Multnomah County Domestic Violence Fatality Review Protocols

Adopted May 18, 2006

Revised June 4, 2007

I. Introduction

A. **Domestic Violence Fatalities in Multnomah County**

Domestic violence homicides make up a significant proportion of all homicides in the Multnomah County. A 20-year review of homicides in the Oregon Tri-County area (Multnomah, Clackamas and Washington County), found that at least 1/3 were related to domestic violence. The Multnomah County Domestic Violence Coordinator's Office has kept an unofficial record of domestic violence homicides/fatalities since 1991. Since that time, the number of homicides/fatalities related to domestic violence has ranged from zero in 2000 to 22 in 1997.

B. **History of Domestic Violence Fatality Reviews in Multnomah County and in Oregon**

In 1994, the Family Violence Intervention Steering Committee (now Family Violence Coordinating Council) reviewed paper files (primarily police files) of almost all domestic violence-related homicides that had occurred in 1992 and 1993. Although there were no specific recommendations issued by the committee, several key points were made, including the following: 1) a significant proportion of cases involved perpetrators killing relatives or friends of their current or former intimate partner; 2) if there were children living in the household at the time of the homicide, they were usually present at the time of the homicide or found the bodies; and 3) murder/suicides were frequent and invariably involved white males as the perpetrators.

In 2004, the Multnomah County Local *Public Safety Coordinating Council (LPSCC)* reviewed the Heather Dunlop homicide and released a report (attached) relating to the events known to public agencies that led up to the homicide and recommendations for changes in agencies' response to domestic violence to prevent future homicides. Attendees at the review "were cautioned that, as there was no special confidentiality protection, they should discuss only information in the public domain. General topics that may not have been specific to this case were discussed, and the group's recommendations include some of these broader issues."

C. **National Best Practice/Recommendations**

Several jurisdictions around the country have been doing domestic violence fatality reviews, some for several years, and can provide valuable insight into how to conduct fatality reviews.

This protocol uses information from articles and from existing fatality review teams. Articles reviewed included: "Reviewing Domestic Violence Deaths," "Reviewing Domestic Violence Fatalities: Summarizing National Developments," and "Domestic Violence Fatality Reviews: Implications for Law Enforcement" by Dr. Neil Websdale of Northern Arizona University and the National Domestic Violence Fatality Review Initiative. Also reviewed were several documents produced by the Washington State Domestic Violence Fatality Review (WSDVFR) including "Advocates and Fatality Reviews," "Defining 'Domestic Violence Fatality' and Understanding the Scope of the Problem," and "Every Life Lost Is A Call for Change: Findings and Recommendations from the WSDVFR 2004."

The following fatality review projects were also explored and utilized to develop these protocols:

- Philadelphia Women's Death Review, which looks at all deaths of all women between ages 15-60. A multidisciplinary team goes to medical examiner's officers to review "all homicides, suicides, unintentional injury, undetermined, inadequate certificates, peculiar circumstances (AIDS)." Their objective is "to be able to identify any domestic violence directed at decedents in the 12 months prior to the fatality."[i] Each review is thirty minutes in length.
- Florida Mortality Review Project, which examined all deaths in 1994 through collecting available records plus interviews with service providers. The group found substantially more domestic violence deaths than had been coded as domestic violence.[ii] The interdisciplinary group continues to meet, reviewing multiple cases at each meeting (per staff report at the DVFRI Conferenc2005).
- Other projects, such as the Hennipin County Domestic Violence Review Team in Minnesota and the Washington State Domestic Violence Fatality Review Project, focus on reviewing fewer deaths in greater detail. While these projects gather general data on all known domestic violence homicides (for example, the Washington State project collects and tracks all newspaper clippings to create a state-wide database), the panels choose one case for review and focus on a detailed examination of the timeline and factors.

D. 2005 Legislation

The 2005 Oregon Legislature passed an amendment to the Oregon Revised Statutes (ORS 718.012 through 718.018) "relating to establishment of multidisciplinary teams to study domestic violence fatalities." The specifics of the statute are incorporated into this proposed protocol, and include, but are not limited to, purpose, definition of domestic violence, role of local family or domestic violence councils, team membership, confidentiality of information shared, establishment of a statewide interdisciplinary team.

II. Purpose of the "Multnomah County Domestic Violence Fatality Review Protocol" Document

This document outlines the draft protocol for reviewing domestic violence fatalities to be agreed upon by the Multnomah County Domestic Violence Fatality Review Team (Team). It is based upon ORS 718.012 through 718.018 authorizing and defining such reviews, and on best practices established nationally. It is intended to fulfill the requirements of the legislation: "Each fatality review team shall develop written agreements signed by member organizations and agencies that specify the organizations' and agencies' understanding of and agreement with the principles outlined in this section." The attached signature page demonstrates the required understanding and agreement not only with the legislation, but also with the local protocols in this document.

The Team will review this document. A 2/3 majority of the members designated by the legislature will be required for its adoption by the Team. The Multnomah County Family Violence (FVCC) and the Local Public Safety (LPSCC) Coordinating Councils have reviewed it.

Changes to these protocols can be made by a 2/3 vote of members of the Team. The FVCC may make recommendations for changes to the protocols, contingent on acceptance by the Team.

III. Purpose of the Multnomah County Fatality Reviews

The mission of the Multnomah County Domestic Violence Fatality Review Team and Process is to improve our community's response to domestic violence and to reduce the number of fatalities related to domestic violence.

According to ORS 418.714 (2), "the purpose of a fatality review team is to review domestic violence fatalities and make recommendations to prevent domestic violence fatalities by:

(a) Improving communication between public and private organizations and agencies;

(b) Determining the number of domestic violence fatalities occurring in the team's county and the factors associated with those fatalities;

(c) Identifying ways in which community response might have intervened to prevent a fatality;

(d) Providing accurate information about domestic violence to the community; and

(e) Generating recommendations for improving community response to and prevention of domestic violence."

In addition, local fatality reviews "may collect and summarize data to show the statistical occurrence of domestic violence fatalities in the team's county."

The LPSCC Domestic Violence Fatality Review Committee Report, finalized in April 2004 asked "participants to look not only at the specifics of the case, but also to consider whether and how such reviews should be conducted in the future." A list of recommendations were developed by the attendees that addressed issues raised that were specific to this case or to the broader issues of appropriate and effective response to domestic violence in our community. Attendees were cautioned that, as there was no special confidentiality protection, they should discuss only information in the public domain. At the District Attorney's request, only events leading up to the homicides were reviewed. General topics that may not have been specific to this case were discussed, and the group's recommendations include some of these broader issues.

IV. Family Violence Coordinating Council's Role in Domestic Violence Fatality Reviews

ORS 418.714 (1) specifically tasks the local domestic violence coordinating council to establish the review team: "A local domestic violence coordinating council recognized by the local public safety coordinating council or by the governing body of the county may establish a multidisciplinary domestic violence fatality review team to assist local organizations and agencies in identifying and reviewing domestic violence fatalities. When no local domestic violence coordinating council exists, a similar interdisciplinary group may establish the fatality review team."

- The Multnomah County FVCC has agreed to fully participate in the domestic violence fatality review process. FVCC staff will sign the confidentiality agreement and will maintain the confidentiality standards required by ORS 718.012 through 718.018. FVCC staff will provide the following:

- Make recommendations for specific members of the Team from among the membership of the FVCC;
- Assign a specific FVCC representative to participate on the Team;
- Track domestic violence homicides in Multnomah County, maintain aggregate data on them and make recommendations about possible cases to review;
- Invite all members of the Team and convene Team meetings;
- Dedicate staff time to assist in convening and facilitating meetings, compiling lists of issues and recommendations and following up on the recommendations;
- Distribute recommendations, as directed by the Team;
- Provide information, consistent with the recommendations and ORS 718.012 through 718.018, to the statewide interdisciplinary team, regarding domestic violence fatalities
- Track implementation of recommendations by specific member agencies or other community organization; and
- Communicate with LPSCC about the reviews and outcomes in compliance with ORS 718.012 through 718.018.

V. Team Membership

The Fatality Review Team must balance the specific purposes of the Teams to most effectively attain its mission. It is important that Team members respect and trust one another, have high levels of expertise and understanding of domestic violence fatalities and the local response system, maintain continuity and consistency in reviewing cases, and have excellent communication among Team members. It is also important to provide accurate information to the community regarding domestic violence, prevention of fatalities, and improving the community response to domestic violence.

Thus, consistency in membership and attendance is important. A core group of designated or assigned Team members will be identified. They will be asked to make a two-year commitment to participate in the process, to attend Team meetings regularly, and to miss such meetings only occasionally and with good reason. In addition to the regularly assigned staff, DVFR-member agencies may bring additional staff most closely associated with the case under review. These additional staff will be required to individually sign the confidentiality agreement. A secondary group of community representatives may also participate in reviews in order to assist in providing information to specific segments of the community. These community representatives will be required to sign the confidentiality agreement, and prior to their participation, the Team will decide the level of participation.

ORS 418.714 (3) explicitly lists the required members of a fatality review team. The following list indicates both the legislatively required member and the Multnomah County representative(s) to be invited. The FVCC will send invitations to the appropriate individuals, as determined by the member agency, prior to the first meeting of the Team and prior to the meetings scheduled to review specific cases.

- Domestic violence program service staff or other advocates for battered women (FVCC appointee from their membership); recommend three advocates (one from a domestic

violence shelter, one from a non-residential domestic violence program and one from a culturally specific domestic violence program);

- Medical personnel with expertise in the field of domestic violence (FVCC appointee);
- Local health department staff (County Health Department Director or designee);
- The local district attorney or the district attorney's designees;
- Law enforcement personnel (Chiefs of police in Gresham, Portland, Sheriff or their designees);
- Civil legal services attorneys (Multnomah County Legal Aid Services of Oregon Manager/Director or designee);
- DHS CAF representative (District Manager or designee);
- Community corrections professionals (Department of Community Justice and Multnomah County Sheriff or designee);
- Judges, court administrators or their representatives (Presiding and Trial Court Administrator or designees);
- Perpetrator treatment providers (FVCC appointee); recommend one provider
- A survivor of domestic violence (FVCC appointee); recommend two survivors and
- Medical examiners or other experts in the field of forensic pathology (State Medical Examiner or designee);
- Representative of the Multnomah Department of County Human Services (Department Director or designee)
- Representative of the FVCC appointed by the FVCC Executive Committee; and
- Chair or designee of the Local Public Safety Coordinating Council.

In addition, ORS 418.714 (4) provides that "other individuals may, with the unanimous consent of the team, be included in a fatality review team on an ad hoc basis. The team, by unanimous consent, may decide the extent to which the individual may participate as a full member of the team for a particular review."

As a general practice, a representative of the defense bar, not currently or previously involved in the case to be reviewed, will be invited to participate in the review as an ad hoc member of the team.

The following agencies, disciplines or community groups have been recommended for inclusion to the Team on a regular basis in order to assist in providing information to specific segments of the community. Representatives from these agencies are expected to sign a confidentiality agreement and to follow the requirements of these protocols and ORS 718.012 through 718.018 related to confidentiality, but are not expected to make a two-year commitment, but rather their participation is intended to be time-limited (one or two case reviews) and to assist the Team in providing information to specific segments of the community. The Team, by unanimous consent, on a case-by-case basis or as a general practice, will decide on their level of involvement. Potential other members of the DVFRT include:

- Children's program representative (for example, CASA, CARES, Juvenile Rights Project, Morrison Center, Pediatrician, Child Psychologist, etc.);
- Business association; and
- Faith communities.

For specific case reviews, Team members may recommend additional individuals or areas of interest to be represented (for example, specific populations or disciplines). Decisions regarding the composition of the Team will be made prior to each review with unanimous consent.

VI. Selection of Cases

Statutory Definition

Cases to be reviewed will conform to the ORS 418.712 (1-6) definition of a domestic violence fatality as a "fatality in which:

- The deceased was the victim of a homicide committed by a current or former spouse, fiancé, fiancée or dating partner;
- The deceased was the victim of a suicide and there is evidence that the suicide is related to previous domestic violence;
- The deceased was the perpetrator of the homicide of a current or former spouse, fiancé, fiancée or dating partner and the perpetrator also died in the course of the domestic violence incident;
- The deceased was a child who died in the course of a domestic violence incident in which either a parent of the child or the perpetrator also died;
- The deceased was a current or former spouse, fiancé, fiancée or dating partner of the current or former spouse, fiancé, fiancée or dating partner of the perpetrator; or
- The deceased was a person 18 years of age or older not otherwise described in this section and was the victim of a homicide related to domestic violence."

  ORS 718.012 through 718.018 focuses on homicides between intimate or dating partners, but does allow for reviews in other situations. For example, the Team may review (1) a fatality caused by other family members (brother, sister, parent, child, etc.) if the deceased is a child who died in the course of a domestic violence incident and the perpetrator or a parent also dies; (2) a suicide by the victim of previous domestic violence; and (3) a suicide by the perpetrator, even if the victim survives, as long as the suicide is related to domestic violence.

Local Process of Selection of Cases

The Team recognizes the need to review as wide a variety of domestic violence fatalities as possible. This will allow them to become aware of the specific barriers and issues facing domestic violence survivors from a variety of county communities and social/economic situations, and to better understand the extent and impact of specific strategies/tactics used by the perpetrators.

This need to review a wide variety of fatalities must be balanced against the availability of Team members' time to gather information about cases and to participate in reviews. Thus, the annual goal for fatality reviews will be two case reviews per year.

The factors leading to variability in cases to be reviewed are:

- Family size/composition (victim is single, has one or multiple children)
- Race or ethnicity, immigration status
- Sexual orientation/gender identity
- Criminal history
- Disability, including physical or mental ability, alcohol or drug addiction, or mental illness
- Level of involvement with criminal justice and social service systems
- Age
- Socio-economic status
- Relationship between the victim and perpetrator
- Existence of additional victims, such as a murder-suicide or familicide
- Geographic location of fatality or of the residence of the victim or perpetrator
- Degree of prior abuse by the perpetrator.

Generally, the cases to be considered for review will meet the all of the following criteria:

- The fatality occurred in Multnomah County;
- The perpetrator of the homicide/fatality has been identified by the criminal justice system; and
- All criminal actions related to the homicide/fatality are closed.

In all cases, there will be an attempt to interview family, friends, co-workers, neighbors or others who can provide additional insight for the Team. Particularly in cases in which there is little involvement with public entities (such as law enforcement), family, friends, co-workers or neighbors will provide the most substantial information about the prior incidents of domestic violence and/or about the victim or perpetrator for presentation to the Team.

On an annual basis, the Multnomah County District Attorney's Office will compile a list of homicides with a brief summary of the facts of the homicide and relationship between the victim and perpetrator. This list will be provided to the Team to assist in identifying and agreeing on fatalities to be reviewed. Any member of the Team may recommend a fatality for review. To do so, the Team member should provide a summary of the homicide and an explanation of why they or their agency believes it may be of particular interest to the Team.

In general, cases will be selected by agreement of all members of the Team. If the Team cannot come to a unanimous decision**,** a 2/3 majority will determine the selection of cases. However, a Team member can ask for a reconsideration of the vote, if they present compelling reasons for not reviewing the agreed-upon fatality. A 2/3 majority upon reconsideration will still determine the case to be reviewed.

Regardless of the outcome of the vote, no agency is required to disclose information about a case.

VII. Review Process

ORS 418.714 (5) requires that: "Upon formation and before reviewing its first case, a fatality review team shall adopt a written protocol for review of domestic violence fatalities. The protocol must be designed to facilitate communication among organizations and agencies involved in domestic violence cases so that incidents of domestic violence and domestic violence fatalities are identified and prevented. The protocol shall define procedures for case review and preservation of confidentiality, and shall identify team members."

Each fatality review team is required to develop written agreements signed by member organizations and agencies that specify the organizations' and agencies' understanding of and agreement with the principles outlined in ORS 718.012 through 718.018.

Adoption of the following protocols is intended to constitute the required written protocols.

REVIEW PROTOCOLS

A. **Developing and Implementing a Review Mission and Philosophy/Ethic**

Successful fatality reviews depend on shared ethics and philosophy. Team members come from a variety of disciplines, with differing roles and goals. To most effectively utilize a fatality review, it is important that Team members share with other Team members a mission, priorities and understanding of the purpose of fatality reviews.

Areas of particular importance for Team members to come to a shared agreement include:

- **The primary overarching goals for domestic violence intervention are Victim safety and perpetrator deterrence or accountability**
- **The need for facilitation of communication among organizations and agencies**. The purpose of the review is to facilitate communication among organizations and agencies that frequently provide services to the same perpetrators and victims. Such communication can lead to a better understanding of the specific roles and limitations that agencies face, better ways of referring victims to an agency, and more collaboration and coordination among agencies in order to provide more effective services for victims and greater accountability for perpetrators.
- **The Focus is on preventing future deaths, improving responses.**
- **The need to Maintain confidentiality.**
- **That blaming either the victim or a particular responder, agency or group is counter-productive to effective domestic violence fatality reviews.** The National Fatality Review Initiative (NFRI) states, "Balancing 'no blame and shame' with the notion of accountability is another theme that undergirds death review work. Domestic violence fatality review requires a paradigm shift from a culture of blame to a culture of safety in which deaths are reviewed through a lens of preventative

accountability. With vigor, trust, honesty, and candor, communities can establish reliable systems that value accountability and help prevent future deaths and injury from domestic violence. Error recognition, accountability, honesty and systemic improvement should be the focus rather than denial, blame and personalizing the review…It is important to keep the no blame and shame philosophy at the center of the review, while still realizing the need for agency accountability."

- **Team members will communicate with other Team members in a respectful manner and will fully participate in the review process, to the extent permitted by law.** This does not require Team members to present case information if their agency has decided against providing such information.

B. Scope of the Review Process

The scope of the fatality reviews is limited. It is not meant to be an investigation of the crime itself, nor of the appropriateness/inappropriateness of a particular agency's intervention. Rather, it seeks to identify points of potential intervention that could have prevented this fatality or could prevent future fatalities. Thus, the basic information sought and reviewed should focus on the following areas.

- Collecting case statistics for aggregate reporting, such as age, race, gender, relationship between perpetrators and victims.
- Gathering relevant information about the case being reviewed, such as the frequency or severity of the violence, the history of the relationship, help sought by the victims or the perpetrators, and other problems or barriers faced by the victims or perpetrators. This information would be gathered from participating Team members or other public entities, and from other sources such as the media, social services, schools, or family, friends, co-workers or others who have information about the case.
- Compiling a detailed chronology of the relationship, violence within the relationship, attempts by the victim or perpetrator to seek assistance or to end the violence, interventions or attempted interventions by agencies or individuals, and of events leading up to the fatality.
- Summarizing key issues raised by the fatality, the response to the prior domestic violence, or the particular circumstances of the victim or perpetrator.
- Developing recommendations to improve the response to domestic violence and to prevent future fatalities.
- Following up on implementation of recommendations.

C. Confidentiality

ORS 418.714 (10) specifically protects the confidentiality of information presented to the fatality review Team: **"**An oral or written communication or a document related to a domestic violence fatality review that is shared within or produced by a fatality review team is confidential, not subject to disclosure and not discoverable by a third party. An oral or written communication or a document provided by a third party to a fatality review team is confidential, not subject to disclosure and not discoverable by a third party. All information

and records acquired by a team in the exercise of its duties are confidential and may be disclosed only as necessary to carry out the purposes of the fatality review. However, recommendations of a team upon the completion of a review may be disclosed without personal identifiers at the discretion of two-thirds of the members of the team."

Moreover, ORS 418.714(11) provides that "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 a fatality review team."

Despite the confidentiality provided by ORS 718.012 through 718.018 for information and documents provided to the DVFRT, members and other individuals with privileged information are permitted by ORS 718.012 through 718.018 to make their own decisions regarding whether and what level of information they can provide the review Team.

Team members are expected to maintain complete confidentiality related to information presented during a fatality review. Each Team member will be required to sign a confidentiality agreement prior to the start of a review of any fatality. The confidentiality agreement requires the individual to keep all information about a particular case confidential – that is, to not discuss or disclose anything about the case or the response by an agency or individual to that case, unless it is necessary to carry out the purposes of the fatality review An example of something that would be necessary to carry out the purposes of ORS 718.012 through 718.018 would be an intra-agency discussion about an agency's prior responses to the domestic violence survivor or perpetrator or the recommendation that a change in agency procedures or policies be considered by an agency. Team members may disclose information such as the procedures followed for the review process itself, standard operating procedures of local agencies, aggregate information about fatalities (number, demographics of those involved, etc.) as long as it does not lead to the identification of a particular homicide victim or perpetrator and issues and recommendations generated by the review Team, if the Team has agreed to their disclosure.

D. **Interviewing family, friends, co-workers or other community members who knew the victim or perpetrator.**

Interviews with family, friends, co-workers or other community members who knew the victim or perpetrator will focus on topics that will assist the Team in meeting the mission of the review process. The attached list of suggested questions will be used to guide the interviews.

Interviewers will be professionals with experience in interviewing domestic violence survivors, family or friends of homicide victims or perpetrators, or others who have been severely traumatized. Interviewers will be asked to balance the limited time available with the need to follow-up with as many people as possible who have pertinent information. Interviewers will work under the direction of the FVCC staff or the County's Domestic Violence Coordinator's Office and will sign the confidentiality agreement. The DVFRT will determine their level of participation prior to the start of each review.

Interviews will take place prior to the review of the case. Interviewers will be asked to present a summary of the information they have gathered. They may participate in the entire review process as non-voting members, by unanimous consent of the Team. In

particular, they will be asked to provide additional information from the standpoint of family, friends and the community related to the chronology of events, to the issues raised by the fatality and to recommendations proposed.

Before the interview, the family, friends or other informants will be given information about the purpose and process of the fatality reviews, and will be given resources for grief counseling or support groups. After the fatality review has occurred, they will be given the final copy of the recommendations, if the Team has decided to release them.

E. **Prior to a fatality review**

Prior to the meeting, FVCC Staff will contact all review Team members to:

- Invite them to the fatality review meeting;
- Provide them with information regarding review purpose, philosophy, confidentiality requirements and process; and
- Inform them of the case(s) to be reviewed and request that they examine their own agency's records for any case involvement and determine what information they will share with the review Team.[1] The Team member will be asked to provide the following information to the FVCC Staff prior to the meeting:
    - Name and contact information for their agency's representative at the upcoming review; and
    - Any information from their records that they can disclose to assist the FVCC staff to develop a chronology of events leading up to the fatality. This information does not have to be in depth, but should include date, brief description of the incident and response by their agency.

To the extent an agency is willing and able to disclose information, the assigned agency representative is requested to bring the case file or other documentation regarding the specific case to be reviewed to the fatality review meeting and to be prepared to discuss with the Team information that the agency is disclosing contained in the file. The assigned agency representative is not required to provide copies of materials in the file, but may choose to do so where permitted by law. Upon leaving a meeting, each DVFRT member must return all copies of file materials and of notes taken specifically about the case to the agency representative or to the FVCC staff to be shredded.

Examples of information the Team would like to review:

- Records from law enforcement, criminal justice, district attorney, Department of Community Corrections, Court records, coroners reports;
- Records from Oregon Department of Human Services (for example, Child Welfare and Self-Sufficiency)
- Medical Records
- Housing information, when appropriate
- Information from family, friends or co-workers
- Information from other agencies/services.

[1] In some cases, an agency may not be permitted by law to share specific information.

It is recognized that some agencies will not be able to provide the requested information without the DVFRT first obtaining an authorization for release of information from the person who is the subject of the review, or in the case of a deceased subject, the personal representative of the deceased.

F. **Selection and Role of the Convener, Facilitator and staff**

It is hoped that at each fatality review, the Chair of the LPSCC or an appropriate elected official will convene the meeting, welcome members and provide an overview of the purpose and process of the review. This person (the Convener) will invite full participation in the process by the Team members and encourage a spirit of improving our responses to domestic violence, of opening communication among the DVFRT members, and of implementing the recommendations of the DVFRT by agencies Each agency retains the responsibility and discretion to determine how the recommendation might be applied to its own practices and policies. The Convener will not facilitate the review process in order to be free to participate in the fatality review.

A facilitator agreed upon by the Team will:

- Assure that the processes outlined in this document and in ORS 718.012 through 718.018 are adhered to;
- Provide time and opportunity for Team members to report on their agency's involvement, to make corrections to the chronology or to information presented by other agencies; and
- Assist the Team in coming to an agreement about the major issues found in the review, whether agencies not listed in ORS 718.012 through 718.018 should participate and at what level, and whether an additional meeting is necessary to permit this to happen, the recommendations of the Team, and whether or not to release the findings and recommendations.

The facilitator, convenor and any participating FVCC staff will sign the confidentiality agreement.

FVCC, LPSCC or contracted staff will record changes/additions to the chronology, and issues raised and recommendations suggested by the Team. They will document any follow-up items for future meetings and decisions by the Team regarding release of findings and recommendations and changes to the protocol. Minutes for the meeting will reflect any decisions made or changes to the process, but not specifics of the case. Specifics relating to the case reviewed will be kept by FVCC staff in a separate confidential file.

G. **Meeting Process**

i) **Composition of Team for a particular review**

The composition of a Team is defined by ORS 718.012 through 718.018. This protocol acknowledges that not all Team members or agencies may be able to attend a particular meeting to review a fatality. In a case in which a member or members of the Team are absent, a review may still be held if the Team member(s) have been

invited to attend the review and two-thirds of the agencies invited have Team members present.

Prior to the start of a review process, any member of the Team may recommend inclusion of additional Team participants or members, including their level of participation and the justification for their inclusion. Before any invitation can be sent to that individual or agency, the Team must unanimously agree to their inclusion. Upon the invitees' attendance, the invitee will be required to sign the confidentiality agreement.

ii) **Presentation of information by agencies, staff**

Each agency has the right to disclose or not disclose information related to the fatality under review. ORS 418.714 (8-9) states, "Each organization or agency represented on a fatality review team may share with other members of the team information concerning the victim who is the subject of the review. Any information shared between team members is confidential. An individual who is a member of an organization or agency that is represented on a fatality review team is not required to disclose information."

At the Fatality Review meeting:

- All Team members will sign a confidentiality statement (see attached).
- Convener reviews the purpose and philosophy of review (clarifying what review is and is not, emphasizing no blame/no shame approach).
- The "lead" agency or individual with the most comprehensive information about the fatality (usually a law enforcement or victim services agency) provides an overview of the fatality and the history of the relationship or other relevant information.
- Facilitator walks the group through the chronology, eliciting additional points of contact or information about the case, and leading a discussion regarding points of system contact.
- A note taker (FVCC staff or facilitator) makes changes to the chronology based on the information provided and documents issues/findings raised as the discussion evolves. Meeting notes will be used to assist the team members at subsequent DVFRT meetings to remember the details of the case, the discussion and recommendations. Meeting notes are handed out at the meeting, but must be returned at the end of the meeting and shredded following the meeting.
- Staff will assure that all case related materials distributed are left in the room to be shredded or returned to the provider of those materials.

iii) **Documentation of findings**

Documentation of findings or issues raised is intended to assist the review Team and the community, if the report is released, to focus on specific, concrete steps that can be taken to prevent future fatalities and/or to improve the system of response to domestic violence. For example, the Team may identify issues, such as gaps in services, ineffective responses, or particular barriers faced by the victim in a particular fatality.

Following the review of the facts of the case, the Facilitator or note taker summarizes or lists the issues/findings identified in the review. The Team comes to an agreement about the inclusion/exclusion of items in this list and about the reason it is an important finding/issue to address.

iv) Development of recommendations and next steps, including decision regarding release of recommendations or aggregate information to the community

The development of recommendations is a multi-step process, which seeks approval by agency heads.

(1) Based on the findings/issues identified in iii above, the Team identifies specific actions that agencies or individuals can take to prevent future fatalities or to improve the response to domestic violence.

(2) All recommendations are recorded and confidentially forwarded, within 30 days, to the agency or individual responsible for their implementation for the agency's review.

(3) Staff will write a brief report regarding the review, which includes the process used, agencies represented, and recommendations developed.

(4) At a subsequent meeting of the review Team, the staff report, with the list of approved recommendations, is presented. The Facilitator seeks affirmation of the list and approval of the report from the Team, and assists them in deciding whether or not to release the report/recommendations, per the requirements of ORS 718.012 through 718.018[2]. The Team may choose to release all, part or none of the staff report/recommendations.

The Team will also determine how this report/recommendations will be released (report to the community, media advisory, etc.) and who will be the spokesperson for the Team following the release of the report. In general, an annual report of multiple reviews will be released, rather than a report for each fatality reviewed. This will protect the confidentiality of the family, friends, co-workers or others who were interviewed, and of the victims and perpetrators.

H. **Follow-up**

Following the completion of the report/recommendations, staff will:

- Distribute the final report/recommendations to review Team, and to the community if so agreed upon.
- Track implementation of recommendations six months after completion of the report/recommendations.
- Compile aggregate information about the fatalities (age, race, gender of victims and perpetrators, cause of death, relationship between victims and perpetrators, geographic location within the county, etc.) and release to the community at appropriate intervals.

[2] "However, recommendations of a team upon the completion of a review may be disclosed without personal identifiers at the discretion of two-thirds of the members of the team."

- Implement an evaluation of the review process, recommended changes to protocol, and assist the Team in improving the process and in selecting additional cases to review.

[i] National Domestic Violence Fatality Initiative website
[ii] Ibid