

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

**FIRST ANNUAL REPORT**



GOVERNMENT OF THE DISTRICT OF COLUMBIA  
ADRIAN M. FENTY, MAYOR

MARIE LYDIE Y. PIERRE-LOUIS, CHIEF MEDICAL EXAMINER  
OFFICE OF THE CHIEF MEDICAL EXAMINER

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

**FIRST ANNUAL REPORT**

**MISSION:**

**To reduce the number of domestic violence related deaths in the District of Columbia through identifying, evaluating and improving programs and systems responsible for protecting and serving citizens**

**PRESENTED TO:**

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

**July 2007**

## ***DEDICATION***

*This Annual Report is dedicated to the memory of victims of domestic abuse who have lost their lives to senseless acts of violence and suicide. 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.*

**DOMESTIC VIOLENCE  
HURTS EVERYONE**

**DV FACT: DOMESTIC VIOLENCE**

Domestic violence usually involves issues of power and control in intimate relationships. The level of violence often escalates over time, even though there are often periods of calm between abusive episodes. Although they are not necessarily the causes of domestic violence, social and economic factors can play a role. Alcoholism and substance abuse can exacerbate the abusive episodes. But substance abuse should not be considered a primary factor to the abuse in a relationship.

Recognizing those behaviors that are a part of domestic violence is not always easy, even for victims themselves. This is partly because domestic violence is much more than physical abuse. In fact, many victims who are controlled by their partners and who live in danger and fear have never been physically assaulted. In the early stages, the pattern of abuse is hard to recognize. People in abusive relationships, however, consistently report that the abuse gets worse over time.

Domestic violence cuts across all economic and education levels, all age groups, ethnicities and other social and community characteristics. Your neighbor, your office mate, even your closest family member or friend may be in an abusive relationship. Domestic violence touches all of us. It impacts our families, job turnover, school performance, and contributes to the high cost of law enforcement, civil/criminal justice, health services, mental health, and substance abuse treatment, human services and community-based services. Perhaps the most insidious thing about abuse is its effect on children. Research supports the fact that boys who witness abuse are more likely to become abusive, and girls who witness abuse are more likely to be abused. It is estimated that up to 13 million children witness abuse each year.

Stopping domestic violence is a daunting task. But domestic violence is also learned behavior that can be unlearned. "Change is possible. We see it every day".

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## ***EXECUTIVE SUMMARY***

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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 first Annual Report. This Report covers data that resulted from reviews conducted on 13 fatalities from calendar years 2004, 2005, and 2006.

### **TOTAL NUMBER DOMESTIC VIOLENCE FATALITIES**

As of December 2006, the Domestic Violence Fatality Review Board identified a total of 32 cases that met the criteria for a domestic violence fatality review. Between April 2006 and May 2007, a total of 13 cases were reviewed and accepted. The cases reviewed include nine deaths from 2004, three from 2005 and one death from 2006. Currently there are 19 cases that are pending review. Nine of these cases involved fatal child abuse deaths that have had full child fatality reviews and are pending DVFRB statistical reviews. Eight cases are pending with the US Attorney's Office (USAO) and two are scheduled for review. The following is a summary of the data that resulted from the 13 deaths reviewed by the Domestic Violence Fatality Review Board. The information obtained during the data collection process provided limited background information on the majority of the decedents (N = 11) reviewed.

### **DECEDENT DEMOGRAPHICS - GENDER, RACE AND AGE:**

- ❖ Six (6) or 46% of the 13 cases reviewed involved women perpetrators and seven (7) or 54% of the perpetrators were males.
- ❖ Nine (9), or 69% of the 13 decedents were males and four (4) or 31% were females.
- ❖ Ten perpetrators (77%) were Black. Of this number, nine (9) were African-Americans and one (1) or 8% was an African immigrant. Two or 15% of the perpetrators were White. There was no perpetrator involved in the one suicide death.
- ❖ Ten or 77% of the decedents were African-American; three (3) or 23% were White, two (2) of the White decedents were American, and one (1) was a White Romanian immigrant.
- ❖ Age of the perpetrators ranged from 19 through 42 years. The average age was 32.4 and the median was 32. In three cases there was a significant age difference between the decedents and perpetrators that ranged from a low of 13 years to a high of 37 years age difference.
- ❖ The age of the decedents ranged from 19 through 74 years. The average age of the decedents was 26 and the median age was 34.

## **PRIOR CRIMINAL HISTORIES**

- ❖ Seven (7) of the 13 fatalities reviewed (54%) involved perpetrators with prior criminal records. Some of the overall charges included: drug distribution, drug possession, weapons charges assault, assault with a deadly weapon, probation violation, and Bail Act violations.
- ❖ Three (3) or 43% of the seven (7) perpetrators with criminal records had outstanding criminal or court cases at the time of the fatal event.
- ❖ Three (3) or 23% of the thirteen (13) perpetrators reviewed were known to the child welfare system.

## **MANNERS AND CAUSE OF DEATH**

- ❖ Twelve (12) or 92% of the 13 deaths reviewed were Homicides, and one (1) or 8% was a Suicide.
- ❖ Of the Twelve (12) Homicides, the majority of the causes were attributed to blunt impact (N = 6) and the second leading cause was attributed to gunshot wounds (N = 3).
- ❖ Of the thirteen (13) cases reviewed only one fatality was a suicide. The death was determined to meet the DV requirement because the decedent had an open Civil Protection Order (CPO) against a former female intimate partner at the time of his death.

## **PLACE OF FATAL INCIDENT**

Of the thirteen (13) cases reviewed the majority of the fatal events occurred in Ward Eight (N = 5) and Ward Six (N = 3).

## **DVFRB RECOMMENDATIONS FROM FATALITIES REVIEWED**

Recommendations were generated on 1 of the 13 cases reviewed and were adopted by the DVFR Board and transmitted to agencies for response. These recommendations are as follows (See Appendix A for responses):

- ❖ Office of Victim Services (OVS) in collaboration with the Departments of Health (DOH) and Mental Health (DMH) should work with domestic violence programs to develop and implement a city-wide public education campaign to broaden the community's knowledge of the cycle of domestic violence; symptoms of abuse, including emotional and verbal; lethality risk indicators; reporting methods; and services/resources available in the community.
- ❖ OVS in collaboration with DOH and DMH should advocate for professional training for service providers and others involved with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services and resources available in the community. The training should minimally focus on the cycle of domestic violence; lethality risk indicators; protection orders; legal, social, mental health and other community-based resources that are available to this population; significance of risk assessments, early intervention strategies and safety plans for victims and their families.
- ❖ Department of Human Services, Family Services Administration in collaboration with the Community Partnership for the Prevention of Homelessness should increase the number of domestic violence shelters available for victims in the District of Columbia.
- ❖ District-based domestic violence programs should partner with the religious community on methods of identification and prevention of domestic abuse.

## INTRODUCTION

In April 2003, the Uniform Interstate Enforcement of Domestic Violence Protection Orders Act of 2002, DC Law 14-296 was enacted (See Appendix B). This law mandated the establishment of the Domestic Violence Fatality Review Board (hereinafter referred to as the DVFRB or DVFR Board). The DVFRB is currently one of three fatality review Committees/Boards that operate within the Fatality Review Unit under the auspices of the Office of the Chief Medical Examiner (OCME). The mission of the DVFRB is to prevent domestic violence (DV) related fatalities by improving the response of individuals, the community, and District-based public and private service delivery systems. This goal is achieved through the process of making victims lives and experiences real during a multidisciplinary retrospective case review process. The Board attempts to identify high risk factors and trends related to the decedents, perpetrators, and systems responsible for supporting, assisting, and protecting victims of family and intimate partner violence. The case review process provides an opportunity for professionals and/or concerned citizens, through a collaborative effort, to enhance and increase the level of services, and improve the District's response to the issue of domestic violence and the needs of victims.

This Annual Report is a review of the progress achieved by the DVFR Board between October 2005 and May 2007. During this first 18-month period of Board operation, there were many significant accomplishments made during the program planning phase as well as the case review process. This Report will highlight these achievements and provide a summary of the data, trends, and recommendations that resulted from the reviews held. It also includes “**DV FACTS**” that highlight critical data/information on the scope of the domestic violence problem from a national and District perspective and ways that victims, family members, friends, and neighbors can seek help and/or report suspected abuse. These “**DV FACTS**” were abstracted from literature reviewed or were provided for inclusion in the Report by DVFR Board members. (References for this information, when possible are contained in each box highlighting “**DV FACTS**”.)

### ***DV FACT: A REPORT ON HOMICIDE IN THE DISTRICT OF COLUMBIA 2001-2004***

- In cases where victim-offender relationships could be established from 2001 to 2004, MPD reported that there were 51 murders attributed to domestic/family violence, including 41 adult/youth victims of domestic violence, and 10 child/infant victims of child abuse.
- Domestic/family violence homicides, not including child abuse, account for 6% of all murders in the District from 2002 to 2004 in cases where homicide motives can be established.
- Of the murders with identified motives from 2002 to 2004, fourteen percent (14%) of all female murders and 3% of all male murders were the result of domestic/family violence (not including child abuse).
- Of the murders with identified motives from 2002 to 2004, domestic/family violence (not including child abuse) caused 5% of all youth (under age 18) homicide.

Sources: Metropolitan Police Department-- UCR Report, 2005; “*A Report on Homicide in the District of Columbia 2001-2004*”; “*A Report on Juvenile Homicide 2002-2004*”

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## ***DVFRB STRUCTURE AND OPERATIONS***

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### **SUMMARY OF PROGRAM PLANNING/DEVELOPMENT PHASE**

In September 2005, the Office of the Chief Medical Examiner was awarded a grant through the Office of Crime Victims Assistance to facilitate the full planning and program development phase for the DVFR Board. The primary goal of this grant project was to fill a temporary contract professional position to fully support and assist the District in planning, coordinating and organizing the newly established Board; and facilitate the development of protocols, data collection instruments, and other operational modules to implement the mandated fatality review process. A Consultant was hired in December 2005, and during the first six months of the planning phase a tremendous amount of work was accomplished with the Board. Based on the stated objectives of the grant, the following represents accomplishments made during the planning and program development phase:

#### ***Objective 1: Develop Operational Structure and Protocols***

- ❖ Completed national research and literature review to facilitate an assessment of current activities, practices, and protocols of other state DV death review processes.
- ❖ Established a DVFR Protocols Work Group and initiated bimonthly meetings.
- ❖ Developed reference notebooks for Work Group members.
- ❖ Developed and finalized (through full review by Board members) the DVFRB Protocols.
- ❖ Developed and finalized (through full review by Board members) the data collection instrument and other critical forms to be used during the case preparation/finalization process.
- ❖ Developed preliminary version of the DVFRB database.

#### ***Objective 2: Fully Staff and Equip DVFR Board***

- ❖ Completed the process for hiring the DVFRB Coordinator. Selection was made through a panel interview process that included four (4) DVFRB members and the Fatality Review Program Manager. Coordinator reported for duty in February 2006.
- ❖ Completed the process for hiring the FRU Staff Assistant to support the DVFRB. Staff Assistant reported for duty in August 2006.
- ❖ Purchased general supplies, computers and other office furniture and equipment.

#### ***Objective 3: Formalize Collaborative Relationships***

- ❖ Developed working relationships with DVFRB public member agencies (i.e., Office of the Chief Medical Examiner (OCME), Fire and Emergency Medical Services Department (EMS), Metropolitan Police Department (MPD), US Attorneys Office (USAO), DC Superior Court (DCSC), Department of Health (DOH)/Medical Assistance Administration, Department of Mental Health (DMH), Child and Family Services Agency Office of Clinical Practice (CFSA/OCP) and the Department of Corrections (DOC)). Devised a process for requesting and obtaining critical case information.

- ❖ Developed a relationship with several District-based hospitals that provide emergency trauma services and DV community service providers; and devised an agreed upon mechanism for requesting and obtaining case-related information.
- ❖ Developed a relationship with the Prince George's County Sheriff's Office to access CPO information.

#### ***Objective 4: Fully Implement the DVFRB Case Review Process***

- ❖ Formalized and fully implemented the case identification process with the MPD, USAO, and OAG.
- ❖ Formalized and fully implemented the record search process with DVFRB member agencies and stakeholders to obtain program/service information on cases determined to be eligible for review.
- ❖ Initiated the case review process in April 2006, with three test cases, for the purpose of assessing the adequacy of the draft policies, data instruments and other modules developed to make appropriate revisions.
- ❖ Developed schedule of annual meetings and began conducting routine monthly case review meetings beginning in May 2006.

#### ***Objective 5: Broaden Members Knowledge of Domestic Violence***

- ❖ Through funding provided by the Office of Victim Services, seven (7) DVFR Board members attended the 2005 National Domestic Violence Fatality Review conference in Arizona.

### **PHILOSOPHY, MISSION AND OBJECTIVES**

The overall mission of the District's DVFR Board is to reduce the occurrence of DV-related violence and deaths, and to improve the quality of life for victims of domestic violence 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.
- ❖ Ensuring that all systems, both public and private, which are responsible for protecting victims of family and intimate partner violence, are effective, efficient, and accountable.
- ❖ Improving and optimizing systemic responses to violence by evaluating existing statutes, policies, and procedures.

- ❖ Recommending appropriate modifications to existing social, health, criminal justice and civil systems that serve victims and develop new mechanisms to reduce the cycle of violence and hold abusers accountable.
- ❖ Encouraging inter and intra-agency and interdisciplinary education, communication, coordination, and collaboration in the prevention of DV fatalities.
- ❖ Educating the public on the cycle of abuse, the risk indicators and how to seek help.

## **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 occurred in the District. Based on policy, the case review process was initiated with deaths that occurred during the 2004 calendar year. In accordance with DC Law 14-296, the cases selected were based on the following definition of DV fatality:

- ❖ “Domestic violence fatality” means:
  - (A) A homicide under any of the following circumstances:
    - (i) The alleged perpetrator and victim resided together at any time;
    - (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 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:
    - (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.

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 OCME; 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 not to 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
- ❖ Department of Human Services
- ❖ Office of the Attorney General
- ❖ Department of Corrections
- ❖ Fire and Emergency Medical Services Department
- ❖ Department of Health
- ❖ Department of Mental Health/Wendt Center
- ❖ Child and Family Services Agency/Office of Clinical Practice
- ❖ 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
- ❖ District of Columbia Hospitals
- ❖ University Legal Clinics
- ❖ DC Coalition Against Domestic Violence
- ❖ District of Columbia Task Force on Family Violence, Medical Society of the District of Columbia

## 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 perpetrators, 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 whether there had been any contact or involvement with member agencies or other service providers 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, including 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.

Based on written and verbal information presented during the review process, members seek to clarify specific issues related to the services and interventions provided to the decedent, perpetrator, their children and/or other family members 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 compromised 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?

## **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.

## ***SUMMARY OF CASE REVIEW FINDINGS***

### **TOTAL CASES REVIEWED**

As of May 2007, the DVFR Board identified a total of thirty-two (32) deaths from calendar years 2004 through 2007 that met the criteria for a review. Between April 2006 and May 2007, the DVFR Board reviewed a total of fourteen (14) cases that covered calendar years 2004 through 2006. Findings discovered in the review process determined that one (1) death from calendar year 2005 did not meet the criteria and that case was eliminated and the number of cases reviewed was reduced to thirteen (13) official DVFR Board cases.

Currently there are nineteen (19) cases that are pending reviews. These deaths cover years 2004 through 2007. Nine of the 19 cases are fatal child abuse cases that have received full child fatality reviews and are pending DVFRB statistical reviews. Eight cases are pending completion of prosecution, and two cases are scheduled for review.

The information provided in this Section is based on the 13 cases reviewed from calendar years 2004 through 2006 that were accepted by the DVFR Board as domestic violence fatalities.

### **PERPETRATOR/DECEDENT DEMOGRAPHIC DATA**

Information collected on the 13 cases reviewed provided limited background information about decedents in 11 of the cases reviewed. In 2006, one death reviewed was a Suicide and did not involve a perpetrator.

#### ***GENDER OF PERPETRATORS/DECEDENTS***

- ❖ ***Perpetrators*** – Five (5) or 42% of the 12 cases reviewed involved women as the perpetrator; and seven (7) or 58% were males.
- ❖ ***Decedents*** – Nine (9) or 69% of the 13 decedents were males, and four (4) or 31% were females. During the case reviews, the high number of male victims in domestic violence relationships became apparent and of concern to the Board. In light of these findings the DVFRB agreed that the rate of male victimization in intimate partner relationships should be tracked in order to determine whether this is a consistent trend in the District of Columbia and to evaluate the sufficiency and appropriateness of services and resources that are available for male victims of domestic abuse.
- ❖ ***Gender By Year of Death*** - The following table illustrates the gender of the perpetrators and the decedents by year of the death.

	2004		2005		2006	
	Males	Females	Males	Females	Males	Females
<b>Perpetrators</b>	4	5	3	0	0	0
<b>Decedents</b>	8	1	0	3	1	0

## COUPLE RELATIONSHIP

- ❖ Of the four cases where the victims were females, the couples had been in a relationship for over one year; in two cases, the relationship had lasted for at least 10 years.
- ❖ There was also evidence of pending separations as the escalating factor in all four female deaths.
- ❖ In three (3) or 75% of the four female deaths, the female was the primary source of income and the male perpetrator had no history of employment or viable source of income.
- ❖ Two married couples each had three minor children.
- ❖ One (1) married relationship, the wife was the perpetrator.
- ❖ Two (2) or 15% of the 13 cases reviewed were determined to be a male homosexual relationship [One (1) White couple and one (1) African-American couple]. In each of the two relationships, the couple had been together for more than one year, neither couple lived together.
- ❖ One (1) perpetrator in the homosexual relationship was found not guilty of any crimes related to the death and the other perpetrator was sentenced to serve time in jail.

The following table illustrates some of the key facts associated with the couple relationships in cases reviewed.

	Heterosexual Couples			Same Sex Couple (Male)	Victim/Perpetrator Separated At Time of Death
	Total Couples	Couples with Minor Children	Married		
<b>2004</b>	5	2	1	2	4
<b>2005</b>	3	1	2	0	3
<b>2006</b>	1	0	0	0	0

\* The suicide victim is missing from the numbers listed above.

## RACE OF PERPETRATORS\DECEDENTS

As Figure 1 illustrates, the majority of the perpetrators and victims of the 13 domestic violence fatalities reviewed were Black.

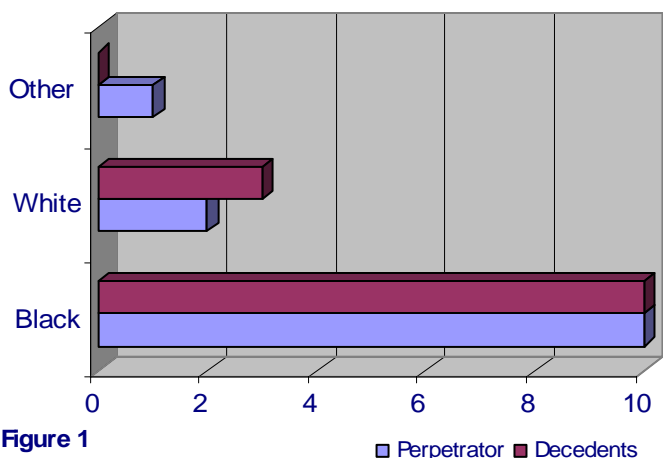


Figure 1

- ❖ **PERPETRATOR** – Ten of the perpetrators (77%) were Black. Of this number nine (9) were African American (5 females and 4 males) and one (1) or 8% was an African immigrant (male). Two or 15% of the perpetrators were White (males). No perpetrator was involved in the one Suicide death.

- ❖ **DECEDENTS** – Ten or 77% of the decedents were African-American (8 males and 2 females). Three (3) or 23% of the decedents were White, two (2) of these decedents were American, and one (1) was a Romanian immigrant (female).

- ❖ ***RACE BY YEAR OF DEATH*** – the following table illustrates the race of the perpetrator and the decedent by the year the death occurred.

	2004		2005		2006	
	Black	White	Black	White	Black	White
<b>Perpetrator</b>	8	1	2	1	0	0
<b>Decedent</b>	8	1	1	2	1	0

## AGE OF PERPETRATOR AND DECEDENT

- ❖ ***Perpetrator*** – The age of the perpetrators ranged from 19 through 42 years. The average age was 32.4 and the median age of the perpetrators was 32. In three cases there was a significant age difference between the decedents and perpetrators that ranged from a low 13 years to a high of 37 year age difference.
- ❖ ***Decedent*** - The ages of the decedents ranged from 19 through 74 years. The average age of the decedents was 26 and the median age was 34.
- ❖ ***Age, Race and Gender of Perpetrators and Decedents*** – The following table illustrates the number of perpetrators and decedents by age, race and gender.

<b>Under 21 Years of Age</b>	<b>Perpetrator</b>	<b>Decedent</b>
Black Males	0	2
Black Females	1	0
White Males	0	0
White Females	0	0
<b>21 thru 35 Years of Age</b>	<b>Perpetrator</b>	<b>Decedent</b>
Black Males	1	3
Black Females	2	1
White Males	1	0
White Females	1	1
Other, White Females	0	1
<b>36 – 60 Years of Age</b>	<b>Perpetrator</b>	<b>Decedent</b>
Black Males	2	2
Other, Black Males	1	0
Black Females	2	1
White Males	1	1
White Females	0	0
<b>Over 60 Years of Age</b>	<b>Perpetrator</b>	<b>Decedent</b>
Black Males	0	1
Black Females	0	0
White Males	0	0
White Females	0	0
<b>TOTAL</b>	<b>12</b>	<b>13</b>

## EDUCATION

❖ **Perpetrators** – The following represents the educational level of the perpetrators for the 13 cases reviewed:

- 2 of the 12 perpetrators had a high school diploma
- 2 perpetrators had some college
- 1 perpetrator had graduated from college
- 7 of the 12 perpetrators **did not** have a high school diploma or GED

❖ **Decedents** – The decedents educational levels were as follows:


- 2 of the 13 decedents had a high school diploma
- 1 had a college degree
- 2 decedents had advance degrees
- 2 did not have a high school education
- Educational information is unknown for 6 of the 13 decedents

## CHILDREN OF PERPETRATOR/DECEDENT

In the majority of the fatalities reviewed, there were no children born to the victim or perpetrator. In two (2) of the three cases the decedents had minor children and the perpetrators were the fathers of the children.

## LOCATION/WARD OF RESIDENCE AND FATAL INCIDENT

The following table illustrates the Ward or State of residence for the decedent and perpetrator; and the Ward where the fatal event occurred. The location of the fatal event may have been different from either the decedent's or perpetrator's residence.

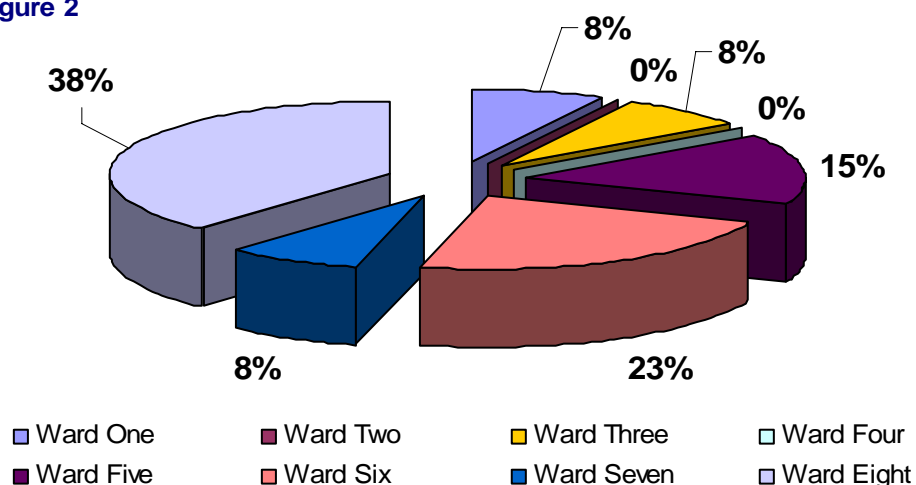
	Residence		Place of Fatal Incident
	Decedents	Perpetrators	
Ward One	1	1	1
Ward Two	0	0	0
Ward Three	1	0	1
Ward Four	0	0	0
Ward Five	2	2	2
Ward Six	4	1	3
Ward Seven	0	1	1
Ward Eight	2	2	5
DC Homeless	0	1	N/A
MD/VA	2	3	0
Other	1	1	0
<b>TOTALS</b>	<b>13</b>	<b>12</b>	<b>13</b>

- ❖ In three (3) fatalities the fatal event occurred at the residence of the decedent. Three incidents occurred inside the home of the perpetrator. Seven incidences occurred on public streets in the District that included three deaths that originated inside the decedents home.
- ❖ In three (3) or 23% of the 13 cases reviewed the perpetrator and the decedent resided in the same household.
- ❖ Two (2) of the couples were married. One couple had been separated for less than one month and the other couple was pending a separation.

Figure 2 below illustrates the Wards where the 13 fatal incidents occurred.

**Ward of Fatal Incidents**

**Figure 2**



## MANNER OF DEATH

The majority of the deaths reviewed (12 or 92%) were determined to be Homicides. One of the DVFRB deaths was determined to be Suicide.

### *Homicides*

- Homicide was the manner of death for 12 fatalities reviewed.
- In one (1) of the 12 homicides reviewed the death was not prosecuted. This is also the only death where the decedent was killed by his wife's boyfriend. The incident was determined to be self-defense.
- In one (1) of the 11 cases prosecuted, the perpetrator was determined to be not guilty of the Homicide.
- In 10 or 91% of the 11 cases prosecuted the perpetrators were determined to be guilty and are currently incarcerated.

### *Suicides*

Of the 13 cases reviewed one fatality (8%) was a Suicide. The Suicide victim had an open Civil Protection Order (CPO) against a former female companion for harassment, stealing his money and physical assault. Based on investigations completed by the police the victim's companion was not involved in his death.

## CAUSES OF DEATH

As Figure 3 illustrates, blunt impact was the leading cause of the domestic violence deaths reviewed, followed by stab and gunshot wounds. The Suicide death was caused by blunt impact and was the result of the decedent jumping from a ninth floor apartment window. (See Appendix C for full listing of the causes and manners of death for the 13 fatalities reviewed by DVFRB.)

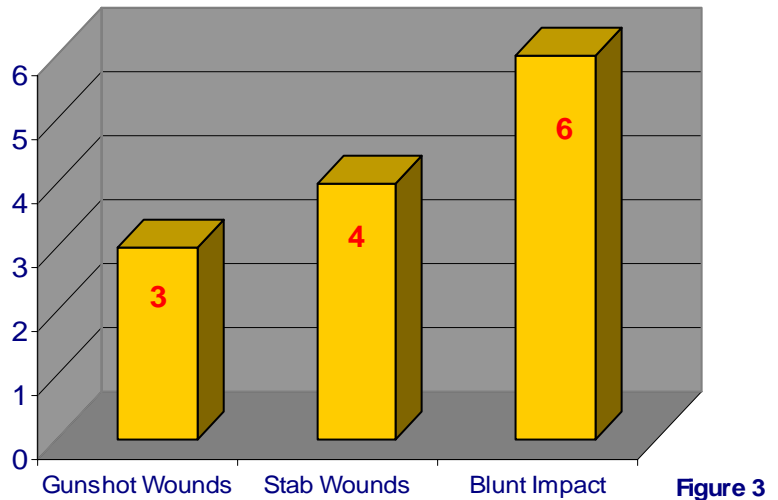
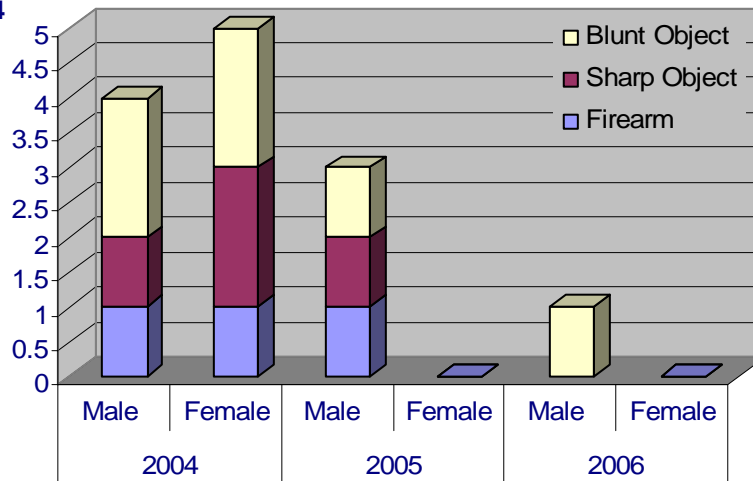


Figure 4 below illustrates the weapons of choice for the 12 Homicide perpetrators. As this figure depicts, all of the deaths perpetrated by females occurred in 2004 (n = 5) and equal numbers (n = 2) were attributed to sharp and blunt objects. For male perpetrators, the weapon of choice was blunt object which was the weapon used in four or 50% of the male perpetrated domestic violence fatalities. Blunt objects included hand, vehicle, crowbar, skillet, etc.

### Perpetrators' Weapons of Choice

Figure 4



### ***DV FACT: INTIMATE PARTNER VIOLENCE***

The Center for Disease Control and Prevention (CDC), defines intimate partner violence as “physical, sexual, or psychological harm by a current or former partner or spouse.” This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. CDC identifies four primary types of intimate partner violence described below:

#### ***Physical Violence***

- Intentional use of physical force with the potential for causing death, disability, injury, or harm including (but not limited to) scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, use of a weapon, and use of restraints or one’s physical strength to restrain another person.

#### ***Sexual Violence***

- Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed.
- Attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, (for example, because of illness, disability, or the influence of alcohol or other drugs or because of intimidation or pressure).
- Abusive sexual contact.

#### ***Threats of Physical or Sexual Violence***

- Use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm or to perform any of the three types of sexual violence.

#### ***Psychological/Emotional Violence***

- Involves trauma to the victim caused by acts, threats of acts, or coercive tactics, including (but limited to) humiliating the victim, controlling what they can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources.

Source: Heron, S. (MD, MPH); “Emergency Medicine”, December 2006

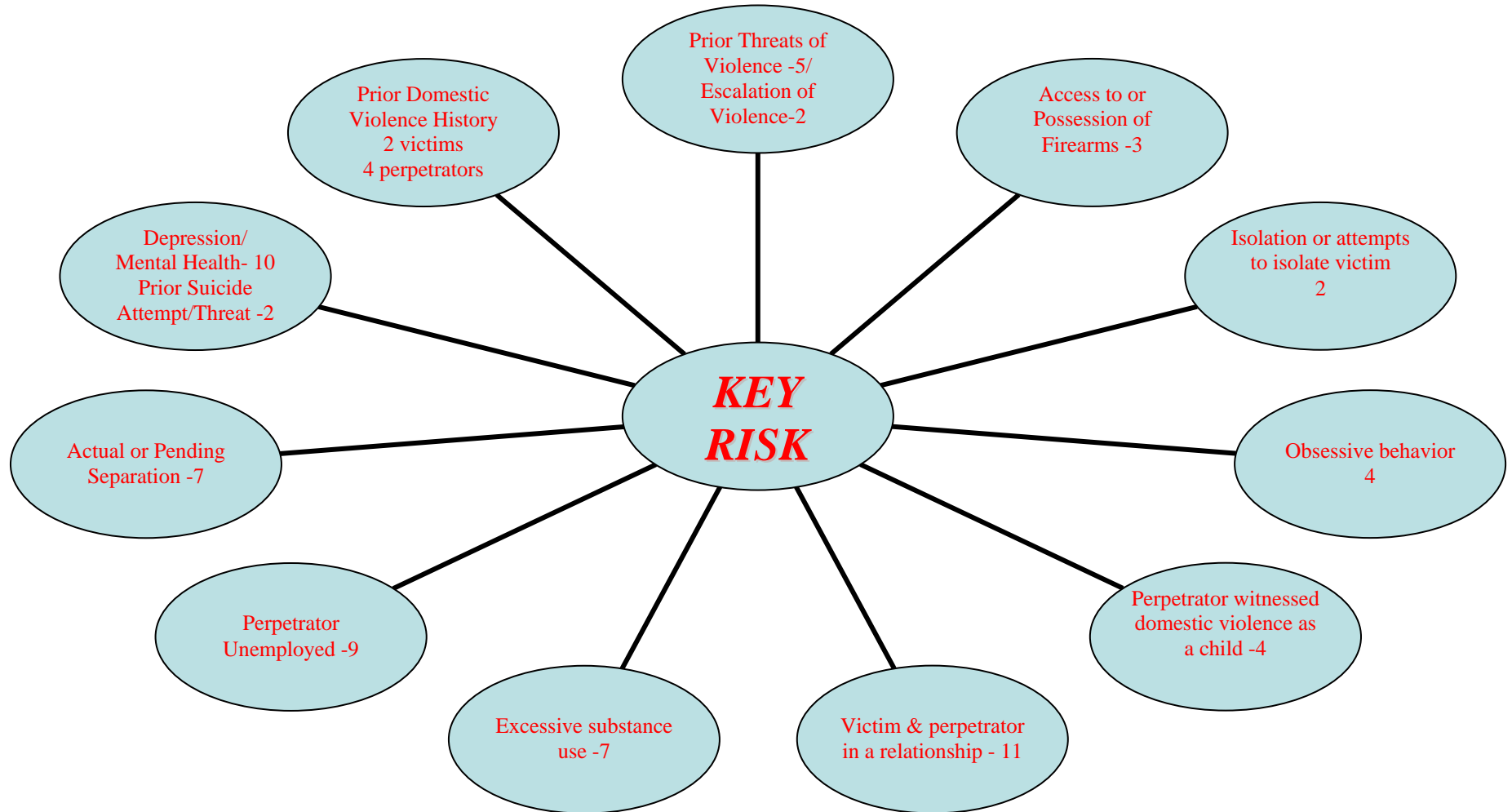
## KEY LETHALITY RISK INDICATORS

During the planning phase an extensive review of other jurisdictions' key lethality risk indicators were evaluated for the District's fatality review process to determine indicators that are most commonly used by abusers to control their partners. The following illustrates the lethality risk indicators that are being tracked by the DVFRB and of the 13 cases reviewed the number where these indicators were present in relationships that resulted in a domestic violence fatality:

- ❖ Victim/perpetrator in a relationship – 11 cases
- ❖ Depression (or other mental health or psychiatric problems) – 10 Cases
- ❖ Perpetrator unemployed – 9 Cases
- ❖ Other factors that increased risk, such as play fighting, unaddressed mental health issues – 8 Cases
- ❖ Actual or pending separation – 7 Cases
- ❖ Excessive substance use (alcohol and/or drugs) – 7 Cases
- ❖ Prior domestic violence history – 6 Cases
  - Two (2) decedents had prior histories of domestic violence
  - Four (4) perpetrators had prior histories of domestic violence
- ❖ Prior threats of violence (threats to kill or harm victim) – 5 Cases
- ❖ Obsessive behavior (including stalking the victim) – 4 Cases
- ❖ Perpetrator witnessed domestic violence as a child – 4 Cases
- ❖ Access to or possession of firearms - 3 Cases
- ❖ New partner in victim's life – 3 Cases
- ❖ Victim experienced prior threats with weapon – 2 Cases
- ❖ Isolation of or attempts to isolate victim – 2 Cases
- ❖ Presence of stepchildren in the home – 2 Cases
- ❖ Escalation of violence – 2 Cases
- ❖ Prior suicide threats/attempts by perpetrator – 2 Cases
- ❖ Destruction of victim's property – 1 Case
- ❖ Extreme minimization or denial of partner/spouse assault history – 1 Case
- ❖ Couple under age 21 – 1 Case

The graph on the following page (page 14) highlights the most common lethality risk indicators that were present on the 13 cases reviewed by the Board.

HIGH RISK LETHALITY INDICATORS MOST COMMONLY PRESENT  
AMONG THE 13 CASES THAT WERE REVIEWED



## SYSTEMIC TRENDS

### *Perpetrators - Past Criminal and/or Abusive Histories*

- ❖ Seven (7) of the 13 fatalities reviewed or 54% had prior criminal records. Some of the overall charges for both males and females included: drug distribution, drug possession, weapons charges assault, assault with a deadly weapon, probation violation, and Bail Act violations.
- ❖ Three (3) or 43% of the seven (7) perpetrators with criminal histories had outstanding criminal cases at the time of the fatal event (1 outstanding court case and 2 outstanding arrest warrants).
- ❖ Three (3) or 23% of the 13 perpetrators were known to the child welfare system.
- ❖ Female Perpetrators
  - Four (4) or 80% of the 5 female perpetrators had histories of prior arrests and charges for domestic violence (none of the cases involved the decedents).
  - Four (4) or 80% of the female perpetrators were known to be abusive, or were suspected to be emotionally, verbally and/or physically abusive to the decedents prior to the deaths based on interviews with family and friends.
- ❖ Male Perpetrators
  - Three (3) or 43% of the seven (7) male perpetrators had previous criminal histories; however, based on information reviewed only one had charges related to domestic violence.

### *Mental Health Issues*

- ❖ Six (6) or 50% of the 12 perpetrators had mental health issues. The perpetrators were also known to the criminal justice system.
- ❖ Two (2) or 17% of the 12 perpetrators had a history of incarcerations for domestic assaults. One failed to attend counseling. It is unknown whether the other perpetrator received mental health services.
- ❖ The Department of Mental Health had no record of one perpetrator until after 2001, despite the perpetrator's early sporadic history as a teenager. This was also the case of another perpetrator who was seen for a short period as a child but her mother discontinued her treatment.
- ❖ Two or, 17% of the 12 perpetrators had 2 suicide attempts as adolescents/teenagers.
- ❖ Two perpetrators attempted suicide after the fatal incident, one of these perpetrators also attempted suicide as a minor child.

## DV FACT: A REPORT ON DOMESTIC VIOLENCE CASE FILINGS IN THE DISTRICT OF COLUMBIA 2001-2004

- In 2005, domestic violence case filings totaled 8,386, an increase of 3.7% over 2004, including 4,426 misdemeanors and 3,960 Intra-family cases.
- Domestic violence misdemeanor cases filed in 2005 increased by 4.3% over 2004, with 4,426 new filings in 2005 versus 4,244 in 2004.
- Domestic violence Intra-family cases filed in 2005 increased by 3.0% over 2004, with 3,960 new filings in 2005 versus 3,845 in 2004.
- Of the 3,748 filings for Civil Protection Orders, 917 (25%) petitions originated from the Southeast Washington Domestic Violence Unit.
- Of the 4,799 misdemeanor cases with dispositions, 2,466 were Prior to Adjudication and 2,333 were Court Adjudications:
  - 2,045 (43%) were left unprosecuted (No papered; Nolle Prosequi)
  - 421 (9%) were declared inactive cases by the court
  - 1,202 (25%) were dismissed (Dismissed; Dismissed for Want of Prosecution)
  - 867 (18%) were pleaded (Plea)
  - 264 (6%) went to trial (Judgment; Acquittal)
- Of the reported 4,545 adjudicated Intra-family cases [Civil Protection Orders (CPOs) only]:
  - 2,211 (49%) were dismissed by the court
  - 249 (5%) were denied
  - 757 (17%) were granted by the court
  - 977 (22%) had consent orders issued
  - 319 (7%) were defaulted
  - 32 (0.1%) were withdrawn
- There were 3,299 requests for Temporary Protection Orders (TPO's) made in 2005. Ninety one percent (91%) were granted; 8% were denied; 1% other.
- Because 2005 court-reported figures did not include Intra-family Contempt filings as in previous years, and the breakdown of figures for 2004 was unavailable, the contempt filing figures have been added to the 2005 domestic violence filing number to make possible accurate comparison from year to year.
- The figures for *Court Adjudication* and *Prior to Court Adjudication* were transposed in the DC Superior Court 2005 Annual Report. They are correctly reported here.
- 2005 caseload for CPO's (4,722) included new filings, pending cases 1/1/05, and reinstated cases.

Source: DC Superior Court Annual Reports 2004-2006.

### ***Perpetrator's Substance Abuse History***

- ❖ In seven (7) or 58% of the twelve (12) cases the perpetrator had histories of drug abuse, although one (1) of the seven (7) perpetrators had not used drugs in two years.
- ❖ Six perpetrators used drugs and/or alcohol at the time of the fatal incident.

### ***Emergency Services***

- ❖ Two decedents had not received immediate medical attention due to travel time. The fatal incidents occurred in the far Southeast area of the city and the victims were transported by

ambulance to a hospital located in the Northwest section of the city. The arrival time of the emergency vehicles on the scene was not viewed as a factor in either death.

***Perpetrators Child Welfare History***

- ❖ Two perpetrators, with a history of maltreatment, were known to CFSA but had not received mental health services.
- ❖ Two perpetrators had experienced severe and devastating emotional, physical, and sexual abuse as children. One of these perpetrators was known to CFSA.
- ❖ One perpetrator, as a child witnessed her mother being abused by her boyfriends.

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## *CASE VIGNETTES*

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The vignettes described below are used as illustrations of the types of cases that are reviewed by the DVFR Board. These cases are composites of several cases and do not represent one case reviewed; rather, they represent common relationships and risk indicators associated with domestic violence. Names and other identifying details have been changed to protect the identities of the victims and their families.

### *PATRICE'S STORY*

Patrice was found beaten to death in the home that she shared with her husband, John and their young child. At the time of her death, the child was sleeping and was awakened by her father beating her mother with a baseball bat. The child called 911 for assistance and opened the door for police to enter. By the time emergency assistance arrived within a few minutes, Patrice was pronounced dead at the scene.

The couple had college degrees and spoke several languages. John and Patrice lived in a long-term temporary housing program. The couple stayed in the housing program for about four years without reported incidents of domestic violence before moving into their own home. They lived together in their home about five years prior to the fatal incident. Patrice was employed part time; John was unemployed but cared for the children and maintained the home. The couple eventually received Section 8 housing and medical coverage. Patrice's parents were constant visitors for extended months and assumed roles and tasks that were generally handled by John. John did not have family or friends in the Metropolitan area and his family members were not known to visit him. Patrice became overwhelmed as John became more and more dependent upon her for all his social and economical needs and became less helpful with the child. John sought counseling from his church and from mental health services. Patrice unwillingly attended a few sessions and shortly afterward sought a divorce. John regarded Patrice's lack of affection as highly insulting.

A week prior to the fatal event Patrice made several calls to police to have John removed from the home. None of the reported incidents involved abuse and Patrice was informed of the process required to have John leave the home. Patrice also inquired into moving back into the housing program, stating that she wanted to leave her husband. Patrice never reported abuse although it was learned after her death that John was physically abusing the child for performing poorly in school. The events that led to the fatal incident are unclear. It is clear that John was unemployed with no means of self-sufficiency due to his legal status. Throughout their stay in the District John was highly dependent upon his wife for his survival and he was in the process of losing his only means of support.

### ***TIM'S STORY***

Tim's girlfriend, Sabrina reported finding Tim dead. It was later learned that Sabrina had brutally beaten Tim while he was inebriated and left him to die while she and a male friend, who witnessed the event, went to have dinner and run errands. The two returned with an eyewitness to substantiate finding Tim dead.

Sabrina had a history of homelessness, domestic assaults, and mental health issues. Her charges included: drug distribution, drug possession, weapon charges assault; assault with a deadly weapon, probation violation, Bail Act violations. Tim was initially a friend to Sabrina and allowed her to live with him. The two entered into a romantic relationship.

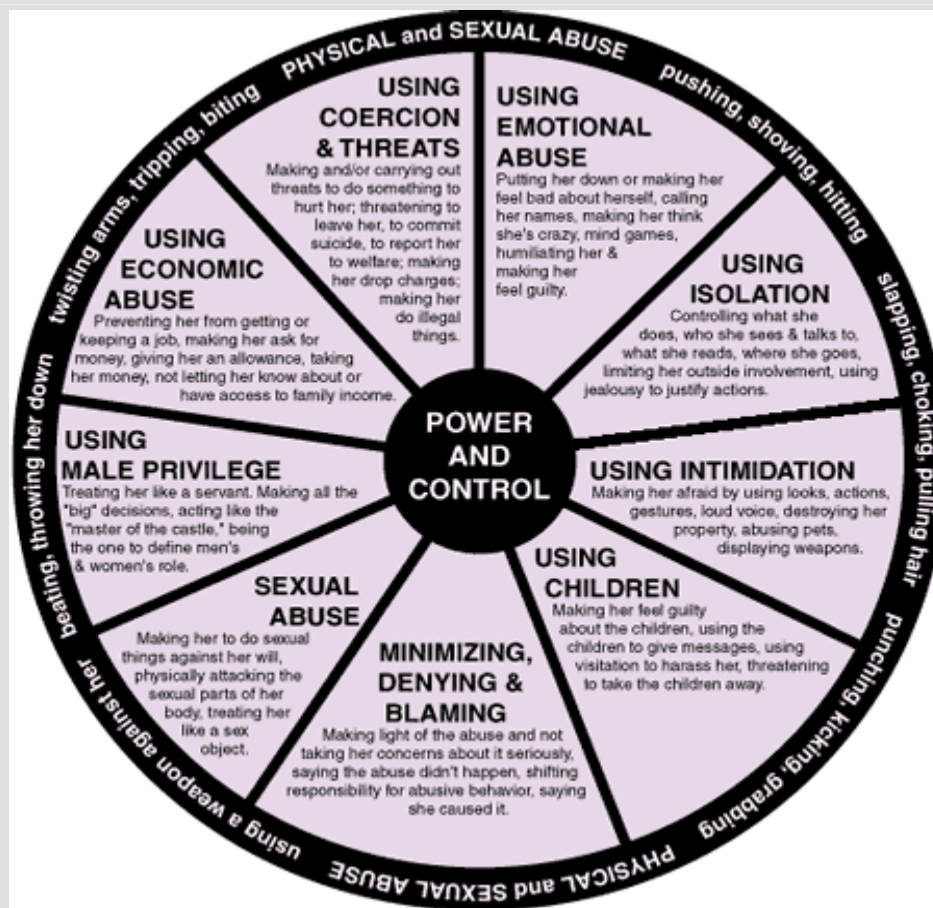
Neighbors reported to Tim's adult children that Sabrina was physically abusive to their handicapped father. The decedents' children would later report often seeing bruises and marks on Tim's face and arms.

As a child, Sabrina was known to the child welfare system due to sexual and physical abuse and neglect. While Sabrina was involved in child welfare, she received very little intervention that would assist her as an adult in controlling her abusive and destructive patterns of behavior.

### DV FACT: POWER & CONTROL WHEEL

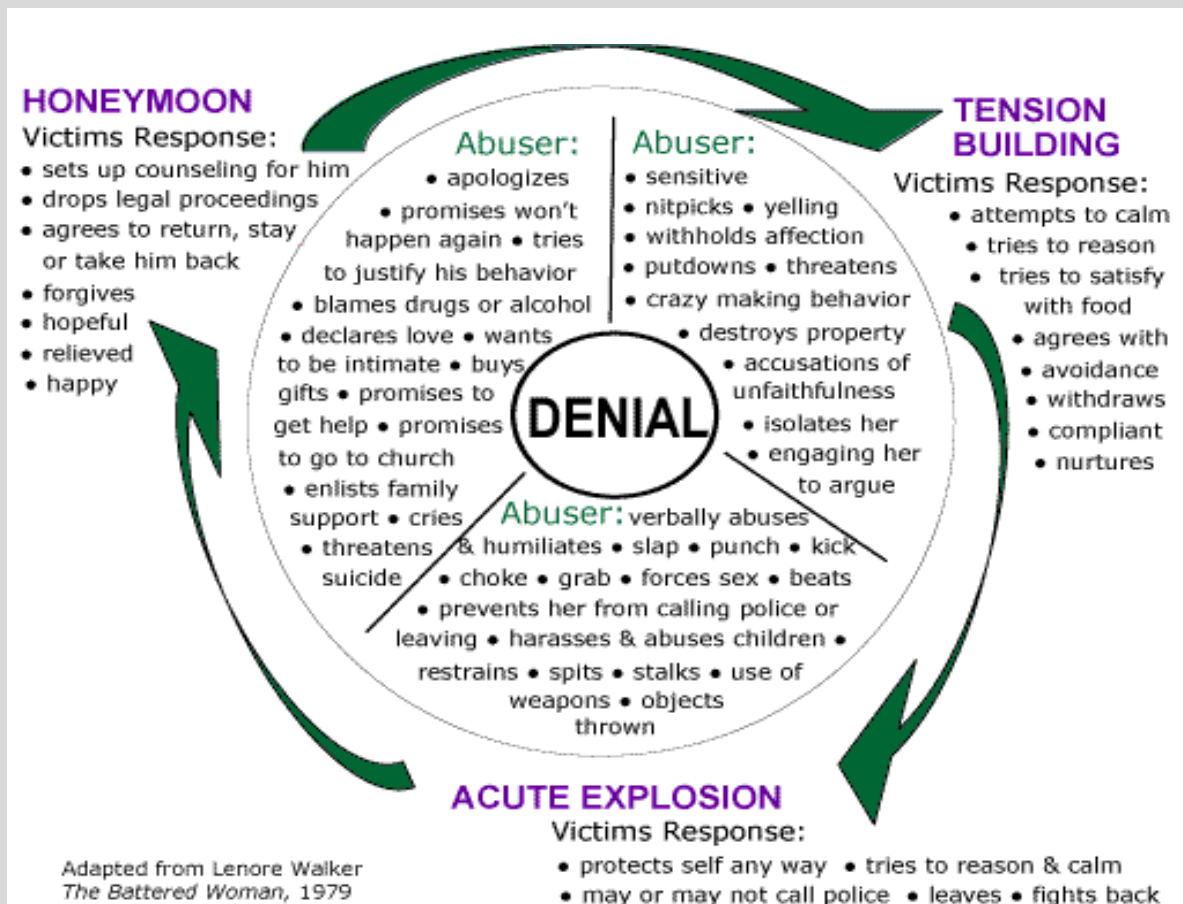
The Power and Control Wheel was developed after interviewing battered women in support groups and men in batterer's groups. The women were asked to identify the ways in which they felt they were controlled, and the men were asked to identify what tactics they used to maintain an environment of fear and control (Pence, 1987).

At the center of the Wheel is the intention - the purpose - of all the abusive tactics - to establish power and control. Each spoke of the Wheel represents a particular tactic (i.e. economic abuse, threats, and intimidation). The rim of the Wheel that holds it together is physical abuse and the threat of violence (Pence, 1987).



### DV FACT: STAGES IN THE CYCLE OF VIOLENCE

Many victims of domestic violence stay in abusive relationships because at times, their partners may exhibit loving and caring behavior. This leads the victim to believe the violence is over, and it will not happen again. Most often, victims do not realize that the domestic violence is cyclical. The stages in the cycle of violence are below:



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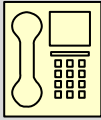
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Sources: District of Columbia Coalition Against Domestic Violence: Metropolitan Police Department-- UCR Report, 2005; A Report on Homicide in the District of Columbia 2001-2004; A Report on Juvenile Homicide 2002-2004

Sources: District of Columbia Coalition Against Domestic Violence Sources: DC Superior Court Annual Reports 2004-2006; District of Columbia Office of the Attorney General, 2006



## DV FACT: HELP FOR VICTIMS OF DOMESTIC ABUSE AND VIOLENCE

First and foremost, everyone needs to become aware of the dangers of Domestic Violence. Through education and understanding, violence and threats of violence will no longer be minimized or tolerated.

Don't Wait! If Domestic Violence is pervasive in your home or that of a loved one, take advantage of resources that are available.

The [National Domestic Violence Hotline](#) provides crisis intervention, information, and referral to victims and their friends and families. Services are available 24 hours a day, 365 days a year, in more than 140 different languages and a teletypewriter line is available for the disabled. The Hotline can be reached either by the internet (Web site: <http://www.ndvh.org>) or telephone: (800) 799-7233, (800) 799-SAFE, or (800) 787-3224(TTY).

The [District of Columbia](#) provides a list of women's shelters, domestic violence programs, batterer's intervention programs, victim/witness programs, counseling services and crisis hotlines. For additional information contact the DC Coalition Against Domestic Violence (202-879-7851/[www.dccadv.org](http://www.dccadv.org)) or the Superior Court of the District of Columbia, Domestic Violence Intake Unit (202-879-0152).

**VICTIMS IN NEED OF EMERGENCY ASSISTANCE SHOULD IMMEDIATELY CALL 911.**

Remember that your home computer stores a record of which internet sites you visit, so use your public library or a friend's computer in your Domestic Violence searches.

# APPENDICES

It Shouldn't Hurt  
To Go Home.



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## ***DVFRB RECOMMENDATIONS AND AGENCY RESPONSES***

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Recommendations were generated on 1 of the 13 cases reviewed. The DVFR Board members reviewed all the recommendations that were provided verbally and in writing on this case and the following were adopted and transmitted for response:

- ❖ Office of Victim Services (OVS) in collaboration with the Departments of Health (DOH) and Mental Health (DMH) should work with domestic violence programs to develop and implement a city-wide public education campaign to broaden the community's knowledge of the cycle of domestic violence; symptoms of abuse, including emotional and verbal; lethality risk indicators; reporting methods; and services/resources available in the community.

*Agency Response:* Response Pending

- ❖ OVS in collaboration with DOH and DMH should advocate for professional training for service providers and others involved with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services and resources available in the community. The training should minimally focus on the cycle of domestic violence; lethality risk indicators; protection orders; legal, social, mental health and other community-based resources that are available to this population; significance of risk assessments, early intervention strategies and safety plans for victims and their families.

*Agency Response:* Response Pending

- ❖ Department of Human Services, Family Services Administration in collaboration with the Community Partnership for the Prevention of Homelessness should increase the number of domestic violence shelters available for victims in the District of Columbia.

*DHS Response:* "The budget for the shelter program is established by the City Council and funding for additional domestic violence shelters was not included for FY '07. In considering requests for FY '08, the Family Services Administration consulted with the Office of Victim Services. Currently, the Office of Victim Services advises that there is not a shortage of emergency safe shelter beds because the DV Intake Center can refer victims seeking safe shelter to hotels if the victims obtain a Civil Protection Order.

The Office of Victim Services understands that hotel rooms are not the most effective type of safe shelter, and advised that funding has been awarded to two confidential safe shelters in the District, to expand shelter services for victims of domestic violence. [These two confidential programs are] expanding its shelter and acquiring or building a new facility.

Currently, the Family Services Administration and The Community Partnership for the Prevention of Homelessness are focusing on moving families from the shelter system into permanent housing and have no plans to add additional safe shelter facilities to the shelter network."

- ❖ District-based domestic violence programs should partner with the religious community on methods of identification and prevention of domestic abuse.

*Agency Response:* Response Pending

## 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."

ENROLLED ORIGINAL

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

Amend  
§ 16-1005

(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)."

New  
Subchapter  
IV,  
Chapter 10,  
Title 16

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

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

New  
§ 16-1041

"§ 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

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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.

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

New  
§ 16-1043

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that a valid foreign protection order exists and that the order has been violated, shall enforce the order as if it were the order of a tribunal of the District. Presentation of a protection order that identifies both the protected individual and the respondent and, on its face, is currently in effect constitutes probable cause to believe that a valid foreign protection order exists. For the purposes of this section, the protection order may be inscribed on a tangible medium or may have been stored in an electronic or other medium if it is retrievable in perceivable form. Presentation of a certified copy of a protection order is not required for enforcement.

"(b) If a foreign protection order is not presented, a law enforcement officer may consider other information in determining whether there is probable cause to believe that a valid foreign protection order exists.

"(c) Registration or filing of an order in the District is not required for the enforcement of a valid foreign protection order pursuant to this subchapter.

"§ 16-1044. Registration of order.

New  
§ 16-1044

"(a) The Superior Court of the District of Columbia is authorized, subject to appropriations, to create a registry in the District of Columbia for foreign protection orders and protection orders issued in the District of Columbia.

"(b) Any individual may register a foreign protection order in the District. To register a foreign protection order, an individual shall:

"(1) Present a certified copy of the order to the Superior Court; and

"(2) File an affidavit by the protected individual stating that, to the best of the protected individual's knowledge, the order is currently in effect.

"(c) When a registry is created pursuant to subsection (a) of this section, upon receipt of a foreign protection order, the Superior Court shall register the order in accordance with this section. After the order is registered, the Superior Court shall furnish to the individual registering the order a certified copy of the registered order. The Superior Court shall not notify or require notification of the respondent that the protection order has been registered in the District unless requested to do so by the party protected by the order.

"(d) The Superior Court shall register an order upon presentation of a copy of a protection order that has been certified by the issuing State. A registered foreign protection order that is inaccurate or is not currently in effect shall be corrected or removed from the registry in accordance with the law of the District.

"(e) A foreign protection order registered under this subchapter may be entered in any existing state or federal registry of protection orders, in accordance with applicable law.

"(f) A fee may not be charged for the registration of a foreign protection order, nor may a fee be charged for service of a foreign order in the District of Columbia.

"§ 16-1045. Immunity.

New  
§ 16-1045

"The District and its officers and employees, a law enforcement officer, prosecuting attorney, clerk of court, or any state or local governmental official acting in an official capacity, is immune from civil and criminal liability for conduct arising out of the registration or enforcement of a foreign protection order or the detention or arrest of an alleged violator of a foreign protection order if the conduct was done in good faith in an effort to comply with this subchapter.

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“§ 16-1046. Other remedies.

New  
§ 16-1046

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

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

New  
§ 16-1047

“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.

“§ 16-1048. Transitional provision.

New  
§ 16-1048

“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  
Subchapter  
V,  
Chapter 16,  
Title 16

*“Subchapter V. Domestic Violence Fatality Review Board.*

“§ 16-1051. Definitions.

New  
§ 16-1051

“For purposes of this subchapter, the term:

“(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:

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

“(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.

New  
§ 16-1054

“(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

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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

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“(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.

New  
§ 16-1057

“(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.

“(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.

New  
§ 16-1058

“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.

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"§ 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.

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Chairman  
Council of the District of Columbia

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Mayor  
District of Columbia

## ***FATALITY LISTING***

### **2004 – NINE VICTIMS**

<b>2004</b>	<b>Perpetrator</b>	<b>Race</b>	<b>Age</b>	<b>Victim</b>	<b>Race</b>	<b>Age</b>	<b>Cause</b>	<b>Manner</b>
1	Female	AA	41	Male	AA	74	Stab Wound to Chest with Injury to Lung & Aorta	Homicide
2	Female	AA	18	Male	AA	20	Stab Wound to Chest Perforating Heart	Homicide
3	Male	AA	29	Male	AA	34	Stab Wound to Neck Injuring Vasculature	Homicide
4	Male	AA	35	Female	AA	35	Gunshot Wound to Face Fracturing Base of Skull and Injuring Brain	Homicide
5	Male	AA	39	Male	AA	34	Blunt Impact Head with Fractures of skull and contusions of Brain; compression of Neck with Fracture of Cricoid Cartilage	Homicide
6	Female	AA	26	Male	AA	31	Blunt Impact to Neck, Torso and Extremity and Trauma	Homicide
7	Female	AA	30	Male	AA	45	Blunt Impact Injuries of Head with Subdural Hemorrhage, Brain Contusion and Cerebral Edema	Homicide
8	Male	W	27	Male	W	44	Multiple Blunt Impact Injuries	Homicide
9	Female	AA	43	Male	AA	19	Gunshot Wound to Chest with Perforation of Aorta, Lungs and Spinal Cord	Homicide

### **2005 -THREE VICTIMS**

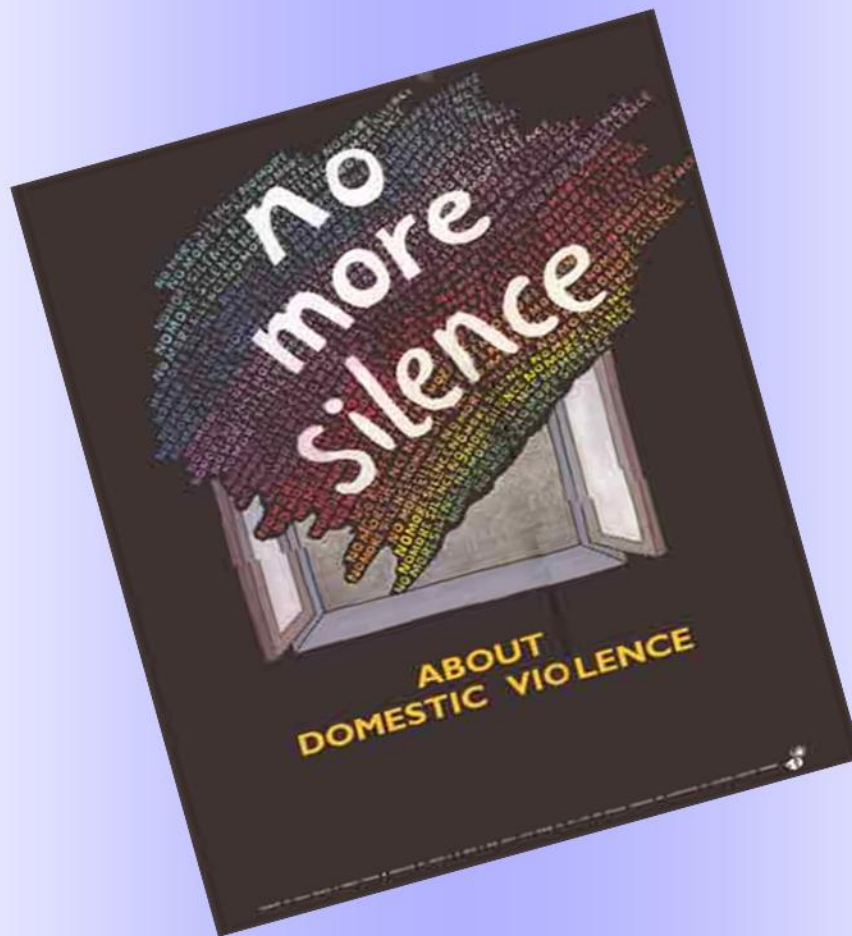
<b>2005</b>	<b>Perpetrator</b>	<b>Race</b>	<b>Age</b>	<b>Victim</b>	<b>Race</b>	<b>Age</b>	<b>Cause</b>	<b>Manner</b>
1	Male	A	39	Female	RW	33	Blunt Impact Head Trauma	Homicide
2	Male	W	37	Female	W	30	Gunshot to Head, Injury to Brain	Homicide
3	Male	AA	41	Female	AA	37	Stab Wounds to Neck, Injuring Major Blood Vessels	Homicide

**2006 – ONE VICTIM***Suicide Death – No Perpetrator Involved*

<b>2006</b>	<b>Perpetrator</b>	<b>Race</b>	<b>Age</b>	<b>Victim</b>	<b>Race</b>	<b>Age</b>	<b>Cause</b>	<b>Manner</b>
1	N/A	N/A	N/A	Male	AA	33	Multiple Blunt Impact Injuries	Suicide

## ***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 2006 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 develop a strong fatality review structure and framework by which to review domestic violence fatalities. Representatives from these agencies/programs and community individuals generously shared their experience, professional resources and support throughout the program developmental process. Your knowledge and expertise was invaluable in the development of policy, procedures, and practices that the Board continues to utilize in the case review process. The unwavering dedication and hard work of all these highly committed experts was a constant source of inspiration and support and contributed to a productive first year for the DVFR Board.



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