GOVERNMENT OF THE DISTRICT OF COLUMBIA DOMESTIC VIOLENCE FATALITY REVIEW BOARD

SECOND ANNUAL REPORT



The Purple Ribbon is a symbol of hope, a symbol to stop relationship violence. It signifies the countless victims who suffer alone in silence and hide physical and emotional bruises. The Purple Ribbon is a symbol to educate and end apathy toward the victims of relationship violence. It is a symbol that society will not tolerate abusive behavior and that society will not enable abusers."

Unknown Author

Adrian M. Fenty, Mayor Government of the District of Columbia

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

DISTRICT OF COLUMBIA DOMESTIC VIOLENCE FATALITY REVIEW BOARD

SECOND ANNUAL REPORT

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 2008

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 Second Annual Report. This Report covers data that resulted from reviews conducted between July 2007 through May 2008, on 15 fatalities that occurred during calendar years 2004 through 2007.

TOTAL DOMESTIC VIOLENCE FATALITIES IDENTIFIED (N = 62)

- ✤ As of May 2008, 62 deaths were identified by the Domestic Violence Fatality Review Board as meeting the criteria for review. These deaths occurred in calendar years 2004 through 2008.
- The majority of the deaths identified were Homicides, which ranged from 71% to 100% of domestic violence related deaths annually.
- Most of the deaths involved District residents and eight were residents from other States but died in the District. The largest number of decedents resided in Wards Eight, Six and Five.
- ✤ As of May 2008, 45 of the 62 DVFRB deaths identified (73%) were reviewed and 17 were pending review. Of the 17 cases pending review, 12 were pending completion of prosecution and five were scheduled for DVFRB review in the 2008 calendar year.

SUMMARY OF TOTAL DEATHS REVIEWED (N = 15)

The following is a summary of major data factors and the recommendations that resulted from the 15 deaths reviewed by the Board between July 2007 and May 2008.

MANNERS AND CAUSE OF DEATH

- Thirteen (87%) of the 15 deaths reviewed were Homicides, and two (13%) were Suicides.
- Most of the deaths reviewed were caused by Gunshot Wounds (N = 6), followed by Blunt Impact Trauma (N = 5).

DECEDENT DEMOGRAPHICS - GENDER, RACE AND AGE

- The 13 Homicide cases involved 14 perpetrators (one case involved two perpetrators). Three of the 14 perpetrators were females and 11 were males. Thirteen (93%) were Black/African American and one was White. The average age of the perpetrators was 37.3%.
- Of the 15 decedents, 11 (73%) were females and four were males. One hundred percent of the decedents were Black/African American and the average age was 47.

PRIOR CRIMINAL HISTORIES

- Eleven (79%) of the perpetrators had prior criminal histories and three (20%) had an active Civil Protection Order (CPO) at the time of the fatal event.
- Six (40%) of the decedents had prior criminal records and one (7%) had an active CPO to stay away from the perpetrator at the time of the fatal event.

WARD OF DECEDENT'S RESIDENCE AND FATAL INCIDENT

Wards Eight and Five had the highest number of residents to die from domestic violence related injuries (N = 4 and 3 respectively) and the highest number of fatal events (N = 5 and 4 respectively) also occurred in those Wards.

DVFRB RECOMMENDATIONS FROM FATALITIES REVIEWED

Based on the 15 deaths reviewed, the following recommendations were adopted by the Board and transmitted to agencies for responses (see page 10, Part IV: DVFRB Recommendations):

- Office of Victim Services (OVS), in collaboration with the Department of Health (DOH) and Department of 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.
- 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.

INTRODUCTION

The Domestic Violence Fatality Review Board (DVFRB) is a city-wide collaborative effort that was established by the Uniform 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 response of individuals, the community and District-based public and private service delivery systems. This mission is achieved through a multidisciplinary analysis of the victims' experiences and the circumstances surrounding their death. Through the case review process, the Board identifies high-risk factors and trends related to the decedents, perpetrators and systems. These systems are responsible for supporting, assisting and protecting the victims from family and/or intimate partner violence. The DVFRB review process, as a cooperative effort, provides an opportunity for professionals and/or concerned citizens to enhance and increase services and improve the District's response to addressing the needs of victims. (See Appendix B: Mission Statement and Description of DVFRB Review Process.)

The District's DVFRB is a formally established mechanism for tracking domestic violencerelated fatalities, assessing the circumstances surrounding the deaths and associated risk indictors. Homicide and Suicide fatalities are selected for review based on referrals from the US 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 depends 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 during its second year of operation. *Part I* of the Report provides a general overview of all domestic violence deaths that were referred to the Board as meeting the criteria for review. It summarizes decedent demographics as well as the manners and causes of death for the total DVFRB population. *Part II* of the Report provides a synopsis of the demographic data, trends and recommendations that resulted from the 15 cases reviewed by the DVFRB between July 2007 and May 2008.

PART I: TOTAL DISTRICT DOMESTIC VIOLENCE FATALITIES

TOTAL CASES IDENTIFIED

As of May 2008, the DVFRB identified a total of 62 deaths that occurred between 2004 and 2008 and met the criteria for review. Figure 1 illustrates the total number of deaths identified for each calendar year¹.

RACE, GENDER AND AGE OF TOTAL DVFRB DEATHS IDENTIFIED

As Table 1 illustrates, the majority of the victims identified as domestic violence

fatalities were Black/African American. White decedents ranked second, followed by Hispanics.

TABLE 1: DECEDENT'S RACE BY YEAR (N = 56							
YEAR	BLACK	WHITE	HISPANIC				
2004	14	2	1				
2005	12	2	1				
2006	11	0	1				
2007	12	0	0				

✤ Figure 2 illustrates the gender of the total domestic violence victims annually. Female victims ranged from 42% to 60%, with the greatest number of female deaths occurring in

2005 (N = 9). The highest number of male deaths occurred in 2004 (N = 9).

✤ The ages of the victims of domestic violence fatalities ranged from 2 months to 87 years. As

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Figure 3 illustrates, the majority of the deaths reviewed involved victims who were 18 years of age or younger and those between 19 through 39 years of age.

The number of decedents younger than 19 years of age ranged from three to six cases annually, and the majority of these children were under the age of 5 years (N = 13). The



19 - 39

40 - 59

0

Under 19





Figure 3: Decedent's Age By Year

(N = 56)

60 - 79

80 & Over

¹ Calendar year 2008 data represents deaths identified as of May 2008. Because the data for 2008 is incomplete, Figures 2 through 5 and Tables 1 and 2 in Part I of the Report do not include the six deaths from that year.

children/youth under 19 years of age represent an overlap population with the Child Fatality Review Committee $(CFRC)^2$. Based on the District's mandated review criteria and consistent 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. The majority of the children/youth in this age category died at the hands of a parent or caregiver (N = 15).

The number of decedents age 19 through 39 years ranged from two to eight each year, representing 17% to 47%.



WARD OF RESIDENCE

Of the 56 domestic violence deaths identified by the DVFRB between 2004 through 2007, 47 decedents were residents of the District of Columbia. Eight deaths involved residents of other States (Maryland, Virginia and Delaware) but, the fatal event occurred within the District. As Figure 4 illustrates, of the 47 District residents Wards Eight, Six and Five had the highest overall number of residents who died from domestic violence related incidents, with deaths represented in each of the four years. During 2007 Ward Seven had the highest number of deaths but no deaths occurred during the previous years.

MANNER OF DEATH

- Homicide was consistently the leading manner of death for domestic violence fatalities for all calendar years. As Figure 5 illustrates, Homicides accounted for 71% to 100% of the deaths identified from 2004 through 2007 calendar years
- There was one Suicide that occurred in calendar years 2005 through 2007 and none in 2004.



² The Child Fatality Review Committee is the District's fatality review process that operates within the District of Columbia and is responsible for reviewing the deaths of all children and youth 18 years of age and younger. A total of 17 CFRC cases were referred to the DVFRB for statistical purposes only.

STATUS OF DVFRB CASE REVIEW PROCESS

Table 2 illustrates the status of the case review process by calendar year. Between July 2007 and May 2008, 15 domestic violence deaths were reviewed that occurred in calendar years 2004 through 2007. As of May 2008, there were 17 cases pending review and 12 of these cases were pending completion of prosecution. Five cases were scheduled for review in the 2008 calendar year.

TABLE 2: DVFRB CASES IDENTIFIED, REVIEWED AND PENDING						
Year	# Cases Identified # Cases Reviewed #		# Pending Review			
2004	17	17	0			
2005	15	13	2			
2006	12	6	6			
2007	12	7	5			

DOMESTIC VIOLENCE REVIEWS

"Domestic violence reviews can be a powerful tool for catalyzing change. However, participants, organizations and advocates involved in these projects must guard against them becoming routine meetings which reflect, rather than challenge, problems in community response to domestic violence. When advocates are able to offer a strong, clear vision of the potential of fatality reviews, they can provide important leadership, guidance and inspiration to their collaborators on review teams."

> Margaret Hobart Washington State Coalition Against Domestic Violence June 2004; Advocates and Fatality Reviews

PART II: SUMMARY OF CASE REVIEW FINDINGS

The information contained in this section will cover the data and findings that resulted from cases reviewed by the DVFRB during the period of July 2007 through May 2008 (N = 15). Based on established protocols, data in the graphs and tables represent deaths that occurred during multiple years. Two of the deaths reviewed were Suicides and as such did not involve perpetrators. Of the 13 Homicides reviewed there were 14 perpetrators, as one homicide involved two perpetrators.

PERPETRATOR/DECEDENT DEMOGRAPHIC DATA *Gender of Perpetrators/Decedent*

- Perpetrators Twenty-one percent (N = 3) of the 14 perpetrators were females and 79% (N = 11) involved males (one of the 13 Homicide was committee by two perpetrators).
- **Constants** Twenty-seven percent (N = 4) of the 15 decedents were males, and 73% (N = 11) were females.
- Gender By Year of Death Based on the 15 deaths reviewed, Table 3 illustrates the gender of the perpetrators and the decedents by year of death.

TABLE 3: GENDERBY YEAR (N = 15)	2004		2005		2006		2007	
	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
Perpetrators	1	1	3	1	4	1	3	0
Decedents	0	2	2	3	0	4	2	2

AGE OF PERPETRATOR AND DECEDENT

- Perpetrator The age of the perpetrators ranged from 18 to 87 years. The average age was 37.3, and the median age was 41. There was one male perpetrator over the age of 80 years.
- Decedent The ages of the decedents ranged from 18 to 84 years. The average age of the decedents was 47, and the median age was 42. There were two female decedents over the age of 80 years.



RACE OF PERPETRATORS

- PERPETRATOR Thirteen (93%) of the 14 perpetrators were Black/African-American and one (7%) was White.
- DECEDENTS Fifteen (100%) of the decedents were Black/African American.



Figure 7: Victim/Perpetrator Relationship

PERPETRATOR AND DECEDENT RELATIONSHIP

Figure 7 illustrates the relationship between the victims and perpetrators of the 13 Homicides reviewed by the Board.

- Of the nine intimate partner relationships, seven (78%) were heterosexual and two (27%) were same sex couples. One (7%) of the same sex couples was residing together at the time of the fatal event but was in the process of separating.
- Of the seven heterosexual relationships, one couple was married and had lived together 55 years at the time of the death.
- Four (57%) of the heterosexual couples were unmarried and resided together. However, two victims were in the process of separating at the time of the fatal event. At least one of the victims was involved in another intimate relationship at the time of the death.
- Two (29%) of the heterosexual couples were separated at the time of the death and at least one was involved with another intimate partner.
- Three (23%) of the 13 Homicides involved parent and child relationships (one case involved a son and daughter-in-law as perpetrators). One child had been asked to leave the home prior to the fatal event.
- In one Homicide, the victim and perpetrator were unrelated however the perpetrator had an intimate partner relationship with the victim's daughter.

EDUCATION LEVEL OF PERPETRATOR AND DECEDENT

Educational level was unknown for six of the perpetrators and 11 of the decedents.

Perpetrators (N = 14)

As Figure 8 illustrates, two (14%) of the perpetrators had a high school diploma (one female and one male) and three males (21%) had obtained a GED. Three male (21%) perpetrators had not completed high school (N = 2) or middle school (N = 1).



Decedent

Decedents (N = 15)

Two (13%) of the 15 decedents had a high school diploma (one female and one male) and one female had obtained a GED. One (7%) female decedent had completed several years of college.

CHILDREN OF PERPETRATOR/DECEDENT

- Three (20%) of the 15 decedents had minor children and the perpetrators were the fathers of these children. Two children ages two and six years were in the home and were reported to be asleep at the time of the fatal event.
- ✤ In three (27%) of the 15 cases reviewed, the perpetrators were the children of the decedents.

LOCATION/WARD OF RESIDENCE AND FATAL INCIDENT

- Based on the 15 cases reviewed, most of the domestic violence victims resided in Wards Five and Eight. Combined there were seven (46%) decedents who were residents of these Wards.
- Of the 15 fatal incidents, most occurred in Wards Five (N = 4), Six (N = 3) and Eight (N = 5). Eighty percent (80%) of the deaths occurred in these Wards.

Figure 9 illustrates the decedents' Wards of residence and the Wards where the fatal incidents occurred. The location of the fatal event may differ from either the decedent's or perpetrator's residence.



TABLE 4: LOCATION OF FATAL INCIDENT					
LOCATION	HOMICIDE	SUICIDE			
Shared Residence	8	2			
Decedents' Residence	2	0			
Perpetrators' Residence	2	0			
Public Street	1	0			

Of the 15 fatalities reviewed, the majority of the fatal incidences occurred in the home that was shared by the perpetrator and decedent. Eight Homicides (62%) and the two Suicides (100%) occurred in shared residences.

in the decedent's home (N = 2) and the perpetrator's home (N = 2). \clubsuit Equal number of Homicide victims died

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MANNER AND CAUSE OF DEATH

Manner of Death

As Figure 10 illustrates, 13 (87%) of the DVFRB deaths reviewed were ruled Homicides and two (13%) were ruled as Suicides.

Homicides

- Eleven (85%) of the 13 Homicides reviewed were prosecuted and 10 of the perpetrators are currently incarcerated.
- Two (18%) of the 11 Homicides prosecuted were viewed to most likely have been accidental deaths that were not attributed to malice.



Suicides

- Of the two Suicides reviewed, one of the victims had been in an eight-year relationship and there had been a history of prior domestic violence.
- In the second Suicide, the perpetrator had been married to the victim for 55 years, and there was no known history of violence in that relationship.

Cause of Death

Figure 11 below represents the causes of death for the 15 cases reviewed.

- Data resulting from DVFRB cases reviewed consistently showed that access to firearms was a major factor in six (40%) of the 15 domestic violence deaths reviewed. Two (2) of the deaths caused by Gunshot Wounds were determined to be Suicides.
- Solution \therefore Blunt impact objects ranked second (N = 5, or 33%), followed by Stab Wounds (N = 3). During the second DVFRB review year, one death was due to lethal intoxication (7%).



PART III: KEY LETHALITY RISK INDICATORS

Key lethality risk factors are nationally recognized as 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 of violence in relationships. The more risk indicators present in a relationship/case, the greater the risk of escalating violence, or even death. Table 5 below illustrates the most common key lethality risk indicators that were present in the relationships of the 15 deaths reviewed by the DVFRB.

	INDICATORS
TABLE 5: KEY LETHALITY RISK INDICATORS MOST COMMONLY	IDENTIFIED IN
IDENTIFIED	CASES
Prior domestic violence history	10
Escalation of violence	10
Prior threats of violence (threats to kill or harm victim)	5
Obsessive behavior (including stalking the victim)	2
Access to or possession of firearms	6
Depression (or other mental health or psychiatric problems)	8
Isolation of or attempts to isolate victim	1
New partner in victim's life	2
Presence of stepchildren in the home	1
Hostage-taking	1
Extreme minimization or denial of partner/spouse assault history	1
Couple under age 21	2
Actual or pending separation	6
Prior threats to kill or harm victim	5
Prior suicide threats/attempts by perpetrator	1
Excessive substance use (alcohol and/or drugs)	6
Child custody dispute (informal, no court involvement)	2
Perpetrator unemployed	4
Victim/perpetrator in a relationship	8
Destruction of victim's property	3
Chokes victim	1
Perpetrator witnessed domestic violence as child	2
Prior criminal history	12
• Perpetrators (7)	
• Decedents (5)	
Other factors that increased risk, such as:	25
• Perpetrator: low functioning skills (3); un-addressed mental	
health issues (6); history of TPO-dismissed (3); history of CPO (2);	
CPO active at time of fatal event (3); threatened family members (1);	
high crime areas (2).	
• Decedent: fear for life (1), unaddressed mental health issues	
identified (2), incapacitate mentally and physically (1), bedridden (1)	

PART IV: DVFRB RECOMMENDATIONS

The following recommendations resulted from the 15 cases reviewed. These recommendations were formally adopted by the DVFRB and were transmitted to the appropriate agencies for response.

Office of Victim Services (OVS) in collaboration with the Department of Health (DOH) and the Department of 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. (DVFRB reissued this recommendation during the 2007/2008 review period)

Office of Victim Services Response: This issue has been and continues to be addressed by OVS and to a lesser extent by DHS. OVS dedicated substantial resources (\$750,000) over a three-year period that was managed by DC Coalition Against Domestic Violence and distributed to other domestic violence service providers. We continue to dedicate funds in this area. The more the better, but additional funding sources must be identified.

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.

DC Public Schools Response: Pending

2004	Perpetrator	Race	Age	Victim	Race	Age	Cause	Manner
1	Male Ex-boyfriend	AA	45	Female	AA	37	Blunt impact stab wounds	Homicide
2	Female/ Girlfriend	AA	41	Female	AA	33	Multiple blunt impact trauma	Homicide
2005	Perpetrator	Race	Age	Victim	Race	Age	Cause	Manner
1	NA	NA	NA	Male	AA	87	Gunshot wound of head; asphyxia by hanging	Suicide
2	Male Spouse	AA	87	Female	AA	84	Multiple blunt impact trauma	Homicide
3	Male Boyfriend	AA	32	Female	AA	25	Gunshot wound to head	Homicide
4	Male Ex-boyfriend of daughter	AA	21	Female	Female AA 37		Multiple gunshot wounds	Homicide
5	Female Girlfriend	AA	43	Male	AA	53	Blunt impact head trauma w/ hemorrhage skull fracture	Homicide
2006	Perpetrator	Race	Age	Victim	Race	Age	Cause	Manner
1	Male Son	AA	31	Female	AA	61	Gunshot of back with perforation of aorta, pulmonary artery & lungs	Homicide
2	Male/Female Son/Daughter in law	AA W	55 43	Female	AA	83	Acute & chronic cocaine intoxication	Homicide
3	Male Son	AA	21	Female	AA	45	Blunt Impact Head Trauma w/ Sudural Hematoma	Homicide
4	Male Ex-boyfriend	AA	46	Female	AA	43	Stab wounds of torso	Homicide
2007	Perpetrator	Race	Age	Victim	Race	Age	Cause	Manner
1	NA	NA	NA	Male	AA	34	Gunshot wound to head	Suicide
2	Male Boyfriend	AA	18	Female	AA	18	Gunshot wound to head	Homicide
3	Male Ex-boyfriend	AA	34	Female	AA	24	Stab wounds of torso	Homicide
4	Male Boyfriend	AA	43	Male	AA	42	Blunt Impact & asphyxia due to smothering	Homicide

Fatality Listing – DVFRB Cases Reviewed

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 (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, batterers' intervention programs, victim/witness programs, counseling services and crisis hotlines. Contact the DC Coalition Against Domestic Violence (DCCADV) at 202-299-1181 or www.dccadv.org or the Domestic Violence Intake Center at 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

Appendix A

ENROLLED ORIGINAL

AN ACT

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2003 Supp

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IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

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. Subpoens power.

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

"16-1057. Immunity.

"16-1058, Rules.

"16-1059. Sunset.".

Codification District of Columbia Official Code, 2011 Editor

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

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

"(I) 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 ξ 16-1004(b). shall be punishable as contempt. Upon conviction, criminal contempt shall be nunished by a fine not exceeding \$1,000 or imprisonment for not more than 180 days, or both.".

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

"(a) Any person who violetes 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 misdemeenor 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:

"(In) For purposes of establishing a violation under subsection (a) 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

"{ 16-1941. Definitions.

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"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 whore 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.

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

"(6) "Protection order" means to injunction or other order, whether temporary or (mg), issued by a tribungl for the purpose of preventing violent or threatening acts or hardssment enderst, contact or communication with, or physical proximity to, another individual.

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

"(8) "State" means a State of the United States, the District of Columbia, Puerto Rizo, 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.

"(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 exparie 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.

"(c) A foreign protection order valid on its face is prime facic 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 matual foreign protection order which favor a respondent only if:

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

"(2) The tribunel 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

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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.

"(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.

"(h) 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 m 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 insecurate or is not currently in effect shall be corrected or removed from the registry in accordance with the law of the District.

"(c) 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. Immunky.

"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 imagine from civil and creminal 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 fureign protection order if the conduct was done in good faith in an effort to comply with this sufichapter.

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"A protected individual who pursues remedies under this subchapter is not precluded	ξ Ι \$-Ι(:Α(
from pursuing other legal or equitable remedies against the respondent.	
16-1047. Uniformity of application and construction.	New
"In applying and constraing this Uniform Act, consideration must be given to the need	\$ 16-1647
to promote uniformity of the law with respect to its subject matter among States that enact it	
"This subchapter applies to protection orders issued before the effective date of this	tren E Iantoise
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	Nev
protection order occurring before the effective date of this subchapter is governed by this	Sebela pro N
subchapter.	Chapter 10
"Subchapter V. Domestic Violence Fatality Review Board.	THE IS
**§ 16-1051. Definitions.	A64
"For purposes of this subchapter, the term:	\$ 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:	
"(i) The alleged perpetrator and victim resided together at any	
tune;	
"(ii) The alleged perpetrator and victim have a child in common;	
"(iii) The alleged perpetitetor and victim were matried, 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 penod 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

"(fii) 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.

(x) 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 fistalities, including identification of cases to be reviewed, coordination mang the agencies and professionals involved, and improvement of the identification, data coffection, 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.

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

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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 Unites States Attorney for the District of Columbia;

"(3) District of Columbia hospitale;

"(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 & 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

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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 husiness in the District of Columbia who provided services to the victim, the victim's immediate family, or the allegeperpetrator of domestic violence which led to the death of the victim; and

"(4) Information made confidential by §§ 4-1302.03, 4-1303.06, 7-215.7-1203.02, 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.

"(c) 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 anthority to issue subpoents to compel witnesses to appear and testify and to produce books, papers, correspondence, memoranda, documents, or other relevant records.

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"(b) Except as provided in subsection (c) of this section, subpoents half 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, sugaged by the Board. "(c) 15, after a reasonable attempt, personal service on a winness or winness' agent cannot be obtained, a special process server identified in subsection (b) of this section may serve a subpoens by registered or certified mail not less than 8 business days before the date the witness must appear or the documents must be produced.

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"(d) If a witness who has been personally summoned negleous 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 subpoens to the same extent as witnesses may be compelled to obey the subpoenas of the coun-"\$ 16-1056. Confidentiality of information and proceedings; penalty for unlawful disclosure of information.

"(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 arc 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 pfine 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 the 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.

(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 to: 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.

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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 Ac. 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 §)-200.02(c)(1)), and publication in the District of Columbia Register.

Chairman Council of the District of Cohumbia

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Mayor District of Columbia

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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 statues 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
- * 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
- Office of the Attorney General
- Wendt Center for Healing and Loss
- District of Columbia Community Ward Representatives
- 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 Domestic Violence Fatality Review Board 2007 Second Annual Report would not be complete without recognizing the organizations who contributed to the work of the Domestic Violence Fatality Review Board. 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 DVFRB.



ABOUT DOMESTIC VIOLENCE

Government of the District of Columbia Office of the Chief Medical Examiner Fatality Review Unit ♦ Domestic Violence Fatality Review Board (DVFRB) 2000 U Street, NW 4th Floor ♦ Washington, DC 20010 Telephone 202-481-3404 ♦ 202-481-3426

FOR ADDITIONAL COPIES OF THE ANNUAL REPORT, CONTACT DVFRB