Domestic Violence Fatality Review

A Guide for Florida's Domestic Violence Fatality Review Teams

Sponsored by Women in Distress, Inc. and the State of Florida, Department of Children and Families.

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INTRODUCTION

The mission of the Statewide Domestic Violence Fatality Review Team is to identify statewide trends, systemic gaps, and potential solutions that increase safety and justice for survivors and their children, hold perpetrators accountable for their violence through coordinated community response efforts, and prevent the likelihood of domestic violence fatalities in the future. The statewide and local fatality review teams operate based on sections 741.316 and 741.3165. F.S., (7) and create a timeline of events leading up to the fatal incident to examine agency/system involvement and the degree of coordination to craft recommendations for improved future response. All teams comply with Florida statutory mandates to maintain confidentiality and public records exemptions when reviewing fatality-related information. These statutory mandates ensure that team members may freely discuss the circumstances and issues relating to the fatalities.

An innovative way to view the provision of services is through a lens that integrates awareness of high-risk indicators for lethality and primary and secondary prevention strategies. Utilizing knowledge about coercive control and recognizing the presence of high-risk indicators for lethality can shift how we respond to the needs of the people we serve by increasing perpetrator accountability and safety measures for survivors and their children. Every interaction or moment of impact with families presents an opportunity to provide trauma-informed, culturally responsive, and accessible services that help prevent future homicides.

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

OVERVIEW OF DOMESTIC VIOLENCE FATALITY REVIEW

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

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

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

Local teams in Florida began to review intimate partner homicides between 1996 and 1999 before the Florida Legislature provided teams with confidentiality protections in 2000.[3] In 2008, The previous statewide Domestic Violence Coalition, the Florida Coalition Against Domestic Violence (FCADV) implemented the Statewide Fatality Review Steering Committee, comprised of key representatives from state and local agencies to address local domestic violence fatality review (DVFR) team challenges to conducting fatality reviews. In 2009, the previous statewide Coalition (FCADV) and the Florida Office of the Attorney General implemented the Florida Attorney General's Statewide Domestic Violence Fatality Review Team after a dramatic rise in statewide domestic violence homicides demanded additional attention toward these tragic deaths. Florida's Statewide Domestic Violence Fatality Review Team convenes at least four times each year to conduct a comprehensive review of a domestic violence homicide that

[1] Dr. Neil Websdale, Director, National Domestic Violence Fatality Review Initiative, phone interview, March 2017.
[2] See s. 741.316 and s 741.3165, F.S. in Appendix B
[3] Dr. Neil Websdale, Director, National Domestic Violence Fatality Review Initiative, phone interview, March 2017.

occurred in a community that does not have a local DVFR team, to enhance Florida systems and prevent fatalities.

In addition to the cases reviewed by the Statewide Domestic Violence Fatality Review Team, local teams conduct reviews in their respective communities. Teams use a uniform data collection tool to gather and report information identified about the characteristics of the victim and the perpetrator, including known domestic violence histories, criminal records, and a range of observable evidence-based risk factors. These are included in an annual report published by the Office of Domestic Violence.

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

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

ORGANIZING A DOMESTIC VIOLENCE FATALITY REVIEW TEAM

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

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

- Define the purpose, philosophy, and goals of the team.
- Identify stakeholders to participate in the team.
- Review Florida Statute 741.316 to ensure the team operates in accordance with the law.
- Decide how the team will obtain, share, and manage case review documents and generate final reports with recommendations for preventing future homicides.
- Establish a meeting schedule that allows for maximum participation, including how often and how long each meeting will be.
- Develop confidentiality agreements for both individual team members and agencies.
- Teams have the option of virtual, in-person, or hybrid meetings and are responsible for ensuring confidentiality is maintained.
- Develop protocols for what the team will review, including the scope and types of homicides. For example:
    - Decide what types of fatalities will be included and if they involve intimate partner violence only, adults only, closed cases, murder-suicides, near-fatal, suspicious deaths, or other specific categories.
    - Evaluate how many fatalities the team plans to review each year and what the purpose of the review is. Establish whether the team will review several cases to evaluate aggregate data for trends or conduct one comprehensive review to identify specific systemic gaps.

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

Domestic Violence Fatality Review Philosophy

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

No Blame, No Shame

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

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

> *In a domestic violence homicide, the perpetrator is ultimately responsible for causing the death. At the same time, agencies that work with perpetrators and victims of domestic violence may have had opportunities to intervene more effectively. It is essential that review teams gather information to make informed*

decisions about how to introduce changes to prevent domestic violence and in particular intimate partner homicide.

Team Membership

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

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

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

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

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

Team Policies and Protocols

Organizational meetings to develop protocols are an important step in the formation of a DVFR team. These meetings help build trust among the members and outline how the team will operate. Teams may vary slightly in how they organize when they meet, or what cases they review, but the general purpose and philosophy of the reviews are consistent with the Statewide Domestic Violence Fatality Review Team: to examine the homicide and develop intervention strategies and services that interrupt the pattern of violence and prevent domestic violence homicide. This goal is usually identified within the local Fatality Review Team's mission statement.

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

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

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

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

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

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

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

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

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

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

The unidentifiable data from each local review is entered by the teams into a uniform survey tool through a team-specific link and password provided by DCF. Data from local teams is compiled by the Office of Domestic Violence and currently published in the Department Office of Domestic Violence Annual Report. Some teams regularly publish their annual reports based on their findings and make specific recommendations to their local communities. The reports help shape policy and highlight the work of the team. If a local team decides to publish a report, the team should identify who is responsible for writing the report, the structure of the report, and who approves and prints the final report.

Reviewable Cases and Selection Criteria

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

Florida fatality review legislation enables DVFR teams to review fatal and near-fatal domestic violence incidents to evaluate the incidents and ways to prevent such incidents.[11] The type of death most frequently reviewed is femicide, a male killing his female partner. Teams may review closed cases, rather than open cases, to avoid the possibility of interfering with an active investigation. The State Attorney in each circuit may determine whether a closed case is eligible for review. In some jurisdictions, homicide cases that have been adjudicated are eligible, while in others, cases are not reviewed until the appeals process is exhausted. Although statute does not prohibit review of open domestic violence homicide cases, best practices are to review closed domestic violence homicides cases so not to impact discoverability until the case is closed.

Near-fatalities allow teams to learn a great deal from the survivors and their families and friends about the importance of interventions that save lives. The depth of knowledge available from individuals who lived with and through the violence is invaluable if they are open to participating in the process and feel safe to do so. Reviewing near-deaths requires the team to revise its information-sharing methods because the victim/survivor is alive. Information about

[10] See s. 741.316 F.S. in Appendix B
[11] 1Ibid.

the near fatality requires the approval and authorization to release information that may not be required for some agencies when the victim is deceased.

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

Florida has a very diverse population. Reflecting on the mission to "identify statewide trends, systemic gaps, and potential solutions that increase safety and justice for survivors and their children…" Teams should take into consideration diversity and unserved and underserved communities in the case selection process. For example, as the 55-year-old and older population in the U.S. continues to increase, researchers and service providers have become more aware of domestic violence between older partners. The work of a DVFR team may help uncover a more detailed and accurate version of the events leading up to the homicide of victims who were later in life.

Interviewing Family Members

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

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

- Remember that every survivor is different.
- Be ready to listen.

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

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

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

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

Domestic Violence Fatality Review Confidentiality

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

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

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

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

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

Confidentiality considerations include:

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

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

Potential Data Sources

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

- Law enforcement reports or interviews;
- Media Reports;

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

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

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

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

CONDUCTING A DOMESTIC VIOLENCE FATALITY REVIEW

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

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

Timelines may be completed in a variety of formats:

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

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

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

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

[18] Snider, et.al; IPV:"A Brief Risk Assessment for the Emergency Department".AcadEmerMed .2009 Nov 16(11)1208-16.
[19] Campbell, JC. Assessing Dangerousness: Violence by Batterers and Child Abusers. Springer: 2007.

Additionally, listing known agency involvement can help identify opportunities for other agencies and community partners to participate in the coordinated response.

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

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

Creating Recommendations

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

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

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

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

DOMESTIC VIOLENCE FATALITY REVIEW SUSTAINABILITY

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

Many Florida teams have created sustainability through localized efforts. Efforts have included surveying members to improve engagement and processes, reviewing meeting cadence and length of time, co-chairs, or vice-chairs, for succession planning as well as maintaining professional diversity and perspectives, publishing reports for community leaders (law enforcement, elected officials, education, hospitals, and so forth).

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

Training and Technical Assistance

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

APPENDIX A DOMESTIC VIOLENCE FATALITY REVIEW RESOURCES

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

Florida Department of Children and Families, Fatality Review Team
https://www.myflfamilies.com/services/abuse/domestic-violence/programs/fatality-review-teams

Florida Domestic Violence Collaborative (FLDVC)
www.FLDVTraining.org

Florida Partnership to End Domestic Violence (FPEDV)
www.FPEDV.org

Arizona Child and Adolescent Survivor Initiative
https://nau.edu/Family-Violence-Institute/ACASI/
ACASI's mission is to deliver a multi-county, trauma-informed system of care to provide specialized victim services and support to children who have lost a parent to intimate partner homicide (IPH).

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

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

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

National Domestic Violence Fatality Review Initiative
www.ndvfri.org

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

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

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

APPENDIX B FLORIDA STATUTES

Florida Domestic Violence Fatality Review Statutes

- https://www.flsenate.gov/Laws/Statutes/2022/0741.316
- **741.316** Domestic violence fatality review teams; definition; membership; duties
- **741.3165** Certain information exempt from disclosure

Florida Domestic Violence Confidentiality/Privilege Statutes

- https://www.flsenate.gov/Laws/Statutes/2022/39.908
- **39.908** Confidentiality of information received by department or domestic violence center
- https://www.flsenate.gov/Laws/Statutes/2022/90.5036
- **90.5036** Domestic violence advocate-victim privilege

Florida Domestic Violence Fatality Review Statutes

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

a) Law enforcement agencies.
b) The state attorney.
c) The medical examiner.
d) Certified domestic violence centers.
e) Child protection service providers.
f) The office of court administration.
g) The clerk of the court.
h) Victim services programs.
i) Child death review teams.
j) Members of the business community.
k) County probation or corrections agencies.
l) Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence, or suicide, including research, policy, law, and other matters connected with fatal incidents.
m) Other representatives as determined by the review team.

(2) A domestic violence fatality review team may be established at a local, regional, or state level to review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides. The review may include a review of events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and the parties, and any information or action deemed relevant by the team, including a review of public records and records for which public records exemptions are granted. The purpose of the teams is to learn how to prevent domestic

violence by intervening early and improving the response of an individual and the system to domestic violence. The structure and activities of a team shall be determined at the local level. The team may determine the number and type of incidents it wishes to review and shall make policy and other recommendations as to how incidents of domestic violence may be prevented.

(3)(a) There may not be any monetary liability on the part of, and a cause of action for damages may not arise against, any member of a domestic violence fatality review team or any person acting as a witness to, incident reporter to, or investigator for a domestic violence fatality review team for any act or proceeding undertaken or performed within the scope of the functions of the team, unless such a person acted in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.
(b) This subsection does not affect the provisions of s. 768.28.

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

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

741.3165 Certain information exempt from disclosure.

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

(2) Portions of meetings of any domestic violence fatality review team regarding domestic violence fatalities and their prevention, during which confidential or exempt information, the

identity of the victim, or the identity of the children of the victim is discussed, are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

Florida Domestic Violence Center Confidentiality/Privilege Statutes

39.908 Confidentiality of information received by department or domestic violence center.
(1) Information about clients received by the department or by authorized persons employed by or volunteering services to a domestic violence center, through files, reports, inspection, or otherwise, is confidential and exempt from the provisions of s. 119.07(1). Information about the location of domestic violence centers and facilities is confidential and exempt from the provisions of s. 119.07(1).
(2) Information about domestic violence center clients may not be disclosed without the written consent of the client to whom the information or records pertain. For the purpose of state law regarding searches and seizures, domestic violence centers shall be treated as private dwelling places. Information about a client or the location of a domestic violence center may be given by center staff or volunteers to law enforcement, firefighting, medical, or other personnel in the following circumstances:

a) To medical personnel in a medical emergency.
b) Upon a court order based upon an application by a law enforcement officer for a criminal arrest warrant which alleges that the individual sought to be arrested is located at the domestic violence shelter.
c) Upon a search warrant that specifies the individual or object of the search and alleges that the individual or object is located at the shelter.
d) To firefighting personnel in a fire emergency.
e) To any other person necessary to maintain the safety and health standards in the domestic violence shelter.
f) Information solely about the location of the domestic violence shelter may be given to those with whom the agency has an established business relationship.

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

a) Communications from domestic violence shelter staff or volunteers to law enforcement officers when the information is directly related to a client's commission of a crime or threat to commit a crime on the premises of a domestic violence shelter; or
b) Reporting suspected abuse of a child or a vulnerable adult as required by law. However, when cooperating with protective investigation services staff, the domestic violence shelter staff and volunteers must protect the confidentiality of other clients at the domestic violence center.

90.5036 Domestic violence advocate-victim privilege.

(1) For purposes of this section:

a) A "domestic violence center" is any public or private agency that offers assistance to victims of domestic violence, as defined in s. 741.28, and their families.
b) A "domestic violence advocate" means any employee or volunteer who has 30 hours of training in assisting victims of domestic violence and is an employee of or volunteer for a program for victims of domestic violence whose primary purpose is the rendering of advice, counseling, or assistance to victims of domestic violence.
c) A "victim" is a person who consults a domestic violence advocate for the purpose of securing advice, counseling, or assistance concerning a mental, physical, or emotional condition caused by an act of domestic violence, an alleged act of domestic violence, or an attempted act of domestic violence.
d) A communication between a domestic violence advocate and a victim is "confidential" if it relates to the incident of domestic violence for which the victim is seeking assistance and if it is not intended to be disclosed to third persons other than:

1. Those persons present to further the interest of the victim in the consultation, assessment, or interview.
2. Those persons to whom disclosure is reasonably necessary to accomplish the purpose for which the domestic violence advocate is consulted.

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

(3) The privilege may be claimed by:

a) The victim or the victim's attorney on behalf of the victim.
b) A guardian or conservator of the victim.
c) The personal representative of a deceased victim.
d) The domestic violence advocate, but only on behalf of the victim. The authority of a domestic violence advocate to claim the privilege is presumed in the absence of evidence to the contrary

APPENDIX C STATEWIDE DOMESTIC VIOLENCE SAMPLES

Additional samples may be found:

National Domestic Violence Fatality Review Initiative (NDVFRI)
https://ndvfri.org/resources/documents/

Statewide Domestic Violence Fatality Review Team Confidentiality Agreement

As a member of the Statewide Domestic Violence Fatality Review Team, my signature below indicates that I acknowledge and agree to the following, including the items related specifically to remote/virtual fatality review meetings:

1. according to Section 741.316(4), Fla. Stat., all information and records acquired by a domestic violence fatality review team are not subject to discovery or introduction into evidence in any civil or criminal action or administrative or disciplinary proceeding by any department or employing agency if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team. However, information, documents, and records otherwise available from other sources are not immune from discovery or introduction into evidence solely because the information, documents, or records were presented to or reviewed by such a team. A person who has attended a meeting of a domestic violence fatality review team may not testify in any civil, criminal, administrative, or disciplinary proceedings as to any records or information produced or presented to the team during meetings or other activities authorized by this section. This subsection does not preclude any person who testifies before a team or who is a member of a team from testifying as to matters otherwise within his or her knowledge.
2. Under Section 741.3165, Fla, Stat., (1)(a) Any information that is confidential or exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution and that is obtained by a domestic violence fatality review team conducting activities as described in s. 741.316 shall retain its confidential or exempt status when held by a domestic violence fatality review team.
   (b) Any information contained in a record created by a domestic violence fatality review team pursuant to s. 741.316 that reveals the identity of a victim of domestic violence or the identity of the children of the victim is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
   (2) Portions of meetings of any domestic violence fatality review team regarding domestic violence fatalities and their prevention, during which confidential or exempt information, the identity of the victim, or the identity of the children of the victim is discussed, are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.
3. I will not disclose to any outside person or entity the content of team discussions

relating to the case under review, or any documents, records, or other materials relating to the case under review obtained and held by the Statewide Fatality Review Team.

4. Remote/Virtual Fatality Reviews:
    - I will use a laptop or computer with a secure internet connection. I will not use a mobile device or public Wi-Fi. If using a computer that is shared with other users, such as household members, I will take steps to ensure that information and records are stored in a manner that does not permit access by others.

    - I will maintain hard or electronic copies of confidential case records in a secure and confidential physical or electronic file.
    - If using a shared printer, I will collect the copies from the printer promptly.
    - I will maintain current updates and/or patches on my computer/laptop.
    - I will maintain confidentiality by working from a private physical location during the meeting and ensuring my voice, as well as the sound and screen on my device, are only within hearing and sight range of myself or other members of the Statewide Domestic Violence Fatality Review Team. I will use a headset if possible.

_____ _____

Signature

APPENDIX D LOCAL DOMESTIC VIOLENCE FATALITY REVIEW TEAM PROTOCOLS

National Domestic Violence Fatality Review Initiative (NDVFRI)
https://ndvfri.org/resources/

Florida Domestic Violence Collaborative (FLDVC)

- Request Local Florida Team Protocol Samples
  www.FLDVTraining.org
- General TandTA (Training and Technical Assistance) Request
  https://fldv.coalitionmanager.org/formmanager/formsubmission/create?formId=196