

**DOMESTIC VIOLENCE
FATALITY
REVIEWS:
RECOMMENDATIONS
From a National Summit**

Louis W. McHardy

*Executive Director, National Council of Juvenile and Family Court Judges
Dean, National College of Juvenile and Family Law*

Meredith Hofford

*Director, Family Violence Department
National Council of Juvenile and Family Court Judges*

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**DOMESTIC VIOLENCE
FATALITY
REVIEWS:
A NATIONAL SUMMIT**

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INTRODUCTION

In October 1998, professionals from around the country gathered together at Domestic Violence Fatality Reviews: A National Summit (Summit) to advance the state of the art of domestic violence fatality reviews, a potentially invaluable tool by which courts and related agencies across the nation can improve their response to cases involving domestic violence.

The Summit was organized and sponsored by the Family Violence Department of the National Council of Juvenile and Family Court Judges and the Governor's Task Force on Domestic and Sexual Violence, Florida Department of Community Affairs. It was funded by the State Justice Institute; and by the Office for Victims of Crime in the Office of Justice Programs, U.S. Department of Justice.

Participants at the Summit heard briefings from a variety of experienced and thoughtful practitioners of domestic violence fatality reviews. They participated as members on simulated fatality review teams and worked concurrently on four reality-based cases, set in hypothetical but realistic community contexts. On the basis of the informational presentations, the hypothetical cases, and their expertise, the teams developed recommendations on structure, procedures, and policies for conducting domestic violence fatality reviews. An educational module accompanies the recommendations.

Those recommendations follow.

PURPOSE AND GOALS

Fatality review teams across the country have been established for a variety of reasons. Some communities established their domestic violence fatality review teams in direct response to domestic violence fatalities. In each such instance, the murder provided the impetus for drawing together professionals and community members to analyze the death in hopes of identifying ways to prevent such deaths in the future or to help the community heal from the fatality. In other communities, fatality review teams are the outgrowth of coordinating councils or other coordination bodies, and may have been established as a mechanism for ongoing review of policies and case practice. In some areas, fatality review teams seek to identify the degree to which domestic violence contributes to the community's overall mortality. Because reviews are operated with an end in mind, often related to systems improvements, many fatality review teams have issued reports with key recommendations that have led to changes in their communities' responses to domestic violence. For examples of reviews conducted and the reports and systems changes derived from those reviews, see *Domestic Violence Fatality Reviews: Summarizing National Developments*.¹ The Summit participants felt that, regardless of a community's reasons for establishing its review committee, it is crucial for the committee to define clearly its purpose and goals. They identified two major purposes of fatality review teams:

1. **Homicide/suicide prevention**
2. **Community awareness**

Other goals for fatality review teams identified by participants include:

- Prevention of domestic violence
- Identification of domestic violence-related deaths
- Systems improvement
- Identification of gaps in community systems, particularly related to those groups traditionally underserved
- Coordination of information
- Early intervention

Note: For the Summit, participants worked with a predetermined purpose: to conduct a single-case review with the intention of making recommendations for systems improvements to prevent future fatalities.

¹ Websdale, Neil, Sheeran, M., Johnson, B. (1998). *Domestic Violence Fatality Reviews: Summarizing National Developments*. This publication was distributed at the Domestic Violence Fatality Reviews: A National Summit.

TEAM STRUCTURE/ORGANIZATION

Summit participants developed recommendations for such issues related to team structure and organization as: formation, administration, membership, and leadership.

Formation of the Team

The purpose and resource needs of a fatality review team are special considerations in determining how to form a team and institutionalize its authority. How teams are formed will determine many issues: the degree of formality or informality of a team; its ability to access information, subpoena records, receive funding, and protect members from liability; who can or will serve on the team, etc.

In selecting preferences for how a team should be formed, Summit participants identified four preferred options for formation of fatality review teams:

1. **Formed by legislative mandate**
2. **Formed by a domestic violence victim service provider**
3. **Formed under the auspices of a domestic violence council or task force**
4. **Formed separately from a domestic violence council or task force**

Of the four major preferred options, many participants voiced a particular preference for mandating fatality review teams legislatively. These participants felt a legislative mandate would help address problems of access to information, provide authority for the reviewing body, create a funding mechanism for the team's work, send a clear message about the importance of the team's work, mandate participation by key players, and address confidentiality and liability.

Other methods of formation recommended include:

- Through a research project
- Through grant funding
- By requirement of a federal Violence Against Women grant
- By administrative order of the court
- By commission of a governor

Informal reviews: It is important to note that the Summit and this document focus on formal fatality review teams and procedures. Yet, a handful of presenters and Summit participants expressed a desire that professionals working to end domestic violence also remember the benefits derived from reviewing domestic violence fatalities informally, without convening a team or developing review procedures.

Administration of the Team

Summit participants made recommendations on such administrative issues related to fatality reviews as team staffing, funding, housing, and meeting location.

Staffing: Summit participants recommended staff be dedicated to the fatality review team. They suggested that teams could be staffed by either full-time or part-time paid or voluntary staff.

Funding: Summit participants suggested that fatality review teams should be funded and that the funds could be derived from state legislatures or grants.

Housing: Summit participants indicated the following preferences for where the fatality review team is housed (at the community level):

1. **Local shelter/domestic violence victim services program**
2. **Domestic violence coordinating council or task force**
3. **University with access to grants/interns/research (could be state level)**

Other ideas for housing a fatality review team at the community level include:

- Medical examiner's office
- District attorney's or prosecutor's office
- Law enforcement office
- Court administrator's office
- Private business
- Medical center
- Public health agency

For fatality review teams operating at the state level, participants indicated the following preferences for housing the team's operations:

1. **Office of chief medical examiner (state)**
2. **Office of the state attorney general**
3. **Supreme court**
4. **Domestic violence coordinating council**
5. **University with access to grants/interns/research (could be community level)**

As outlined by participants, criteria for deciding where to house the fatality review team include:

- Whether there is an official or legislative mandate
- Potential for ongoing funding
- Political climate
- Diversity
- Representation of key stakeholders
- Relationships with law enforcement, health, and human service agencies
- Potential for legislative authority
- Whether there has been an initial informal review
- Whether there are initial startup funds

Location: The main preference for meeting location was a community center. Considerations in selecting the meeting location included whether it was accessible by public transportation and the convenience of parking. Summit participants also stressed that a neutral location be sought or that the meeting sites rotate.

Membership of the Team

One of the greatest assets of a fatality review team is its membership. These are the professionals and community members committed to the mission of the team and on whom the team can rely for information and expertise. The committee should identify members of the community who come into contact with victims or perpetrators of domestic violence or their children as a way of identifying potential members for the committee. Teams should be careful to ensure that the broadest representation is achieved, while limiting participation to a workable group size relative to the community.

Summit participants recommended that fatality review teams strive to be:

- Diverse in terms of race and ethnicity
- Diverse in terms of professions and expertise
- Rich in knowledge and experience
- Committed to the mission
- Accepting of diverse perspectives
- Trained in the fatality review process
- Productive
- Confidential
- Accountable
- Ethical

It is crucial to keep the teams to a workable size. Key members of a team vary depending upon the dynamics of a community and could include:

- Survivor of domestic violence
- Domestic violence service provider
- Law enforcement representative
- Prosecutor
- Domestic violence advocate within a prosecutor's office
- Batterer intervention provider
- Medical examiner/coroner
- Judges of civil and criminal jurisdictions
- Clerk of the court
- Child protective service worker
- Civil attorney working for victims of domestic violence, possibly through the legal aid office
- Clergy member
- Animal control officer
- Health care professional
- Probation/parole officer
- Mental health provider
- Educator
- Military liaison (for communities near military installations)
- Business sponsor
- Local government representative
- Clerical support staff

Summit participants also identified other professions or community members who might serve on the fatality review team. Those include:

- Rape crisis advocate
- Public defender
- Researcher
- Statistician

- Homicide support group member
- Cultural task force representative
- Substance abuse specialist
- Child fatality review team member
- Day care provider
- Tribal representative
- Emergency services personnel
- Employment assistance or human resources professional
- Representatives from communities of color
- Migrant worker expert
- Immigration expert
- Gay and lesbian coalition representative
- Representative from the media
- Community leader
- Prostitution expert
- Representatives from community service agencies, such as welfare-to-work programs

Team Leadership

Summit participants agreed that a strong leader was an important element to ensuring a well-functioning team or committee. In selecting a chair for the committee, team members should look for a person who:

- **Has both connections with business and community support**
- **Is able to get others to the table**
- **Knows opposition and supporters**

Both domestic violence program providers and law enforcement officials were selected as potential chairs for the committee. In some communities, a judge serves as chair. One suggestion was to have an open chair.

SCOPE

Once the team has clearly defined its goal and purpose, it can begin to determine the scope of cases to be reviewed. Among the factors which influence scope are geography, type of deaths, and disposition of cases. Another consideration affecting scope of cases is whether to review new fatalities or other non-fatalities.

Geography

The committee may select all cases occurring within a certain geographic area, such as a city, county, state, judicial district, coroner's district, etc.

Type of Deaths/Assaults

Tying back to their goals, Summit participants suggested teams review all domestic violence-related deaths and directly related child deaths. This would include homicides, suicides, accidents, and suspicious deaths.

Disposition of Cases

For many reasons, fatality review teams must consider very carefully the disposition of cases to be reviewed. Summit participants grappled with whether to review open cases, i.e., those that had not been fully adjudicated. Generally, participants agreed that for many reasons – confidentiality, discovery, liability, etc. – closed murder cases or open murder/suicide cases were the most appropriate to review.

Non-fatalities

Summit participants suggested that useful information could be gleaned by reviewing cases that involved not only deaths, but also life-threatening injuries, attempted murder/suicides, severe repeated assaults, animal cruelty, and disappearances.

INFORMATION GATHERING

A variety of factors influence the ways in which fatality review teams gather information. Some information is confidential (see confidentiality section). Some information can come directly from the membership, e.g., the law enforcement representative on the team gathers information about that agency's involvement in the case.

Screening for cases

Key to initiating a fatality review process is the identification of cases that match the scope of the team's work. Participants identified the following as ways to screen for cases to be reviewed:

- Identify all deaths (every death certificate) and have members flag cases for in-depth review (after committee members are trained to identify key "markers")
- Identify deaths through media reports
- Have the domestic violence agency identify cases for review
- Identify cases through vital statistics or the health department

Information Sources

Participants identified the following case-related materials as potential sources of information helpful to a review team's work:

- Law enforcement reports – all incident reports and call history, 911 tapes
- Court files – all cases, including criminal, civil, family, juvenile
- Mental health records
- National Crime Information Center (NCIC) or criminal history records
- Juvenile records
- Weapons records
- Shelter/domestic violence service provider records
- Court advocate records
- Probation files
- Child protective services records
- Social services (such as welfare, housing) records
- Medical and dental records, including photographs from emergency room visits
- Interviews with perpetrator's former intimate partners
- Information from victim's and perpetrator's family members and friends
- Interviews with medical personnel (prenatal nurse, ob/gyn, pediatrician)
- Photographs from emergency room visits
- Prosecution records
- Newspaper articles/media accounts
- Witness interviews
- Autopsy reports
- Pre-trial service records
- Batterer intervention services reports
- Landlord or apartment building maintenance and complaint files

- Interviews with security guards
- School records
- Genograms with family history of violence
- Interviews with witnesses and neighbors
- Insurance policies
- Records of or interviews with other services (suicide hotline, child support enforcement, job training programs, legal services)
- Records of or interviews with service providers in other communities of residence for the perpetrator or victim
- Animal control reports
- Marriage counseling files
- Interviews with clergy and congregation
- Records from victim advocate in the police department
- Employment records
- Military records
- Adoption records
- Attorney files

Barriers to Obtaining Information

Many barriers exist to obtaining all the information necessary for a thorough fatality review. Summit participants identified the most common barriers, including:

- Confidentiality/privilege
- Statutory restrictions (including those on NCIC dissemination)
- Professional ethical requirements
- Agency or departmental policies
- Fear of liability or self-incrimination
- Personal resistance from individuals due to:
 - grief
 - lack of trust
 - invasion of privacy
 - guilt/denial
 - media exposure
- Missing/incomplete/altered records
- Inadequate or untrained staff
- Difficulty in finding information by name or time lapses
- Lack of subpoena power
- Lack of releases of information by victims
- Lack of standardized data collection
- Lack of standardized number systems
- Victim-blaming
- Turf protection
- Domestic violence issues not seen or understood
- Implication of defendant through disclosure
- Personal relationships of system players, especially in rural/small communities
- Open cases and their accompanying complications
- Sealing/expunging of records related to domestic violence misdemeanors
- Sources of information unknown or no longer available

Solutions

Summit participants identified a variety of potential solutions to barriers to information. The three tools recommended most were:

- 1. Legislative mandates for subpoenaing medical personnel or for exemptions to confidentiality**
- 2. Interagency agreements**
- 3. Standing court order for child protective services to release information as appropriate**

Other solutions include:

- Develop confidentiality releases
- Secure information after the investigation is complete and police and court records become public information
- Request permission from the victim's family/estate for release of the victim's records from a domestic violence program, unless counselor-victim privilege ends at death
- Subpoena records
- Secure transcripts of other proceedings
- Get reports verbally
- Apply semi-public pressure
- Secure information pursuant to the Freedom of Information Act
- Develop data form
- Develop advisory committee of decision-makers
- Develop policies and protocols within each agency coordinated with those of the other agencies
- Engage in an interview process
- Ensure that key players, including potential detractors, are invited to participate prior to developing the team

Confidentiality

Key to the successful operation of a fatality review team is ensuring the confidentiality of both the information brought to the meetings and the team's deliberations. Summit participants developed recommendations for enhancing confidentiality related to fatality reviews and identified key elements of a confidentiality policy for review teams.

Recommendations for enhancing confidentiality

- Enacting legislation that addresses protections for the team, its records, and its participants; creates exemptions for civil liability; and excludes records from discovery, subpoena, or use in disciplinary process.
- Establishing guidelines and activities to address competing confidentiality conflicts.
- Developing a media policy and designating one person to communicate with the media.
- Establishing procedures to define breach of confidentiality and procedures for enforcement/redress.
- Using raw data to produce an annual report and recommendations to the public, then returning the data to the information sources that produced it.
- Establishing and clarifying procedures for obtaining copies of records, tapes, etc.; and restricting/prohibiting material from being taken away from the meetings.
- Establishing a confidentiality agreement is to be signed by each member at each meeting.

Contents of a Confidentiality Policy

- All information is to be kept confidential, except recommendations and aggregate statistics.
- Documents and files are to be brought in and taken out by the agencies providing them.
- Communications, oral and written, and documents related to all aspects of a fatality review are to be confidential, not subject to disclosure or discoverable* in any criminal or civil case by any third party, including but not limited to the representatives of the deceased, the accused, any governmental agency, the media, and the general public.
- All case-related information discussed at the fatality review committee and all related subcommittee meetings are to be kept confidential.
- Members are to keep confidential all information obtained through the process and are not to use any material or information obtained for any reason other than for which the review committee intends it to be used.
- Any fatality review committee member is to notify the fatality review team if she/he is subpoenaed for information in this capacity.
- Information is to be released only in the aggregate outside of committee meetings.
- Any member who violates confidentiality is to be removed from the committee.
- Any member who leaves the committee must return all information received to the committee chair.
- If, in the course of the review, there is information which may be indicative of a new crime, the team chair is to report it promptly to the most appropriate authority. The team is to decide whether the review should be suspended as a result of these actions.
- The annual report and recommendations are public and are to be released to family members.
- Summary information of small jurisdictions may need to be combined in aggregate form in order to protect the confidentiality of individuals.
- Members are to abide by the confidentiality procedures established by and for the committee.

*May not be possible in all jurisdictions.

FAMILY-MEMBER PARTICIPATION

Summit participants discussed at length the participation of family members in the fatality review process and, in general, produced conflicting suggestions about family member involvement. Following is a list of all suggested approaches from all of the teams regarding family member involvement:

- Limited participation from the family as witnesses and information sources will be allowed, but the review process cannot be used as grief counseling.
- In order to lessen the impact on families, the team will make screening sheets and a victim impact statement for family, neighbors, and witnesses. A subcommittee of individuals will do interviews for the purpose of fact-finding.
- The team will identify victim-assistance programs that provide counseling and survivor funds for psychiatric care.
- On a case-by-case basis, family and friends will have an opportunity to give input at the beginning of the process, either in person or through a victim-advocate program. The team will provide a good explanation of why further participation is not appropriate.
- The review team will invite the family to attend one meeting for a specific time. Family members will be allowed to provide and raise their concerns, but will not receive information.
- The fatality review team will give the case report to the family prior to public release.
- The fatality review team will send a special team to interview the family and explain the team's purpose.
- The victim-witness program will develop a brochure explaining the fatality review process to the family. Input from the family will be received in writing rather than in person.
- Family members will be permitted to provide information at the outset of the review. This information can be provided through staff and may include a victim-impact statement. However, family members will not appear before the review team.
- Families will be allowed to participate within the following parameters:
 - A victim advocate chairs a sub-committee to develop and document the process and identify and interview family members
 - A questionnaire is sent to family members
 - Family members are given opportunities for input in their choices of format
 - Perpetrator's family is interviewed if they have important information for the review

PROCESS RECOMMENDATIONS

Based on their experiences at home and in their hypothetical communities and their mock reviews, Summit participants offer the following recommendations and advice for running efficient, inclusive fatality review teams:

- Structure meetings to allow fuller participation
- Evaluate process on an ongoing basis
- Emphasize regular attendance by key players
- Have a strong facilitator (not necessarily the most visible person; this could mean an outside facilitator)
- Set up ground rules for interaction at the outset
- Manage time wisely
- Develop a policy for replacing members who miss meetings
- Maintain a sense of humor as a means of dealing with emotions

DOMESTIC VIOLENCE INTERVENTIONS: SUGGESTED IMPROVEMENTS

As stated earlier, participants were divided into simulated fatality review teams and worked concurrently on four reality-based cases, set in hypothetical but realistic community contexts. Based on their review of the cases, they identified improvements to domestic violence interventions in their “communities,” improvements which, in combination with effective fatality review, they believe will be helpful to all communities seeking to end domestic violence.

Those suggested improvements include:

- **Developing a multi-disciplinary, community-wide advocacy system**
 - Computers linking all agencies
 - Closer collaboration between and among agencies
 - Case management system
 - Central advocacy unit
 - On-call victim advocates, 24 hours per day, with a toll-free number
- **Holding perpetrator accountable by means of**
 - Certified batterer intervention program with 30-day judicial review and further options
 - Police training on enforcement of protection orders, stalking, firearm confiscation, lethality assessments
 - Domestic violence coordinator/investigator in police department
 - Community-based policing
 - Coherent prosecution and consistent sentencing and supervision
 - Interagency communication about the batterer
- **Developing vertical prosecution** consisting of
 - Domestic violence court (one family, one court) with qualified personnel
 - Dedicated domestic violence detective
- **Training, developing protocols, and increasing awareness** by means of
 - Better training for everyone on risk assessment and domestic violence dynamics, including responding to protection order violations
 - Training for judges on issues
 - Requiring the training of other professionals, including health care practitioners, mental health care providers, and attorneys
 - Child protective services (CPS)/domestic violence cross-training
 - Training/protocols for employers
 - CPS protocol for children who witness domestic violence
 - CPS policy/protocol related to domestic violence, including provision of treatment and services
 - Public awareness campaigns (TV, newspapers, schools) – bilingual, targeting neighbors, employers: “Domestic Violence – it is your business”
 - General domestic violence education through posters at day care centers, gun shops, thrift stores, etc.

- Telephone company-provided domestic violence information about harassing phone calls, and use of cell phones
- Outreach through the faith community – recruiting volunteers, educating religious leaders through a summit for agency representatives, “Domestic Violence in Faith Community”
- Joint domestic violence awareness campaign co-sponsored with sister communities
- Domestic violence summit featuring
 - Local government official to convene
 - Commitment/buy-in from designated agencies
 - Domestic violence information day
 - “Selling” concept to community
 - Involvement of the faith community
 - Focus on cost domestic violence imposes on the community
 - Focus on life
- **Improving interagency communications/coordination by**
 - Information-sharing/protocols among agencies so people know what is available
 - Case-staffing component of coordinated community coalition to focus on cases that seem to be falling through the cracks
 - Data systems integration for all courts and law enforcement, including 911
 - Multiple and coordinated lethality assessment (initial/baseline – subsequent)
- **Improving services/advocacy with**
 - Alternative safe housing
 - Police-based victim advocacy
 - Special services and response for teens
 - Supervised probation – better monitoring/assessment from first offense
 - Males against violence – leadership on issue of domestic violence
 - Hotline or website to identify batterers for pre-dating inquiries
 - Increased funding for advocacy
 - Neighborhood Watch – organizing neighborhoods to assist in victim identification, surveillance (sponsored by victim groups, faith, public health communities)
- **Others including**
 - Weapons screening policy
 - Court Watch – with civic group assistance
 - Survivor impact statements at three- and five-year intervals (post-death)
 - Suicide reviews – suicide is a flag for domestic violence

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