state attorney, police chief or victim advocate may assume a leadership role in mobilizing partners to join the effort. In Florida communities, team development and organization has been a collective effort, often led by certified domestic violence centers and a state attorney or law enforcement agency.

Consistency in how a review is conducted, as well as established practices, create an atmosphere of trust within the team. Protocols help teams identify how to resolve challenges that may become present during a review. The work of previously established teams and the challenges they have encountered during the review process can support the development of newer teams.[4] The following are basic steps for establishing a team:

- Define the purpose, philosophy and goals of the team.
- Identify stakeholders to participate on the team.
- Review Florida Statute 741.316 to ensure the team operates in accordance with the law.
- Decide how the team will obtain, share and manage case review documents and generate final reports with recommendations for preventing future homicides.
- Establish a meeting schedule that allows for maximum participation, including how often and how long each meeting will be.

[4]Bowman, Alana. 1997. "Establishing Domestic Violence Review Teams." Domestic Violence Report, August/September 1997: 93-94.

- Develop confidentiality agreements for both individual team members and agencies.
- Develop protocols for what the team will review, including the scope and types of homicides. For example:
    - Decide what types of fatalities will be included and if they involve intimate partner violence only, adults only, closed cases, murder-suicides, near-fatal, suspicious deaths or other specific categories.
    - Evaluate how many fatalities the team plans to review each year and what the purpose of the review is. Establish whether the team will review several cases to evaluate aggregate data for trends or conduct one comprehensive review with the purpose of identifying specific systemic gaps.

Domestic Violence Fatality Review Philosophy

Discussions about team philosophy are central to the DVFR process. The foundational philosophy of DVFR is grounded in a multidisciplinary process, moving from a culture of accusation and cover-up to a culture of safety and cooperation based on trust and respect. The homicides are *reviewed* rather than *investigated* in order to better understand their complexity and improve system response to future domestic violence incidents. The philosophy of teams, their membership and the depth of the review process all influence recommendations for change, as well as implementation of those recommendations.

No Blame, No Shame

The failure to prevent deaths through inaction, negligence and/or the inability to better coordinate service delivery is not uncommon in many fields. Each year in hospitals across the country, there are hundreds of cases of "wrong site" surgery, which is the performance of a surgical procedure or operation on the wrong part of the body. Medical fatality reviews investigate questionable deaths that occur in hospital settings, where personnel involved with deceased patients present information to the review team. The systematic sharing of information among those involved in the review can lead to improvements in the coordination of care, better cross-checking to detect inevitable mistakes stemming from human error, and a reduction in deaths due to these mistakes. If DVFR teams employ the tendency to blame or shame individuals or agencies, the review process becomes an unproductive practice that increases the likelihood of cover-ups and fragmented communities, instead of the open sharing of vital information and coordinated efforts to prevent future homicides.

DVFR teams work within a philosophy of kindness and concern that respects the rights of surviving family members and those killed, with the recognition that better agency coordination can save lives. Balancing the no blame, no shame perspective with the notion of accountability requires careful thought. With trust, honesty and candor, communities can establish reliable systems that value accountability and help prevent future death and injury from domestic violence. Error recognition, accountability and systemic improvement should be the focus rather than denial and blame. Well-rounded domestic violence fatality reviews stress the importance of holding agencies and individuals accountable for their actions while at the same time placing the blame for the death(s) solely at the hands of the perpetrator/murderer.

In a domestic violence homicide, the perpetrator is ultimately responsible for causing the death. At the same time, agencies that work with perpetrators and victims of domestic violence may have had opportunities to intervene more effectively. It is essential that review teams gather information to make informed decisions about how to introduce changes to prevent domestic violence and in particular intimate partner homicide.

TEAM MEMBERSHIP

Inclusive team membership provides the opportunity to consider the diverse perspectives of the experiences, options, challenges and choices a victim of domestic violence homicide may have considered. Rather than viewing services and opportunities solely through the lens of the professional experts, the inclusion of various community partners in diverse fields presents a more holistic perspective of the violence and available resources. According to Florida Statute 741.316,[5] domestic violence fatality review team membership includes, but is not limited to, representatives from the following agencies or organizations:

- Law enforcement agencies
- The state attorney
- The medical examiner
- Certified domestic violence centers
- Child protection service providers
- The office of court administration
- The clerk of the court
- Victim services programs
- Child death review teams
- Members of the business community
- County probation or corrections agencies
- Any other persons who have knowledge regarding domestic violence fatalities, non-lethal incidents of domestic violence, or suicide, including research, policy, law, and other matters connected with fatal incidents
- Other representatives as determined by the review team

Florida teams may also include representatives from batterer intervention programs, school districts, mental health and substance abuse providers, healthcare providers, and lesbian, gay, bisexual, transgender, immigrant and faith communities. Inclusive membership offers perspectives on the lives of victims and perpetrators from communities that may not otherwise be considered. Such participation increases the likelihood of developing homicide prevention strategies that are culturally diverse and therefore relevant for a larger population of people.

Membership should reflect the area's diversity, strengths and challenges. For example, a representative from the military may serve on a team located near one of the nine military bases throughout Florida in order to share insight on how the military installment may influence the community for those living within and outside of the military base. In a rural community that has a large agricultural and farming industry, inviting a community-based agency that serves farmworker populations may increase the understanding of barriers in that community and provide additional systemic support and safety for this underserved population.

[5]See s. 741.316, F.S. in Appendix B

TEAM POLICIES AND PROTOCOLS

Organizational meetings to develop protocols are an important step in the formation of a DVFR team. These meetings help build trust among the members and outline how the team will operate. Teams may vary slightly in how they organize, when they meet or what cases they review, but the general purpose and philosophy of the reviews are consistent with the Statewide Domestic Violence Fatality Review Team: to examine the homicide with the intention of developing intervention strategies and services that interrupt the pattern of violence and prevent domestic violence homicide. This goal is usually identified within a mission statement such as the one created by the Broward County Fatality Review Team, *"The mission of the Broward County Fatality Review Team is to reduce the incidence of domestic violence deaths by examining and evaluating the circumstances of domestic homicide/suicide cases, by developing findings from these death reviews, and by expanding, increasing or enhancing the involvement, coordination and communication among agencies and systems."*

Pursuant to section 741.316, F.S., "the structure and activities of the team are determined at the local level."[6] Most of Florida's teams have developed protocols and policies that support the local team's needs, whether the team represents a Judicial Circuit, a county or multiple counties. Policies for the teams include team membership, term limits for specific team positions, eligible cases for review, selection process for the case, the frequency and length of meetings, confidentiality and dissemination of information.[7]

Given the amount of trust developed within a team and the commitment to upholding the no blame, no shame philosophy, it is important that the team has a process for determining when new members may join, who is responsible for inviting them and how the team established the inclusion of new team members. Team members may be sought for their specific expertise and/or to replace existing team members who are no longer able to serve. Teams may invite new members throughout the year or may only allow new members to join at the beginning of a year. Membership should include a balance of partners who provide direct services to survivors or perpetrators, policy makers and other professionals whose work or experience are integral to a review.

[6]See s. 741.316 F.S. in Appendix B

[7]Samples of local Florida Statewide Domestic Violence Fatality Review Team protocols and policies can be found in Appendix D.

Team members must have the availability to attend meetings consistently.[8] Teams, or a designated team member, may interview prospective team members prior to inviting them to join the team to ensure they are able to commit the time necessary to participate in the review process. A team policy may include the expectation that all members attend meetings and a process for removing members who do not attend regularly. The time available to attend meetings, a non-defensive approach, direct experience with survivors and/or perpetrators, and the ability to influence policy are factors to consider when choosing team members.

It is important to establish the responsibilities of team roles and to determine the process for selecting the positions based on the needs of the local community. In a majority of Florida's local teams there is a designated chairperson and approximately 30% of teams have co-chairs. The benefits of co-chairs includes sharing the workload and maintaining consistency if one chairperson is no longer able to serve on the team. Chairpersons are responsible for scheduling and facilitating meetings and distributing materials to the team. Some teams designate a member to send out meeting notices or input information into the statewide data collection tool. However, the team chair or co-chair often assumes these responsibilities.

Teams should develop protocols on how information is obtained for homicide reviews and require that all team members abide by the protocols.[9] Team members often gather documents and information related to their own agency's involvement in the homicide response or with the individuals prior to the homicide. Each member of the team should assist in this process by contacting their professional colleagues for relevant information. For instance, the team's law enforcement officer makes contact with the law enforcement agency that investigated the death. Similarly, the team's prosecutor reaches out to the assistant state attorney who knows the facts of the case being reviewed. Once the material is collected, it is passed on to the coordinator for dissemination to the rest of the team, either digitally, in hard copy or verbally at the review.

[8]Norling, M. Family and Intimate Partner Violence Fatality Review Team Protocol and Resource Manual. Virginia Department of Health, office of the Chief Medical Examiner, 3:2009, P.2.

[9]Aiken, Alicia. "Confidentiality and Fatality Review: 10 Frequently Asked Questions". Fatality Review Bulletin, 2014, Vol. II, 2-6.

The information gathered for the review can be disseminated in a variety of ways. Teams may send public information via email with a confidentiality disclaimer attached to each mailing, provide the information through a secure, password-protected website, use a file hosting service or send hard copies through the mail. Team members may also bring hard copies of the information related to their agency's involvement to the review. No matter how the information is communicated, teams must consider the importance of collecting the greatest amount of information, as well as protecting confidential information from falling into the hands of non-team members. Any material provided at the review should be given to the designated team member to be shredded at the end of each meeting.

The unidentifiable data from each local review is entered by the teams into a uniform survey tool through a team specific link and password provided by FCADV. Data from local teams is compiled by the Statewide Domestic Violence Fatality Review Team Coordinator and used by the statewide team to create recommendations in the annual *Faces of Fatality* report. Currently, two of the 25 teams regularly publish their own annual reports based on their findings and make specific recommendations to their local communities. The reports help shape policy and highlight the work of the team. If a local team decides to publish a report, the team should identify who is responsible for writing the report, the structure of the report and who approves and prints the final report.

Reviewable Cases and Selection Criteria

Teams may differ in the number and type of cases reviewed as well the methodologies used to review cases based on team membership, time available for reviews and the number of domestic violence homicides in the area. Florida Statutes mandate that "The structure and activities of a team shall be determined at the local level. The team may determine the number and type of incidents it wishes to review and shall make policy and other recommendations as to how incidents of domestic violence may be prevented."[10] Fatality review teams typically do not review all domestic violence related deaths, but select cases for review based on the impact of the case on the community, the legal difficulties associated with reviewing a particular case, the resources of the team and the potential the case might have for identifying preventive strategies.

Florida fatality review legislation enables DVFR teams to review fatal and near-fatal domestic violence incidents in order to evaluate the incidents and ways to prevent such incidents.[11] The type of death most frequently reviewed is femicide, a male killing his female partner. Teams may review closed cases, rather than open cases, to avoid the

[10]See s. 741.316 F.S. in Appendix B

[11]Ibid.

possibility of interfering with an active investigation. The State Attorney in each circuit may determine whether a closed case is eligible for review. In some jurisdictions, homicide cases that have been adjudicated are eligible, while in others, cases are not reviewed until the appeals process is exhausted. The Duval County DVFR Team currently reviews all domestic violence homicides from the previous year including open cases and uses only public record information. The team believes that it is important to review all domestic violence homicides in the shortest time possible, so that recommendations for intervention strategies can be made quickly, rather than waiting for cases to close.

Near-fatalities allow teams to learn a great deal from the survivors and their families and friends about the importance of interventions that save lives. The depth of knowledge available from individuals who lived with and through the violence is invaluable, if they are open to participating in the process and feel safe to do so. Reviewing near-deaths requires the team to revise its information sharing methods because the victim/survivor is alive. Information about the near-fatality requires the approval and authorization of releases of information that may not be required for some agencies when the victim is deceased.

Teams may also review suspicious deaths or domestic violence homicides that may have been mischaracterized by media, law enforcement or social service providers, such as later in life homicide/suicides. Social service providers and law enforcement agencies sometimes wrongly assume that because people are in later life they are not capable of committing or experiencing domestic violence. This attitude can translate into an assumption that homicide/suicides among the elder community take the form of "mercy killings" or "suicide pacts." Investigations into these homicides often include notes stating that the couple could no longer live with the ailing health of one or both partners. Historically, research in Florida surrounding such homicides has uncovered that the female victim had expressed to other family members a desire to live, not die.[12]

As the 55 years and older population in the U.S. continues to increase, researchers and service providers have become more aware of domestic violence between older partners. The work of a DVFR team may help uncover a more detailed and accurate version of the events leading up to the homicide of victims who were later in life.

[12]Cohen, Donna. Cited in Charles Patrick Ewing, 1997. Fatal Families. Page 143.

Interviewing Family Members

Sometimes, surviving family members have asked to tell their story in order to contribute to preventing similar tragedies in the future. It is important for teams to establish a process for interviewing family or friends of either the victim or perpetrator. More often than not, family members who have chosen to participate in a fatality review have described the experience as cathartic. However, some family members and friends may not want to discuss the homicide for a myriad of reasons, including the perceived or actual insensitivity of service professionals who initially notified them of the death of their loved one.

Shirley Bostrum, whose son-in-law murdered her daughter, Margie, created an outline of tips for involving surviving family members:[13]

- Remember that every survivor is different.
- Be ready to listen.
- Consider how the family was notified of the death of a loved one and what tone may have been set for future encounters with various systems.
- Be as transparent as possible. Survivors want to know what the team learned.
- Try to find out what the survivor's relationship with the deceased was at the time of the murder.
- Consider whether the police or the media blamed the victim for contributing to her own death and the impact that may have on the family.
- The team member that makes the initial contact with the victim's family needs to stress that sharing their loved one's story will help other survivors.
- A trained, sensitive, skilled interviewer who is familiar with fatality review work should interview each family member or friend alone.[14]

Teams may reach out to family members via phone or through the mail. Both options have benefits and shortcomings. Frank Mullane, who lost his sister and nephew in a familicide, researched letters written to families and found that the best written letters used sensitive and down-to-earth language. He states, "As a matter of important courtesy, you need to start the letter acknowledging the tragedy and expressing your condolences. Possibly the worst style to use is to be overly formal. Such a tone may be interpreted as 'the authorities,' which at this stage, families may believe let them down."[15] Local Florida DVFR teams have created protocols for how they invite family members to participate in the review.[16] Teams should not be discouraged if family members choose not to respond to the invitation to participate and should respect their decision.

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[13]Bostrum, Shirley. "A Survivor's Point of View." Fatality Review Bulletin, Summer 2010: 5-6.

[14]If a family or friend asks or is asked to attend the review for an interview, an individual interview should be initiated first to discuss the possibility. Teams must be prepared for a sensitive and thoughtful team review that respects the friend or family member's experiences.

[15]Mullane, Frank. The Victim's Perspective Should Permeate Domestic Violence Murder Reviews. Fatality Review Bulletin, Summer 2010: 7.

[16]Local team protocols can be found in Appendix D.

DOMESTIC VIOLENCE FATALITY REVIEW CONFIDENTIALITY

Nearly all states conduct fatality reviews under the protection of confidentiality statutes. In general, confidentiality provisions for DVFR teams vary across state and tribal lines. DVFR teams must be familiar with the confidentiality laws and rules prior to beginning review activity and adhere to the laws and rules in their states. These laws shield the deliberations of teams from subpoena and guarantee the information cannot be used in lawsuits or for disciplining professionals handling these homicides.

Teams should generally follow the law that extends the greatest protection when two different laws may apply or conflict, and seek assistance from attorneys if questions arise about accessing information. For example, recent changes to the federal Violence Against Women Act (VAWA) confidentiality regulations, s. 90.4, C.F.R. permit VAWA regulated agencies to provide information about survivors to fatality review teams under certain conditions set forth in the regulation. However, Florida's confidentiality law, section 39.908, F.S. is stricter and would not permit certified domestic violence centers to provide information without prior written consent of the victim notwithstanding VAWA's new regulation. Team members must understand what confidential information is legally protected under state or federal law, and if the information is protected after a person's death.

Confidentiality considerations include:

- The importance of team members to differentiate between public, private and confidential information and not to breach parties' privacy and confidentiality.
- Criminal and civil legal concerns of open cases. Review teams may decide to review only homicide/suicide cases, where there are not survivors and typically no complex civil or criminal legal concerns as to not inadvertently interfer with an ongoing investigation or court proceeding. If there is an open investigation, a criminal conviction is appealed or in a review of a near death, there may be limitations on information available for the review.
- Homicide victims who have received confidential services from Florida certified domestic violence centers retain their right to confidentiality after their death.[17]

Most fatality review laws do not permit fatality review teams to share information with family members or anyone else concerning the homicide, unless that information is part of the public record. If family members or friends approach review teams and state a willingness to provide information to the team, it is essential for the team to clearly define the limitations regarding what the team may share about the case. It is important for homicide survivors to feel they have access to the review team; at the same time, the review team must adhere to its statutory duties regarding the disclosure of information.

[17]See s. 90.5036, F.S. in Appendix B

POTENTIAL DATA SOURCES

Teams usually obtain information about the case from some or all of the following:

- Law enforcement reports or interviews;
- Newspaper articles;
- Transcripts of interviews conducted by investigators with witnesses and other involved parties;
- Data from prior protective orders and/or pre-sentence investigation reports (probation);
- Civil court data regarding divorce proceedings, termination of parental rights, child custody disputes and child visitation issues;
- Criminal histories of perpetrators and victims;
- Child protective services data;
- Summaries of psychological evaluations;
- Medical examiners' reports/autopsy reports;
- Workplace information;
- Public health data including emergency room data;
- Shelter and advocacy information;
- School data pertaining to abuse reports; and
- Statements from neighbors, family members, friends, witnesses and others.

Data concerning substance abuse treatment histories, school records, some probation records, military records, contacts with local certified domestic violence centers or sexual violence programs, mental health records, attorney-client or other privileged communications such as clergy, physical health records, autopsy photographs, gun purchase and background check records may be more difficult or impossible to obtain, especially without the cooperation of executors of estates/legal representatives of the deceased.

It can be counterproductive for the team to attempt to be overly scientific. The cases reviewed do not meet the threshold of scientific analysis, such as case control or comparison cases, except that they include demographic data, arrest data, and protection order data. There is always missing data in a fatality review. For example, proxy informants may know different things about the victim's experience; the mother of a woman killed may know things that neither her siblings nor a father knew. Good fatality review can include concrete variables and careful analysis, but DVFR is not classified as scientific research.

CONDUCTING A DOMESTIC VIOLENCE FATALITY REVIEW

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Reviewing a fatality involves several steps, beginning with the creation of a timeline and ending with the creation of recommendations for policy changes and intervention strategies that can enhance the community response to domestic violence. As the process unfolds, the team should identify any outstanding questions, assign members to answer these questions and report back to the team accordingly. It is important that teams develop a method for each of the following actions:

Create a timeline. A timeline is the foundation of the actual review process and a tool for identifying all significant events in a linear chronology that maps the case. It organizes the myriad of details received by the team and puts them in a format that creates a scope of the events leading up to the death(s). A thoughtful timeline outlines the information in a visual manner that helps teams gain a wider perspective on the events preceding the death and in some cases, sheds light on significant events that occur after the homicide, such as the arrest of the perpetrator.

Timelines may be completed in a variety of formats:

- Using rolls of butcher paper or whiteboards, with different colors to differentiate between years;
- Placing events on individual sheets of paper before hanging them on a wall, allowing for easy movement if dates or other elements turn out to be in the wrong place;
- Listing review elements on an Excel spreadsheet and projecting them on a wall or screen; and/or
- Using three columns in the construction of a timeline – what happened, when it occurred and where the information came from.

Teams may use one type of timeline construction and then change their process as their reviews become more complex or technology provides new options. Regardless of how it's presented, it is important that a thorough and clear timeline is included in the work of a review team.

Identify events leading up to the homicide and risk indicators. Create a list of events and risk indicators that may highlight the principal signs that the perpetrator was going to commit a serious injury or homicide. Risk indicators for femicides include, but are not limited to: prior history of domestic violence, extreme jealousy, threats to kill, abuse during pregnancy, use or threatened use of a weapon,[18] non-fatal strangulation, stalking, forced sex, and threats to harm children.[19] Teams should consider risk indicators that are research-based or widely documented by other DVFR teams rather than relying on common assumptions or opinions about risk factors.

List any known interventions by agencies and community involvement with the victim and/or perpetrator. Identifying the agencies and communities that had contact with the perpetrator, victim or other family members can help determine strategies that will enhance the community's domestic violence response. Determining the degree of coordination can help establish opportunities for greater communication and referrals among those involved. Additionally, listing known agency involvement can help identify opportunities for other agencies and community partners to participate in the coordinated response.

Define and address any outstanding or unresolved questions. Questions may include issues the team identifies at the end of a case review pertaining to information, systems or missing data. For example, questions the team has about the policies of a partnering agency may help clarify how that agency responds to domestic violence. Questions regarding the findings of a review may indicate a trend in the community that needs to be explored further. Additionally, questions for discussion might include whether to interview friends or family of the victim or the perpetrator for further information. Teams may choose to gather more data before creating recommendations when there are unanswered questions. However, there may not be an answer to every question the team has about the lives of the victim, perpetrator or the community involvement.

[18]Snider, et.al; IPV:"A Brief Risk Assessment for the Emergency Department".AcadEmerMed .2009 Nov 16(11)1208-16.

[19]Campbell, JC. Assessing Dangerousness: Violence by Batterers and Child Abusers. Springer: 2007.

Identify Possible Interventions. Teams should consider potential interventions that decrease gaps in services when formulating recommendations. Areas of focus may include agency, systemic or community changes that help prevent future homicides, increase safety for survivors and their children and hold perpetrators accountable.

Creating Recommendations

A key element of DVFR is to inform and influence policies, procedures and public perceptions. Recommendations for systemic change are one of the most important aspects of DVFR. The team's work has the potential to become a blueprint for change in law enforcement, the judiciary, child protective services, faith communities, advocacy, and victim services. The goal of each of these recommendations is to improve or enhance services for survivor safety and offender accountability.

Recommendations for suggested improvement may include policy change, improved communication among system partners, heightened collaboration, more regular and predictable enforcement of existing law, expanded education about the effects of domestic violence on the family and the community, and/or reform of outdated practices. The number of recommendations is less important than their feasibility for implementation. If the recommendation is ambitious and high-impact, the steady efforts of the DVFR team for a full year or more may be required to achieve implementation. Recommendations should be specific and include the following details:

- Identify the agencies that need to be involved in the recommended task;
- Specify what the change will do and why it is important; and
- Detail a brief explanation of the process to accomplish the recommendation.

This very public aspect of the team's work is identified with the individuals who serve on the team. They represent the DVFR team to the community at large and to their professional colleagues. Recommendations are most effective if they are created through a process of consensus. It is important that the team is seen as leading and supporting the oftentimes challenging work necessary to implement recommendations. Those who know and work with team members may also become more willing to engage in the change implementation when provided with such leadership.

DOMESTIC VIOLENCE FATALITY REVIEW SUSTAINABILITY

DOMESTIC VIOLENCE FATALITY REVIEW SUSTAINABILITY

DVFR teams may become inactive for a variety of reasons and lose key members due to personnel changes or community priorities that shift. Cases may still be processing through the court system and in smaller communities, teams may have reviewed most of the closed cases in recent years. Occasionally, teams that have been operating for some time lose enthusiasm, and member attendance at reviews decreases.

Many Florida teams have created sustainability through localized efforts. For example, one team surveyed members on ways to improve its team process. As a result, it changed the structure of the monthly meetings to two hours instead of the previous three hour timeframe. Another team is now co-chaired by the certified domestic violence center and a local law enforcement agency. Pairing law enforcement with a domestic violence advocate enables the team to distribute the workload and increase multiple perspectives that have contributed to its sustainability. Two Florida teams regularly publish annual reports for their community, which provides a tangible product that demonstrates the work they have completed, as well as offering concrete guidance to the community through recommendations.

Teams may also expand the scope of their approach to maintain momentum. Reviewing intimate partner homicides/suicides that occur in later life and near-deaths, expanding team membership to include surviving family members in the review process, and partnering with other local communities or municipalities to expand the review area can sustain motivation and contribute to a meaningful review process.

Training and Technical Assistance

Training for DVFR teams can help establish a shared language among team members and create cohesion that helps teams work together effectively. A mutual understanding of the dynamics of domestic violence, risk indicators and the purpose of the review is important for teams to establish unified goals. FCADV conducts training to Florida teams on the dynamics of domestic violence, DVFR organization, mock reviews, identification of evidence-based high-risk indicators and provides technical assistance during the review process.

Florida Coalition Against Domestic Violence
425 Office Plaza Drive • Tallahassee, FL 32301
Phone: (850) 425-2749 • Fax: (850) 425-3091 • www.fcadv.org

APPENDIX A

DOMESTIC VIOLENCE FATALITY REVIEW RESOURCES

Florida Coalition Against Domestic Violence
www.fcadv.org
425 Office Plaza Drive
Tallahassee, FL 32301
Phone: (850) 425-2749
Fax: (850) 425-3091

Florida Domestic Violence Hotline: (800) 500-1119
TDD: (800) 621-4202
Florida Relay 711

The Florida Coalition Against Domestic Violence is the private, nonprofit organization that serves as the statewide professional association for Florida's 42 certified domestic violence centers. In this role, FCADV provides leadership, advocacy, education, training, technical assistance, and support to certified domestic violence centers, their community partners, and other statewide professionals to improve services, practices, and policies related to domestic violence. FCADV provides staff support to the Attorney General's Statewide Domestic Violence Fatality Review Team, conducts training on identifying high-risk indicators, and provides technical assistance on starting and sustaining a DVFR team. FCADV also serves as the primary voice for survivors of domestic violence and their children in the public policy arena and with system partners.

Arizona Child and Adolescent Survivor Initiative
https://nau.edu/Family-Violence-Institute/ACASI/
PO Box 15026
Flagstaff, AZ 86011
acasi@nau.edu
Phone: (928) 523-2119
Fax: (928) 523-2210

ACASI's mission is to deliver a multi-county, trauma-informed system of care to provide specialized victim services and support to children who have lost a parent to intimate partner homicide (IPH).

Battered Women's Justice Project
www.bwjp.org
1801 Nicollet Ave. S.
Suite 102
Minneapolis, MN 55403
Phone: (800) 903-0111
Fax: (612) 824-8965

The Battered Women's Justice Project provides information on the criminal and civil justice systems' response to intimate partner violence.

Marcus Bruning Training and Consulting, LLC
www.marcusbruning.com
3769 Estate Court NE
Bemidji, MN 56601
Phone: (218) 232-3762
Email: marcusbruning@gmail.com

Marcus Bruning Training and Consulting, LLC provides educational programs in special investigations and coordination training in domestic violence, sexual assault and crimes against persons from the very young to the elderly.

Montana Domestic Violence Fatality Review Commission
https://dojmt.gov/victims/domestic-violence-fatality-review-commission/
Matthew Dale, Executive Director
Office of Victim Services
Department of Justice
P.O. Box 201410
Helena, MT 59620-1410
Phone: (406) 444-1907
Fax: (406) 442-2174
E-mail: madale@mt.gov

The Fatality Review Commission, authorized by MCA 2-15-2017, seeks to reduce homicides caused by family violence. The Commission meets twice yearly to review closed domestic homicide cases. The review seeks to identify gaps in Montana's system for protecting domestic violence victims and better coordinate multi-agency efforts to protect those most at risk of domestic homicide.

National Domestic Violence Fatality Review Initiative
www.ndvfri.org
Dr. Neil Websdale, Director
Family Violence Institute
Northern Arizona University
Flagstaff, AZ 86011
Phone: (928) 523-9205
Fax: (928) 523-8011

The mission of the National Domestic Violence Fatality Review Initiative (NDVFRI) is to provide technical assistance for the reviewing of domestic violence related deaths with the underlying objectives of preventing them in the future, preserving the safety of battered women, and holding accountable both the perpetrators of domestic violence and the multiple agencies and organizations that come into contact with the parties.

(continued on next page)

Praxis International
www.praxisinternational.org
179 Robie St. E., Suite 260
St. Paul, Minnesota 55107
Phone: (651) 699-8000
Fax: (651) 699-8001
Email: info@praxisinternational.org

Praxis International has developed and pioneered the use of the Safety Audit process as a problem-solving tool for communities that are interested in more effective intervention in violence against women. The Safety Audit is a tool used by interdisciplinary groups and community-based advocacy organizations to further their common goals of enhancing safety and ensuring accountability when intervening in cases involving violence against women. Its premise is that workers are institutionally organized to do their jobs in particular ways—they are guided to do jobs by the forms, policies, philosophy, and routine work practices of the institution in which they work. When these work practices routinely fail to adequately address the needs of people it is rarely because of the failure of individual practitioners. It is a problem with how their work is organized and coordinated. The Audit is designed to allow an interagency team to discover how problems are produced in the structure of case processing and management.

The Training Institute on Strangulation Prevention
www.strangulationtraininginstitute.com
101 W. Broadway, Suite 1770
San Diego, CA 92101
Phone: (888) 511-3522

The Training Institute on Strangulation Prevention, a program of Alliance for HOPE International, was launched in October 2011. The Institute was developed in response to the increasing demand for Intimate Partner Violence Strangulation Crimes training and technical assistance (consulting, planning and support services) from communities across the world. The Institute provides training, technical assistance, web-based education programs, a directory of national trainers and experts, and a clearinghouse of all research related to domestic violence and sexual assault strangulation crimes. The goals of the Institute are to: enhance the knowledge and understanding of professionals working with victims of domestic violence and sexual assault who are strangled; improve policy and practice among the legal, medical, and advocacy communities; maximize capacity and expertise; increase offender accountability; and ultimately enhance victim safety.

APPENDIX B
FLORIDA STATUTES

Florida Domestic Violence Fatality Review Statutes

741.316 Domestic violence fatality review teams; definition; membership; duties.

(1) As used in this section, the term "domestic violence fatality review team" means an organization that includes, but is not limited to, representatives from the following agencies or organizations:

(a) Law enforcement agencies.

(b) The state attorney.

(c) The medical examiner.

(d) Certified domestic violence centers.

(e) Child protection service providers.

(f) The office of court administration.

(g) The clerk of the court.

(h) Victim services programs.

(I) Child death review teams.

(j) Members of the business community.

(k) County probation or corrections agencies.

(l) Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence, or suicide, including research, policy, law, and other matters connected with fatal incidents.

(m) Other representatives as determined by the review team.

(2) A domestic violence fatality review team may be established at a local, regional, or state level in order to review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides. The review may include a review of events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and the parties, and any information or action deemed relevant by the team, including a review of public records and records for which public records exemptions are granted. The purpose of the teams is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence. The structure and activities of a team shall be determined at the local level. The team may determine the number and type of incidents it wishes to review and shall make policy and other recommendations as to how incidents of domestic violence may be prevented.

(3)(a) There may not be any monetary liability on the part of, and a cause of action for damages may not arise against, any member of a domestic violence fatality review team or any person acting as a witness to, incident reporter to, or investigator for a domestic violence fatality review team for any act or proceeding undertaken or performed within the scope of the functions of the team, unless such person acted in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) This subsection does not affect the provisions of s. 768.28.

(4) All information and records acquired by a domestic violence fatality review team are not subject to discovery or introduction into evidence in any civil or criminal action or administrative or disciplinary proceeding by any department or employing agency if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team. However, information, documents, and records otherwise available from other sources are not immune from discovery or introduction into evidence solely because the information, documents, or records were presented to or reviewed by such a team. A person who has attended a meeting of a domestic violence fatality review team may not testify in any civil, criminal, administrative, or disciplinary proceedings as to any records or information produced or presented to the team during meetings or other activities authorized by this section. This subsection does not preclude any person who testifies before a team or who is a member of a team from testifying as to matters otherwise within his or her knowledge.

(5) The domestic violence fatality review teams are assigned to the Florida Coalition Against Domestic Violence for administrative purposes.

741.3165 Certain information exempt from disclosure.

(1)(a) Any information that is confidential or exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution and that is obtained by a domestic violence fatality review team conducting activities as described in s. 741.316 shall retain its confidential or exempt status when held by a domestic violence fatality review team.

(b) Any information contained in a record created by a domestic violence fatality review team pursuant to s. 741.316 that reveals the identity of a victim of domestic violence or the identity of the children of the victim is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2) Portions of meetings of any domestic violence fatality review team regarding domestic violence fatalities and their prevention, during which confidential or exempt information, the identity of the victim, or the identity of the children of the victim is discussed, are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

Florida Domestic Violence Center Confidentiality/Privilege Statutes

39.908 Confidentiality of information received by department or domestic violence center.

(1) Information about clients received by the department or by authorized persons employed by or volunteering services to a domestic violence center, through files, reports, inspection, or otherwise, is confidential and exempt from the provisions of s. 119.07(1). Information about the location of domestic violence centers and facilities is confidential and exempt from the provisions of s. 119.07(1).

(2) Information about domestic violence center clients may not be disclosed without the written consent of the client to whom the information or records pertain. For the purpose of state law regarding searches and seizures, domestic violence centers shall be treated as private dwelling places. Information about a client or the location of a domestic violence center may be given by center staff or volunteers to law enforcement, firefighting, medical, or other personnel in the following circumstances:

(a) To medical personnel in a medical emergency.

(b) Upon a court order based upon an application by a law enforcement officer for a criminal arrest warrant which alleges that the individual sought to be arrested is located at the domestic violence shelter.

(c) Upon a search warrant that specifies the individual or object of the search and alleges that the individual or object is located at the shelter.

(d) To firefighting personnel in a fire emergency.

(e) To any other person necessary to maintain the safety and health standards in the domestic violence shelter.

(f) Information solely about the location of the domestic violence shelter may be given to those with whom the agency has an established business relationship.

(3) The restriction on the disclosure or use of the information about domestic violence center clients does not apply to:

(a) Communications from domestic violence shelter staff or volunteers to law enforcement officers when the information is directly related to a client's commission of a crime or threat to commit a crime on the premises of a domestic violence shelter; or

(b) Reporting suspected abuse of a child or a vulnerable adult as required by law. However, when cooperating with protective investigation services staff, the domestic violence shelter staff and volunteers must protect the confidentiality of other clients at the domestic violence center.

90.5036 Domestic violence advocate-victim privilege.

(1) For purposes of this section:

(a) A "domestic violence center" is any public or private agency that offers assistance to victims of domestic violence, as defined in s. 741.28, and their families.

(b) A "domestic violence advocate" means any employee or volunteer who has 30 hours of training in assisting victims of domestic violence and is an employee of or volunteer for a program for victims of domestic violence whose primary purpose is the rendering of advice, counseling, or assistance to victims of domestic violence.

(c) A "victim" is a person who consults a domestic violence advocate for the purpose of securing advice, counseling, or assistance concerning a mental, physical, or emotional condition caused by an act of domestic violence, an alleged act of domestic violence, or an attempted act of domestic violence.

(d) A communication between a domestic violence advocate and a victim is "confidential" if it relates to the incident of domestic violence for which the victim is seeking assistance and if it is not intended to be disclosed to third persons other than:

1. Those persons present to further the interest of the victim in the consultation, assessment, or interview.

2. Those persons to whom disclosure is reasonably necessary to accomplish the purpose for which the domestic violence advocate is consulted.

(2) A victim has a privilege to refuse to disclose, and to prevent any other person from disclosing, a confidential communication made by the victim to a domestic violence advocate or any record made in the course of advising, counseling, or assisting the victim. The privilege applies to confidential communications made between the victim and the domestic violence advocate and to records of those communications only if the advocate is registered under s. 39.905 at the time the communication is made. This privilege includes any advice given by the domestic violence advocate in the course of that relationship.

(3) The privilege may be claimed by:

(a) The victim or the victim's attorney on behalf of the victim.

(b) A guardian or conservator of the victim.

(c) The personal representative of a deceased victim.

(d) The domestic violence advocate, but only on behalf of the victim. The authority of a domestic violence advocate to claim the privilege is presumed in the absence of evidence to the contrary.

APPENDIX C

FLORIDA STATEWIDE DOMESTIC VIOLENCE FATALITY REVIEW DOCUMENTS

Statewide Domestic Violence Fatality Review Team
Letter of Invitation

Dear _____,

The Attorney General's Statewide Domestic Violence Fatality Review Team (FRT) was created in 2009 as authorized in s. 741.316, Florida Statute (F.S.). Co-chaired by the Florida Office of the Attorney General and the Florida Coalition Against Domestic Violence (FCADV), the Team conducts a yearly comprehensive review of a domestic violence fatality with the ultimate goal of preventing future domestic violence homicides. The Statewide Domestic Violence FRT identifies gaps in service delivery systems and offers recommendations to strengthen safety factors and reduce risk factors that contribute to these deaths based on data collected by both the statewide and 25 local teams across the state.

The Attorney General's Statewide Domestic Violence Fatality Review Team is comprised of representatives from various local and state entities that interact with survivors, their children and perpetrators of domestic violence. Members represent the court system, probation, and parole, law enforcement, faith-based organizations, educational institutions, certified domestic violence centers, legal providers, health care providers and the defense bar. Both the statewide and local teams employ a "no blame no shame" philosophy and operate in accordance with statutory mandates to maintain the confidentiality and public records exemptions when reviewing fatality related information.

We invite you to serve on The Attorney General's Statewide Domestic Violence Fatality Team for (fiscal year). You have been recommended for your respected knowledge and experience and will make a valuable contribution to the team. Thank you for your work in creating comprehensive access to safety and justice for survivors of intimate partner violence, their children and families.

Please consider our invitation and confirm your appointment by (date). I look forward to hearing from you.

Please feel free to contact 850-425-2749 with any questions.

Sincerely,

Statewide Fatality Review Coordinator

Statewide Domestic Violence Fatality Review Team Confidentiality Agreement

As a member of the Statewide Domestic Violence Fatality Review Team, my signature below indicates that I acknowledge and agree to the following:

1. Pursuant to Section 741.316(4), Fla. Stat., all information and records acquired by a domestic violence fatality review team are not subject to discovery or introduction into evidence in any civil or criminal action or administrative or disciplinary proceeding by any department or employing agency if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team. However, information, documents, and records otherwise available from other sources are not immune from discovery or introduction into evidence solely because the information, documents, or records were presented to or reviewed by such a team. A person who has attended a meeting of a domestic violence fatality review team may not testify in any civil, criminal, administrative, or disciplinary proceedings as to any records or information produced or presented to the team during meetings or other activities authorized by this section. This subsection does not preclude any person who testifies before a team or who is a member of a team from testifying as to matters otherwise within his or her knowledge.

2. Pursuant to Section 741.3165, Fla, Stat., (1)(a) Any information that is confidential or exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution and that is obtained by a domestic violence fatality review team conducting activities as described in s. 741.316 shall retain its confidential or exempt status when held by a domestic violence fatality review team.

   a. Any information contained in a record created by a domestic violence fatality review team pursuant to s. 741.316 that reveals the identity of a victim of domestic violence or the identity of the children of the victim is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

   b. Portions of meetings of any domestic violence fatality review team regarding domestic violence fatalities and their prevention, during which confidential or exempt information, the identity of the victim, or the identity of the children of the victim is discussed, are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

3. I will not disclose to any outside person or entity the content of team discussions relating to the case under review, or any documents, records or other materials relating to the case under review obtained and held by the Florida's Statewide Domestic Violence Fatality Review Team.

_____ _____

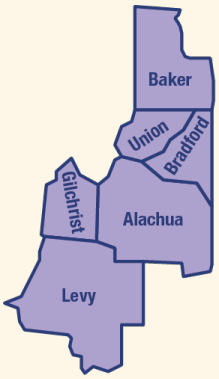
Signature Date

APPENDIX D

LOCAL DOMESTIC VIOLENCE FATALITY REVIEW TEAM PROTOCOLS

THE EIGHTH JUDICIAL CIRCUIT OF FLORIDA DOMESTIC VIOLENCE FATALITY REVIEW TEAM PROTOCOL FOR CASE REVIEW

Outline



Preface

Florida's Domestic Violence Fatality Review Teams are created by State Statute. Designated members are drawn from various local agencies and organizations. See Appendix A: Chapter 741.316 of Florida Statutes. The Eighth Judicial Circuit of Florida Domestic Violence Fatality Review Team (DVFRT) seeks to fulfill this Statute in service of the six counties in the Circuit: Alachua, Baker, Bradford, Gilchrist, Levy, and Union Counties. As put forth in Statute, the Eighth Circuit DVFRT will be organized and run in a manner that suits the unique needs of this region. The Protocol will serve as a reference guide for the Eighth Circuit DVFRT, giving structure to the case review process and ensuring thoroughness, efficiency, and inclusiveness.

Definition of "Domestic Violence," "Domestic Violence Fatality," and "Near Death"

The Eighth Circuit DVFRT selects cases for review based on its definition of "Domestic Violence Fatality." The State of Florida's definition of "Domestic Violence" is limited (See Appendix B: Chapter 741.28 of Florida Statutes), as is the counting of only Domestic Violence Homicides as "Domestic Violence Fatalities." Therefore, the Eighth Circuit DVFRT chooses to adopt a broader definition of "Domestic Violence" (and "Domestic Violence Fatality") which is in line with more widely accepted definitions.

The Eighth Circuit DVFRT defines "Domestic Violence Fatality" as any death in which intimate partner violence and/or its sequelae are a contributing factor. This includes fatalities in which it is determined that the manner of death is homicide, suicide, accidental, natural, or unknown.

"Near Death" cases are defined by the Eighth Circuit DVFRT as incidents where the level of injury could have easily led to a fatality but the victim survived, and where intimate partner violence and/or its sequelae are a contributing factor. Near Death cases may be selectively reviewed team when it is determined to be appropriate, with consideration of victim availability.

Selection and Classification of Cases for Review

Prior to the Annual Planning Meeting in any given year, the DVFRT Coordinator will identify all possible DV Fatalities in the Eighth Judicial Circuit of Florida, and will collaborate with appropriate personnel to determine which cases have been closed. A case is defined as "closed" which it adheres to the following criteria:

Any criminal activity associated with the terminal event has been investigated and adjudicated, and the case is considered "closed" from a legal standpoint.

All Medical Examiner, Law Enforcement, Court, and other pertinent documents related to the case have been finalized.

All possible cases of Domestic Violence Fatality determined to be closed in the above manner will be brought before the Eighth Circuit DVFRT as a whole at the Annual Planning Meeting. At that time, the Eighth Circuit DVFRT as a whole will select up to four cases to review before the next planning meeting. The outputs of the review process will be submitted to the Statewide DVFRT. Policy and Practice recommendations will be derived from these case reviews.

Timeline for Case Review

Case Review will occur on a cyclical basis. An annual planning meeting will be held to select the cases to be reviewed in the year following that meeting. A goal of the DVFRT will be to complete the review and submission process for all categorized cases (i.e. cases that have been closed) within twelve months from the Annual Planning Meeting; however, failure to do so will not disqualify a case from review. Rather, in the following planning meeting, the status of all eligible cases which have not yet been reviewed will be re-evaluated.

Also at the first review in each year, all present will sign the annual confidentiality agreement (see Appendix C: Chapter 741.316 of Florida Statutes and Appendix D).

Case Review Process and State Reporting

In summary, the Case Review is conducted locally to the fatality or near-death, and is carried out by representatives from the DVFRT and individuals involved with the case at the local level. The Statewide Survey is filled out to the fullest extent possible and reported directly following the review. See also, Appendix I: In-Depth Case Review Outline.

At the Annual Planning Meeting, the DVFRT will decide on a tentative date and location for the Review. In a timeframe decided by the DVFRT, members of the DVFRT will communicate with their contacts in the location of the fatality to finalize (a) when and where the Review will take place, and (b) who not already volunteering to participate in the Review should be notified of the Review and be invited to participate.

Once the details of time, location, and participants in that year's Review are finalized, a mass email will be sent out to all involved verifying this information and also providing instructions on how to submit case information to the DVFRT Coordinator. When possible, the case to be reviewed will be identified with a link to a news article.

(continued on next page)

Those with access to case information will be obliged to submit a summary of their data to the DVFRT Coordinator no later than two weeks prior to the Review date. The full documentation shall be brought to the review by those who submitted a summary or a representative from their agency. Documentation may include, but is not limited to, word processing or other office documents (reports, transcripts, or database outputs), images including scanned documents, publications such as newspaper articles or obituaries, and sound and video recordings.

Another method of information gathering will be conducting interviews of survivors and others connected with the case. This will planned by the DVFRT Coordinator and those who worked with the case previously. Survivors may also be invited to participate in the Review itself. Interviewees can include anyone who had a family, personal, business other community-level connection with the Victim or Perpetrator. These may include, but are not limited to: parents, current or former spouses, friends, coworkers, supervisors, educators, or members of the faith community.

Prior to the Review, the DVFRT Coordinator will fill out the Statewide Survey to the extent possible with the submitted information.

At the Review meeting, participants will be asked to bring copies of their documentation in order to reference them during the Review. Prior to the start of the Review, all present will be required to sign a confidentiality agreement for that specific In-Depth Review. This will be a way of reminding regular DVFRT members of their commitment to confidentiality. All new participants will be required to sign the full confidentiality agreement.

Each Review will begin with a period of time to allow participants to read the data collected by the DVFRT Coordinator. This will be followed by a reading of the Vision, Mission, and Values of the Eighth Circuit DVFRT as a reminder of the purpose of the fatality review. Then the collective review of the data will take place with the creation of the timeline and discussion surrounding the identification of red flags, agency involvement, and general findings from the case. The focus of the discussion should be in the prevention of domestic violence homicides. The DVFRT Coordinator is empowered to moderate the discussion to ensure that it remains constructive, relevant to the case, and focused on the Vision, Mission, and Values of the Eighth Circuit DVFRT. Those present at the Review may create diagrams, timelines, charts, or any other visual aid to assist in the sharing of information and discussion, so long as these visual aids can be easily and permanently destroyed at the conclusion of the review.

Once the Statewide Survey is filled out to the satisfaction of those present at the Review, the Coordinator or other designee will lead the group through identifying red flags, listing the agencies involved, and general findings, as described below, which will be in shared with the DVFRT as a whole and disseminated to the public. The Coordinator or other designee will record the group consensus. This information will be used in the creation of policy recommendations at the annual planning meeting.

Red Flags- These are things that are known or seem to be indicators of potential lethality. These can come from both informed knowledge of lethality markers and from specific perceptions shaped by the case being reviewed.

Agencies Involved- A list of all known interactions by both the victim and the perpetrator is created. Agencies can refer to criminal justice organizations, social services, churches, schools, as well as other systems.

The Coordinator or other designee will adjourn the meeting with a moment of silence to recognize the lives lost. All documents created during the meeting, excluding the Statewide Survey and generalized findings from the discussion, must be destroyed permanently directly following the review. Paper documents must be shredded, and digital documents must be permanently erased from device hard drives. The meeting in its entirety is confidential and subject to the limitations posed in the Confidentiality Agreements.

Disseminating Community Reports with Policy and Practice Recommendations

The DVFRT will disseminate an annual Community Report, with Policy and Practice Recommendations along with de-identified data from the prior year and, when it becomes feasible, concurrent data over a longer period. This will be released to the public with approval from the group as a whole. Each Annual Report will include a focus for the upcoming year, which will be selected from the prior year's Findings by vote of the members of the DVFRT. The DVFRT Coordinator will, with support from the team, take active initiative toward the changes needed for the focus Policy and Practice Recommendation.

MIAMI-DADE COUNTY DOMESTIC VIOLENCE FATALITY REVIEW TEAM

Domestic Violence-Related Homicide/ Suicide FRT Case Process Outline

Data gathering procedures

- Identification of cases
- Daily media searches
- Notifications from police/victim advocates/team members
- DCF/CPT/court/service providers
- Team Notifications
- Start a file on the case
- Send notification of incident out to Team members within 48-hours
- Preliminary info consists of:
- Basic decedent/perpetrator information
- Description of fatal incident and jurisdiction
- Criminal, civil, family court history check
- DV history including police reports and injunctions
- DCF information (on whether the fatal incident was called in)
- If there are surviving children who need placement, dependency/juvenile records
- Marriage license search
- (*Later complete Case Checklist*)

Why is this beneficial?

- Cases where Perpetrator does not commit suicide usually take a long time to close, meaning that the review of the case could occur years later.
- When the parties have open cases in the system (you send a team and internal notification) - Allows you to inform judges, staff and agencies about death of a party.
- Allows you to build the case (you follow the family's story and add documents to file as time goes on). Any new information is added as it is learned.

Monthly Case reviews-merged of DVFRT and CADRT

- Case identifier data emailed out so that members can prepare for the meeting. Allows members to run checks on the parties involved
- Prior to review, Information collected from all respective agencies: *(Complete case checklist)*

Presentation of cases

- Staff reads timeline of family
- Chronology describe what it includes and who
- Members/guests present information
- Q&A
- Data Collection Instrument (ending with lethality indicators)
- Findings and recommendations are discussed and a rough draft is written. The draft is e-mailed out to participating members approximately one week after the meeting for finalization.

Use of excel for record keeping

- Death tables with all homicide/suicides
    - Statistical purposes
    - Report writing
    - To keep track of which cases have been reviewed and which one have been closed
- Yearly percent change analysis of DV incidents and DV deaths

OSCEOLA COUNTY DOMESTIC VIOLENCE FATALITY REVIEW TEAM PROCEDURE MANUAL

Mission Statement

The purpose of this committee is to review domestic violence fatalities and to identify any red flags that might prevent future fatalities.

Goals And Objectives

- Review current procedures in an effort to reduce and eliminate domestic violence thereby averting future domestic violence fatalities.
- Enhance communication and coordination between agencies.
- Promote education for the criminal justice system, social services providers and the community as a whole.
- Review community services currently available to children and families affected by domestic violence and the community at large.
- Remove barriers to service and identify underserved populations including surviving minor children.
- Explore possible funding sources for services to meet the diverse needs of victims and their families.
- Identify any special needs of the community.
- Recognize racial and ethnic diversity of the county demographic population.
- Identify lethality factors.

Philosophy

The Team philosophy is accountability without blame. While the business of reviews and staying on task is extremely important, it is also believed that the process is equally as important. Cases are reviewed in-depth and will take as much time as needed to thoroughly review each case. The Team will consider the emotional well-being of the surviving family as well as the Team itself when conducting reviews and make appropriate conditions for the environment to be safe and non-traumatic.

Eligible Cases For Review

Closed cases in which the perpetrator has been tried and sentenced or homicide/suicides.

In an effort to address current issues, open cases may be eligible for a “closed” review at the discretion of the investigating agency, SAO, and FRT Chair.

Meeting Structure

The Team meets the 4th Monday every other month (or as needed), from 2:00-4:00pm at the [address removed for confidentiality purposes]. The agenda consists of business first followed by case review. The meetings will end with an open discussion for Team members to process their response to the case review.

Team Membership

The membership of the Team shall follow F.S. 741.316. Representatives from the following organizations shall be included:

- Certified domestic violence centers
- Child protection service providers
- Clerk of the court
- County probation and corrections agencies
- Child death review teams
- Law enforcement agencies
- Medical examiner
- Members of the business community
- Office of Court Administration
- State attorney
- Victim services programs
- Any other persons who have knowledge regarding domestic violence fatalities, non-lethal incidents of domestic violence or suicide, including research, policy, law and other matters connected with fatal incidents
- Other members may be added as deemed necessary by the team. The expertise of community representatives will be utilized as needed

When a Team member is no longer able to serve, they are asked to give notice to the team and assist in the replacement of a similarly trained individual. Orientation material will be provided to new Team members, including copies of all pertinent handouts given to team members. When possible, the Team member who invited the new Team member shall assist with the orientation process and make sure they have been provided with all materials and information.

Case Review Information

When a new case is introduced for review, each team member shall go back to their respective offices and determine whether their agency had any involvement with the case. Any hard copies of relevant information may also be brought to the review. This paperwork shall be returned to the agency immediately following the review. Public records may be copied and distributed to all team members. Any extra copies of public documents shall be shredded at the end of each review meeting. Whenever possible, information from non-participating agencies will be obtained per F.S. 741.316.

Confidentiality

Each Team member and guest will sign the enclosed Confidentiality Form at each meeting.

Contacting Family Members

The Team will make every attempt to contact surviving family members to inform them that their loved one's death is being reviewed. A letter is sent explaining the review process. Family members are invited to contact the Team with any information about the life or death of their loved one that they choose to share. The Team may also contact the surviving family with a follow up phone call when doing so would assist or benefit the review process. The Team will decide in advance who will contact the family. The family member's may speak to the advocate over the phone or through a personal interview. Team members will place the privacy and rights of surviving family members above obtaining information. At this point in time, our Team has decided not to invite family members to participate in the actual review.

Findings

When time permits, an annual report will be prepared according to FCADV guidelines and presented to the Osceola County Domestic Violence Task Force. The Team will work towards policy changes as needed in addition to submitting a formal report of findings.

PALM BEACH COUNTY DOMESTIC VIOLENCE FATALITY REVIEW TEAM

Mission

The Palm Beach County Fatality Review Team will review deaths associated with domestic violence in order to improve coordination and delivery of services to prevent incidents of domestic violence and death that result from domestic violence.

Goals and Objectives

A domestic violence fatality review team may be established at a local, regional, or state level in order to review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides. The review may include a review of events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and the parties, and any information or action deemed relevant by the team, including a review of public records and records for which public record exemptions are granted. The purpose of the team is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence. The structure and activities of a team shall be determined at the local level. The team may determine the number and type of incidents it wishes to review and shall make a policy and other recommendations as to how incidents of domestic violence may be prevented.

Eligible Cases for Review

Applicable cases from each year will be reviewed. These cases will be closed cases in which the perpetrator has been tried and sentenced, if convicted. Cases eligible for review are:

- Domestic violence homicide/suicides
- Domestic violence fatalities
- Domestic violence near fatalities

Team Membership

Pursuant to F.S.S. 741.316:

Domestic violence fatality review teams; definition; membership; duties.

(1) As used in this section, the term “domestic violence fatality review team” means an organization that includes, but is not limited to, representatives from the following agencies or organizations:

(a) Law enforcement agencies.

(b) The state attorney.

(c) The medical examiner.

(d) Certified domestic violence centers.

(e) Child protection service providers.

(f) The office of court administration.

(g) The clerk of the court.

(h) Victim services programs.

(i) Child death review teams.

(j) Members of the business community.

(k) County probation or corrections agencies.

(l) Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence, or suicide, including research, policy, law, and other matters connected with fatal incidents.

(m) Other representatives as determined by the review team.

The Fatality Review Team must function as a cohesive team in order to most effectively attain its mission. It is important that team members trust one another, understand domestic violence fatalities and the local response system, maintain continuity and consistency in reviewing cases, and have excellent communication among team members. The team should also have members whose own disciplines or experience offer additional perspectives.

Consistency in membership and attendance is crucial. We ask that members make a two year commitment to participate in the process, and attend meetings regularly. In the event that a member resigns or is unable to perform duties expected and is removed from the team, the team will identify and extend an invitation for a replacement member with similar expertise. Outgoing team members shall provide, if able, the new member with the duties and responsibilities required for their agency's participation. If we do not have a quorum of at least 6 people, the meeting will be cancelled.

At times community representatives may be asked to participate in reviews in order to provide additional information to the team. These community representatives will be required to sign the confidentiality agreement and the team will decide what level of participation is needed.

Fatality review is not an avenue to find fault or place blame, but rather a non-judgmental evaluation of the events leading up to the family or intimate partner violence fatality.

Protection of Victim and Confidentiality

All information and records acquired by a domestic violence fatality review team are not subject to discovery or introduction into evidence in any civil or criminal action or administrative or disciplinary proceeding by any department or employing agency if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team. However, information, documents, and records otherwise available from other sources are not immune from discovery or introduction into evidence solely because the information, documents, or records were presented to or reviewed by such a team. A person who has attended a meeting of a domestic violence fatality review team may not testify in any civil, criminal, administrative, or disciplinary proceedings as to any records or information produced or presented to the team during meetings or other activities authorized by this section. This subsection does not preclude any person who testifies before a team or who is a member of a team from testifying as to matters otherwise within his or her knowledge.

Pursuant to F.S.S. 39.908:

Information about clients received by the department or by authorized persons employed by or volunteering services to a domestic violence center, through files, reports, inspection, or otherwise, is confidential and exempt from the provisions of s. 119.07(1).

All team members and guests will sign a confidentiality agreement at the beginning of each meeting.

An annual report containing aggregate findings will be issued and presented annually to the FCADV. The team will work towards suggesting systemic changes on an ongoing basis whenever possible in addition to submitting formal reports of findings.

PASCO COUNTY DOMESTIC VIOLENCE FATALITY REVIEW TEAM PROCEDURE MANUAL

Mission Statement

The purpose of this committee is to review domestic violence fatalities and to identify any red flags that might prevent future fatalities

Goals And Objectives

- Review current procedures in an effort to reduce and eliminate domestic violence thereby averting future domestic violence fatalities.
- Enhance communication and coordination between agencies.
- Promote education for the criminal justice system, social services providers and the community as a whole.
- Review community services currently available to children and families affected by domestic violence and the community at large.
- Remove barriers to service and identify underserved populations including surviving minor children.
- Explore possible funding sources for services to meet the diverse needs of victims and their families.
- Identify any special needs of the community.
- Recognize racial and ethnic diversity of the county demographic population.
- Identify lethality factors.

Philosophy

The Team philosophy is accountability without blame. While the business of reviews and staying on task is extremely important, it is also believed that the process is equally as important. Cases are reviewed in-depth and will take as much time as needed to thoroughly review each case. The Team will consider the emotional well-being of the surviving family as well as the Team itself when conducting reviews and make appropriate conditions for the environment to be safe and non-traumatic.

Eligible Cases For Review

Closed cases in which the perpetrator has been tried and sentenced or homicide/suicides.

All applicable cases from each year starting with 1996 may be reviewed.

In addition, the Team may review near-fatalities, attempted murders, or domestic violence suicides when identified.

In an effort to address current issues, open cases may be eligible for a “closed” review at the discretion of the investigating agency, SAO, and FRT Chair.

Meeting Structure

The Team meets the 4th Wednesday every other month (or as needed), from 9:00-11:00 am at the [location removed for confidentiality purposes]. The agenda consists of business first followed by case review. Information for a new case may be presented before the previous case is closed. The meetings will end with an open discussion for Team members to process their response to the case review.

Team Membership

The membership of the Team shall follow F.S. 741.316. Representatives from the following organizations shall be included:

- Attorney General's Office
- Batterers intervention program
- Certified domestic violence centers
- Child protection service providers
- Clerk of the court
- County probation and corrections agencies
- Child death review teams
- Faith community
- Guardian ad Litem
- Health Department
- Law enforcement agencies
- Legal Aid
- Medical examiner
- Mental health services
- Schools
- State attorney
- Victim services programs

Other members may be added as deemed necessary by the team. The expertise of community representatives will be utilized as needed.

When a Team member is no longer able to serve, they are asked to give notice to the team and assist in the replacement of a similarly trained individual. Orientation material will be provided to new Team members, including copies of all pertinent handouts given to team members. When possible, the Team member who invited the new Team member shall assist with the orientation process and make sure they have been provided with all materials and information.

Case Review Information

When a new case is introduced for review, each team member shall go back to their respective offices and determine whether their agency had any involvement with the case. Any hard copies of relevant information may also be brought to the review. This paperwork shall be returned to the agency immediately following the review. Public records may be copied and distributed to all team members. Any extra copies of public documents shall be shredded at the end of each review meeting. Whenever possible, information from non-participating agencies will be obtained per F.S. 741.316.

Confidentiality

Each Team member and guest will sign the enclosed Confidentiality Form at each meeting.

Contacting Family Members

The Team will make every attempt to contact surviving family members to inform them that their loved one's death is being reviewed. A letter is sent explaining the review process. Family members are invited to contact the Team with any information about the life or death of their loved one that they choose to share. The Team may also contact the surviving family with a follow up phone call when doing so would assist or benefit the review process. The Team will decide in advance who will contact the family. The family member's may speak to the advocate over the phone or through a personal interview. Team members will place the privacy and rights of surviving family members above obtaining information. At this point in time, our Team has decided not to invite family members to participate in the actual review.

Findings

When time permits, an annual report will be prepared according to FCADV guidelines and presented to the Pasco County Domestic & Sexual Violence Task Force. The Team will work toward policy changes as needed in addition to submitting a formal report of findings.

PINELLAS COUNTY DOMESTIC VIOLENCE FATALITY TEAM QUESTIONS FOR DETECTIVES

Helpful data for the fatality review team regarding domestic incidents[23]:

1. Date, time, day of week of call to police.
2. Who called it in? What kind of call was it (did caller say disturbance, murder, domestic, etc.)?
3. Date, time, day of week of actual incident.
4. Age, race of victim
5. Age, race of subject
6. Marital status or relationship status of victim and subject.
7. Occupation of victim. Income level?
8. Occupation of subject. Income level?
9. Educational level of victim.
10. Educational level of subject.
11. Basic details of incident (anything leading up to, what occurred during incident, anyone else present at scene, what weapon used, what injuries, what did defendant/subject do after the incident, etc.)
12. Any prior domestic calls to residence or with these parties?
13. Any prior domestic calls involving victim or subject and another partner?
14. Any threats reported to police? By friends/family/acquaintances?
15. Any stalking reported to police? By friends/family/acquaintances?
16. Any reports of jealousy and/or possessiveness?
17. Any mental health issues? Any mental health medications?
18. Any alcohol use that day? In past?
19. Any illegal drug use that day? What drug? In past?
20. Any prescription drug misuse that day? What drug? In past?
21. Any mention of prior treatment for alcohol or drugs?
22. Any prior domestic violence arrests for subject?
23. Any prior domestic violence arrests for victim?
24. Any criminal history for subject?
25. Any criminal history for victim?

[23]Direction for answering questions: "The team realizes that you may or may not know the answers to all of these questions. That's okay. We are just asking you to report any answers that you do know. Some of these questions are related to a state data form that we complete after each case is reviewed."

26. Any reports of subject being violent towards others (neighbors, family, friends, coworkers, law enforcement)?
27. Any prior firearm issues for subject?
28. Any medical issues?
29. Any homelessness issues?
30. Any poverty/economic issues?
31. Any reports of pet abuse?
32. Any reports of child abuse with any of children in house? To police? By family or friends?
33. Any prior marriages or relationships for victim or subject? Any violence in any of those relationships?
34. Any children together in this relationship?
35. Any children in home from victim's prior relationship? Any from subject's prior relationship?
36. Any history of childhood abuse for subject or victim?
37. Any family history of witnessing domestic violence as a child for subject or victim?
38. Any talk of or hint of or discussion of getting an injunction for protection?
39. Any talk of a divorce?
40. Any talk of separating?
41. Any significant change in relationship?
42. Any perceived betrayal (subject feeling victim betrayed them)?
43. Any new relationship for victim or subject?
44. Any mention of infidelity by either party?
45. Any mention of subject threatening to commit suicide (during this event or in past)? Any suicidal attempts?
46. Any suicidal attempts by victim?
47. Add any additional information that you feel is pertinent.

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FCADV
Florida Coalition Against Domestic Violence

Florida Coalition Against Domestic Violence

www.fcadv.org
850.425.2749

Florida Domestic Violence Hotline
1.800.500.1119

TDD
1.800.621.4202

Florida Relay
711