

# **SOLANO COUNTY DOMESTIC VIOLENCE DEATH REVIEW TEAM**

## **PROTOCOLS**

October 2006

### **Purpose:**

The purpose of the Solano County Domestic Violence Death Review Team is to identify and review all domestic violence related deaths.

### **Mission:**

The Solano County Domestic Violence Death Review Team will carefully and critically review deaths associated with domestic violence in order to improve coordination and delivery of services to prevent incidents of and deaths as a result of domestic violence.

### **Goals:**

Solano County Domestic Violence Death Review Team will achieve this mission by:

- Identifying domestic violence related deaths
- Reviewing circumstances of domestic violence related deaths
- Identifying patterns that lead to fatal outcomes
- Determining whether reviewed deaths may have been preventable
- Identifying strategies for prevention of domestic violence related deaths, including, but not limited to, delivery of agency services and intervention methods
- Developing intervention strategies to reduce fatalities and eliminate ongoing abuse
- Identifying ways to improve and enhance interagency reporting and communication
- Identifying methods, services and strategies that were used effectively and efficiently

### **Membership:**

Core membership will consist of representatives of:

Sheriff/Coroner  
Forensic Pathologist  
Office of Family Violence Prevention

Ancillary members include representatives of:

Courts  
Public Health  
District Attorney  
Probation  
Travis AFB Family Advocacy Office  
All law enforcement agencies within Solano County  
Victim Advocates  
Victim Witness  
Medical professional  
Mental Health  
NorthBay Regional, Sutter, Kaiser Permanente, VacaValley Hospitals,

NorthBay Hospital, David Grant Hospital, Partnership Health Plan  
County Counsel  
EMS  
Adult protective Services  
Child Welfare Services

Other members may be added by majority vote of the core members. Core members are those members who are expected to be regular participants in all DVDRT meetings and reviews. Ancillary members send representatives with case specific information upon request.

**Statutory Authority:**

California Penal Code Sections 11163.3 through 11163.6.

**Meeting Schedule:**

The Solano County Domestic Violence Death Review Team will meet twice a year unless the team deems it necessary to increase or decrease the number of meetings based on the number of cases to be reviewed. The time and location of the meetings will be determined by the team members. In addition, the DVDRT may convene one summary meeting annually to review the findings and recommendations. Identifiable problems pertaining to a single agency will be orally addressed with that agency in private.

**Confidentiality:**

Death Review Team Members recognize that confidentiality is essential to the review process. Confidentiality must be approached on two levels: team confidentiality and member confidentiality. Team confidentiality includes all activities that occur during a team meeting. Written information will be disseminated, reviewed, collected at the end of the meeting and then shredded.

Member confidentiality dictates that individual members must keep confidential any information that is revealed about specific cases. Other than as permitted by law, or required for a criminal or Coroner's investigation, team members should not share or speak about case information with anyone else, including others in their organization. Information should not leave the meeting room and each member will be expected to sign and adhere to confidentiality agreements.

Each participant in the death review process will be expected to sign an agreement prior to participation that he/she will abide by the confidentiality laws and will not discuss team matters outside the meetings or the purview of team operations or disclose documents to third parties. Non-members shall not attend meetings except for the purpose of providing training to team members or receiving non-case specific recommendations from the team. Non-members shall not be present during case review.

At the discretion of a majority of members of the team, recommendations of the team, at the conclusion of a review, may be disclosed to agencies within the domestic violence intervention

system that may be affected by the recommendations. Recommendations will not include any information that is otherwise confidential and not subject to disclosure. Confidentiality as it relates to the review process will be implemented according to the following guidelines:

- Dissemination of information beyond the scope and purpose of the review team is prohibited.
- Case information is limited to the actual review process to enlist interagency cooperation.
- Use of any material for reasons other than that for which it is intended is prohibited.
- Team members are prohibited from creating any files with specific case identifying information gathered from the DVDRT meetings. Case files that are the property of the agency prior to participating in the DVDRT will remain the property of the agency.

### **Case Review Criteria:**

California Family Code Section 6211 (a-d) defines “domestic violence” (DV) as abuse perpetrated against any person who is a (a) spouse or former spouse, (b) A cohabitant or former cohabitant, as defined in Section 6209, (c) A person with whom the respondent is having or has had a dating or engagement relationship, (d) A person with whom the respondent has had a child, where the presumption applies that the male parent is the father of the child of the female parent under the Uniform Parentage Act (Part 3 (commencing with Section 7600) of Division 12). The Solano County Domestic Violence Death Review Team will review cases of domestic violence related deaths for adults ages 18 to 64 who meet any one of the following criteria:

- All DV related homicides;
- Suicides if it can be determined that the individual who committed suicide had a history of perpetrating DV;
- Suicides if it can be determined that the individual was a victim of DV;
- In the instance of teen dating violence, the case is referred to the DVDRT by the Interagency Child Death Review Team (IACDRT);
- In the instance of elder abuse related DV, the case is referred to the DVDRT by the Elder Death Review Team (EDRT);
- Any case wherein the attending physician requests review of the death;
- Accidental death from asphyxiation, toxicity, or overdose, provided history of DV is established;
- Any child or family member killed in a domestic violence incident.

Any case identified for review will be placed on a meeting agenda. Each regular team member and each necessary ancillary team member will be notified via email of the cases to be reviewed and will be expected to attend and bring any case information available. Case information, (reports, etc.) brought to the meeting by any team member will not be copied or distributed, and will remain the property of individual members and their agencies.

Meeting email will include the name of the victim, date of birth and date of death, name of the facility or facilities involved with the victim. If members need additional information about the case, they should contact the review team facilitator.

At the review team meeting, members will review the facts and information gathered for each case. Following review of all cases on the agenda, the team may discuss proposed, non-case specific recommendations for policies and procedures that can prevent future domestic violence related deaths . Written materials generated from the meeting such as case summaries or notes pertaining to the case will be collected by the team facilitator or chairperson at the end of the meeting. After the materials have been used to formulate recommendations, all notes and written material will be shredded. All data collected for future reference will be encoded to ensure confidentiality.

If the team develops non-case specific recommendations as a result of a death review team meeting, the team may, in the discretion of a majority of the core members, convene an additional meeting to communicate those recommendations to affected ancillary team members who did not participate in the death review, or to other outside agencies which, in the team's discretion, may benefit from the recommendations. No case-specific information will be disclosed, and all confidentiality provisions and agreements with respect to the death review team will remain in full force and effect.

### **Data Collection:**

As permitted by statute, data will be collected and summarized by the team to show the statistical occurrence of domestic violence deaths in Solano County that occur under the following circumstances:

- (1) The deceased was a victim of a homicide committed by a current or former spouse, fiancé or dating partner;
- (2) The deceased was the victim of a suicide, was the current or former spouse, fiancé, or dating partner of the perpetrator and was also the victim of previous acts of domestic violence;
- (3) The deceased was the perpetrator of the homicide of a former or current spouse, fiancé or dating partner and the perpetrator was also the victim of a suicide;
- (4) The deceased was the perpetrator of the homicide of a former or current spouse, fiancé, or dating partner and the perpetrator was also the victim of a homicide related to the domestic homicide incident;
- (5) The deceased was a child of either the victim of domestic violence or the perpetrator, or both;
- (6) The deceased was a current or former spouse, fiancé, or dating partner of the perpetrator;
- (7) The deceased was a law enforcement officer, emergency medical personnel or other agency responding to a domestic violence incident;
- (8) The deceased was a family member, other than identified above, of the perpetrator;
- (9) The deceased was the perpetrator of the homicide of a family member, other than identified above;
- (10) The deceased was a person not included in the above categories and the homicide was related to domestic violence.

Statistical data gathered from the death reviews will be aggregated and original case review forms will be shredded annually.

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