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DOMESTIC VIOLENCE FATALITY REVIEWS: A NATIONAL SUMMIT

EDUCATION MODULE

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DECEASED - NAME: Glenda Lee Lucas
SEX: F
DATE OF DEATH: 2-14-97
RACE: White
COUNTY OF DEATH: Comstock
CITY, TOWN, OR LOCATION OF DEATH: Gold Mountain
STATE OF BIRTH: Nevada
SOCIAL SECURITY NUMBER: 530-33-0528
USUAL OCCUPATION: Assistant Manager
KIND OF BUSINESS OR INDUSTRY: Restaurant
RESIDENCE - STATE: Nevada
STREET AND NUMBER: 432 Copper Drive, #218
FATHER - NAME: Geoffrey ... Silverman
MOTHER - NAME: Judith Glenda Miller
INFORMANT - NAME: Geoffrey E. Silverman
MAILING ADDRESS: ... Rexburg, Nevada

PART I - DEATH WAS CAUSED BY:
(a) Subdural Hematoma with associated multiple contusions — 3 hrs 30 mins
(b) Blunt force trauma (beating)

PART II - OTHER SIGNIFICANT CONDITIONS: Remote blunt force injuries
AUTOPSY: Yes
IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH: Yes

ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED: Homicide
DATE OF INJURY: 2-14-97
HOUR: 12:30PM
HOW INJURY OCCURRED: Beaten by known assailant
INJURY AT WORK: No
PLACE OF INJURY: Home
LOCATION: 432 Copper Dr. #218, Gold Mountain, Nevada

CERTIFICATION - PHYSICIAN: N/A
CERTIFICATION - CORONER: HOUR OF DEATH 12:30 PM
THE DECEDENT WAS PRONOUNCED DEAD: 2 14 97 1700 PM
CERTIFIER - NAME: John James, MD
DEGREE OR TITLE: M.D.
DATE SIGNED: 2-14-97
MAILING ADDRESS - CERTIFIER: P.O. Box 7177, Gold Mountain, NV 89506

BURIAL, CREMATION, REMOVAL: Cremation
CEMETERY OR CREMATORY - NAME: Forest Lawn Memorial
LOCATION: Gold Mountain, NV
DATE: 2-18-97
FUNERAL HOME - NAME AND ADDRESS: Freitas Funeral Home, 2144 Boothe St., Gold Mtn. NV 89506
DATE RECEIVED BY LOCAL REGISTRAR: 2-20-97

03295

179143

DOMESTIC VIOLENCE

RELEASE ...

...persons by these presents: That I, ... do by these presents, for myself, me heirs, executors, administrators or assigns, release each, every and all dully appointed Peace Officers of the State of Nevada, from any claim action, demand ... of the United States of America ... of the Reno Police Department ... in equity, I ever had or now have or which I, or my ... of city and county of any State ... claims and demands whatsoever ... by reason of any matter, cause, or thing whatsoever ... sums of money, controversies, trespasses, judgments, executions ... any Peace Officers ... vehicle, pursuant to the stolen report which I have this day ... administrators or assigns, hereafter can, shall or may have against ... conveying ... said Peace Officer or Peace Officers recovering, holding, storing ...

(SIGNED)

...TICALLY LIST VIN & PLATES

...E, RACE, SEX, DOB, PHYSICAL DESCRIPTION, CLOTHING
...ESTED: YES ☐ NO X Dewayne Lucas Cauc, M, (husband)

179143

DOMESTIC VIOLENCE FATALITY REVIEWS:

EDUCATION MODULE

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

Written by
Lonnie Weiss
Weiss Consulting

Funded by

State Justice Institute

Office for Victims of Crime in the
Office of Justice Programs, US. Department of Justice

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Box 6000
Rockville, MD 20849-6000

DOMESTIC VIOLENCE

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A NATIONAL SUMMIT

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Northern Arizona University
Flagstaff, Arizona

Jay Whitworth, MD
Children's Crisis Center, Inc.
Jacksonville, Florida

This project was funded under grant award SJI-98-N-043 by the State Justice Institute; and the Office for Victims of Crime in the Office of Justice Programs, US. Department of Justice. The points of view expressed are those of the authors, and may not be construed as official positions or policies of those organizations or of the National Council of Juvenile and Family Court Judges or the Florida Governor's Task Force on Domestic and Sexual Violence.

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PREFACE

This education module is based on the design of a conference entitled "Domestic Violence Fatality Reviews: A National Summit" held October 25-27, 1998, in Key West, Florida. The purpose of the Summit was to advance the state of the art of this potentially invaluable tool, domestic violence fatality reviews, and thereby to assist courts and related agencies across the nation to improve their response in cases involving domestic violence.

The Summit was organized and sponsored jointly 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 domestic violence 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 protocols for conducting domestic violence fatality reviews.

Domestic Violence Fatality Reviews: A National Summit Recommendations (*Recommendations* publication) highlights the outcomes reached by the Summit participants and provides an orientation and overview of the relevant issues that are covered in the Module. The *Recommendations* publication serves as a basis from which to begin working with the Module in order to help communities develop domestic violence fatality reviews. Although a written module cannot duplicate the experience of a two-day, face-to-face event, this module offers a guided group process and a format that can help community-based teams tailor an approach to their own community's needs regarding domestic violence fatality reviews.

Although the dynamics of domestic violence and the organizational and institutional structures throughout this country are fairly universal, each community is unique. Domestic violence laws vary in every state. The history of cooperation and animosity, competition and collaboration, politics and personalities shapes each jurisdiction and community and requires a unique approach.

Therefore, the module is not prescriptive. It offers a set of basic questions and issues that experience shows must be addressed in a community wishing to launch a domestic violence fatality review process. The module provides fictionalized cases and community contexts with which to practice working out challenging decisions. It suggests methods by which team members can develop their own answers to the issues that impact their particular community. The responsibility for deciding what precise combination of ingredients will work best in developing domestic violence fatality reviews is left to the individual communities.

OVERVIEW

This training guide is designed to support a collection of people in creating or reshaping a domestic violence fatality review process in their community. "Community" can mean a municipality, county, region, state, or tribe. Whatever the geography or jurisdiction, the multi-disciplinary group will represent many agencies, organizations, and institutions that do or could influence the lives of people impacted by domestic violence.

Communities may be building on a long-standing tradition of information sharing and coordination. Or community members may have been at odds for a long time, but now find that a particular situation calls for new levels of cooperation. No matter what the impetus, addressing the fact that domestic violence sometimes results in death will provide heightened awareness and renewed appreciation for the vital importance of working together to stop domestic violence in all communities.

Purpose

This module is designed to guide a group of community members through tasks to develop a well thought out approach to conducting domestic violence fatality reviews that will serve their community's needs and help prevent future domestic violence deaths.

Intended Outcomes

- Identify critical issues that must be addressed before launching an effective domestic violence fatality review process in the community.
- Work through preliminary decisions on these issues.

Learning Objectives

- Clarify views of the purpose and approach for domestic violence fatality reviews.
- Examine practical matters of scope and structure for a fatality review team.
- Determine who must and should be represented on such a team.
- Experience assessing community organizations' involvement in a case.
- Practice identifying sources of information in a case.
- Explore issues in obtaining access to needed information.
- Develop a draft confidentiality agreement for a fatality review team.
- Develop a draft family participation policy.
- Practice identifying system improvement recommendations.
- Practice composing a press release about a domestic violence fatality case review.

STRUCTURE AND USE OF THIS MODULE

The module is designed to prepare a multi-disciplinary group to implement domestic violence fatality reviews in its community. Rather than handling a myriad of issues directly and simultaneously, the module leads the group through a sequence of tasks in order to consider key preliminary issues, to simulate a review of a hypothetical domestic violence fatality case, and to determine what is effective in interventions as well as in team work.

Using a hypothetical case helps prepare the group to take on actual decisions with greater detachment from a death *per se* and give more attention to the process and approach. The participants will document on worksheets their decisions, discussion points, and unanswered issues and questions that are raised by working through the hypothetical case. This documentation will constitute the first draft of a plan for how to conduct domestic violence fatality reviews in their community.

After having gone through the entire sequence of tasks, the participants will be prepared to review their draft plan in light of their community's realities, dropping the fiction of the hypothetical case. This is also an opportunity to adjust the group's membership, composing a more ideal fatality review team.

The newly formed domestic violence fatality review team will be prepared to develop its community's policies, protocols, and agreements thoughtfully. Further, the worksheets will provide a template to develop and document a community's decisions or, if appropriate, its recommendations to another community.

Preparatory Reading

Facilitators and participants should prepare for this education module by reviewing basic information about domestic violence fatality review purposes, structure, and related issues. The *Recommendations* publication from the 1998 National Summit on Domestic Violence Fatality Reviews is a brief and useful document, well suited to distribute as a learning tool. It is available from the Family Violence Department of the National Council of Juvenile and Family Court Judges.

Alternate Uses And Modifications

This module can be adapted from the basic agenda for use in varied contexts. Materials in the module attachments offer a variety of adaptations.

- **Alternate Agendas** allow a group to split the full day of tasks into three half days; to incorporate the program into a multi-jurisdictional conference or training program; and potentially to use the module for direct implementation of domestic violence fatality reviews.

- **Hypothetical Cases** are provided for use in Sessions B and C. The module offers suggestions as to what to include if the group chooses to compile its own hypothetical case instead of using one of the two provided.

- **Alternate Community Descriptions** are provided for use in multi-jurisdictional training contexts. In order to remove participants from the realities and limitations of their different home communities, the facilitator can choose from among the towns, cities, and state descriptions provided herein in order to select one hypothetical, but shared community.

- **Sample Press Releases** are given in Session C, which allow participants to consider how they might structure press releases for their community.

- **Overhead Transparency Masters** are provided for use in group sessions that are too large to allow participants to see flipcharts.

Who Are The Participants?

Participants are the people who will be members of the community's domestic violence fatality review team.

The full complement of appropriate members may not be known at the time the module is scheduled. The training can be done with a core group of people who are certain to be included on the team. One outcome of their work may be an expanded list of people and organizations who should be invited to participate in further shaping the domestic violence fatality review team.

When To Conduct This Training?

When the community is ready to get serious about launching a domestic violence fatality review process.

Who Is The Facilitator?

The facilitator can be anyone from within the involved community agencies and organizations, preferably with these qualities:

- Experienced in conducting training.
- Experienced and skilled in guiding group decision-making.
- Experienced and skilled in handling group dynamics and conflict.
- Conversant with the issues and the institutions.
- Comfortable in this role and with the people in the group.
- Ideally:
  - Is not a member of the group,
  - Does not report directly to any group member, and
  - Is respected by group members.

If these neutral relationships are not possible and an outside facilitator cannot be arranged, address the complexities of this role directly and negotiate a contract for a local person to fill this neutral role temporarily.

FACILITATOR GUIDE

LOGISTICS

Module Format

This module provides worksheets, a detailed program description, and other materials that support a facilitator in guiding a group through reflection, discussion, and decisions on critical elements in establishing a domestic violence fatality review team and process in its community. The module is organized in three sessions, each structured with a worksheet. Each session takes between 1.5 and 2.5 hours to complete. Sessions B and C are based in large part on group analysis of a hypothetical domestic violence fatality case file.

Group Size

The module is designed to be conducted with a community team consisting of seven to 20 people or more. In sessions B and C, if the group is larger than 12, smaller groups may be formed to work with the hypothetical case. Subgroups of seven to 10 people of diverse professions and affiliations are the ideal small group. Note that if the small groups are formed, extra time should be built in for the small groups to report back after each task.

Space Requirements

Room set-up will vary depending on the size of the group. Key criteria are:

- Visibility – participants should be able to see each other, not just the facilitator.
- Tables – participants will need a surface on which to work.
- Comfortable chairs, adequate space – participants should not feel crowded.

Tasks & Products

Participants will be doing two things at once:

- Conducting their own fatality review of a hypothetical case, and
- Developing first draft protocols and procedures that will be the basis for their community's actual domestic violence fatality review approach.

The result of this work will be to create the approach and develop protocols and procedures for performing domestic violence fatality reviews within a community. Recommendations that are formed may require approval by another body. However, since the participants involved in the module will probably be the same people who will serve on the domestic violence fatality review team, their thoughtful work likely will be taken seriously and their recommendations adopted.

Documentation

The worksheets provided for each set of tasks will form the documentation of the participants' work. Completed worksheets should be kept and used as the basis for further review and development as the domestic violence fatality review team's functioning protocols and procedures.

Materials and Supplies

- Worksheets A, B, & C, one per participant per session, plus a few extras
- Flipchart pads and easels
- Markers and tape
- Additional handouts
  - ➢ Hypothetical case (Sessions B & C)
  - ➢ Example Press Releases (Session C)
  - ➢ Alternate Community Description, optional (see Alternate Agenda B.2)
- Overhead projector and overhead transparencies, optional (see Alternate Agenda B.3)

Team Methods and Ground Rules

As the group will be addressing many complex issues and is likely to hold differing personal and professional views, it will be important to observe constructive norms in group communication. A possible statement about ground rules may be helpful, for instance:

- Each person should use his or her best meeting skills in the team meetings.
- Everyone's voice is valuable and deserves to be heard.
- Respect common courtesies: be on time, avoid interrupting, and listen well, especially to people whose experience and perspectives are different.
- Each person should speak up when he or she has something to say, and ask questions when he or she does not understand something.
- Aim for consensus in the team's decision making. A consensus decision is the best decision the group can find at the time, supported by all.
- Any conflict in the team process is likely to be constructive.
- Each person is responsible to state his or her concerns, and the group is responsible to seek a solution that satisfies everyone's concerns.
- If there is not enough time to reach consensus on an issue, make a written note of the alternate views so all voices in the team are honored.

FACILITATOR TIPS

The Facilitator's Role

The facilitator is responsible for establishing an open environment in which participants feel free to share information and opinions, to listen and learn, and to think together. The facilitator's behavior will be a model for people in the program. An open, self-disclosing, honest, and accepting attitude on the part of the facilitator will help establish a tone of respect and safety in the group. Part of being prepared includes a full understanding of the concepts in this program.

Preparation for the Sessions

- Read and understand all materials and recommended preparatory materials.
- If working with a co-facilitator, divide responsibilities and build familiarity with each other's strengths and styles.
- Consider who the participants are and their reasons for getting involved.

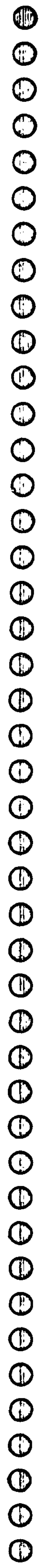
- Select and duplicate a case, the worksheets, and any other materials needed.
- Check time estimates; revise the agenda as needed.
- Check the meeting location and room set-up options.
- Distribute the (revised) agenda to participants in advance.
- Prepare flipcharts in advance: Agenda, Issues Board, and Ground Rules.
- Get excited about this program; it can make a real difference in the community!

General Pointers in Facilitating any Session

- Operate on the principle of no surprises. Review the agenda early in the session, give time frames, note planned breaks.
- Set ground rules early on, either suggesting them or eliciting them from the group. Invoke them if necessary to keep the group on task and to balance participation.
- Keep the purpose and objectives of the program always in mind and use them to guide the process. Each decision made during the session should support getting to the objectives.
- Remain open to issues that arise spontaneously, yet balance them with the agreed upon objectives. Post a blank piece of newsprint titled Issues Board in the room. Use it to record ideas, issues, or concerns that come up but cannot be addressed because of time and task constraints. Try to address these issues by the end of the program, or at least collect and document them.
- Accept and respect all perspectives and feelings as valid.
- Treat everyone in the room as an expert and a resource.
- Use open-ended questions, not yes-no questions.
- Provide synthesis at the end of discussions, if no one else has done so.
- Keep the team process moving and focused. Bring the process back to the stated tasks.
- Use internal data to determine own level of engagement and interest during the session and as a signal to check in with the group. If something does not seem right the group may need more time on an earlier discussion, or a break.

Tips Specific to this Module

- At the start, ask participants to introduce themselves briefly:
    - ➢ Name
    - ➢ Community
    - ➢ Function
- The bulleted questions and statements provided are reasonable starting points for discussions on each issue in this program.
- Keep in mind that the subject of death and the related issues come with many emotions attached. Participants will have varying degrees of familiarity and experience with these issues and with their personal responses to domestic violence deaths. This may need to be acknowledged in the group.



WORKSHEET A

Setting Up A Team

1. **Issues in Forming a Fatality Review Team**

   Establishing a domestic violence fatality review team and process in a community touches on many issues and concerns. List the issues that ought to be considered.

2. **Purpose and Approach of Reviews**

   There are various approaches to, and purposes for, doing domestic violence fatality reviews. Discuss several different approaches. As a group, agree why a community would want to have domestic violence fatality reviews, and what is expected to be learned or to be different as a result.

3. Team Structures

Structure issues include:

- ➢ How is the team created?
- ➢ Where is it housed administratively?
- ➢ Where are meetings held?
- ➢ How frequently does it meet?
- ➢ Other issues

List possible structures of a Domestic Violence Fatality Review Team.

➢ Discuss the alternatives to domestic violence fatality reviews. Then, agree on a preferred structure for the Domestic Violence Fatality Review Team. Identify the desired structure and the reasons for selecting it.

4. Scope

The scope of a Domestic Violence Fatality Review Team's work includes:

- ➢ How are cases screened?
- ➢ How are cases selected?
- ➢ How is the approach that will be taken in these cases to be determined?

List factors in determining the scope of a team's work.

➢ Discuss the various ways to set the scope for a Domestic Violence Fatality Review Team. Identify the team's preference for scope and the rationale.

5. Team Membership

List the ideal membership of a Domestic Violence Fatality Review Team.

➢ Review the list as a group. Identify the absolutely essential team members a team must have.

WORKSHEET B

Information & Confidentiality

6. Community Involvement

List community agencies and individuals that somehow touched this case.

- Identify the agencies or individuals that intervened in the case.

  - Add to the list agencies or individuals that might have intervened, but did not in this case.

7. Information Sources

List the reports or sources of information available to the Domestic Violence Fatality Review Team for this case review.

- What additional information or reports also should be made available?

- Review the lists of information sources and reports. Identify three to five items that are needed the most in a domestic violence fatality review.

8. Issues in Getting Information

Discuss the expected barriers to be encountered in obtaining information that the Domestic Violence Fatality Review Team needs. List these barriers on the left, below. On the right, list ways the team could obtain the most needed information identified above.

BARRIERS TO GETTING INFORMATION	WAYS TO OBTAIN INFORMATION

9. Confidentiality Agreement

Draft a Confidentiality Agreement and a policy statement about what will be released at the conclusion of the domestic violence fatality review.

➢ Make a clean copy of the team's Confidentiality Agreement. Have each member of the team sign the agreement.

10. Family Participation Policy

Consider the possibility that members of the victim's family may want to participate in the review. Discuss the team's response to such request. What will be the team's response if a similar request is made from members of the perpetrator's family? Draft a Family Participation Policy for your team.

WORKSHEET C

Reflecting Back & Looking Ahead

11. Effective Interventions

Reflect on the list of interventions from Question 6 on Worksheet B. Discuss which interventions were most helpful, and why. Discuss which interventions were least helpful, and why. Note which agencies or individuals the team would commend, and those that the team would use as examples of areas for improvement in a final report.

COMMENDABLE	IMPROVABLE

12. System Improvements

Imagine a better system. What interventions, coordinated efforts, and collaborative approaches would have to happen in an ideal version of a community?

- ➢ Take the dream and blend in practicality. List the recommendations for system improvements that the team would include in a final report.

- ➢ Star your strongest recommendation.

13. Final Report / Press Release

Draft a press release the team would present upon completion of this case review.

- Consider a final report. Discuss and decide on the audience it would be written for, the form of the report, and the nature of the content to be included.

14. Team Structure Improvements

Having worked through the process of a case review, revisit the Domestic Violence Fatality Review Team's structure decisions from Worksheet A. What, if anything, would change, based on the team's experience so far?

15. Team Process Improvements

Reflect on the team's discussion and decision making process. What worked well that the team wants to keep doing? What improvements can be made?

WHAT WORKS IN OUR PROCESS	AREAS FOR IMPROVEMENT

- Identify the two or three strongest recommendations for improvement, and write down one action step to take on each.

Note the team's thoughts on how to deal with the emotions involved in doing domestic violence fatality reviews.

OVERHEAD TRANSPARENCY MASTERS

Most community groups will be small enough to work comfortably with individual worksheets and flipcharts on easels or the wall. Overhead transparencies may be used for groups accustomed to using overheads, or for larger groups (for instance, a training program including several communities) so that everyone can see the work of the group. These overhead masters may be reproduced.

1. Issues in Forming a Domestic Violence Fatality Review Team

2. Purpose and Approach of Reviews

3. Team Structures

➢ **Preferred Domestic Violence Fatality Review Team structure and reasons.**

4. Scope

➢ **Preferred scope and rationale.**

5. Team Membership

6. Community Involvement

7. Information Sources

8. Issues in Obtaining Information

BARRIERS TO OBTAINING INFORMATION	WAYS TO OBTAIN INFORMATION

9. Confidentiality Agreement

10. Family Participation Policy

11. Effective Interventions

COMMENDABLE	IMPROVABLE

12. System Improvements

13. Final Report / Press Release

14. Team Structure Improvements

15. Team Process Improvements

WHAT WORKS IN OUR PROCESS	AREAS FOR IMPROVEMENT

➢ **Steps to take**

➢ **Dealing with emotions**

CASES FOR PRACTICE AND ANALYSIS

This program is designed around the review of a domestic violence fatality case. Two hypothetical cases are provided. Each of the cases is based on real domestic fatalities, but is fictionalized to disguise the facts. It is recommended that one of these cases be used in the program.

Alternatively, the team may wish to create a different hypothetical case to use in its program delivery. If so, follow the pattern in the cases provided and include the following:

- Case summary
- Newspaper article
- Justice system history
- Public health / medical history, including Medical Examiner's report
- Advocacy summary
- Other services and interactions as known

These are the major elements relevant to examining and analyzing a domestic violence homicide. The team will need to create most of these summaries based on more extensive data. (Consider that this program is a time-limited training event and do not overburden the participants with full case files.) Write the synthesis and summaries before conducting the program and present a packet of no more than 12 pages.

If it creates its own case, the team will probably build off a real case or a combination of elements from several cases. Take great care to avoid cases that are now, or have a chance of becoming, active court cases.

The team should not use an unedited local case. The program's emphasis is on developing a process for the team to use in conducting domestic violence fatality reviews. Team members should not be distracted from the process by the content or by memories of the story, personal or known involvement in the case, or feelings that could be stimulated by revisiting an actual case.

CASE 1: Maria Rendon

Summary

On March 28th Maria Rendon, a 39-year-old Hispanic woman, was shot and killed by her estranged husband, Felix Rendon, a 41-year-old Hispanic male, as she was manicuring a client's nails in the living room of her home. The couple came to the United States on the Mariel boat lift from Cuba in 1980 and had been married at least 20 years. After years of suffering abuse, Maria moved out into her own apartment. The immediate trigger for the homicide seems to have been Felix's discovery of Maria's divorce plans. Felix burst into Maria's new apartment by smashing through the sliding glass door. The client told police that Felix shot Maria three times and then pointed the gun at his own head. He then mumbled something unintelligible before pointing the gun at his face. Finally, Felix exited the scene only to shoot himself the next day. He survived his self-inflicted gunshot wound and was subsequently convicted of second-degree murder.

CASE 1: Newspaper Article

Title: "Man who killed estranged wife shoots self."

Date: March 30th.

A day after Felix Rendon broke into his estranged wife's home and shot her to death, he turned the gun on himself Tuesday morning, police said. Rendon remains in critical condition at Jackson Memorial Hospital, less than 24 hours after allegedly killing his wife, police said.

Friends and neighbors said Rendon was an abusive husband. He frequently beat his wife, Maria, and verbally abused her, said friend Miriam Lueck, a former neighbor. "She endured so much. He made her life impossible," Lueck said.

Maria Rendon, a manicurist, tried to leave her husband several times before, but he threatened to harm her family, Lueck said. "She was a beautiful person," Lueck said. "If you needed something from her, it was yours."

When he was sober, Rendon was hardworking and easy going, Lueck said. He was a construction worker by trade and completely remodeled the home the couple shared in the 1100 block of Walsh Drive.

Neighbors said police cars frequently paid visits to the couple's home.

"I always said something was going to happen," said another neighbor, Warman Fuzzy.

The couple had been separated for several months, but Rendon kept going near his wife, police said. She had a restraining order prohibiting him from going near her apartment in the 200 block of Fifth Street.

But Monday night, while Maria sat with a friend, Rendon crashed through a sliding glass door and shot her, police said.

Police had been searching for him for 12 hours when Rendon shot himself about 8:35 a.m. Tuesday, March 29th, at 6th Street and Pine Drive.

CASE 1: Justice System

The Rendon's relationship was marked by escalating woman-battering to the point that Maria reported to friends she just had to leave. She had left on a number of other occasions but returned after Felix threatened members of her family. The Rendon's son, Jose, confirmed that his father Felix had threatened Jose's and his mother's life on a number of occasions. Jose told police that Felix brazenly told Maria, "One day I'm going to kill you."

At the time of her death Maria had a restraining order in place against Felix. According to neighbors Felix broke the order with impunity. However, when police arrived Felix had always fled. One couple said that the police had been to Maria Rendon's residence several times a week for the three months prior to Maria's death. Jose confirmed that his mother was constantly being stalked by Felix, who "kept coming by the residence every couple of hours since he found where they resided and had knocked on doors and windows often." Like the neighbors, Jose also stated in the homicide report that police officers responded to that address on numerous occasions because of Felix's behavior.

Felix had a long history of committing domestic violence. The police were well aware of this history. From June 1984 to January 1994 he was arrested at least seven times. Four of these arrests resulted in convictions – one for aggravated assault on his wife and three for domestic battery. Two months before the killing, Felix was arrested for breaking the terms of the protective order. Other convictions included DUI, petty theft, and carrying a concealed weapon and firearm. Another witness noted that Felix frequently discharged his weapon in the back yard of the family home.

At the time of the killing Felix was on probation for a recent misdemeanor assault. One condition of his probation was that he attend anger management and substance abuse counseling programs in addition to the private psychiatric assistance he sporadically received.

Case 1: Public Health/Medical History

Health history

Mrs. Rendon came with her husband to the local mental health clinic. She primarily was seeking help for her husband who was diagnosed with major depression and admitted to intermittent/excessive alcohol use. The couple also was seeking marital counseling related to Mr. Rendon's problems with his temper. Mr. Rendon was prescribed antidepressant medication and referred to Alcoholics Anonymous. Mrs. Rendon was assessed as having serious sleeping problems, depressive symptoms, and anxiety symptoms. Her symptoms were assessed as being related to her husband's problems and their frequent quarrels. She also works long hours in her home as a manicurist and is apparently under continuous stress. She was referred to Alanon. The couple was scheduled to return for further marital counseling but did not keep their appointment.

Mrs. Rendon was treated in the Emergency Department on one prior occasion for bruises and lacerations to her throat following an assault by Mr. Rendon (see handwritten attachment).

Psychiatrist

Felix saw a psychiatrist for depression and substance abuse. The psychiatrist prescribed Prozac, which Felix did not take. The psychiatrist knew that Felix "lost his temper at home sometimes" but saw these outbursts as being primarily associated with Felix's addiction to drugs and alcohol. In a counseling session that both Felix and Maria attended, the psychiatrist recommended that Maria stop "enabling" Felix in subtle ways regarding his drug use and try to work on her codependency issues.

Medical examiner's report

Name of Deceased: Maria Rendon, 39-year-old Hispanic female appearing her stated age. A 5 x 5 mm. gunshot entrance wound is present at the left temporal area at a level 5 cms. above the level of the eyes at a distance of 8 cm. to the left from the anterior midline. The bullet penetrated the skin and scalp. It created an entrance perforation in the skull measuring 8 x 9 mm. with internal coning. The perforation is located at the lateral and posterior extremity of the left frontal fossa immediately adjacent to the lateral termination of the left sphenoid ridge. The bullet traversed the subarachnoid space and entered the brain at the inferior gyrus of the left frontal lobe. It traversed gray matter, white matter, the left ventricle, crossed the midline and continued through the posterior horn of the left ventricle and impacted on the lateral aspect of the right occipital bone at a distance of 8 cm. to the right from the posterior midline. The bullet ricocheted and lodged within the right occipital lobe laterally. The bullet is markedly deformed, partially flattened and measures 10x9x6 mm. It has a 5 x 6.5 mm. slightly oval and distorted back. Slight left subdural hemorrhage.

Pathological anatomical diagnoses.

Central nervous system: Through and through gunshot tract of brain, subarachnoid hemorrhage.
Cardiovascular system: No pathological diagnosis.
Respiratory system: No pathological diagnosis.
Gastrointestinal system: No pathological diagnosis.
Reticuloendothelial system: No pathological diagnosis.
Endocrine system: No pathological diagnosis.
Genitourinary system: No pathological diagnosis.
Integumental system: One gunshot entrance wound.

Cause of Death: This 39-year-old Hispanic female died of the consequences of a gunshot wound to the head significant enough to immediately immobilize and kill this woman.
The manner of death is homicidal.

Richard O. Smith
M.D. District Medical Examiner

CASE 1: Advocacy

Domestic violence program

The domestic violence program's records indicated that their first known contact with Maria Rendon was three years prior to her death. She wanted to leave her very abusive husband. Maria was unable to go into the shelter because her son was too old to reside with her. She refused to leave her son behind, so she and Jose went into a homeless shelter. Within a few days, Felix found them at the homeless shelter and threatened to kill her family if she did not return to him. Consequently, she returned to him.

Maria called the domestic violence program on several other occasions. During one call, Maria told the advocate that Felix continued to batter her, at least twice a month. She was not planning to leave Felix because she was afraid he would kill her, Jose, or another family member. Maria talked with the advocate for a while who told her that they had regular support groups that Maria might want to attend. Maria said she could not leave the house except to go to church because Felix thought she was sleeping with other men.

During the last known call to the domestic violence program, Maria told the advocate she felt she needed to leave Felix. The advocate told Maria about support groups and restraining orders. They also discussed safety planning and options for escape.

Court advocate

Approximately three months before her death, Maria took out a restraining order and moved out with her son to their own apartment in a guarded, gated complex. The advocate suggested Maria give a copy of the order to the security guards at the gate.

Felix repeatedly violated the restraining order, but was not arrested. Maria called the advocate for advice. The advocate suggested that Maria go to the courthouse and file a complaint for violation of the order. Maria did file that complaint.

CASE 1: Other Known Services/Interactions

Animal Control

Five years prior to the murder, a neighbor called Animal Control to report that Felix brutally beat the family dog. Shortly after that episode, Felix shot and killed the family dog because it would not quit barking. Animal Control personnel were particularly disturbed by this case because Felix hung the dead dog over a wire in the family's backyard.

School

When Jose was 14, his teacher suggested that he see the guidance counselor because his grades were slipping and he seemed distracted. Jose told the counselor that he hated his father because he was abusive toward his mother, but not him. Jose was also very angry with his father for killing his dog. The guidance counselor referred the case to Child Protective Services because Jose was a minor child who had witnessed domestic violence.

Church

Maria attended the same church every Sunday for years. A number of the congregation knew of her plight as a battered woman and sympathized with her. The priest talked with her about her marriage and encouraged her to try to "work things out" with Felix, while at the same time acknowledging that "Felix was a difficult man." Roughly a year before her murder, Maria suddenly stopped attending church.

Neighbors

The neighbors were well aware of Felix's extremely abusive nature. They had heard him threaten Maria, saying he would kill her one day. They had seen him verbally abuse Jose.

CPS

A CPS case had been opened on the Rendons when Felix's school, Memorial High School, contacted the agency in reference to a child witness to domestic violence. The CPS worker contacted the family and was reassured when she heard that Felix was participating in anger management and substance abuse counseling programs. Given that Felix had not physically assaulted Jose at the time the worker made contact with the family, CPS closed the case as unfounded.

CASE 2: Trish Temple

Summary

Trish Temple, a 19-year-old white female, was found dead on a sidewalk lying in a pool of blood. She was shot dead at 11 p.m. on Thursday, February 17th, by her ex-boyfriend, Rod Clements, a 22-year-old white male, as she was walking home from a concert with a girlfriend. Rod Clements then unsuccessfully attempted suicide by shooting himself in the head. Trish had recently ended her cohabiting relationship with Clements, with whom she had a two-year-old son.

The two met in high school in 1988 in their hometown and dated from around 1991. They left their hometown and moved to another state about a year prior to the murder. Rod kept her mostly confined to their apartment, forbidding her to go out. The relationship was violent, with Rod battering Trish on an ongoing basis.

CASE 2: Newspaper Article

Title: "Twisted Love Caused Fatal Shooting."

Date: Saturday, February 19th

Tired of the beatings and harassing telephone calls, Trish Temple talked earlier this week of getting a restraining order against her ex-boyfriend. But Rod Clements had other plans. He left a message on Temple's answering machine Thursday afternoon, expressing his love in a quiet, stilted voice.

"Babe, I love you. We're going to be together forever. I promise you. It will be a good life."

Hours later, police say, Clements found the love of his life among a crowd leaving a concert at the University. Witnesses say he caught up with her on a dormitory walkway and shot her once in the head at point-blank range. Temple died instantly.

Clements, 22, was spotted walking a block north of the campus less than an hour later and, in a confrontation with two deputies, was shot twice. Sheriff's officials said Clements shot himself in the head, but they weren't sure Friday if a second wound in his side was self-inflicted or from a deputy's gun. Clements, of 833 Timber Pond Drive, remained in critical condition Friday.

The shooting was the second slaying on the main campus in the University's history. In 1985, a secretary was raped and killed by a student in a campus office.

Friday morning, Temple's friends gathered at her rented Morrison Avenue house to sort out the tragedy. Clements and Temple's two-year-old son, Walter, played quietly in the house and front yard.

Temple, 19, and Clements had a rocky relationship since meeting in their hometown about six years ago, said her cousin, Billy Hannon. It got worse in the past year. Police were called at least twice when Temple complained her boyfriend beat or threatened her.

In a statement to police following a fight last March, Temple said Clements choked her, threw her into a chair, hit her in the chest, and ripped off her clothes. The police report noted scratches on Temple's chest and welts on her neck. "If no action was taken at that point, the propensity for violence would continue," wrote Sgt. David Jones, who arrested Clements on a charge of battery.

But a judge dismissed the charge a month later when Temple refused to testify. She had moved back to her hometown in another state and said she was too afraid to testify, said Marianne Bolshy, a victim's advocate.

Bolshy didn't know when Temple returned to this community but said she heard from her again after another beating Jan. 9. Temple left her apartment after that and moved in with a woman friend, Rene Webb. Clements threatened Temple in a series of harassing telephone calls between Jan. 28 and Feb. 8, according to a complaint Webb filed with police.

Temple spoke with Webb about getting a restraining order again Tuesday. However, Temple's schedule as a food server conflicted with the hours the restraining order office was open. But a restraining order "isn't bulletproof," Bolshy said. "Even if she had it, there's no guarantee it would save her life."

Friends who saw Clements at the concert Thursday night said they wanted to keep him away from Temple but didn't think he'd do anything violent. Brian Bush said he saw Clements outside the heavy metal show. Clements said he only wanted to get some clothes back from Temple, Bush said.

University Police used metal detectors on concert-goers, so Clements either left his gun outside or somehow got it past security, said University Police Lt. Bob Bishop. The shooting took place on the walkway outside a residence hall.

As Clements approached Temple he said, "I want to say something to you," recalled Webb, who was standing next to her roommate when she was shot. Clements was so close, his .32-caliber semiautomatic handgun may have touched Temple's head, Webb said.

Shortly after, a sheriff's deputy saw a man matching Clements' description walking on North 42nd Street. The deputy told Clements to remove his hand from the army jacket, and he did, pulling a gun at the same time, according to sheriff's officials. A second deputy responding to the scene heard a gunshot while getting out of his car across the street. Deputy Sean Fitzpatrick saw Clements on the ground, still pointing his gun, and fired, officials said.

Fitzpatrick was placed on routine administrative leave Friday pending an investigation by the Sheriff's Office and state attorney. In 1984, a man committed suicide in an incident similar to Thursday's. Following a rock concert, the man shot his estranged wife, who survived, before turning the gun on himself. He died two days later.

CASE 2: Justice System

A police report made on March 4, 1993, regarding a battery charge against Rod, revealed the following comment made by Trish:

"My boyfriend and I live together at a friend's apartment. The argument has been endless for 2 days because Rod is not taking any responsibility for his son. He can go out and party but my son has no diapers.... Then he approached me choking me to the point I'm unable to gasp for any air. He let go once but did it again. When I got up to move he threw me into the wicker chair.... He punched me in the chest and I lost it. I hit him back several times, yelling, 'I'm tired of being beat!' He got worse pulling my hair extremely hard, beating my chest and face and head. He grabbed my breasts, squeezing them and hurting them. I ran out of the house, he was behind me ripping my clothes. I got in the car and went to the Women's Center and called the police."

Rod was charged with battery for the aforementioned violence. But a judge dismissed the case after Trish refused to testify. Trish told a victim's advocate that she was moving back to her hometown in a different state and was too scared to testify. Eventually she returned to this community. She was beaten again on January 9, 1994, and as a result moved out of her apartment to stay with Rene Webb, her girlfriend. From January 28 to February 8, 1994, Rod threatened Trish over the telephone on a number of occasions to the point that Trish's roommate filed a complaint with the police. Rod's friends told police that Rod could not get Trish out of his mind. One of his friends told police that on one occasion after talking with Trish he was so angry that he fired his gun into a dresser at his father's residence. Rod's messages on her answering machine attest to his obsession with her. One of his friends told police that one week before the killing Rod called Trish saying something like, "I can't believe what you've done to me. I'm going to kill you." The day before the killing he said, "I love you no matter what happens, you're always gonna be mine, no matter what happens." On the day of the shooting a message Rod left implied he had already decided to kill her. He said, "wait till you see what I've got for you tonight." He said something similar to this last statement just before killing Trish.

The police report also revealed that on the night of the shooting a friend of Rod's gave him a ride to a gas station where the friend thought Rod bought marijuana from "his supplier." Somehow, Rod got a ride from the gas station to the concert. Before the concert Rod attended an Alcoholics Anonymous meeting. Rod had prior drug arrests, both here and in the state he resided in previously, and was on probation at the time of the killing. As conditions of probation he was mandated to attend both Alcoholics Anonymous meetings and batterer's treatment.

CASE 2: Public Health/Medical History

Health history: Trish Temple

HPI: 19 year old, GI, PI, presents for an annual visit to the Health Clinic. Presents with complaint of lower abdominal pelvic discomfort, unrelated to menses, dysparunia x7 months. No pain with bowel movement, no dysemenorrhea. Review of systems negative. Past medical and surgical history negative.
GYN HX: Menarche at age 12. 30 day cycle x 3-5 days. Denies dysmenorrhea.
History of gonorrhea-treated. Denies any abnormal PAP smears. Last PAP greater than one year.
OB HX: GI, PI, SVDx1, 7lbs. 20 oz. male. No complications.
SOCIAL: No tobacco, alcohol, drugs, transfusions. Lives with roommate.
Works as food server. Separated from FOB past two months. History of domestic violence. See attached records. Family Hx: Non-contributory.
PHYS: EXAM: AFVSS
GENERAL: WF cooperative, distracted, no acute distress. Appears older than stated age.
HEENT: WNL, CV, RRR, LUNGS: Bilaterally CPA: BREASTS: Symmetrical, no masses, no retractions, no nipple discharge. ABDOMEN: Positive bowel sounds. No rebound. Bilateral lower quadrant tenderness.
EXTREMITIES: No clubbing, cyanosis or edema. SKIN: Left chest bruises 5x7 cms. Right arm bruised on inner aspect 5x5 cms. Inner Rt. thigh 7x7 cm. bruise.
PELVIC: Normal external female genitalia. Vagina pink, moist, well rugated. Cervix parous without lesions. Uterus 4 weeks in size, anteverted, tender to palpation. Adnexa, non-tender, no masses.

LABS: PAP, GC/Chlam obtained. Wet mount neg.

ASSESSMENT/PLAN: 19 year old, GI, PI.

1. Annual visit. PAP, cultures obtained. Discussed contraception, condoms.
2. Chronic pelvic pain. Possible etiologies include endometriosis, adenomyosis, domestic violence. Suspect the latter to be the most likely source. Discussed medical management. Patient refuses treatment.
3. Domestic Violence: Patient states that bruises were inflicted by ex-boyfriend, Rod, three days ago. Informed patient of several shelter services and provided written referral to shelter. States she and child are safe at home and she does not wish assistance from shelter at this time. States she has used shelter services in the past and knows how to access them. States that she did not file a police report of this incident but has filed in the past on at least two occasions.

Follow-up in two weeks to review labs and discuss domestic situation.

Patient did not return for F/U visit.

Medical Examiner's Report

Toxicology report: Trish Temple

Results negative: Report Attached

Date of Autopsy: 2/18.

Medical Examiner: Dr. Martin

Report of Autopsy Opinion
Diagnosis: Gunshot wound of head penetrating skull and brain.
Cause of Death: Gunshot wound of head penetrating skull and brain.
Manner of Death: Homicide (shot by another person).

Autopsy Examination Name: Trish Temple

Present at autopsy: Lt. T.J. Norton and Detective James Ricci.
External examination: This is the unembalmed body of a normally developed and nourished white woman measuring 5'3", weighing 105 pounds, and appearing the age of record of 19 years.

The body is dressed in a leather bolero type jacket and brassiere, panties, shorts, lace up mid-thigh length black stockings, and lace up black boots.

The cranial hair is straight brown to longer than shoulder length. The irises are hazel and there is no conjunctival icterus, injection or pettechiation. The lips and gums are arraumatic and the teeth are natural and in good condition. The external genitalia, breasts, and anus are unremarkable.

Tattoos include a lion on the outside of the right upper arm and a rose on the anterior left thigh. These tattoos are professionally executed. On the extensor right forearm is a tattoo of a heart and the initial "T."

Non gunshot acute injuries: On the outside of the left shoulder is an abrasion. There is a 3/4" abrasion over the prominence of the proximal joint of the left thumb and a 1 1/2" abrasion over the radial left wrist and back of hand. There is a 1 1/4" laceration through the lateral left eyebrow, which is located roughly in the center of a 1 1/2" circular abrasion.

Gunshot wound:
Entrance: On the medial left cheek just lateral to the left nostril, with its center 4 1/2" from the top of the head and 1/2" to the left of the midline, is a close range gunshot entrance wound with 3/16" marginally abraded central perforation within a 3" in diameter circle of the characteristic punctuate abrasions of powder tattooing.

Wound track: The track traverses the facial structures and enters the cranial vault through the anterior midline of the sphenoid bone, passes through the sella wrcica, passes through the pons

nearly severing this structure, and passes between the inferior posterior cerebellum at the midline, then between the occipital lobes furrowing the apposed medial surfaces, then producing a punched out fracture of the occipital bone, ending in the scalp between the occipital bone and skull where a medium caliber, round nosed, fully jacked except for the base, almost undeformed bullet is recovered. The direction of this tract is from front to back, slightly from left to right, and slightly upward.

Internal examination: The pneumothorax test is negative. Body cavities have smooth shiny surfaces and contain physiologic amounts of fluid. The heart weighs 200 grams and the ventricles are contracted. The atria, pulmonary, and aortic trunks contain a small amount of blood not mixed with air. The epicardial surfaces, cut surface of the myocardium, chambers, and leaflets and cusps of the valves are unremarkable; the right coronary ostium rises approximately 1" above its normal position. The distribution of this vessel is unremarkable. The coronary artery circulation is balanced. There is minimal coronary and systemic arteriosclerosis and the major veins are normal.

The laryngeal orifice is unobstructed and the hyoid bone, larynx, and adjacent soft tissues atraumatic. The tracheobronchial tree has an unremarkable mucosa and contains a small amount of blood-tinged fluid in the intrapulmonary portions. The lungs are normally expanded. The right lung weighs 305 grams, the left 300, and the pleural surfaces are an indistinctly mottled gray-white with mild carbon pigmentation and a deeper purple cast in the dependent areas. The cut surfaces are of normal resilience and aeration. The pulmonary vascular trees are free of thromboemboli or significant sclerosis.

The esophagus, small and large intestines are unremarkable. The stomach contains 50 ml of turbid brown fluid and there are no gastric mucosal lesions.

The liver weighs 945 grams and the smooth capsule encloses a light brown tissue of normal consistency. The gallbladder and other structures of the porta hepatis are unremarkable. The pancreas is normal in size, configuration, and on section.

The lymph nodes and 110-gram spleen are unremarkable.

The right kidney weighs 110 grams, the left 105, and the capsular and cut surfaces are unremarkable as are the ureters and urinary bladder. The uterus and ovaries are normal in size, configuration, and on section. There is no luteal activity. The endometrium is a uniform low light brown.

The pituitary, thyroid, and adrenal glands are unremarkable.

There are no organic lesions or injuries of the musculoskeletal system other than those described.

The scalp and cranial bones are unremarkable as are the dura and transparent leptomeninges. The cerebrospinal fluid is clear. The brain weighs 1300 grams. Multiple sections through the brain reveal no organic lesions. The cerebral arteries are mildly sclerotic.

CASE 2: Advocacy

Trish entered a domestic violence shelter in February 1993. She resided in shelter for about a week prior to leaving to return to her hometown in another state. While in shelter, she was written up twice (once for failing to perform lunch chores and once for having a friend drop her off too close to the shelter). Shelter staff advocated successfully for her admittance into a job-training program. Shelter staff also worked to help her receive food stamps and welfare, to pursue enforcement of child support, and to begin moves toward finding independent subsidized housing. They also provided her with transportation to day care for her child, assistance with retrieving her belongings, and help with obtaining various items from a local thrift store.

While in shelter Trish told shelter staff that Rod "very frequently," "pushes and shoves me around," "hits and punches my arms and body," "physically throws me around the room," and "tries to choke and strangle me." Trish also noted that Rod "makes me afraid for my life all of the time."

CASE 2: Other Known Services/Interactions

School

Trish and Rod were together from a young age. Rod became abusive shortly after they started dating. Her grades started falling and teachers were concerned and suggested she talk to the high school counselor. Trish told the school counselor that she had other priorities, she was pregnant, and probably would drop out. Trish did say that her boyfriend was particularly jealous, but that once the baby came, things would get better.

Battered women's program in Trish's home town

A friend knew that Trish was being abused and suggested Trish contact the domestic violence program. While the program did not have its own shelter, it did have shelter options. However, since Trish was still a minor, shelter staff needed verification Trish was emancipated. In the end, she decided to stay with Rod.

Food stamp office

Trish was eligible for WIC and food stamps. She went to the office to apply. When asked about baby's father, she said he was abusive and that she and her baby would try to make a go of it alone.

Job training program

Trish signed up for a job-training program, which would allow her to get her GED and some job training.

Legal services program through the university

Rod is currently serving 18 years for second degree murder. After Trish was murdered, Trish's mother started to raise Trish's son, Walter. But, when Rod's dad wanted to take Walter to see Rod, Trish's mother let the child go. Rod's father had Rod sign adoption papers. The legal services program through the university is helping Trish's mother fight for child custody of Walter.

ALTERNATE COMMUNITIES

When using this program for a community group it will usually be natural and appropriate to adopt participants' actual community as the context in reviewing the hypothetical case.

However, this program can be used with a mixed audience composed of groups or representatives from multiple communities, for example, in a conference or regional training program. In these situations it may be helpful to assign participants a hypothetical community context that is not exactly like any of their home communities, yet is similar and provides a shared context.

Several alternate community descriptions follow. Select one or more of the community descriptions, copy the descriptions, and distribute them as needed.

OCEAN VIEW

A historic southeastern coastal city of 250,000, Ocean View is situated on a natural harbor to the Atlantic Ocean, and flanked by beautiful barrier islands to the north and south. The Medical University's National Crime Victim's Research and Treatment Center has been a national leader in violence and sexual assault prevention. The African-American Police Chief has for many years been a leader in the area of domestic violence, having served on the US Attorney General's Task Force on Family Violence in 1984. As in many southern locales, community leadership is "thick." Services for battered women include a shelter and support groups, but little else. The courts and judiciary lag far behind those of other jurisdictions in both access and their responses to domestic violence.

HILL CITY

A small old town in the Blue Ridge Mountains, Hill City is the county seat of a county of 85,000. The town itself lies about an hour from a large metropolitan area and is a bedroom community for commuters who work there and live in the several new subdivisions which have grown up on the outskirts of town during the past few years. Of the native population, about 60% are Caucasian and 40% African-American; and many of their families have lived in Hill City for generations. The town itself has a police force and is the home base of the county sheriff's office. Hill City has a good hospital surrounded by a thriving medical campus. A domestic violence program in the town provides shelter, transitional housing, support groups, and courthouse advocacy for victims and their children.

DEER FOOT

The capital city of a northwestern state. The city has a population of 100,000 and is one of only three large cities (100-150,000) in the state. The bulk of the state is rural in nature. Much of the economy is based on ranching and tourism, and a recent growth spurt in the state stems from the influx of people moving in from more densely populated areas. Natives are not necessarily pleased about the "foreigners" moving in. Property costs are now sky high, and many native ranchers are having to sell to "Hollywood-types" who are posting much of the land to those who had previously freely hunted and enjoyed the land with very little limitation. In addition, with few employment opportunities, many of the young of Deer Foot leave the state. The city is conveniently located to three very large Indian reservations. Male patriarchy is alive and thriving in Deer Foot as evidenced by those serving on the police force, the judiciary and other local agencies. These folks have for the most part refused to deal with the domestic violence advocates until "they get their act together." It is very common to see pickup trucks parked one next to the other in front of the many, many bars in town, rifles proudly displayed in the gun racks. These same bars sell ammunition and six packs to go.

METROPOLIS

An eastern seaboard city of 6 million, has long been considered a major financial center for the entire nation. Within the sprawling confines of the city are individual ethnic/religious communities of incredible diversity and large numbers of undocumented immigrants. The population's economic standing runs the gamut from desperately impoverished all the way to extremely wealthy. Although the governor of the state understands the nature and scope of domestic violence and the political wisdom of prioritizing it, the mayor and city council are pulled in the other direction by the competing demands of rampant violent crime, comprised in significant parts of gang warfare and organized crime and an old, outdated infrastructure suffering from decades of neglect; and citizens in many of the ethnic enclaves who consider domestic violence a family matter and women the property of their partners. The police, medical and social services agencies are huge, labyrinthine and bureaucratized; and the domestic violence services providers overwhelmed by demand. Domestic violence advocacy services are provided as part of court services, along with translators for the myriad non-English language speakers who appear in the many family courts daily.

SANTA KARMA

A Pacific Coast city of almost 1 million, Santa Karma is the largest city in a county of more than 2 million. One of the largest and oldest cities in California, Santa Karma is well known throughout the world for its cutting edge high-tech companies. Although the area was formerly agricultural, residents now pride themselves on the many technical innovations that have come out of the Santa Karma Valley in the last 20 years. Blessed with an abundance of good weather throughout the year and many recreational activities, Santa Karma has experienced an unprecedented influx of people in the last 10 years. Approximately 35% of the population in Santa Karma are Caucasian, 35% Latino, 20% Asian-Pacific Islander and 10% African-American. Although the unemployment rate in Santa Karma is very low and wages are high, the cost of living, especially housing, is very high. Santa Karma County is fortunate to have three battered women's shelters and one transitional housing program for battered women and their children.

GOLD MOUNTAIN

Gold Mountain is a dusty old mining town of 40,000 in the western mountains, part of a larger county of 250,000. The largest city in the county is a recreation/gambling destination. The nearest hospital is a 30-minute drive. This town boomed in the mid to late 1800's, when gold mining was at its peak.

While Gold Mountain has its own small domestic violence program which provides telephone crisis intervention, most services – courthouse advocacy, shelter, transitional housing, support groups – are provided by the domestic violence program located in the county's largest city.

Transportation to and from Gold Mountain can be particularly treacherous during the winter because of snow and because an individual can enter and exit the town only on curvy mountain roads.

CLEAR ACRES

Clear Acres is a Midwestern college town of 125,000, the county seat, and the center of the surrounding agricultural community. As the county seat, the town has a large county hospital as well as two smaller hospitals.

The state college has an enrollment of approximately 3,000, many of whom drive each day to school from the surrounding towns and farms. There are also two business colleges and a junior college. While Clear Acres has a steady population, the county is experiencing a steady loss of younger people to the larger cities.

Most residents of Clear Acres have deep ties to the community and are, on the whole, conservative and slow to adapt to changes. The majority of the residents are Caucasian, with a sizable number of Native Americans living in town and on a nearby reservation and, recently, a small number of seasonal migrant farm workers.

Unfortunately, not even this small town in the heartland is immune to gang-related racial problems. There has been a sharp increase in crime and violence in the past ten years. Domestic violence, which has historically been a "family problem," is beginning to emerge as a community concern.

BORDERTOWN

Bordertown is a southwestern city of 100,000 located, as its name suggests, on the border with Mexico. Bordertown is the largest town in a county of 500,000 residents. Approximately 80 percent of Bordertown's population are Mexican-American.

Bordertown has experienced an enormous growth spurt over the past 10 years as more industries are moving to the area to capitalize on its easy access to Mexico. However, the city continues to experience very high unemployment rates ranging from 15 - 20 percent. It is in one of the poorest counties in the country.

Bordertown has three major hospitals which serve county residents as well as residents of northern Mexico. It also serves as a major shopping Mecca for area residents as well as shoppers coming from Mexico.

SKY HIGH

Sky High is a major western city of 750,000, located in the Rocky Mountains. Tourism is a key part of the city's success. People come from all over the country to experience the beauty and recreational activities just outside the city. Downtown boasts a flourishing nightlife and is home to several professional sports teams.

Sky High has a diverse population with 66% Caucasian, 20% Hispanic, 12% African American, and 2% Asian American residents. It is one of three cities making up the metropolitan area. The population in the metro area has doubled in the last year.

Sky High is the most progressive of the three communities. Yet Sky High has the second highest incidence of domestic violence per capita among all the communities in the state and has only two battered women's shelters.

Sky High is a city within its own county. Both city and county level authorities continue to have cross-jurisdictional issues within Sky High and with neighboring municipalities.

THE STATE OF NEW DEVON

New Devon is a northeastern state with a population of 1.1 million. Its population is 94% Caucasian. It has a very low unemployment rate of approximately 3 percent. The state's largest city, which houses the state's major (yet small) airport, has a population of fewer than 100,000.

Services in New Devon are as varied as the state's communities, which range from small urban to very rural. Some communities have progressive, comprehensive domestic violence programs, while others, the rural ones, struggle to provide services.

Domestic violence interventions are coordinated at the state level through a statewide domestic violence coordinating council. Politically, residents place a high value on local control and individualism.

SAMPLE PRESS RELEASES

These documents are examples of press releases prepared by domestic violence fatality review teams. They are the products of the participants at the National Fatality Review Summit held in Key West, Florida, in October, 1998.

These example press releases and presentation notes for press conferences refer to the hypothetical cases included in this module. The cases are situated in hypothetical communities created for the purpose of the Summit learning experience, some of which are described in this program's "Alternate Communities."

These examples vary in style, emphasis, and tone. The press releases may offer ideas about how to frame reports from a community's domestic violence fatality review team.

NEW DEVON ANNOUNCES DOMESTIC VIOLENCE FATALITY REVIEW

I. **Trish Temple -- overview of case information**

II. **Convening the First Fatality Review Team**
- Multi-disciplinary
- 16 members

III. **Findings**
- A preventable homicide
- Community failed her
- Recommendations for systems improvement

IV. **A Call to Action**
- Honoring Trish Temple
- A seamless system so women such as Trish do not fall through the cracks again

PRESS RELEASE
OCTOBER 27, 1998
SANTA KARMA, CA

Eighteen men, women, and children were killed last year in Santa Karma, CA, by the same perpetrator. And that perpetrator was domestic violence.

Three times that many children were left without a parent.

Ten of those children actually witnessed their parent being savagely murdered.

How can we stop this pattern of death and harm?

The Santa Karma Multi-disciplinary Domestic Violence Fatality Review Team was established to try to answer that question.

With the generous funding of Macro-Hard, a religiously based software company, judges, police, victim advocates, attorneys, medical personnel, clergy, and mental health practitioners have joined forces to make recommendations that will help prevent these deaths in the future.

This Fatality Review Team has identified cracks in the system and is making recommendations for change with a commitment to implement those recommendations and report back its progress to the citizens of Santa Karma.

One key recommendation of this team is to establish a multi-disciplinary, citywide advocacy system comprised of the following:

Central case management services providing the domestic violence victim with better access to services;
24-hour, on-call access to advocates for victims with a toll-free number;
Central-advocacy unit to coordinate services of different agencies; and
Computer linkages among agencies providing improved access to information.

Mayor Jack E. Campbell enthusiastically endorses these recommendations and pledges the resources needed to end the murderous onslaught so that never again will you wake up to a Santa Karma Gazette headline describing the murder of our mothers, daughters, sisters, and friends.

GOLD MOUNTAIN PRESS RELEASE (OFFICIAL)

Maria Rendon's tragic death brought many community agencies together to explore ways we can work together and communicate more effectively to keep survivors of domestic violence safe and to hold batterers accountable. There have been several meetings among law enforcement, prosecutors, judges, shelter representatives, health care professionals, Child and Family Services, and court personnel to review the circumstances of this senseless murder.

As a result of these meetings, these agencies have committed to create interagency agreements that both identify and make best use of existing resources. Our commitment does not end there. We will continue to meet to share information and to improve our ability to keep battered women and their children safe.

In the course of our meetings we have identified gaps in the resources of our community. One thing on which we all agree is that we must work harder to hold batterers accountable. We have identified, for example, that there is no mechanism in our community to enable appropriate agencies to share information about the risks Maria Rendon faced. Our first priority will be to create and implement such a mechanism.

Our city prides itself on being "The Community with a Heart of Gold." Now it's time to live up to that motto. It's time to open our hearts and save the lives of battered women and their children.

GOLD MOUNTAIN PRESS RELEASE (UNOFFICIAL)

The Ad Hoc Domestic Violence Death Review Committee of the town of Gold Mountain – "The City with a Heart of Gold" – today issued a blistering indictment of a majority of the town's citizens. The committee issued its Final Report on the shooting death of Maria Rendon by her estranged husband Felix, who later tried to shoot himself.

Mr. Rendon's incompetence at killing *himself* was an example of the incompetence of every person who touched this family, the committee said. The perfectly preventable death of Maria Rendon was not prevented.

Judges failed to prevent Maria's death by declining to hold Felix accountable, by failing to enforce their own restraining orders, and by sentencing him to a *total* of 30 days in jail on four separate domestic violence assault convictions.

Prosecutors failed to prevent Maria's death by allowing many charges against Felix to go unprosecuted.

Probation officers failed to prevent Maria's death by allowing *repeated* probation violations without arresting Felix.

A psychiatrist failed to prevent Maria's death by putting the parties in joint counseling, excusing Felix's violence as being the result of his drug and alcohol use, and by blaming Maria for "enabling" Felix's behavior.

The local Emergency Room failed to prevent Maria's death by *noticing* the bruises and lacerations on Maria's throat and *not* noticing that she needed help.

Animal control officers failed to prevent Maria's death by raising no Hell when Felix beat, then shot the family dog.

Maria and Felix's friends, neighbors, relatives, and church congregation failed to prevent Maria's death by ignoring their increasingly obvious and increasingly violent family crisis.

And finally, all the rest of the community failed to prevent Maria's perfectly preventable death by providing *none* of the well-known procedures for protecting domestic violence victims and holding batterers accountable.

"Shame on all of you," the Domestic Violence Death Review Committee said. "Now, get to work."

ALTERNATE AGENDAS

A. THREE HALF-DAY SESSIONS

It may be impossible for the key participants in this program and the ensuing domestic violence fatality review team to set aside a full day for this work. It can be split into three sessions of two-and-a-half to three hours each by simply scheduling sessions A, B, and C on different half days. The disadvantage of this schedule is that the group is likely to lose some people for some of the sessions.

Note that the times given are estimates. It would be preferable, if possible, to reserve a full three hours for each half-day session and allow a little more time for each topic. The group members may wish to extend the time for Session C, as shown below, to include discussion of action plans and the next steps for establishing a domestic violence fatality review team in their community.

SESSION A

8:30 Session A Start Up

8:50 Issue Identification

9:05 Purpose and Approach of Reviews

9:30 Team Structures

10:00 BREAK

10:15 Scope

10:35 Team Membership

10:50 Session Close

11:00 End

SESSION B

8:30	Session B Start Up
8:40	Case Review
8:50	Community Involvement
9:15	Information Sources
9:30	Issues in Getting Information
9:45	BREAK
10:00	Confidentiality Agreement
10:45	Family Participation Policy
11:10	Session Close
11:15	End

SESSION C

8:30	Session C Start Up
8:35	Effective Interventions
8:55	System Improvements
9:20	Final Report / Press Release
10:05	BREAK
10:20	Team Structure Improvements
10:35	Team Process Improvements
10:50	Planning / Next Steps
11:20	Program Close
11:30	End

B. CONFERENCE OR TRAINING PROGRAM SETTING

The Basic Program Agenda may be used in the context of a conference or other training program where people from several different communities come together to work on domestic violence fatality review issues. Three modifications are discussed below.

B.1. INTACT COMMUNITY-BASED GROUPS

If multi-disciplinary teams attend the program from the various communities, have them work in parallel, community-based subgroups. Even if the teams are not complete, this serves as preparation for further development later in their full teams.

- Arrange seating in team-based clusters.
- Frame the day as preliminary work to be completed back home.
- Shorten the time slightly on some of the discussions.
- Add report-backs and brief discussions after some of the issues, such as:
  - Purpose and Approach
  - Team Structures
  - Issues in Getting Information
  - Family Participation Policy
  - System Improvements
  - Team Process Improvements.

B.2. MIXED MEMBERSHIP GROUPS

If some communities have several people attending and others have only one or two, it can work well to create maximum mixed groups for the experience of discussion and learning. Even more than in option B.1., the program is framed as background learning and an opportunity to consider strategies in preparation for repeating the process with a fully configured group back home. Select a hypothetical community to serve as the shared context.

- Create subgroups with diverse professional or agency affiliations.
- Distribute an Alternative Community description and a Hypothetical Case.
- Proceed as in B.1. above.

B.3. ADDDITIONAL ISSUE TRAINING

If the group has members with experience and expertise in regard to key issues related to the subject, there is potential to create a two or two-and-a-half day learning and practice experience that will add depth to this basic program. The agenda flow from the 1998 National Summit on Domestic Violence Fatality Reviews is offered as one model.

Briefings were typically limited to one half-hour. Presenters included a broad array of experts from the advocacy, legal, health care, judiciary, law enforcement, prosecution, research, and activist communities.

Opening Evening

- Opening session
- DINNER & Introduction to the Communities and the Cases

First Day

- Briefing: Purposes and Approaches
- Team Session A
- LUNCH & Informational Briefing
- Briefing: Liability and Confidentiality
- Team Session B (1st half)
- Briefing: Thinking About the Victim and Victim Advocacy

Second Day

- Briefing: Role of the Justice System
- Team Session B (2nd half)
- Briefing: Social Justice
- LUNCH & Roundtable Discussions
- Briefing: Role of Health Care Systems
- Team Session C
- Team Report Outs

C. DIRECT IMPLEMENTATION

Direct implementation is not recommended except in two contexts.

A. The community has recently completed this educational program as written. Having considered structure issues and practiced on a hypothetical case, the group is now ready to use its thoughts, captured on Worksheets A, B, and C, as a first draft toward final decisions on how actually to implement fatality reviews in its community. When shifting from using this program as education to implementation, group membership should be adjusted to compose the domestic violence fatality review team in full.

B. The community has been working well as a Coordinated Community Response Team for some time and has experience conducting informal domestic violence fatality reviews. The group has honed its cooperative working relationships and has practiced dealing with the complexities and emotions linked to domestic homicides.

In these contexts the group may follow the basic agenda with this modification:

Case reviews need not be included in Sessions B and C. Instead, the group should rely on its collective experience of the variety of situations that have emerged in the community to develop the domestic violence fatality review structure, process, and policies that are an extension of current effective approaches.

This will shorten the required time by at least one-and-one-half hours.

A CAUTION: Please be wary of using this modification. Without a specific case to anchor on, members risk operating with very different, unidentified, and unchallenged assumptions. This increases the likelihood of non-productive conflict. Without the grounding of a specific case, members are more likely to make structure and policy decisions that sound good in theory but do not translate well to real practice.

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PROPERTY OF
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Box 6000
Rockville, MD 20849-6000

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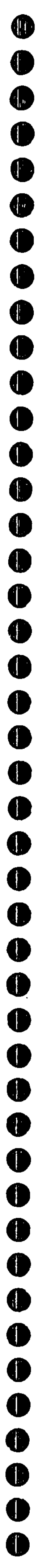


OFFENSE FACE SHEET

LOG ___ CARD ___ TALLY ___
X CRIME ☐ STOLEN VEHICLE ☐ LOST/FOUND PROPERTY
☐ MISSING PERSON ☐ DECEASED PERSON ☐ INCIDENT

CASE NUMBER
AREA RD

VICTIM
LAST NAME, FIRST MIDDLE: LUCAS GLENDA LEE
FIRST NAME IF CRIME AGAINST BUSINESS
RESIDENCE ADDRESS: 432 COPPER DRIVE #218 Gold Mountain NV
RESIDENCE PHONE: (702) 427-1966
BUSINESS ADDRESS (IF STUDENT, NAME OF SCHOOL): N/A
BUSINESS PHONE: ( )
SEX: F RACE: C AGE: 32
IF VICTIM WAS INJURED, INDICATE CASUALTY DISPOSITION CHECK (✓) APPROPRIATE BOX: ☐ WMC ☐ SMRMC ☐ TAKEN HOME ☐ CORONER X REFUSED AID ☐ OTHER (SPECIFY)
DATE OF BIRTH: 5-10-66
SPECIFY EXTENT OF INJURY: MARKS ON NECK - RED FACIAL SWELLING
OCCUPATION: Asst. Mgr. Restaurant
HOURS OF EMPLOYMENT: 1500-2300
Hate Crime ☑

REPORTING PERSON
LAST NAME, FIRST, MIDDLE: SAA
RESIDENCE ADDRESS | SEX | RACE | AGE | DATE OF BIRTH | RESIDENCE PHONE | BUSINESS PHONE
BUSINESS ADDRESS
LOCATION OF OCCURRENCE: ✓ IF SAME AS VICTIM'S ADDRESS

OFFENSE CODE: NRS 200.481 | SOURCE | TITLE: DOMESTIC BATTERY
DATE OCCURRED: 7-13-96 | TIME OCCURRED: 0015 | DATE REPORTED: 7-13-96 | TIME REPORTED: 0045

CRIME ANALYSIS
CHECK (✓) WHERE APPLICABLE

RESIDENCE: ☐ HOUSE X APARTMENT/CONDOMINIUM ☐ MOTEL/HOTEL ROOM ☐ DUPLEX/FOURPLEX ☐ MOBILE HOME ☐ GARAGE ☐ DRIVEWAY ☐ OTHER

☐ BANK ☐ OFFICE BUILDING ☐ MEDICAL OFFICE ☐ DRUG STORE ☐ BAR ☐ LIQUOR STORE ☐ RESTAURANT/FAST FOODS ☐ SUPERMARKET ☐ RETAIL STORE

BUSINESS: ☐ SPORTING GOODS/GUNS ☐ BICYCLE SALES/VEHICLE ☐ PAWN SHOP/SECOND HAND ☐ LAUNDROMAT/CLEANERS ☐ COIN OPERATED MACHINES PHONE BOOTH ☐ THEATER/DRIVE-IN ☐ GAS STATION/GARAGE ☐ MOTEL/HOTEL

☐ WAREHOUSE/STORAGE UNIT ☐ MANUFACTURING FIRM ☐ CONSTRUCTION SITE ☐ FENCED STORAGE ☐ BOX CAR ☐ LONGHAUL TRAILER ☐ CASINO ☐ CONVENIENCE STORE ☐ OTHER

PUBLIC PREMISES: ☐ STREET/HIGHWAY/ALLEY ☐ SCHOOL ☐ PARK/PLAYGROUND ☐ PARKING LOT ☐ PUBLIC BUILDING ☐ CHURCH ☐ HOSPITAL ☐ PARKING GARAGE ☐ OTHER

POINT OF ENTRY — WINDOW: ☐ NONMOVABLE ☐ SLIDING ☐ CRANK TYPE ☐ DOUBLE HUNG ☐ LOUVERED OR WIND-WING; DOOR: ☐ SINGLE SWING ☐ DOUBLE SWING ☐ SLIDING ☐ OVERHEAD ☐ GARAGE ☐ OTHER; OTHER: ☐ FLOOR ☐ ROOF ☐ WALL ☐ ALREADY ON PREMISES ☐ UNKNOWN ☐ BASEMENT

MEANS OF ATTACK: ☐ FIREARM ☐ KNIFE X PHYSICAL/NO WEAPON ☐ OTHER ☐ PRY TOOL ☐ SCREWDRIVER

LOCATION OF ENTRY: ☐ FRONT ☐ REAR ☐ SIDE ☐ ROOF ☐ FORCE ☐ NO FORCE ☐ ATTP. FORCE

METHOD OF ENTRY: ☐ UNLOCKED/OPEN ☐ PRIED ☐ BROKE GLASS ☐ CHANNEL LOCKS ☐ PASS KEY SLIP LOCK ☐ BODY FORCE ☐ CUT PADLOCK ☐ REMOVED ☐ EXPLOSIVE ☐ VEHICLE FORCE ☐ UNKNOWN ☐ OTHER

ALARMS: ☐ NONE ☐ RINGER ☐ SILENT ☐ SILENT/RINGER ☐ NOT SET ☐ BYPASSED ☐ DISABLED

EXTRA COPIES ☐ ISD ☐ DA ☐ CA ☐ P&P

DECEASED / MISSING
DESCRIBE CLOTHING: HEADDRESS, SUIT, DRESS, SHIRT, NECKWEAR, SWEATER, TROUSERS, SKIRT, SHOES, OVERCLOTHING, ETC.
HEIGHT | WEIGHT | BUILD | HAIR | EYES | COMPLEXION
DESCRIBE ARTICLES OF JEWELRY WORN AND IDENTIFICATION CARRIED BY MISSING/DECEASED PERSON
IDENTIFYING MARKS OR TATTOOS, INCLUDING DENTAL WORK

VEHICLE — IF CRIME AGAINST VICTIM'S VEHICLE OR INCIDENT OCCURRED IN A VEHICLE, COMPLETE THE FOLLOWING BOXES
☐ AUTO ☐ MOTORCYCLE ☐ TRUCK ☐ OTHER | MAKE | MODEL | YEAR | LICENSE NO. | STATE | YEAR | VEHICLE COLOR(S) | SOCIAL SECURITY NUMBER
STOLEN VEHICLE: LIST ACCESSORIES | ODOMETER READING | VEHICLE'S IDENTIFICATION NO.

RELEASE AND WAIVER

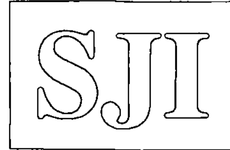
Know all persons by these presents: That I, ___ of the City of ___ County of ___ State of ___, do by these presents, for myself, me heirs, executors, administrators or assigns, release each, every and all duly appointed Peace Officers of any city, county of city and county of any State of the United States of America, of the Reno Police Department of the State of Nevada, from any claim action, demands, dues, sums of money, controversies, trespasses, judgments, executions, claims and demands whatsoever, in law or in equity, I ever had or now have or which I, or my heirs, executors, administrators or assigns, hereafter can, shall or may have against any Peace Officer, for, upon or by reason of any matter, cause or thing whatsoever, as a result of said Peace Officer or Peace Officers recovering, holding, storing, conveying or otherwise dealing with the described vehicle, pursuant to the stolen report which I have this day made.

(SIGNED)

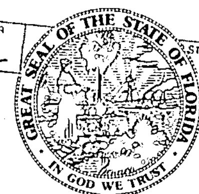
PHONETICALLY LIST VIN & PLATES
PLATES:
VIN:

DOMESTIC VIOLENCE

SUSPECT INFORMATION
NAME, RACE, SEX, DOB, PHYSICAL DESCRIPTION, CLOTHING
ARRESTED: YES ☐ NO X Dewayne Lucas Cauc. M. (husband)
LICENSE NO.: 140WBA | STATE: NV | YEAR: 92 | STYLE | DESCRIPTION: ... Front

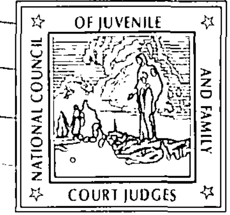


State Justice Institute



Governor's Task Force on Domestic & Sexual Violence
Florida Department of Community Affairs

Office for Victims of Crime



Advocating for the Fair Treatment of Crime Victims

NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES