



DISTRICT OF COLUMBIA
DOMESTIC VIOLENCE FATALITY
REVIEW BOARD

THIRD ANNUAL REPORT



Prepared July 2009



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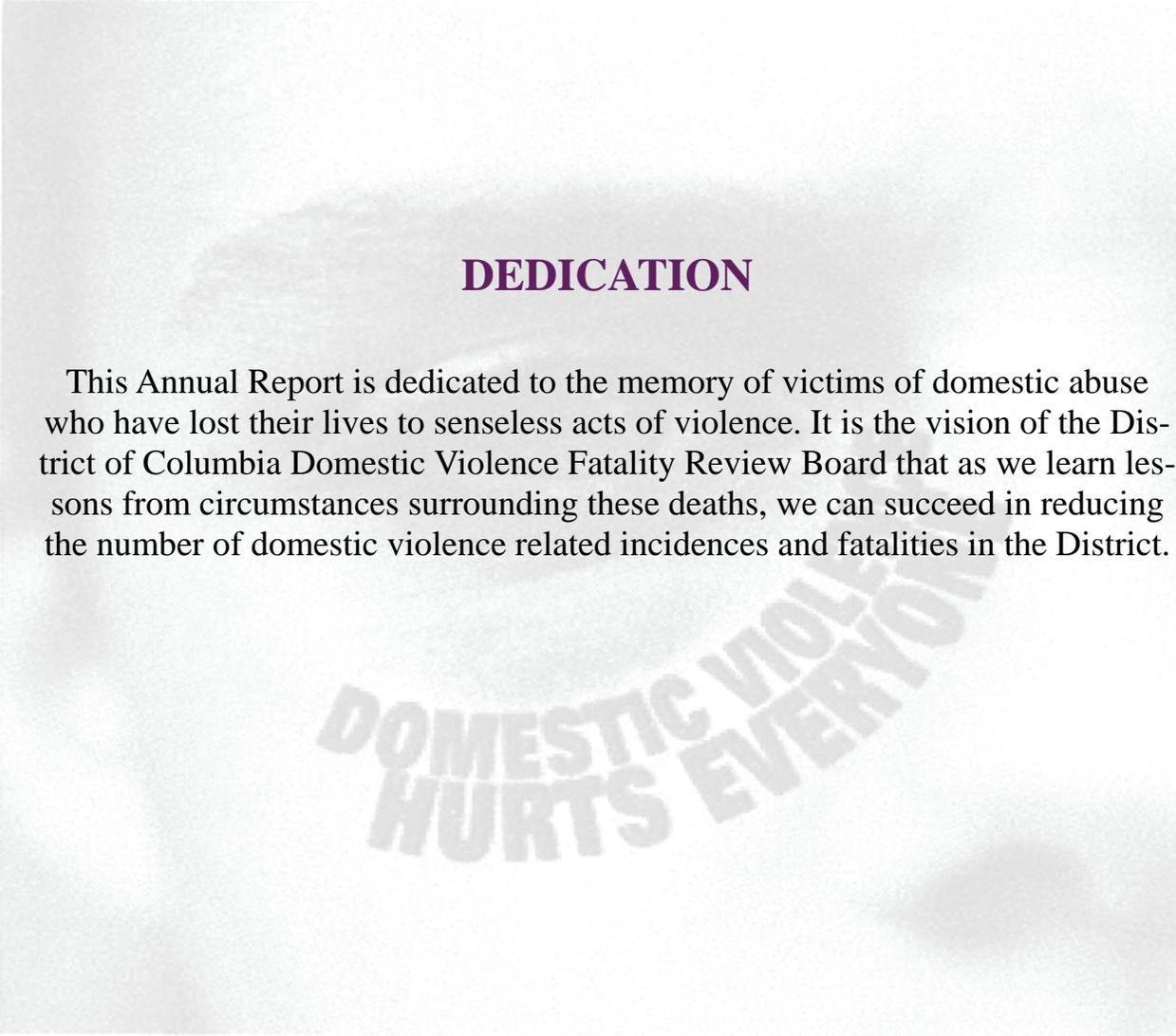
MISSION:

To reduce the number of preventable domestic violence related fatalities in the District of Columbia through identifying, evaluating and improving programs and systems responsible for protecting and serving residents.

PRESENTED TO:

**The Honorable Adrian M. Fenty, Mayor, District of Columbia,
The Council of the District of Columbia**

July 2009



DEDICATION

This Annual Report is dedicated to the memory of victims of domestic abuse who have lost their lives to senseless acts of violence. It is the vision of the District of Columbia Domestic Violence Fatality Review Board that as we learn lessons from circumstances surrounding these deaths, we can succeed in reducing the number of domestic violence related incidences and fatalities in the District.

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EXECUTIVE SUMMARY

*"Never doubt that a small group of
thoughtful, committed citizens can
change the World.*

Indeed, it's the only thing that ever has."

Margaret Meade

The District of Columbia Domestic Violence Fatality Review Board (DVFRB) is pleased to present its Third Annual Report. Since beginning full operation in 2006, the Board has identified 85 fatalities that met the criteria for review. Over a three year period, reviews were completed on 68 deaths where the prosecution or the police investigations were closed. This Report provides a summary of the 85 domestic violence related fatalities identified by the Board; and provides a more in-depth synopsis of the data, trends and recommendations that resulted for the 14 deaths that were reviewed by the Board between July 2008 and June 2009.

PART I. TOTAL DOMESTIC VIOLENCE FATALITIES IDENTIFIED (N = 85)

- ❖ Of the 85 deaths identified by the Board, 96% (N = 82) were Homicides and three were Suicides.
- ❖ Most victims were African American/Black (91%) and female (54%); and victims between the ages of 19 and 39 years represented 35% of the total population identified..
- ❖ Eighty-six percent of the deaths (N = 73) involved District residents; 12% were residents from other States but the deaths occurred in the District. The largest number of decedents resided in Wards Eight (29%), Five (21%) and Six (12%).
- ❖ As of June 2009, 80% (N = 68) of the 85 deaths identified were reviewed and 20% (N = 17) were pending review. Of the 17 pending cases, 15 were pending completion of prosecution.

PART II. SUMMARY OF TOTAL DEATHS REVIEWED (N= 14)

Between July 2008 and June 2009, the DVFRB reviewed 14 domestic violence-related deaths that occurred during the 2005 through 2009 calendar years. The following is a brief summary of major findings that resulted from reviews of these fatalities.

MANNERS AND CAUSE OF DEATH

- ❖ Based on autopsies, 100% of the deaths reviewed were determined to be Homicides. Two of these cases also involved Suicides in that the perpetrator took his life shortly after murdering the victim.
- ❖ Stab Wound was the leading cause of death (50%), followed by Gunshot Wound (29%).

VICTIM/PERPETRATOR DEMOGRAPHICS - AGE, GENDER AND RACE

- ❖ Of the 14 deaths reviewed, nine victims were females and five were males. Twelve (86%) of the 14 victims were African-American/Black. There were equal numbers of White and Hispanic decedents (N = 1). The average age of victims was 48.
- ❖ The majority of the perpetrators of the 14 deaths reviewed were males (N = 10), African-American/Black (N = 12) and the average age was 44. Two of the perpetrators committed Suicide after the Homicides. The Homicide/Suicide incidents occurred during calendar years 2007 and 2008.

PRIOR CRIMINAL HISTORIES

- ❖ Sixty-four percent of the 14 perpetrators had prior criminal histories.
- ❖ Twenty-one percent of the decedents had prior histories with the criminal justice system.
- ❖ None of the perpetrators or the decedents had an active Civil Protection Order (CPO) at the time of the fatal incident.

WARD OF DECEDENT'S RESIDENCE AND FATAL INCIDENT

- ❖ Two (14%) of the decedents were residents of another State, however the fatal incident and death occurred in the District.
- ❖ Of the 12 victims who were District residents, the largest number resided in the Ward Eight quadrant of the District (N = 6), followed by Ward Five (N = 3).
- ❖ 100% of the 14 deaths reviewed occurred in the District. The majority of the fatal incidents also occurred in Ward Eight (N = 7), followed by Ward Five (N = 2).

DVFRB RECOMMENDATIONS FROM FATALITIES REVIEWED

Based on the 14 deaths reviewed, four recommendations were adopted by the Board and transmitted to agencies for responses. These recommendations and the responses from agencies are included in Part IV of this Report, DVFRB Recommendations (see page 13).

INTRODUCTION

The District of Columbia, Domestic Violence Fatality Review Board (DVFRB) is pleased to present its Third Annual Report. This Report covers data that resulted from domestic violence reviews that were conducted between July 2008 and June 2009.

The Domestic Violence Fatality Review Board is a city-wide collaborative effort that was established by the Uniformed Interstate Enforcement of Domestic Violence Protection Orders Act of 2002, DC Law 14-296 (See Appendix A). The mission of the Board is to prevent domestic violence related fatalities by improving the responses of individuals, community and District-based public and private service delivery systems. This mission is achieved through a multi-disciplinary analysis of the victims' experiences and the circumstances surrounding their deaths. Through the case review process, the Board identifies high-risk factors and trends related to the decedents, perpetrators, and systems responsible for supporting, assisting, and protecting victims from family and/or intimate partner violence. The review process provides an opportunity for professionals and/or concerned citizens, through a cooperative effort, to enhance and increase services and improve the District's response to address the needs of residents. (See Appendix B: Mission Statement and Description of DVFRB Review Process)

The District's DVFRB is a formally established mechanism for tracking domestic violence-related fatalities, assessing the circumstances surrounding the deaths and associated risk indicators. Homicides and Suicides are selected for review based on referrals from the U.S. Attorneys Office, the Metropolitan Police Department, the Office of the Attorney General, and the Office of the Chief Medical Examiner. Based upon protocols established by the Board, Homicides are reviewed after closure of the criminal case and Suicides are reviewed upon closure of the law enforcement investigation. The Board obtains records from a variety of public and private agencies/programs that were involved with the victim and the perpetrator. Records are reviewed and a summary is developed for presentation during the monthly case review meetings.

Member representation at Board meetings depend on the type of review and level of involvement with public and community-based programs. *All DVFRB meetings are confidential*, and participants are required to sign a confidentiality statement. Based on written and verbal information shared during the meetings, risk indicators and system trends are identified, and recommendations may be generated.

This *Annual Report* summarizes the work and data collected by the DVFRB between July 2008 and June 2009, the third year of operation. *Part I* of the Report provides a general overview of all deaths referred to the Board since 2006 as meeting the criteria for review. It summarizes decedent demographics as well as the manners and causes of death for the total DVFRB population identified over a three year period. *Part II* provides a synopsis of the demographic data, trends and recommendations that resulted from the 14 Homicide cases reviewed by the Board between July 2008 and June 2009. *Part III* of the Report illustrates the most common key lethality risk indicators that were present in the 14 deaths reviewed, and *Part IV* provides a compilation of the recommendations that resulted from these deaths with agencies' responses.

PART I: TOTAL DOMESTIC VIOLENCE FATALITIES 2004-2009

TOTAL CASES IDENTIFIED

As of June 2009, the DVFRB identified a total of 85 deaths that occurred between 2004 and 2009, which met the criteria for review. Ninety-six percent of the deaths were determined to be Homicides and four percent were Suicides (N = 3). Figure 1 below illustrates the total number of deaths identified for each calendar year. (Endnote #1, see page 16)

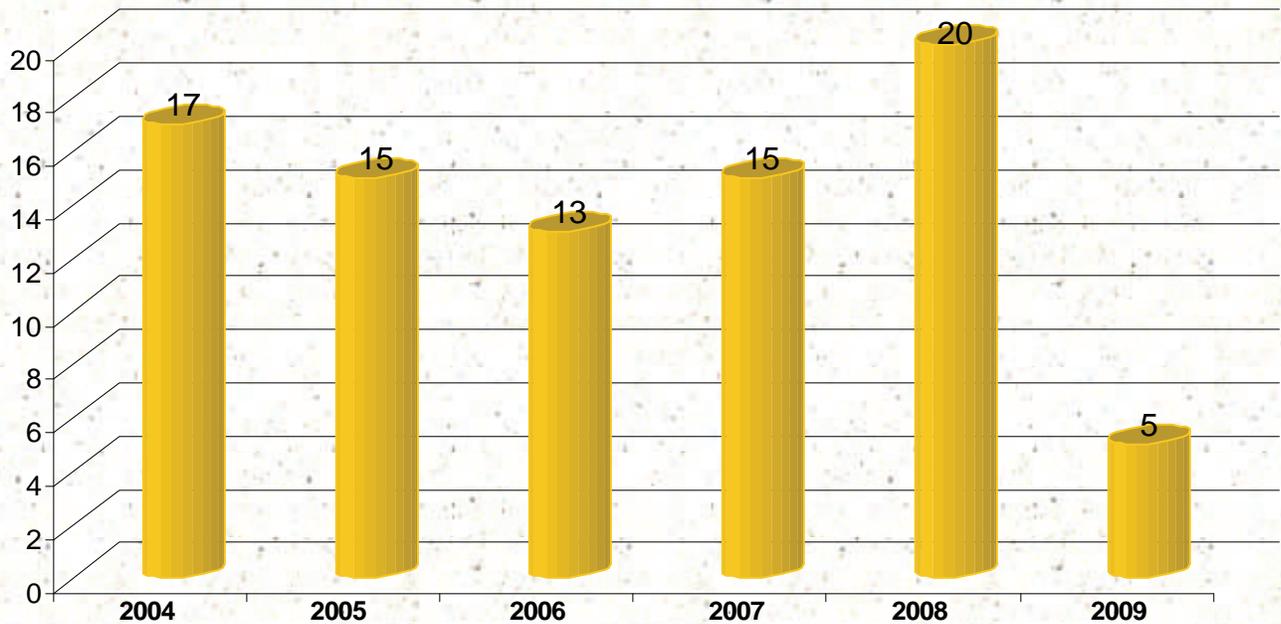


Figure 1: Total DVFRB Deaths Identified - 2004 Thru 2009 (N = 85)

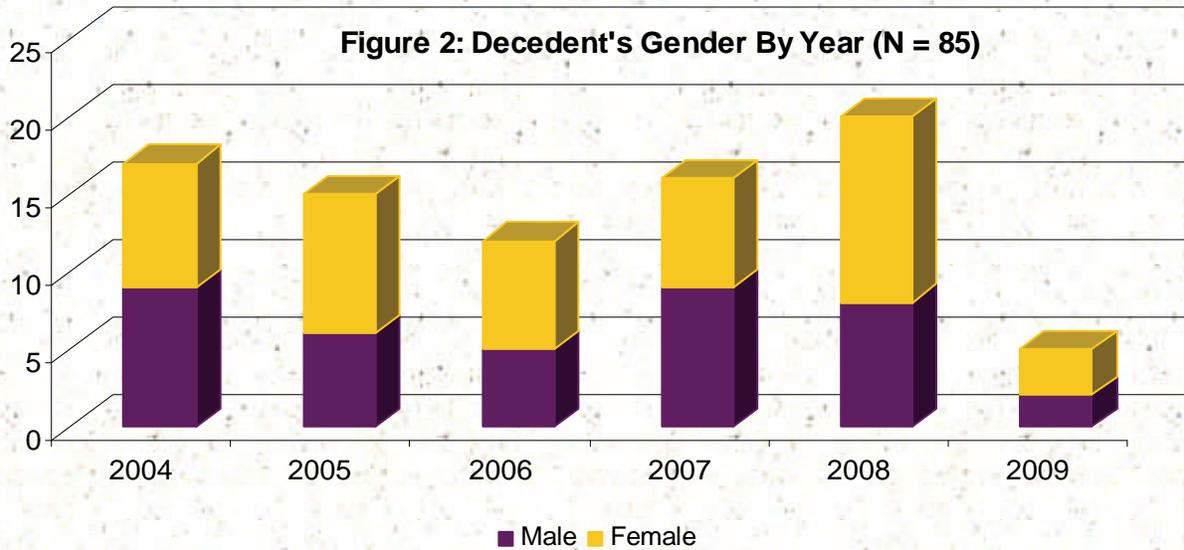
RACE, GENDER AND AGE OF TOTAL DVFRB DEATHS

- ❖ As Table 1 illustrates, 91% of the victims identified as domestic violence fatalities were African-American/Black (N = 77). There were equal numbers of White and Hispanic domestic violence fatalities identified (N = 4 each).

YEAR	BLACK	WHITE	HISPANIC
2004	15	1	1
2005	12	2	1
2006	12	0	1
2007	15	0	0
2008	18	1	1
2009	5	0	0

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- ❖ As Figure 2 illustrates, females victims represent 54% of the 85 domestic violence deaths identified. The greatest number of female deaths occurred in 2008 (N = 12); followed by nine deaths that occurred in 2005 and eight in 2004.



- ❖ The ages of the victims ranged from 37 days to 91 years.
- ❖ As indicated in Table 2 below, the majority of the deaths reviewed involved victims between 19 and 39 years of age (N = 30, or 35%).
- ❖ Children/youth under the age of 19 years represent the second largest death population (N = 29). Thirty-four percent of these children were under the age of 5 years. The children/youth under 19 years of age represent an overlap population with the Child Fatality Review Committee (CFRC) (Endnote #2, see page 21). Based on DVFRB and CFRC protocols, reviews of children/youth in this age category are conducted by the CFRC with the involvement of DVFRB members. These deaths are statistically counted by both the DVFRB and CFRC. Eighty-three percent (N = 24) of the 29 children/youth in this age category died at the hands of a parent/caregiver.

TABLE 2: DECEDENTS AGE BY YEAR (N = 85)						
Category	2004	2005	2006	2007	2008	2009
Under 19	6	5	3	3	10	2
19 – 39	8	7	1	8	4	2
40 – 59	2	1	6	3	5	1
60 – 79	1	0	2	0	0	0
80 & Over	0	2	1	1	1	0
Total	17	15	13	15	20	5

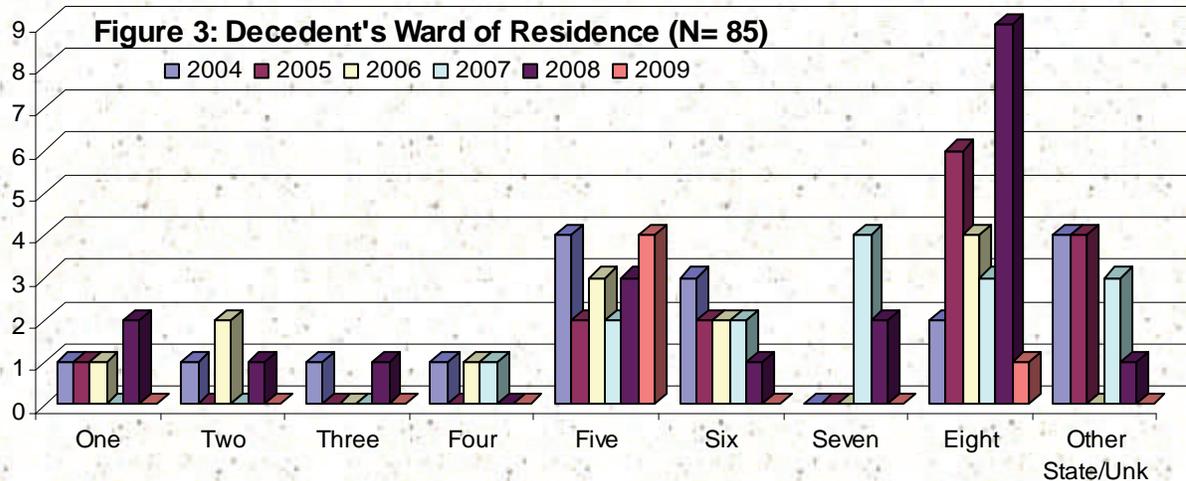
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- ❖ Adults between 40 – 59 years of age ranked third (N = 18, or 21%) and deaths among those 80 and over ranked fourth.

WARD OF RESIDENCE

Of the 85 domestic violence related deaths identified by the DVFRB, 73, or 86% involved District residents; 12% of the decedents (N = 10) were residents from other jurisdictions. Location of residence was unknown for two decedents. As Table 3 and Figure 3 illustrate, of the 73 District residents, Wards Eight, Five, Six and Seven respectively had the highest overall number of residents who died from domestic violence related incidents.

TABLE 3: WARD OF RESIDENCE						
Wards	2004	2005	2006	2007	2008	2009
One	1	1	1	0	2	0
Two	1	0	2	0	1	0
Three	1	0	0	0	1	0
Four	1	0	1	1	0	0
Five	4	2	3	2	3	4
Six	3	2	2	2	1	0
Seven	0	0	0	4	2	0
Eight	2	6	4	3	9	1
Other State	3	4	0	3	0	0
Unknown	1	0	0	0	1	0
Total	17	15	13	15	20	5



MANNER OF DEATH

- ❖ Homicide was consistently the leading manner of death for domestic violence fatalities for all calendar years. As Figure 4 illustrates, Homicides accounted for 96% of the 85 deaths identified (N = 82).
- ❖ Three of the 85 deaths identified were determined to be Suicides. These deaths occurred in calendar years 2005, 2006 and 2007. Based on prior documented histories of domestic violence, these cases met the criteria for a review.

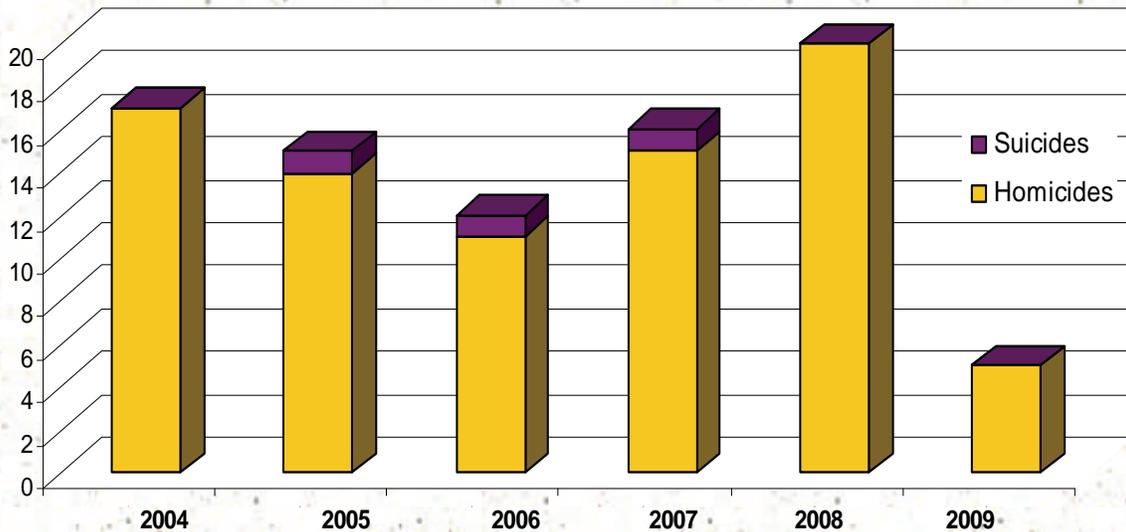


Figure 4: Manner of Death By Year- 2004-2009 (N = 85)

STATUS OF DVFRB CASE REVIEW PROCESS

Table 4 illustrates the status of the case review process by calendar year. Between July 2008 and June 2009, 14 domestic violence deaths were reviewed that occurred in calendar years 2006 through 2009. As of June 2009, two cases were pending review and 15 were pending completion of prosecution.

TABLE 4: DVFRB CASES IDENTIFIED, REVIEWED AND PENDING			
Year	# Cases Identified	# Cases Reviewed	# Pending Review
2004	17	17	0
2005	15	15	0
2006	12	11	1
2007	16	13	3
2008	20	12	8
2009	5	0	5
Total	85	68	17

PART II: SUMMARY OF CASE REVIEW FINDINGS

The information contained in this section covers the data and findings that resulted from cases reviewed by the DVFRB during the period of July 2008 through June 2009 (N = 14). Based on established protocols, data in the graphs and tables represent deaths that occurred during multiple years. Two of the 14 deaths reviewed involved Homicide and Suicide incidents. As a result of the direct association with the Homicide deaths, the Suicide deaths were also reviewed. However, these deaths did not meet the criteria outlined in DC Law 14-296 to support inclusion as a domestic violence related fatality. Therefore, for purposes of this Report, the two Suicide deaths are reflected only in perpetrator data and not victim/decedent data.

PERPETRATOR AND DECEDENT DEMOGRAPHIC DATA

GENDER OF PERPETRATORS AND DECEDENTS

- ❖ **Perpetrators** - Of the 14 deaths reviewed, 71% of the perpetrators were males (N =10) and 29% were females.
- ❖ **Decedents** - Sixty-four percent of the decedents were females (N = 9), and 36% were males (N = 5).

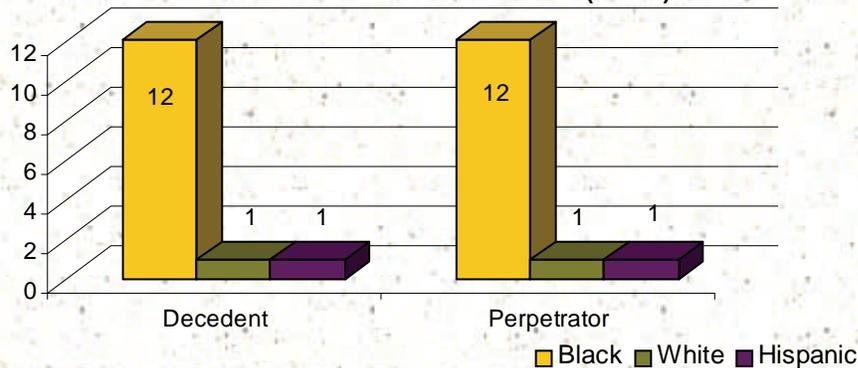
AGE OF PERPETRATORS AND DECEDENTS

- ❖ **Perpetrator** – The age of the perpetrators ranged from 15 to 90 years. The average age was 44, and the median age was 28. There was one male perpetrator over the age of 80 years.
- ❖ **Decedent** - The ages of the decedents ranged from 19 to 91 years. The average age was 48, and the median age was 32. Among the 14 deaths reviewed, there were two decedents over the age of 80 years.

RACE OF PERPETRATORS AND DECEDENTS

- ❖ The racial composition of the decedents and perpetrators was the same.
- ❖ Eighty-six percent of the 14 decedents and perpetrators were African-American (N= 12).
- ❖ There were also equal numbers of White and Hispanic decedents and perpetrators (N = 1 or 7% each).

Figure 5: Race of Decedents and Perpetrators Cases Reviewed (N = 14)



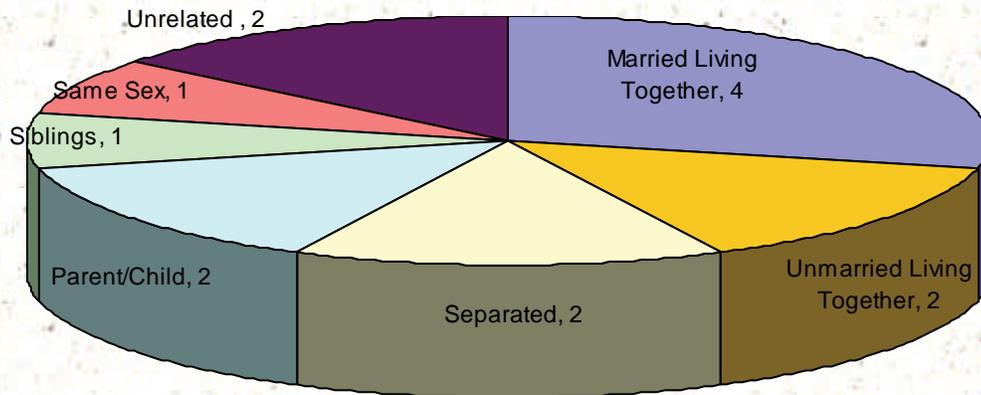
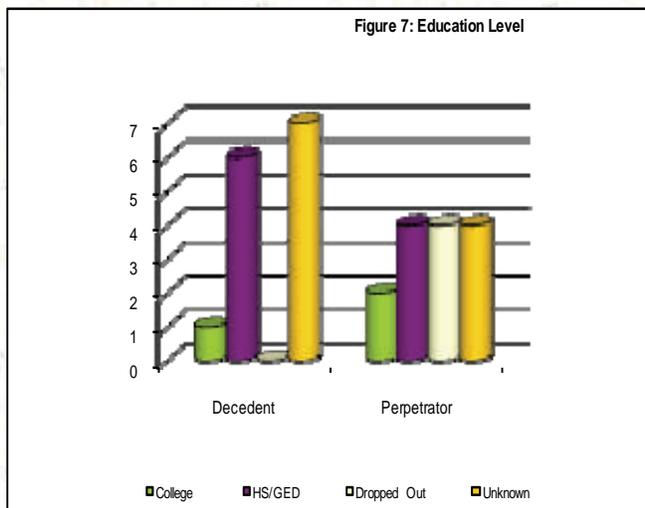


Figure 6: Victim/Perpetrator Relationship (N = 14)

PERPETRATOR AND DECEDENT RELATIONSHIP

Figure 6 illustrates the relationship between the victims and perpetrators of the 14 Homicides reviewed.

- ❖ Sixty-four percent (N = 9) of the 14 deaths involved intimate partner relationships. Of the nine intimate partner relationships, eight (89%) were heterosexual and one was a same sex couple.
 - ❖ Four were married couples.
 - ❖ Two of the couples were unmarried and resided together.
 - ❖ Three couples were separated at the time of the fatal event, including two married and one same sex couple.
- ❖ Two (14%) of the 14 Homicides reviewed involved parent/grandparent and child relationships.
- ❖ One (7%) case involved male siblings and the perpetrator was a minor child.
- ❖ In two (14%) Homicides, the victim and perpetrator were unrelated however in one case the victim had an intimate partner relationship with the perpetrator's wife. In the other case the decedent was involved in a sex-for hire relationship and did not know the perpetrator.



EDUCATION LEVEL OF PERPETRATOR AND DECEDENT

Perpetrators (N = 14)

- ❖ As Figure 7 illustrates, two perpetrators had college background however, only one had completed. Four had a high school diploma, one had obtained a GED and one was in high school. Four perpetrators had dropped out of school. Education level was unknown for two perpetrators.

Decedents (N = 14)

- ❖ Of the 14 decedents, one attended college, four had a high school diploma, and two had obtained a GED. The educational level was unknown for seven decedents.

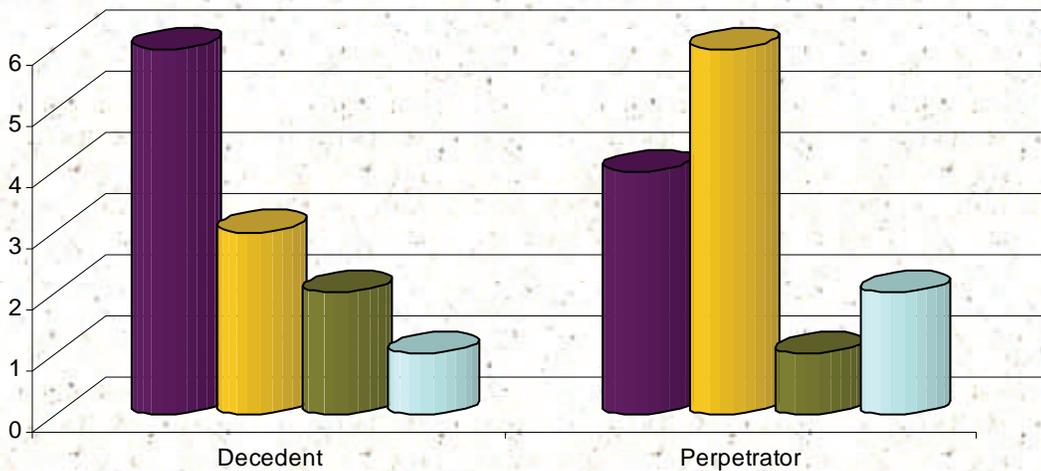


Figure 8: Employment Status (N = 14 Deaths)

■ Employed At Death ■ Unemployed At Death ■ Retired □ In Training/School

EMPLOYMENT STATUS OF PERPETRATORS AND DECEDENTS

Figure 8 illustrates the employment histories and status at the time of the death. Employment information was unknown for two decedents and one perpetrator.

Perpetrators (N = 14)

- ❖ Forty-three percent (N = 6) of perpetrators were unemployed at the time of death; three had no employment histories and three had limited histories.
- ❖ Twenty-nine percent (N = 4) of the perpetrators were employed at the time of death.
- ❖ One each were retired, actively attending high school and in a job training program

Decedents (N = 14)

- ❖ Twenty-one percent (N = 3) of the decedents were unemployed at the time of death and one had no employment history.
- ❖ Forty-three percent (N = 6) of the decedents were employed at the time of the death.
- ❖ Two decedents were retired and one was in a job training program.

PRIOR CRIMINAL, MENTAL HEALTH & SUBSTANCE ABUSE HISTORIES

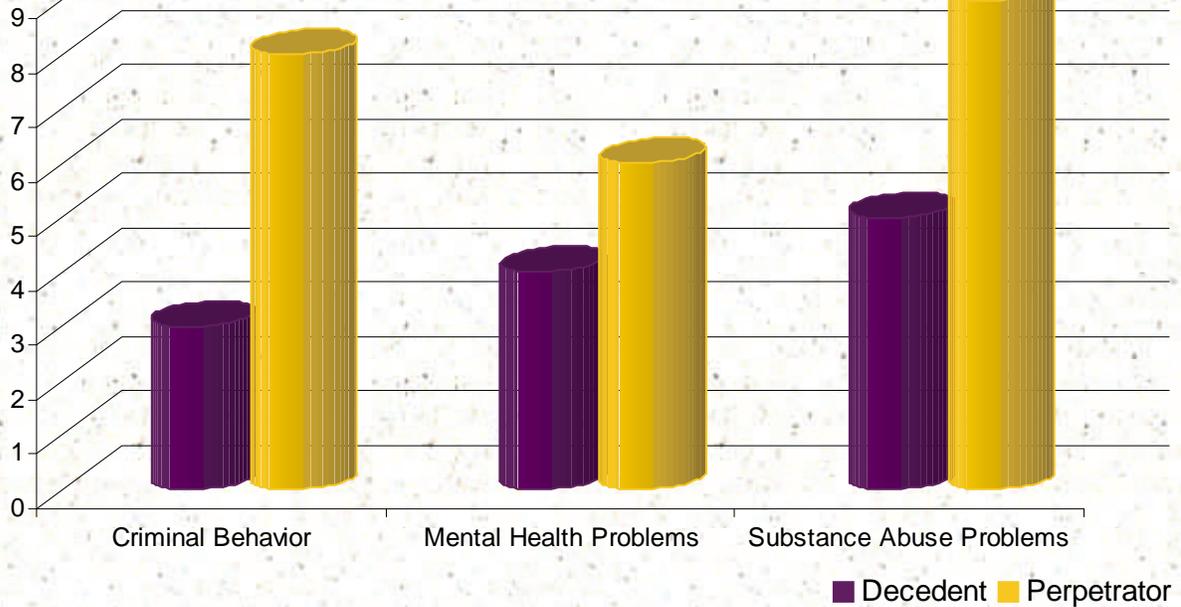
Figure 9 on page 9 depicts the criminal, mental health and substance abuse histories of the decedents and perpetrators.

Perpetrators (N = 14)

Sixty-four percent (N = 9) of perpetrators had prior criminal histories. Eight of these individuals had extensive histories that included numerous assaults, drug and gun related arrests. Of the eight with extensive criminal histories, six had prior arrests that included domestic violence charges and in two of these cases the domestic violence charges involved the decedent.

- ❖ None of the perpetrators had an active Civil Protection Order (CPO) at the time of the fatal incident.

Figure 9: Prior Criminal, Mental Health and Substance Abuse Histories



- ❖ Forty-three percent (N = 6) of the perpetrators had known prior histories of mental health problems and treatment. Two of these individuals had prior mental health institutionalizations and each had attempted suicide on at least two known occasions. Only one perpetrator was in treatment at the time of the fatal incident.
- ❖ Sixty-four percent (N = 9) had prior histories of substance abuse. Six were actively using alcohol and drugs at the time of the fatal incident and also had a criminal history; and three did not have a criminal history but had histories of substance abuse. Only one perpetrator reported having used alcohol and drugs immediately prior to the fatal incident.

Decedents (N = 14)

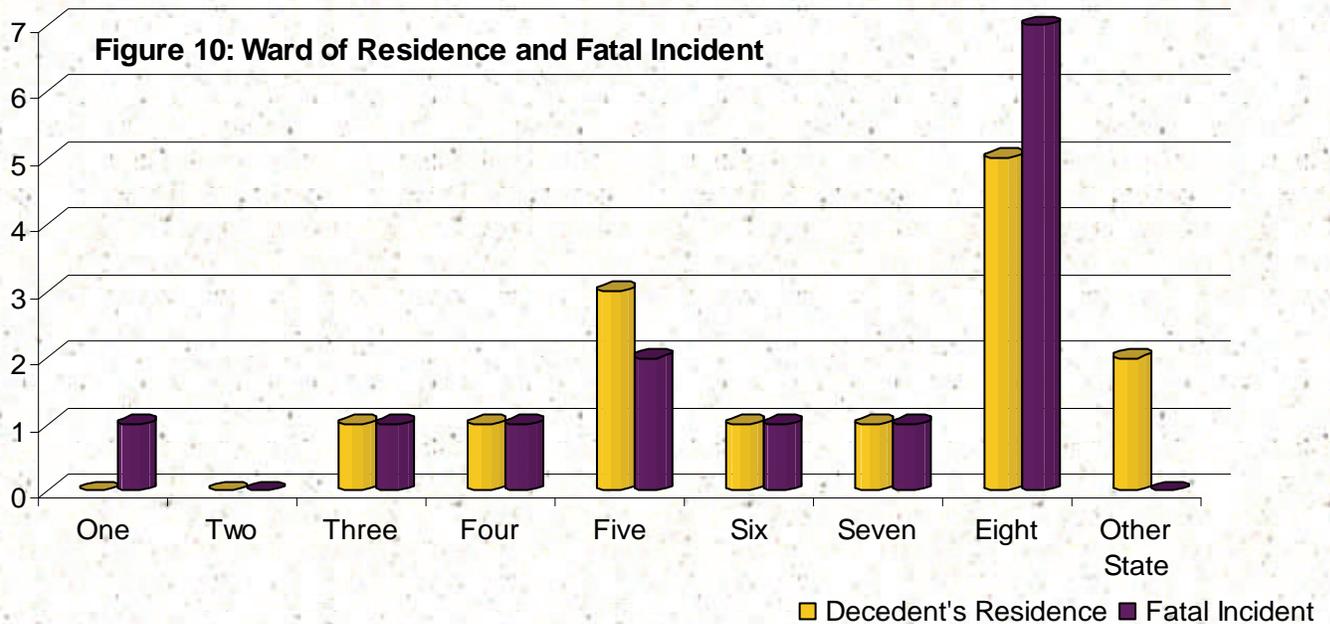
- ❖ Twenty-one percent (N = 3) of the 14 decedents had a prior history with the criminal justice system. Two were arrested for domestic violence related charges, one of which involved the perpetrator; and one decedent was arrested for assaults unrelated to domestic violence.
- ❖ None of the decedents had an active Civil Protection Order (CPO) at the time of the fatal incident.
- ❖ Twenty-one percent (N = 3) of the decedents had prior mental health histories and treatment. Three attempted suicide on several occasions and two of these individuals had prior histories of inpatient psychiatric hospitalizations for treatment of mental illness. Two decedents were in treatment at the time of the fatal incident.
- ❖ Thirty-six percent (N = 5) of decedents had prior histories of substance abuse. Four of the five victims were actively using alcohol and/or drugs at the time of the fatal incident; two of these individuals also had a prior criminal history. One victim with a history of substance abuse had not used alcohol and/or drugs prior to the fatal incident.

CHILDREN OF PERPETRATOR AND DECEDENT/CHILDREN WITNESS TO THE FATAL INCIDENT

- ❖ Twenty-one percent (N = 3) of the 14 decedents had minor children. The perpetrators were the parents of the children in two of these domestic violence related deaths. In two of the Homicides, children of the victims were in the home at the time of the fatal incident and either witnessed the fatal incident or was exposed to the trauma/violence.
- ❖ In Homicide one incident of an estranged couple, there was a one four-year-old unrelated child present who was in the care of the decedent; this child witnessed the fatal confrontation.
- ❖ In 14% (N = 2) of the 14 cases reviewed, two of the cases involved children as the perpetrators.

LOCATION/WARD OF RESIDENCE AND FATAL INCIDENT

- ❖ Figure 10 illustrates the decedents' Wards of residence and the Wards where the fatal incidents took place; Table 5 depicts the location of the fatal event.



- ❖ Of the 14 cases reviewed, the majority of the decedents resided in Ward Eight (N = 5 and N = 7 respectively) where the fatal incidents also occurred.
- ❖ Of the 14 fatalities reviewed, the majority of the fatal incidents occurred in a home shared by the perpetrator and decedent (N = 5), followed by public streets and buildings (N = 3 each).

LOCATION	# OF HOMICIDES
Shared Residence	5
Decedents' Residence	2
Perpetrators' Residence	1
Public Street	3
Public Building	3

MANNER AND CAUSE OF DEATH

MANNER OF DEATH

- ❖ 100% (N = 14) of the DVFRB deaths reviewed were determined to be Homicides.
- ❖ Two of the Homicides also involved a Suicide. The Suicide cases did not meet the legal definition of a domestic violence fatality because there was no documented history of domestic violence prior to the death. For purposes of this Report, Suicide deaths are counted only as perpetrators. Of the two Homicide/Suicide incidents reviewed, one involved a couple who had been married for more than 50 years; and the second involved a victim who had been involved in a same sex relationship with the perpetrator's wife for nearly a year prior to the fatal incident.

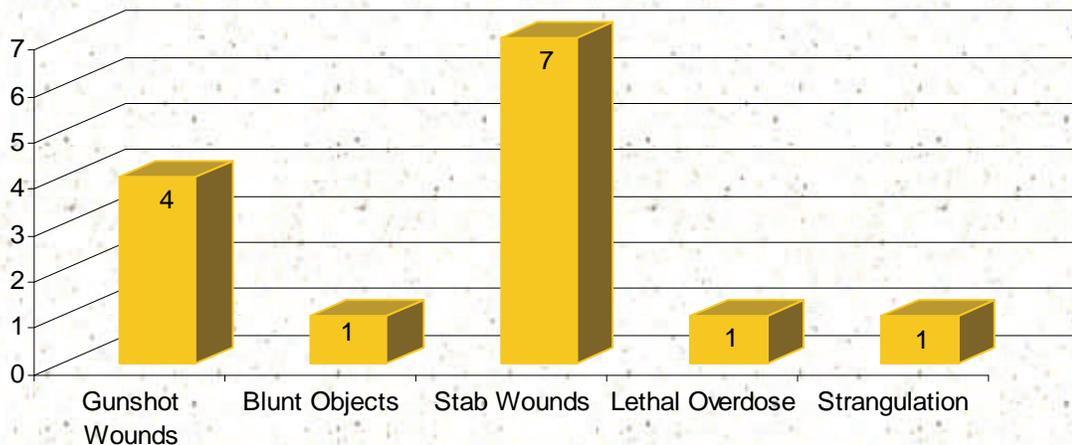
CAUSE OF DEATH

Figure 11 represents the causes of death from the 14 Homicide fatalities reviewed.

- ❖ Based on the autopsy reports, Stab Wound was the cause of death for 50% (N = 7) of the domestic violence deaths reviewed.
- ❖ Twenty-nine percent (N = 4) of the deaths were caused by Gunshot Wounds
- ❖ One death each was the result of blunt impact, intoxication and strangulation.

PROSECUTION STATUS OF DOMESTIC VIOLENCE FATALITY

Figure 11: Causes of Death - Cases Reviewed (N = 14)



- ❖ Of the 14 perpetrators, 79% (N = 11) were prosecuted and convicted in the death of the decedents. One youth offender was sentenced to a juvenile mental health detention center.
- ❖ One was found not guilty by a jury trial;
- ❖ Two perpetrators committed Suicide after the Homicides.

PART III: KEY LETHALITY RISK INDICATORS

Key lethality risk factors are nationally recognized indicators of domestic abuse and are a critical component of the District’s fatality review process. These indicators have been determined to be early signs of high risk violence in relationships. The more risk indicators present in a relationship/case, the greater the risk of escalating violence, or even death. Table 6 below illustrates the most common key lethality risk indicators that were present in the relationships of the 14 deaths reviewed by the DVFRB.

TABLE 6: KEY LETHALITY RISK INDICATORS MOST COMMONLY IDENTIFIED	VICTIM	PERPETRATOR	# OF CASES
Prior domestic violence history	1	7	8
Escalation of Violence		8	8
Prior threats of violence	1	3	4
Obsessive behavior (including stalking the victim)			3
Access to or possession of firearms		4	4
Depression or other mental health/psychiatric problems	3	6	9
Actual or pending separation			7
Prior suicide threats/attempts by perpetrator		3	3
Excessive substance use (alcohol and/or drugs)	5	9	14
Perpetrator unemployed		10	10
Victim/perpetrator in a relationship			10
Prior criminal history	3	9	12
OTHER FACTORS THAT INCREASED RISK			
❖ Perpetrator - Low functioning skills; Unaddressed mental health issues; limited mobility/advanced age; history of TPO/CPO; occurred in high crime area; adolescent perpetrator			23
❖ Decedent - Low functioning skills; unaddressed mental health issues; incapacitated mentally/physically; history of TPO/CPO; married but involved in same sex relationship			10

PART IV: DVFRB RECOMMENDATIONS

The following recommendations resulted from the 14 Homicide and Suicide cases reviewed. These recommendations were formally adopted by the DVFRB and were transmitted to the appropriate agencies for response.

- ❖ Office of Unified Communications (OUC) which handles the District's 9-1-1 calls should reevaluate the quality measures that it currently has in place regarding call-taker performance. If there are no quality measures for call-takers, OUC should develop and implement standards to address who, what, when, and how questions, with respect to obtaining accurate information from 911 callers are posed, and to ensure that 911 callers receive appropriate instructions during an emergency call. OUC supervisors should randomly listen to the performance of call-takers to determine the quality of service that is being provided, the need for individual training, as well as the need for overall staff training. OUC should reinforce protocols to ensure DV first responder safety by immediately publishing an "Alert-Bulletin" and re-train dispatchers against sending a civilian (911 callers) into a domestic violence situation.

OUC Response: The OUC has an internal quality assurance program in which all supervisors are required to monitor calls daily. Supervisors complete a daily monitoring report. The results are evaluated to determine if additional training and coaching is needed, and if so if it is individual training or group training. Monitoring results are also used for employee recognition. The OUC Transcriptions Department which maintains all 911 radio and call recordings also serves as a quality assurance program. As the calls are requested they are also monitored for training and coaching purposes. Training is provided for employee groups either during scheduled training sessions or daily roll calls. Individual sessions are scheduled based on the need. The OUC works cooperatively with the organization Women Empowered Against Violence, Inc. (WEAVE) in providing annual domestic violence training. The last training dates were September 25th and 26th, 2008.

- ❖ The Mayor, should issue an Order declaring that the District is dedicated to the prevention and elimination of domestic violence, sexual assault and stalking. The District has a zero tolerance policy for domestic violence, sexual assault and stalking at the workplace and will take appropriate disciplinary action and/or criminal prosecution against any employee or non-employee who commits such act in a District government office, facility, work-site, and vehicle or while conducting District business.

All District agencies should be directed to establish such policies in writing and the policy elements should include: 1) definitions; 2) statement that using work time or workplace facilities to commit or threaten to commit these acts are cause for discipline up to and including dismissal; 3) a statement that all acts, regardless of whether they occur in or near the workplace, may be caused for discipline and may be considered as part of the employee's work history; 4) information indicating where victims and abusers can go for assistance; 5) guidance regarding training for managers and

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employees; and 6) direction that employers are responsible for making reasonable efforts to promote the safety of all employees. This information must be disseminated and accessible to all employees.

Response: The Executive Office of the Mayor is currently addressing this recommendation

- ❖ Department of Health (DOH) and Department of Health Care Finance (DHCF) should work in collaboration with the District Hospital Association to improve city-wide standards for discharge planning to ensure that when a patient is ready for release and needs supportive care, the hospital discharge plan includes an assessment of a caretaker's ability to provide the patient with appropriate care in a safe environment and linkage with appropriate referrals as needed.

Recommendation Issued June 2009 - DOH Response Pending

DHCF Response: Department of Health Care Finance agrees with the recommendation for the development of improved standards and assessment tools for hospital discharge planning throughout the District that includes not only an assessment of the patient's continued medical, function, and social support needs after hospital discharge, but also an assessment of the entire family unit, caretaker challenges, and home environment to ensure continuity of care for the patient as well as social well being and safety in the home environment. Care coordination of a family member can be a very challenging process for spouses or any family member (s). Hospital discharge planning must focus on the entire spectrum of the patient's environment.

- ❖ The Office on Aging (OOA) should provide ongoing information to educate the community about the broad range of services that are available to the elderly and methods of accessing services.

Recommendation Issued June 2009 - OOA Response Pending

UPDATE ON PREVIOUSLY ISSUED DVFRB RECOMMENDATION

The following recommendation was included in the Second Annual Report and the Board received a response during this review period.

- ❖ In light of the recent Court decision striking down a portion of the District law that banned guns and the problem of easy access to guns, the District should incorporate education on gun safety into health programs in the DC Public School system. The education should emphasize the dangers of possessing guns as well as the need to utilize safety devices and practices when handling or exposed to firearms.

DCPS Response: The health standards, adopted by the DC Board of Education in 2007, included gun safety. DCPS is currently updating its health curriculum pacing guides, with a focus on priority health topics including safety.

Fatality Listing—DVFRB Cases Reviewed

TABLE 7: LISTING OF 14 DVFRB DEATHS REVIEWED - JULY 2008 THROUGH JUNE 2009

<i>2005 Deaths</i>	<i>Victims' Gender</i>	<i>Race</i>	<i>Age</i>	<i>Cause</i>	<i>Manner</i>
	Female	African American	19	Gunshot Wound of Chest & Right Hand	Homicide
	Female	Hispanic	31	Strangulation	Homicide
<i>2006 Deaths</i>	<i>Victims' Gender</i>	<i>Race</i>	<i>Age</i>	<i>Cause</i>	<i>Manner</i>
	Female	African American	77	Acute Hydroxchloriquine Poisoning	Homicide
	Female	African American	44	Two Gunshot Wounds to Head	Homicide
	Male	African American	47	Stab Wound of Neck	Homicide
	Female	African American	39	Gunshot Wound of Head with Injury to Skull & Brain	Homicide
<i>2007 Deaths</i>	<i>Victims' Gender</i>	<i>Race</i>	<i>Age</i>	<i>Cause</i>	<i>Manner</i>
	Male	African American	91	Head Injuries with Complications	Homicide
	Male	African American	53	Stab Wound of Chest	Homicide
	Male	African American	25	Stab Wound to Abdomen	Homicide
	Female	African American	51	Stab Wounds of Abdomen & Left Forearm	Homicide
	Female	African American	27	Multiple Stab Wounds & Blunt Impact Head Trauma	Homicide
	Male	African American	32	Stab Wound to Left Chest	Homicide
<i>2008 Deaths</i>	<i>Victims' Gender</i>	<i>Race</i>	<i>Age</i>	<i>Cause</i>	<i>Manner</i>
	Female	African American	50	Stab Wound to Back	Homicide
	Female	White	84	Gunshot Wound of Chest	Homicide

END NOTES

- Endnote # 1 - Page 2 Calendar year 2009 information represents preliminary data and includes only those deaths identified as of June 2009.
- Endnote # 2 - Page 3 The Child Fatality Review Committee is the District's fatality review process that is responsible for reviewing the deaths of all children and youth 18 years of age and younger. A total of 29 CFRC cases were referred to the DVFRB for statistical purposes only.

APPENDICES

ENROLLED ORIGINAL

AN ACT

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

*Codification
District of
Columbia
Official Code*

2001 Edition

2003 Supp.

West Group
Publisher

To amend Chapter 10 of Title 16 of the District of Columbia Official Code to enact the Uniform Interstate Enforcement of Domestic Violence Protection Orders Act in the District of Columbia, and to establish the Domestic Violence Fatality Review Board.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Uniform Interstate Enforcement of Domestic Violence Protection Orders Act of 2002".

Sec. 2. Chapter 10 of Title 16 of the District of Columbia Official Code is amended as follows:

(a) The table of contents is amended by adding the following at the end:

"Subchapter IV. Interstate Enforcement of Domestic Violence Protection Orders; Uniform Law.

"16-1041. Definitions.

"16-1042. Judicial enforcement of order.

"16-1043. Nonjudicial enforcement of order.

"16-1044. Registration of order.

"16-1045. Immunity.

"16-1046. Other remedies.

"16-1047. Uniformity of application and construction.

"16-1048. Transitional provision.

"Subchapter V. Domestic Violence Fatality Review Board.

"16-1051. Definitions.

"16-1052. Establishment and purpose.

"16-1053. Composition of Board.

"16-1054. Access to information.

"16-1055. Subpoena power.

"16-1056. Confidentiality of information and proceedings; penalty for unlawful disclosure of information.

"16-1057. Immunity.

"16-1058. Rules.

"16-1059. Sunset."

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(b) Section 16-1005 is amended as follows:

(1) Subsection (f) is amended to read as follows:

"(f) Violation of any temporary or final order issued under this subchapter, or violation in the District of Columbia of any valid foreign protection order, as that term is defined in subchapter IV of this chapter, and respondent's failure to appear as required by § 16-1004(b), shall be punishable as contempt. Upon conviction, criminal contempt shall be punished by a fine not exceeding \$1,000 or imprisonment for not more than 180 days, or both."

(2) Subsection (g) is amended to read as follows:

"(g) Any person who violates any protection order issued under this subchapter, or any person who violates in the District of Columbia any valid foreign protection order, as that term is defined in subchapter IV of this chapter, shall be chargeable with a misdemeanor and upon conviction shall be punished by a fine not exceeding \$1,000 or by imprisonment for not more than 180 days, or both."

(3) New subsections (h) and (i) are added to read as follows:

"(h) For purposes of establishing a violation under subsection (g) of this section, an oral or written statement made by a person located outside the District of Columbia to a person located in the District of Columbia by means of telecommunication, mail, or any other method of communication shall be deemed to be made in the District of Columbia.

"(i) Orders entered with the consent of the respondent but without an admission that the conduct occurred shall be punishable under § 16-1005(f) or (g)."

(c) New subchapters IV and V are added to read as follows:

"Subchapter IV. *Interstate Enforcement of Domestic Violence Protection Orders; Uniform Law.*

"§ 16-1041. Definitions.

"For purposes of this subchapter, the term:

"(1) "District" means the District of Columbia.

"(2) "Foreign protection order" means a protection order issued by a tribunal of another State.

"(3) "Issuing State" means the State whose tribunal issues a protection order.

"(4) "Mutual foreign protection order" means a foreign protection order that includes provisions in favor of both the protected individual seeking enforcement of the order and the respondent.

"(5) "Protected individual" means an individual protected by a protection order.

"(6) "Protection order" means an injunction or other order, whether temporary or final, issued by a tribunal for the purpose of preventing violent or threatening acts or harassment against, contact or communication with, or physical proximity to, another individual.

"(7) "Respondent" means the individual against whom enforcement of a protection order is sought.

"(8) "State" means a State of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States. The term "State" includes an Indian tribe or band that has

Amend
§ 16-1005

New
Subchapter
IV,
Chapter 10,
Title 16

New
§ 16-1041

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jurisdiction to issue protection orders.

"(9) "Tribunal" means a court, agency, or other entity authorized by law to issue or modify a protection order.

"§ 16-1042. Judicial enforcement of order.

New
§ 16-1042

"(a) A person authorized by the law of the District to seek enforcement of a protection order may seek enforcement of a valid foreign protection order in a tribunal of the District. The tribunal shall enforce the terms of the order, including terms that provide relief that a tribunal of the District would lack power to provide but for this section. The tribunal shall enforce the order, whether the order was obtained by independent action or in another proceeding, if it is an order issued in response to a complaint, petition, or motion filed by or on behalf of or for the benefit of an individual seeking protection. In a proceeding to enforce a foreign protection order, the tribunal shall follow the procedures of the District for the enforcement of protection orders.

"(b) Except for cases brought under § 16-1005(f) or (g), a tribunal of the District may not enforce a foreign protection order issued by a tribunal of a State that does not recognize the standing of a protected individual to seek enforcement of the order.

"(c) A tribunal of the District shall enforce the provisions of a valid foreign protection order that governs custody and visitation, if the order was issued in accordance with the jurisdictional requirements governing the issuance of custody and visitation orders in the issuing State.

"(d) A foreign protection order is valid if it:

"(1) Identifies the protected individual and the respondent;

"(2) Is currently in effect or was in effect at the time of the violation;

"(3) Was issued by a tribunal that had jurisdiction over the parties and subject matter under the law of the issuing State; and

"(4) Was issued after the respondent was given reasonable notice and had an opportunity to be heard before the tribunal issued the order or, in the case of an ex parte order, the respondent was given notice and has had or will have an opportunity to be heard within a reasonable time after the order was issued, in a manner consistent with the rights of the respondent to due process.

"(e) A foreign protection order valid on its face is prima facie evidence of its validity.

"(f) Absence of any of the criteria for validity of a foreign protection order is an affirmative defense in an action seeking enforcement of the order.

"(g) A tribunal of the District may enforce provisions of a mutual foreign protection order which favor a respondent only if

"(1) The respondent filed a written pleading seeking a protection order from the tribunal of the issuing State; and

"(2) The tribunal of the issuing State made specific findings in favor of the respondent.

"§ 16-1043. Nonjudicial enforcement of order.

New
§ 16-1043

"(a) A law enforcement officer, upon determining that there is probable cause to believe

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jurisdiction to issue protection orders.

"(9) "Tribunal" means a court, agency, or other entity authorized by law to issue or modify a protection order.

"§ 16-1042. Judicial enforcement of order.

New
§ 16-1042

"(a) A person authorized by the law of the District to seek enforcement of a protection order may seek enforcement of a valid foreign protection order in a tribunal of the District. The tribunal shall enforce the terms of the order, including terms that provide relief that a tribunal of the District would lack power to provide but for this section. The tribunal shall enforce the order, whether the order was obtained by independent action or in another proceeding, if it is an order issued in response to a complaint, petition, or motion filed by or on behalf of or for the benefit of an individual seeking protection. In a proceeding to enforce a foreign protection order, the tribunal shall follow the procedures of the District for the enforcement of protection orders.

"(b) Except for cases brought under § 16-1005(f) or (g), a tribunal of the District may not enforce a foreign protection order issued by a tribunal of a State that does not recognize the standing of a protected individual to seek enforcement of the order.

"(c) A tribunal of the District shall enforce the provisions of a valid foreign protection order that governs custody and visitation, if the order was issued in accordance with the jurisdictional requirements governing the issuance of custody and visitation orders in the issuing State.

"(d) A foreign protection order is valid if it:

"(1) Identifies the protected individual and the respondent;

"(2) Is currently in effect or was in effect at the time of the violation;

"(3) Was issued by a tribunal that had jurisdiction over the parties and subject matter under the law of the issuing State; and

"(4) Was issued after the respondent was given reasonable notice and had an opportunity to be heard before the tribunal issued the order or, in the case of an ex parte order, the respondent was given notice and has had or will have an opportunity to be heard within a reasonable time after the order was issued, in a manner consistent with the rights of the respondent to due process.

"(e) A foreign protection order valid on its face is prima facie evidence of its validity.

"(f) Absence of any of the criteria for validity of a foreign protection order is an affirmative defense in an action seeking enforcement of the order.

"(g) A tribunal of the District may enforce provisions of a mutual foreign protection order which favor a respondent only if

"(1) The respondent filed a written pleading seeking a protection order from the tribunal of the issuing State; and

"(2) The tribunal of the issuing State made specific findings in favor of the respondent.

"§ 16-1043. Nonjudicial enforcement of order.

New
§ 16-1043

"(a) A law enforcement officer, upon determining that there is probable cause to believe

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“§ 16-1046. Other remedies.

“A protected individual who pursues remedies under this subchapter is not precluded from pursuing other legal or equitable remedies against the respondent.

New
§ 16-1046

“§ 16-1047. Uniformity of application and construction.

“In applying and construing this Uniform Act, consideration must be given to the need to promote uniformity of the law with respect to its subject matter among States that enact it.

New
§ 16-1047

“§ 16-1048. Transitional provision.

“This subchapter applies to protection orders issued before the effective date of this subchapter and to continuing actions for enforcement of foreign protection orders commenced before the effective date of this subchapter. A request for enforcement of a foreign protection order made on or after the effective date of this subchapter for violations of a foreign protection order occurring before the effective date of this subchapter is governed by this subchapter.

New
§ 16-1048

“Subchapter V. Domestic Violence Fatality Review Board.

New
Subchapter
V,
Chapter 16,
Title 16

“§ 16-1051. Definitions.

“For purposes of this subchapter, the term:

New
§ 16-1051

“(1) “Board” means the Domestic Violence Fatality Review Board.

“(2) “District” means the District of Columbia.

“(3) “Domestic violence fatality” means:

“(A) A homicide under any of the following circumstances:

time;

“(i) The alleged perpetrator and victim resided together at any

“(ii) The alleged perpetrator and victim have a child in common;

“(iii) The alleged perpetrator and victim were married, divorced, separated, or had a romantic relationship, not necessarily including a sexual relationship;

“(iv) The alleged perpetrator is or was married to, divorced, or separated from, or in a romantic relationship, not necessarily including a sexual relationship, with a person who is or was married to, divorced, or separated from, or in a romantic relationship, not necessarily including a sexual relationship, with the victim;

“(v) The alleged perpetrator had been stalking the victim;

“(vi) The victim filed a petition for a protective order against the alleged perpetrator at any time;

“(vii) The victim resided in the same household, was present at the workplace of, was in proximity of, or was related by blood or affinity to a person who experienced or was threatened with domestic violence by the alleged perpetrator; or

“(viii) The victim or the perpetrator was or is a child, parent, sibling, grandparent, aunt, uncle, or cousin of a person in a relationship that is described within this subsection.

“(B) A suicide of an individual where there were implications that the individual was the victim of domestic violence prior to his or her suicide, including the following circumstances:

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"(i) The victim had applied for or received a protection order within the 2-year period preceding the suicide;

"(ii) The victim had undergone counseling or treatment as a result of being the victim of domestic violence within the 2-year period preceding the suicide; or

"(iii) The victim had reported to the police that he or she had been the victim of domestic violence within the 2-year period preceding the suicide.

"(4) "Protection order" means an injunction or other order, whether temporary or final, issued by a tribunal for the purpose of preventing violent or threatening acts or harassment against, contact or communication with, or physical proximity to, another individual.

"§ 16-1052. Establishment and purpose.

New
§ 16-1052

"(a) There is established, as part of the District of Columbia government, a Domestic Violence Fatality Review Board. Facilities and other administrative support may be provided in a specific department or through the Board, as determined by the Mayor.

"(b) The purpose of the Board is to prevent domestic violence fatalities by improving the response of individuals, the community, and government agencies to domestic violence.

"(c) The Board shall:

"(1) Identify and characterize the scope and nature of domestic violence fatalities in the District of Columbia;

"(2) Describe and record any trends, data, or patterns that are observed surrounding domestic violence fatalities;

"(3) Examine past events and circumstances surrounding domestic violence fatalities by reviewing records and other pertinent documents of public and private agencies responsible for investigating deaths or treating victims;

"(4) Develop and revise, as necessary, operating rules and procedures for review of domestic violence fatalities, including identification of cases to be reviewed, coordination among the agencies and professionals involved, and improvement of the identification, data collection, and record keeping of the causes of domestic violence fatalities;

"(5) Recommend systemic improvements to promote improved and integrated public and private systems serving victims of domestic violence;

"(6) Recommend components for prevention and education programs; and

"(7) Recommend training to improve the identification and investigation of domestic violence fatalities.

"(d) The Board shall prepare an annual report of findings, recommendations, and steps taken to implement recommendations. The report shall not contain information identifying any victim of domestic violence, or the victim's family members, or an alleged or suspected perpetrator of abuse upon a victim. The annual report shall be submitted to the public, the Mayor, and the Council on July 1 of each year, and shall be presented to the Council at a public hearing.

"§ 16-1053. Composition of the Board; procedural requirements.

New
§ 16-1053

"(a) The Mayor shall appoint one representative from each of the following District agencies:

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- "(1) Metropolitan Police Department;
- "(2) Office of the Chief Medical Examiner;
- "(3) Office of the Corporation Counsel;
- "(4) Department of Corrections;
- "(5) Fire and Emergency Medical Services Department;
- "(6) Addiction Prevention and Recovery Administration;
- "(7) Department of Health;
- "(8) Child and Family Services Agency; and
- "(9) Mayor's Commission on Violence Against Women.

"(b) The Mayor shall appoint, or request the designation of, members from federal, judicial, and private agencies or entities with expertise in domestic violence, to include one representative from each of the following:

- "(1) Superior Court of the District of Columbia;
- "(2) Office of the United States Attorney for the District of Columbia;
- "(3) District of Columbia hospitals;
- "(4) University legal clinics;
- "(5) Domestic violence shelters; and
- "(6) Domestic violence advocacy organizations.

"(c) The Mayor, with the advice and consent of the Council, shall appoint 8 community representatives, none of whom shall be employees of the District of Columbia.

"(d) Governmental appointees shall serve at the will of the Mayor, or of the federal or judicial body designating their availability for appointment. Community representatives shall serve for 3-year terms.

"(e) Vacancies in membership shall be filled in the same manner in which the original appointment was made.

"(f) The Board shall select a Chairman according to rules set forth by the Board.

"(g) The Board shall establish quorum and other procedural requirements as it considers necessary.

"§ 16-1054. Access to information.

"(a) Notwithstanding any other provision of law, immediately upon the request of the Board and as necessary to carry out the Board's purpose and duties, the Board shall be provided, without cost and without authorization of the persons to whom the information or records relate, access to:

"(1) All information and records of any District of Columbia agency, or their contractors, including, but not limited to, birth and death certificates, law enforcement investigation data, unexpurgated juvenile and adult criminal records, mental retardation and developmental disabilities records, autopsy reports, parole and probation information and records, school records, and information records of social services, housing, and health agencies that provided services to the victim, the victim's family, or an alleged perpetrator of domestic violence which led to the death of the victim;

"(2) All information and records of any private health-care providers located in the District of Columbia, including providers of mental health services who provided services

New
§ 16-1054

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to the deceased victim, the deceased victim's family, or the alleged perpetrator of domestic violence which led to the death of the victim;

"(3) All information and records of any private child welfare agency, educational facility or institution, or child care provider doing business in the District of Columbia who provided services to the victim, the victim's immediate family, or the alleged perpetrator of domestic violence which led to the death of the victim; and

"(4) Information made confidential by §§ 4-1302.03, 4-1303.06, 7-219.7-1203.02, 7-1305.12, 16-2331, 16-2332, 16-2333, 16-2335, and 31-3426.

"(b) The Board shall have the authority to seek information from entities and agencies outside the District of Columbia by any legal means.

"(c) Notwithstanding subsection (a)(1) of this section, information and records concerning a current law enforcement investigation may be withheld, at the discretion of the investigating authority, if disclosure of the information would compromise a criminal investigation or prosecution.

"(d) If information or records are withheld under subsection (c) of this section, a report on the status of the investigation shall be submitted to the Board by the investigating authority every 3 months until the earliest of the following events occurs:

"(1) The investigation is concluded;

"(2) The investigating authority determines that providing the information will no longer compromise the investigation; or

"(3) The information or records are provided to the Board.

"(e) All records and information obtained by the Board pursuant to subsections (a) and (b) of this section pertaining to the deceased victim or any other individual shall be destroyed immediately following the preparation of the Board's annual report. All additional information concerning a review, except statistical data, shall be destroyed by the Board one year after publication of the Board's annual report.

"§ 16-1055. Subpoena power.

"(a) When necessary for the discharge of its duties, the Board shall have the authority to issue subpoenas to compel witnesses to appear and testify and to produce books, papers, correspondence, memoranda, documents, or other relevant records.

"(b) Except as provided in subsection (c) of this section, subpoenas shall be served personally upon the witness or his or her designated agent, not less than 5 business days before the date the witness must appear or the documents must be produced, by one of the following methods, which may be attempted concurrently or successively:

"(1) By a special process server, at least 18 years of age, designated by the Board from among the staff of the Board or any of the offices or organizations represented on the Board; provided, that the special process server is not directly involved in the investigation; or

"(2) By a special process server, at least 18 years of age, engaged by the Board.

"(c) If, after a reasonable attempt, personal service on a witness or witness' agent cannot be obtained, a special process server identified in subsection (b) of this section may serve a subpoena by registered or certified mail not less than 8 business days before the date the witness must appear or the documents must be produced.

New
§ 16-1055

ENROLLED ORIGINAL

"(d) If a witness who has been personally summoned neglects or refuses to obey the subpoena issued pursuant to subsection (a) of this section, the Board may report that fact to the Superior Court of the District of Columbia and the court may compel obedience to the subpoena to the same extent as witnesses may be compelled to obey the subpoenas of the court."
"§ 16-1056. Confidentiality of information and proceedings; penalty for unlawful disclosure of information.

New
§ 16-1056

"(a) Except as provided in this section, information and records obtained or created by the Board are confidential and not subject to civil discovery or to disclosure pursuant to subchapter II of Chapter 5 of Title 2.

"(b) Information and records presented to the Board for review shall not be immune from subpoena, discovery, or prohibited from being introduced into evidence solely because they were presented to or reviewed by the Board if the information and records have been obtained through other sources.

"(c) Information required to be reported under §§ 4-1321.02 and 4-1321.03 shall be disclosed by the Board to the Child and Family Services Agency.

"(d) An individual who appears before or participates in the Board's review of domestic violence cases shall sign a confidentiality agreement acknowledging that any information provided to the Board is confidential.

"(e) Board meetings are closed to the public and are not subject to § 1-207.42.

"(f) Information identifying a victim of domestic violence or that person's family members, or an alleged perpetrator of abuse upon the victim, shall not be disclosed in any report that is available to the public.

"(g)(1) Whoever discloses, receives, makes use of, or knowingly permits the use of information concerning a victim or other person in violation of this section shall be subject to a fine of not more than \$1,000.

"(2) Violations of this section shall be prosecuted by the Office of the Corporation Counsel in the name of the District of Columbia.

"(3) Subject to appropriation for this purpose, any fines collected pursuant to this section shall be used by the Board to fund its activities.

"§ 16-1057. Immunity.

"(a) Any health-care provider or any other person or institution providing information to the Board pursuant to this subchapter shall have immunity from liability, administrative, civil, or criminal, that might otherwise be incurred or imposed with respect to the disclosure of information.

New
§ 16-1057

"(b) If acting in good faith, without malice, and within the parameters of the protocols established by this subchapter, representatives of the Board are immune from civil liability for an activity related to reviews of domestic violence fatalities.

"§ 16-1058. Rules.

"The Mayor shall issue rules implementing the provisions of this subchapter. The rules shall require that a subordinate agency director to whom a recommendation is directed by the Board shall respond in writing within 30 days of the issuance of the report containing the recommendations.

New
§ 16-1058

ENROLLED ORIGINAL

"§ 16-1059. Sunset.

"This subchapter shall expire 7 years after its effective date."

New
§ 16-1059

Sec. 3. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

Sec. 4. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of Congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.

Chairman
Council of the District of Columbia

Mayor
District of Columbia

**DISTRICT OF COLUMBIA DOMESTIC VIOLENCE FATALITY
REVIEW BOARD**

PHILOSOPHY, MISSION AND OBJECTIVES

The overall mission of the District's DVFR Board is to reduce the occurrence of domestic violence related abuse and deaths, and to improve the quality of life for victims and their families. The philosophy governing the District's Domestic Violence Fatality Review Board is one of "no shame, no blame", respect for the rights of victims and their families, and recognition of the need to improve agency/program coordination and accountability. This philosophy is reflected in all aspects of the fatality review policy, process, and meeting deliberations.

Pursuant to DC Law 14-296, the DVFR Board is responsible for conducting retrospective reviews of domestic violence fatalities with a goal of reducing the number of preventable deaths. The data and information obtained from these reviews are invaluable in acquiring a better understanding of the characteristics of victims and perpetrators, the ways in which victims of domestic violence are dying, and ways to improve the safety of victims and their families. The DVFR Board achieves its mission by carrying out the following objectives: Identify trends and patterns related to domestic violence deaths through collecting, reviewing, and analyzing standardized data, and to use such information to improve understanding of the causes and factors that may contribute to DV fatalities. In keeping with this concept, the Board during the review of the information presented seeks clarity on specific issues related to the services and interventions provided to the decedent, perpetrator, their children and/or other family members in order to answer the following questions:

- ❖ Was the investigation/autopsy complete and are there areas of concern that should be considered?
- ❖ Were there social, medical, community, systemic, or legal factors that contributed to the DV death or comprised the decedent's life?
- ❖ Were there social or familial behavior factors that contributed to the decedent's death?
- ❖ Were services and interventions appropriate for the needs of the decedent/perpetrator provided in accordance with established statutes and policies?
- ❖ Was staff involved with the victim prepared to provide protection or other required services?
- ❖ Are statutes and policies adequate?
- ❖ Was there adequate communication among the various entities/services providers who were involved with the decedent and/or perpetrator?

REVIEW CRITERIA

The DVFR Board is responsible for conducting reviews of all domestic violence related homicides and suicides. This includes victims of all ages and involved in all types of intimate/familiar relationships, who are determined to be residents of the District of Columbia and non-residents where the death occurs in the District. Based on policy, the case review process was initiated with deaths that occurred during the 2004 calendar years. In accordance with DC Law 14-296, the cases were selected based on the definition of a domestic violence fatality.

Domestic violence deaths are selected for review based on referrals from the US Attorneys Office, the Metropolitan Police Department and Office of Attorney General. Potential cases are also identified from the OCME data base however these deaths require verification from the primary referral sources (USAO, MPD and OAG). Cases are reviewed within the following timeframes:

- ❖ *Homicides* - within six months after closure of criminal cases (including sentencing, dismissals and decisions to not prosecute but excluding the appeals process); and
- ❖ *Suicides* - within six months of closure of the law enforcement investigation.

DVFR BOARD MEMBERSHIP

Due to the confidential nature of the information being shared, the DVFR Board meetings where cases are being discussed are closed to the public. Only Board members or individuals determined to have had some involvement with the victim or perpetrator are invited to participate. All participants, including DVFRB members must sign a confidentiality statement prior to case discussion. DVFR Board membership, by law, is multidisciplinary, representing a broad range of individuals from public and private service agencies, programs and institutions. Membership is unique in that it includes, by law, District Ward community representation. Members are represented from the following District public and private agencies:

- ❖ Metropolitan Police Department
- ❖ Office of the Chief Medical Examiner
- ❖ Office of Attorney General
- ❖ Department of Corrections
- ❖ Fire and Emergency Medical Services Department
- ❖ Department of Health
- ❖ Child and Family Services Agency/Office of Clinical Practice
- ❖ Office of the Attorney General
- ❖ Wendt Center for Healing and Loss
- ❖ District of Columbia Community Ward Representatives
- ❖ Mayor's Commission on Violence Against Women
- ❖ Superior Court of the District of Columbia
- ❖ Office of the United States Attorney of the District of Columbia
- ❖ University Legal Clinics
- ❖ District of Columbia Hospitals
- ❖ Department of Human Services
- ❖ Domestic Violence Advocacy Organizations

REVIEW PROCESS AND MEETING

The DVFR Board has the discretion of deciding the scope of review for other categories of deaths. The three types of review processes that are currently available to the Board are as follows:

- ❖ **Multi-agency Review** – In-depth reviews utilizing a multi-agency, multi-disciplinary approach to evaluating causative factors and appropriateness of interventions. Most deaths are reviewed through the multi-agency review process.
- ❖ **Cluster Review Team** – An examination of groups of fatalities based on similar trends, characteristics, causes/manner of death, or lethality risk indicators, etc. Reviews are directed toward obtaining general information that is consistent throughout the cluster grouping that may highlight prevailing community problems or contributing risk factors. Cluster reviews are *not* designed to examine factors unique to any individual decedent and family.
- ❖ **Statistical Review** – cases in which only data is abstracted from documents routinely obtained on victims and perpetrator, i.e., death certificates, death reports, criminal justice/court, police and legal records.

The Domestic Violence Fatality Review Board holds monthly case review meetings. Once the basic information is provided by the USAO, MPD or other member agency, the DVFRB Coordinator is responsible for determining if there had been any contact or involvement with member agencies or other service provider in the District. If agencies were involved with the victim or perpetrator the records are requested for review. Based on the information provided, the Coordinator prepares a case summary that documents basic demographic information on the victim and perpetrator; the events surrounding the death, investigation and prosecution; all services provided, and any lethality risk indicators. The summary is distributed to all review team participants and is the primary document utilized during the case review meetings.

RECOMMENDATIONS PROCESS

During the case review meeting, based on individual case discussion, recommendations are developed to address the issues/findings highlighted. These recommendations are finalized and adopted by members in subsequent meetings and are transmitted to the appropriate agencies for implementation consideration. Recommendations are also included in annual reports with agencies responses.

ACKNOWLEDGEMENT

The Annual Report would not be complete without recognizing the organizations who contributed to the work of the Domestic Violence Fatality Review Board and the production of the 2008 Third Annual Report. We'd like to thank the members of the Board and other representatives of public and private agencies and the general community who committed their time and energy to review domestic violence fatalities each month. Representatives from these agencies/programs and community individuals generously shared their experience, professional resources and support throughout the year in the case review process. Your knowledge and expertise was invaluable, as well as the dedication and hard work of all these highly committed experts who remained a constant source of inspiration and support for the DVFR Board.

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