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California's

Domestic Violence

Death Review Team

PROTOCOL

California Attorney General's Office
Crime and Violence Prevention Center
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Introduction

Valerie and John were husband and wife. In 1994, Valerie refused John sex, and he hit her. Two weeks later, Valerie reported the incident to the police department, but refused to cooperate; no charges were filed by the district attorney's office. Later that year, John claimed Valerie hit him, but again, there was no cooperation and, therefore, no arrests were made by police. In August 1996, Valerie and John separated. However, no formal paperwork was filed. Valerie kept the family home and took custody of their children. In December 1996, John told a friend that he was depressed and suicidal because of the separation. He had also recently lost his job. On Christmas Day, John arrived at Valerie's house with his mother and sister to see the children. An argument between John and Valerie erupted, and John stabbed Valerie almost to death in front of the Christmas tree. His mother, sister and children witnessed the event. John's mother and sister tried to intervene. One was cut by the knife, and the other was bitten by John. Valerie managed to get out of the house and run to a nearby coffee shop. She collapsed out front, but was able to tell everyone within earshot that her husband had stabbed her. Valerie died later at the hospital.[1]

Many people think of domestic violence as an insult, shoving or hitting, but as Valerie's tragic case shows, domestic violence all too often can lead to death. In California, 32 percent of murdered women are killed by their husbands, ex-husbands or boyfriends.[2] California law enforcement received 196,832 domestic violence calls in 1998, with firearms involved in 136,658 of these cases.[3] In 1998, in California alone, 165 men and women lost their lives in domestic violence-related incidents.[4] Preventing these devastating deaths is the focus of a Domestic Violence Death Review Team (DVDRT).

Establishment of Domestic Violence Death Review Teams

The concept of the DVDRT is an outgrowth of the collaborative efforts between legal, health, criminal justice, advocacy and judicial groups that have been developing across the nation for several years. The DVDRT model is based on the original Los Angeles County Child Death Review Team (CDRT) begun in 1978. A major role of CDRTs is to function as a case investigating agency, providing in-depth analysis by many agencies on the possible causes of infant and child deaths in specific cases.

However, despite the many successes experienced by CDRTs, several public agencies were reluctant to participate in the review of domestic violence-related deaths via a DVDRT without statutory authority, which prompted action by the California Legislature. In 1995, California Penal Code section 11163.3 (a) (Senate Bill 1230—Solis, Chapter 710, Statutes of 1995) authorized counties to:

> ...establish interagency DVDRTs to assist local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. Interagency domestic violence death review teams have been used successfully to ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives to reduce and eradicate the incidence of domestic violence. (See Appendix A for Penal Code section 11163.3.)

Currently in California, at least 15 counties have established DVDRTs. (See Appendix B for team information.)

Establishment of a Domestic Violence Death Review Team Protocol

Recognizing that counties might need assistance in establishing DVDRTs, Penal Code section 11163.4 addressed the need for a DVDRT protocol — a guide counties could follow to assist them in developing effective DVDRTs. The law directed the Attorney General's Office to "develop a protocol for the development and implementation of inter-agency domestic violence death review teams for use by counties, which shall include relevant procedures for both urban and rural counties."

In an effort to create a statewide DVDRT protocol, the Departments of Health Services and Justice initiated two focus group sessions in 1996. During these sessions, 12 counties and over 15 agencies and disciplines involved in the domestic violence prevention and response fields participated in a dialogue aimed at understanding the role of DVDRTs in domestic violence prevention and response efforts. Participants listed DVDRT issues that might require specific statewide guidance — via a statewide protocol. These issues included: (1) deciding which cases to review; (2) sharing confidential information; and (3) accessing data.

In late 1997 and early 1998, members of the Attorney General's Crime and Violence Prevention Center visited several established DVDRTs throughout California. Staff examined a variety of different DVDRT procedures and styles and invited several DVDRT members — with backgrounds in law enforcement, health, judicial, social and health services — along with representatives from state domestic violence coalitions to participate in an advisory committee on how to best design the DVDRT protocol.

The protocol advisory committee was charged with assisting the Department of Justice in developing a set of recommended statewide guidelines. During the protocol advisory committee meeting, members recommended that some policies and procedures currently being implemented by existing DVDRTs be strongly suggested to future DVDRTs.

This protocol contains recommendations on DVDRT structure, procedures and policies that appear to be working and which should prove helpful in establishing additional DVDRTs in California. It is hoped that the remaining counties in the state which currently do not have DVDRTs will utilize this step-by-step guide and join in the statewide DVDRT effort to eradicate domestic violence-related injuries and deaths in California.

Endnotes

1. Santa Clara County Domestic Violence Death Review Team, Final Report, October 1993 - September 1997.
2. California Department of Health Services, 1998.
3. Department of Justice, Criminal Justice Statistics Center, 1999.
4. Ibid.

Purpose of Domestic Violence Death Review Teams

Mission Statement

According to Penal Code section 11163.3 (a), the purpose of DVDRTs is to "ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives...."

Based on this language, the protocol advisory committee developed the following mission statement:

> *The purpose of a DVDRT is to review domestic violence-related fatalities, strengthen system policies and procedures and identify prevention strategies to reduce future incidents of domestic violence-related injuries and deaths.*

Goals

Protocol advisory committee members recommended specific goals that DVDRTs can use as building blocks to help them achieve this mission:

- Provide a confidential forum for the systematic review of domestic violence-related deaths
- Improve communication and collaboration among local agencies
- Identify system gaps and shortcomings to facilitate improvement
- Create and maintain a standardized database of information relating to domestic violence-related deaths

Out-of-County Cases

Another issue addressed by the protocol advisory committee focused on out-of-county cases. In these cases, the victim resides in county A, yet is killed by her partner in county B. Protocol advisory committee members suggested that although this type of situation is rare, when it does occur, the DVDRTs of the two counties involved should exchange the necessary information with one another and decide which county should review the case.

Case Information

Once cases are identified for review, the DVDRT chairperson should send the following information to DVDRT members prior to the meeting: name of the victim and perpetrator, date of births (DOBs), other names the victim and perpetrator may have used (AKAs), children's names, children's DOBs, and the social security and driver's license numbers of the victim and perpetrator. The protocol advisory committee members suggested faxing or e-mailing this information as a fast and easy way to provide case information. However, no mention of the DVDRT should be made, since the fax could be seen by others before it is received by the DVDRT member. With the case information, DVDRT members should gather the necessary information pertaining to the specific case and report about their organization's involvement (or noninvolvement, whatever the circumstance may be) at the DVDRT meeting. (Some DVDRTs provide their members with a worksheet that lists core questions to ask about each case and their organization's involvement.)

At the meeting, DVDRT members should thoroughly discuss the facts and information gathered for each case and identify any policies and procedures that could be strengthened or measures that could have been taken to prevent the death from occurring. This is not a "finger-pointing" session, but rather a means to modify current procedures in an effort to prevent future injuries and deaths.

Written materials generated from the meeting such as case summaries or notes pertaining to the case should be collected by the person designated as the data collector, clerical/support person or the chair. All data should then be organized in a computerized database by the data collector for future summary. The notes should be shredded or put into a confidential file after the material has been used to formulate recommendations. (See the Recommendations section later in this protocol.)

Endnote

5. Santa Clara County Domestic Violence Death Review Team, Final Report, October 1993 - September 1997.

Confidentiality

In The Case Review Process

Confidentiality Issues

Confidentiality has proven to be a significant issue in establishing DVDRTs. Penal Code section 11163.3 (e) describes the importance of confidentiality in a DVDRT meeting:

> An oral or written communication or a document shared within or produced by a domestic violence death review team related to a domestic violence death review is confidential and not subject to disclosure or discoverable by a third party. An oral or written communication or a document provided by a third party to a domestic violence death review team, or between a third party and a domestic violence death review team, is confidential and not subject to disclosure or discoverable by a third party. Notwithstanding the foregoing, recommendations of a domestic violence death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the domestic violence death review team.

DVDRT members must consider that although confidentiality is essential to the DVDRT process, the overall goal is to strengthen system policies and procedures and identify prevention measures to stop future incidents of domestic violence-related injuries and deaths.

Protocol advisory committee members defined confidentiality, specifically as it relates to the DVDRT process, as:

- Prohibiting any unauthorized dissemination of information beyond the purpose of the review process
- Acknowledging that nonidentified, aggregate data will be collected by the DVDRT and stored in a secured database, but prohibiting DVDRT members from creating any new files with specific case identifying information
- Limiting the case identification to the actual review process to enlist interagency cooperation and prohibiting the use of any material for reasons other than that which was intended

Penal Code Section 11163.3 (f) and (g) were added in 1999 to further clarify the confidentiality statement:

(f) Each organization represented on a domestic violence death review team may share with other members of the team information in its possession concerning the victim who is the subject of the review or any person who was in contact with the victim and any other information deemed by the organization to be pertinent to the review. Any information shared by an organization with other members of a team is confidential. This provision shall permit the disclosure to members of the team of any information deemed confidential, privileged, or prohibited from disclosure by any other statute.

(g) Written and oral information may be disclosed to a domestic violence death review team established pursuant to this section. The team may make a request in writing for the information sought and any person with information of the kind described in paragraph (2) of this subdivision may rely on the request in determining whether information may be disclosed to the team.

(1) No individual or agency that has information governed by this subdivision shall be required to disclose information. The intent of this subdivision is to allow the voluntary disclosure of information by the individual or agency that has the information.

(2) The following information may be disclosed pursuant to this subdivision:

(A) ... medical information.

(B) ... mental health information.

(C) ... information from elder abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.

(D) ... information from child abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.

(E) State summary criminal history information, criminal offender record information, and local summary criminal history information ...

(F) ... information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or of persons suffering physical injury where the injury is a result of assaultive or abusive conduct, and information relating to whether a physician referred the person to local domestic violence services as recommended...

(G) ... information in any juvenile court proceeding.

(H) Information maintained by the Family Court ...

(I) Information provided to probation officers in the course of the performance of their duties, including, but not limited to, the duty to prepare reports ... as well as the information on which these reports are based.

(J) ... records of in-home supportive services, unless disclosure is prohibited by federal law.

Protocol advisory committee members identified confidentiality on two levels: team confidentiality and member confidentiality. Team confidentiality is defined as all activities that occur during a DVDRT meeting. Any information shown or discussed within a DVDRT meeting must not be discussed with anyone outside the group. The only exceptions are the DVDRT recommendations. In these instances, recommendations may only be discussed with others if a majority of DVDRT members agree.

Member confidentiality is more difficult to achieve. DVDRT members must remember that when they are given information about specific cases (i.e., to conduct the necessary inquiries about their organization's involvement or noninvolvement, whatever the circumstance may be), the information must be kept confidential. DVDRT members should not share or speak about case information with others in their organization.

Confidentiality Agreement

The 15 DVDRTs currently in existence provide confidentiality agreements for their members and for any meeting guests they may have (see Appendix D for a sample confidentiality agreement). The agreements spell out the seriousness of confidentiality and remind DVDRT members and guests that any information shown or discussed within a DVDRT meeting must not be shared with anyone outside the group. It is also recommended that at the beginning of each meeting, the confidentiality agreement should be stated again to make clear that any information discussed at the meeting is not to leave the room. A majority of the existing DVDRTs stated that as time has passed and members have learned to trust each other, the issue of confidentiality has become less of a concern, and the focus has returned to the DVDRT's goal of saving lives.

However, some victim's advocacy groups remain unsure of whether the law permits them to disclose information on clients to DVDRTs. The recently added amendments to the Penal Code, sections 11163.3 (f) and (g), which became effective January 1, 2000, should help allay any doubts that remain regarding the legality of disclosing information to DVDRTs (see discussion on the previous page).

Breaching Confidentiality

Protocol advisory committee members stressed the importance of trust among DVDRT members. Although it is a rare occurrence, if new information should be brought to the attention of the prosecutor during a DVDRT meeting, he or she may have a constitutionally mandated duty to disclose this new information to the defense in cases where the perpetrator is either awaiting trial or has already been convicted. Protocol advisory committee members agreed that this is the *only* exception to the confidentiality agreement permitted. If any other DVDRT member violates confidentiality, he or she should be removed from the DVDRT.

Participation of Victim's Family

Protocol advisory committee members discussed whether to allow the participation of the victim's family (to disclose the victim's side of the story) during the case review process, but were split on how to handle such situations. Some stated that due to confidentiality issues, no outsiders should be allowed into meetings, while others agreed that having family members sign a confidentiality agreement was enough for participation. Still others thought that the victim/witness DVDRT member should interview surviving family members before the meeting and report to the DVDRT. Protocol advisory committee members agreed that individual DVDRTs should ultimately make this decision. If teams choose to bring family members into the discussion, follow-up services for those individuals may be needed and should be made available.

Data Collection

Local Efforts

Penal Code section 11163.6 suggests that "in order to ensure consistent and uniform results data may be collected and summarized by local DVDRTs.."

The protocol advisory committee stressed the importance of collecting data to provide the basis for identifying "patterns" or trends in the information gleaned from the case review process. This data should include:

- Details of the incident (including where it occurred)
- Race and age of the parties involved
- Prior history of the victim and perpetrator
- Prior intervention contacts with the system
- Alcohol and/or drug use
- Pregnancy information
- Use of weapons
- Whether children were present at the time of the homicide

(See Appendix E for a sample data collection form.)

After the DVDRT has reviewed several cases, the data should be used to formulate recommendations for changes in system policy and procedures and to identify domestic violence prevention strategies. The protocol advisory committee suggested that adequate staff and funding be made available to conduct a successful data collection effort.

State Efforts

Penal Code section 11163.5 suggests that the Department of Justice cooperate with the Department of Social Services, Department of Health Services, California State Coroner's Association, County Welfare Directors Association, and the state domestic violence coalition to "coordinate and integrate state and local efforts to address fatal domestic violence, and to create a body of information to prevent domestic violence deaths."

To accomplish the purpose of this section, these agencies may engage in the following activities:

(1) Collect, analyze, and interpret state and local data on domestic violence death in an annual report to be available upon request. The report may contain, but need not be limited to, information provided by state agencies and the county domestic violence death review teams for the preceding year.

(2) Develop a state and local data base on domestic violence deaths.

  (A) The state data may include Department of Justice statistics, the State Department of Health Services Vital Statistics and information obtained by other relevant state agencies.

  (B) The Department of Justice, in consultation with the agencies and organizations specified in paragraph (1) of subdivision (b), may develop a model minimal local data set and request data from local teams for inclusion in the annual report.

(3) Distribute a copy of the report to public officials in the state who deal with domestic violence issues and to those agencies responsible for domestic violence death review investigation in each county.

The Department of Justice, with the assistance of the Department of Health Services, hopes to develop a statewide standardized data collection form, which would include incident-based data, to be provided to local DVDRTs. As more DVDRTs are initiated across the state, data collected with the statewide standardized data collection form could produce many positive results, including: (1) state agencies may discover commonalities among counties; (2) local teams may be able to secure additional grant funding to help strengthen system policies and procedures; (3) the "big picture" of domestic violence-related homicide may be better illustrated statewide; and (4) local and state leaders may be better able to promote increased public awareness about domestic violence and initiate legislation to prevent future domestic violence-related injuries and deaths.

Recommendations

For Improving The Domestic Violence System

Recommendations are an important function of the DVDRT to assist in preventing future incidents of domestic violence-related injuries and deaths. They are meant to improve the domestic violence system, not to place blame on any agency or organization. Recommendations are made based on what DVDRT members discover during the case review process. Six types of recommendations have been identified:

- ***Policy/Advocacy:*** These recommendations identify the political body that can make a policy change and the action desired such as a new ordinance or piece of legislation. The political body may be a board of supervisors, a city council or the state Legislature.
- ***Organizational Practices:*** These recommendations identify which agency or agencies need to make an internal change in their procedures or protocols and should describe the recommended change.
- ***Interagency Services/Linkages:*** These recommendations identify the agencies that need improved linkage, communication and training; problem areas that need improvement; and which agency representative will see that the changes are made.
- ***Training:*** These recommendations identify the groups who should receive training; the individual or agency to take responsibility for organizing the training; and a time line.
- ***Community-based Education:*** These recommendations identify the message that needs to be disseminated to the public; an identified organization that will conduct the media campaign; and a time line.
- ***Strengthening Individual Knowledge and Skills:*** These recommendations identify the need for additional knowledge in a given population; the curriculum needed to raise the knowledge level; and the person or agency that will implement the curriculum.

After DVDRTs develop their recommendations, DVDRT members should assess the progress of the recommendations being implemented. At subsequent meetings, DVDRT members should review the progress of current recommendations before discussing new recommendations.

Recommendations from existing DVDRTs include the following:

- When children are present during a domestic violence-related death, law enforcement should initiate automatic referral to Child Protective Services.
- Domestic violence service providers should ensure that all education materials include cultural awareness and take into account that domestic violence also occurs in the gay and lesbian community.
- Domestic violence service providers, law enforcement, health professionals and others should continue to promote the idea that victims of domestic violence obtain restraining orders.
- The district attorney and local law enforcement should take full advantage of existing firearm laws, including search warrants, to remove guns from any person alleged to have perpetrated domestic violence.
- The media should be encouraged to report on the availability of assistance for domestic violence victims so that victims, family members and others have the information necessary to obtain needed services.

Some DVDRTs have held press conferences, often around Valentine's Day, Mother's Day or during Domestic Violence Awareness Month in October, to report their findings and recommendations to the community. As a result, DVDRT recommendations have strengthened local domestic violence policy and procedures. Other DVDRTs have released annual reports that are distributed to local legislative boards and the media to help the community find ways to reduce domestic violence-related injuries and deaths.

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Appendices

Appendix A
Penal Code sections 11163.3 - 11163.6

Appendix B
California Domestic Violence Death Review Teams

Appendix C
Domestic Violence Death Review Team Relationship Matrix

Appendix D
Sample Confidentiality Agreement

Appendix E
Sample Data Collection Form

Appendix A

Penal Code Sections 11163.3 through 11163.6

11163.3. (a) A county may establish an interagency domestic violence death review team to assist local agencies in identifying and reviewing domestic violence deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. Interagency domestic violence death review teams have been used successfully to ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives to reduce and eradicate the incidence of domestic violence.

(b) For purposes of this section, "abuse" has the meaning set forth in Section 6203 of the Family Code and "domestic violence" has the meaning set forth in Section 6211 of the Family Code.

(c) A county may develop a protocol that may be used as a guideline to assist coroners and other persons who perform autopsies on domestic violence victims in the identification of domestic violence, in the determination of whether domestic violence contributed to death or whether domestic violence had occurred prior to death, but was not the actual cause of death, and in the proper written reporting procedures for domestic violence, including the designation of the cause and mode of death.

(d) County domestic violence death review teams shall be comprised of, but not limited to, the following:

(1) Experts in the field of forensic pathology.
(2) Medical personnel with expertise in domestic violence abuse.
(3) Coroners and medical examiners.
(4) Criminologists.
(5) District attorneys and city attorneys.
(6) Domestic violence shelter service staff and battered women's advocates.
(7) Law enforcement personnel.
(8) Representatives of local agencies that are involved with domestic violence abuse reporting.
(9) County health department staff who deal with domestic violence victims' health issues.
(10) Representatives of local child abuse agencies.
(11) Local professional associations of persons described in paragraphs (1) to (10), inclusive.

(e) An oral or written communication or a document shared within or produced by a domestic violence death review team related to a domestic violence death review is confidential and not subject to disclosure or discoverable by a third party. An oral or written communication or a document provided by a third party to a domestic violence death review team, or between a third party and a domestic violence death review team, is confidential and not subject to disclosure or discoverable by a third party. Notwithstanding the foregoing, recommendations of a domestic violence death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the domestic violence death review team.

(f) Each organization represented on a domestic violence death review team may share with other members of the team information in its possession concerning the victim who is the subject of the review or any person who was in contact with the victim and any other information deemed by the organization to be pertinent to the review. Any information shared by an organization with other members of a team is confidential. This provision shall permit the disclosure to members of the team of any information deemed confidential, privileged, or prohibited from disclosure by any other statute.

(g) Written and oral information may be disclosed to a domestic violence death review team established pursuant to this section. The team may make a request in writing for the information sought and any person with information of the kind described in paragraph (2) of this subdivision may rely on the request in determining whether information may be disclosed to the team.

(1) No individual or agency that has information governed by this subdivision shall be required to disclose information. The intent of this subdivision is to allow the voluntary disclosure of information by the individual or agency that has the information.

(2) The following information may be disclosed pursuant to this subdivision:

  (A) Notwithstanding Section 56.10 of the Civil Code, medical information.
  (B) Notwithstanding Section 5328 of the Welfare and Institutions Code, mental health information.
  (C) Notwithstanding Section 15633.5 of the Welfare and Institutions Code, information from elder abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.
  (D) Notwithstanding Section 11167.5 of the Penal Code, information from child abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.
  (E) State summary criminal history information, criminal offender record information, and local summary criminal history information, as defined in Sections 11075, 11105, and 13300 of the Penal Code.

(F) Notwithstanding Section 11163.2 of the Penal Code, information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or of persons suffering physical injury where the injury is a result of assaultive or abusive conduct, and information relating to whether a physician referred the person to local domestic violence services as recommended by Section 11161 of the Penal Code.

(G) Notwithstanding Section 827 of the Welfare and Institutions Code, information in any juvenile court proceeding.

(H) Information maintained by the Family Court, including information relating to the Family Conciliation Court Law pursuant to Section 1818 of the Family Code, and Mediation of Custody and Visitation Issues pursuant to Section 3177 of the Family Code.

(I) Information provided to probation officers in the course of the performance of their duties, including, but not limited to, the duty to prepare reports pursuant to Section 1203.10 of the Penal Code, as well as the information on which these reports are based.

(J) Notwithstanding Section 10825 of the Welfare and Institutions Code, records of in-home supportive services, unless disclosure is prohibited by federal law.

(3) The disclosure of written and oral information authorized under this subdivision shall apply notwithstanding Sections 2263, 2918, 4982, and 6068 of the Business and Professions Code, or the lawyer-client privilege protected by Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code, the physician-patient privilege protected by Article 6 (commencing with Section 990) of Chapter 4 of Division 8 of the Evidence Code, the psychotherapist-patient privilege protected by Article 7 (commencing with Section 1010) of Chapter 4 of Division 8 of the Evidence Code, the sexual assault victim-counselor privilege protected by Article 8.5 (commencing with Section 1035) of Chapter 4 of Division 8 of the Evidence Code, and the domestic violence victim-counselor privilege protected by Article 8.7 (commencing with Section 1037) of Chapter 4 of Division 8 of the Evidence Code.

11163.4. Subject to available funding, the Attorney General, working with the state domestic violence coalition, shall develop a protocol for the development and implementation of interagency domestic violence death review teams for use by counties, which shall include relevant procedures for both urban and rural counties. The protocol shall be designed to facilitate communication among persons who perform autopsies and the various persons and agencies involved in domestic violence cases so that

incidents of domestic violence and deaths related to domestic violence are recognized and surviving nonoffending family and household members and domestic partners receive the appropriate services.

11163.5. (a) The purpose of this section is to coordinate and integrate state and local efforts to address fatal domestic violence, and to create a body of information to prevent domestic violence deaths.

(b) (1) The Department of Justice is hereby authorized to carry out the purpose of this section with the cooperation of the State Department of Social Services, the State Department of Health Services, the California State Coroner's Association, the County Welfare Directors Association, and the state domestic violence coalition.

(2) The Department of Justice, after consulting with the agencies and organizations specified in paragraph (1), may consult with other representatives of other agencies and private organizations to accomplish the purpose of this section.

(c) To accomplish the purpose of this section, the Department of Justice and agencies and organizations involved may engage in the following activities:

(1) Collect, analyze, and interpret state and local data on domestic violence death in an annual report to be available upon request. The report may contain, but need not be limited to, information provided by state agencies and the county domestic violence death review teams for the preceding year.

(2) Develop a state and local data base on domestic violence deaths.

(A) The state data may include the Department of Justice statistics, the State Department of Health Services Vital Statistics, and information obtained by other relevant state agencies.

(B) The Department of Justice, in consultation with the agencies and organizations specified in paragraph (1) of subdivision (b), may develop a model minimal local data set and request data from local teams for inclusion in the annual report.

(3) Distribute a copy of the report to public officials in the state who deal with domestic violence issues and to those agencies responsible for domestic violence death review investigation in each county.

(d) The Department of Justice may direct the creation of a statewide domestic violence death review team directory, which shall contain the names of the members of the agencies and private organizations participating under this section, the members of local domestic violence death review teams, and the local liaisons to those teams. The department may maintain and update the directory annually.

(e) The agencies or private organizations participating under this section shall participate without reimbursement from the state. Costs incurred by participants for travel or per diem shall be borne by the participant agency or organization. Any reports prepared by the Department of Justice pursuant to this section shall be in consultation with the state domestic violence coalition.

11163.6. In order to ensure consistent and uniform results, data may be collected and summarized by the domestic violence death review teams to show the statistical occurrence of domestic violence deaths in the team's county that occur under the following circumstances:

(a) The deceased was a victim of a homicide committed by a current or former spouse, fiancé, or dating partner.

(b) 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.

(c) 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.

(d) 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.

(e) The deceased was a child of either the homicide victim or the perpetrator, or both.

(f) The deceased was a current or former spouse, fiancé, or dating partner of the current or former spouse, fiancé, or dating partner of the perpetrator.

(g) The deceased was a law enforcement officer, emergency medical personnel, or other agency responding to a domestic violence incident.

(h) The deceased was a family member, other than identified above, of the perpetrator.

(i) The deceased was the perpetrator of the homicide of a family member, other than identified above.

(j) The deceased was a person not included in the above categories and the homicide was related to domestic violence.

Appendix B

California Domestic Violence Death Review Teams

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Appendix C

Domestic Violence Death Review Team Relationship Matrix

What the people in Column A need from the people in the other columns for victim safety & abuser accountability.

Column A	Victim	Shelter Victim Advocate	Rape Crisis Victim Advocate	Medical Provider	9-1-1 Police Dispatch	Police Officer	Jail Correctional Officer	Victim-Witness Advocate
Victim		Needs immediate shelter; supportive victim advocate. Timely response. Help with the legal process.	Needs supportive victim advocate. Timely response. Help with the legal process.	Let victim know if reporting to police. Call immediately. Request victim to stay until police arrive.	Need to be believed. Direct questions & tactful phrasing of questions. Stay on the line.	Timely response. Separate parties. Treat with respect. Say D.A. will press charges, not victim.	Needs notification of abuser's release date/time. If incarcerated for other charges, in custody DV & AOD info.	Help getting restraining orders. Financial compensation. Help with court appearances.
Shelter Victim Advocate	Evaluate basic situation. Initial intake. Get her story.			Is report made? Does the victim want to talk to shelter? Is it domestic violence? Does she know report is made?	What is the response time? How it works. Prioritites? How calls are assigned. Scanners-confidentiality issues.	Response procedures & protocol. Are they booking the abuser? What are the charges?	Needs notification of abuser's release date/time.	Sharing case information.
Rape Crisis Team Victim Advocate	Consent for services.	Identification of sexual abuse. Offer of NCRCT services. Communication with survivor's consent.		Follow SART protocol. Offer NCRCT services. Explain to survivor that a report to police is being made.		Offer NCRCT services to survivor. Contact NCRCT ASAP to speed contact with survivor.	Access to clients who may be incarcerated. Info on release status of assailant.	Court calendar updates. Offer of NCRCT services.
Medical Provider	Give informed consent; honest history. Make safety plan. Abuser's location. Weapon info. Status of kids.	Current resource guides. Staff in-services. Timely response to calls for assistance. Current laws.	Current resource guides. Staff/SART in-services. Timely response to calls for assistance. Current laws.		How to report incident. How long until police arrive. Courtesy, & timely referral if necessary.	Report forms. Discretion upon arrival. Timely response while client is in facility. Safety eval; evidence.		Brochures of current services and resources. Restraining order info.
9-1-1 Police Dispatch	Cooperation. Provide suspect I.D. & location/access to weapons. Stay on line until released by operator.	Operators won't have most needed info. Officer has info. Operators just relay info via radio from officer.	Operators won't have most needed info. Officer has info. Operators just relay info via radio from officer.	Estimate the wait for the victim's treatment, e.g., is the E.R. full? Operators may choose another hospital.		Make their own notification phone calls-they have needed answers & won't risk confidentiality (radio).	Advise on case sensitive releases so operators can quickly prioritize 9-1-1 calls from victim if suspect contacts.	If jail notifies of suspect's release, they could give operators victim I.D./location, & concerns about suspect.
Police Officer	History of DV. Medical release form signed. Phone # where they can be reached. Weapons status.	Wants more support for role of police & prosecution. Explain the prosecution process to victim.	Explain the prosecution process to victim. Provide advocate for SART process.	Make mandated report while victim is still in medical facility, if possible.	Provide 9-1-1 call tape and call history. Were weapons involved?	Need training and support from administration for handling DV cases effectively.		Help to get the victim to support the prosecution.
Jail Correctional Officer	Encarcerated victims can get DV & alcohol-drug abuse info. Call to request abuser release notification. Honesty.	Victim advocates can come to jail to support domestic violence victims incarcerated for other crimes.	Victim advocates can come to jail to support sexual assault victims incarcerated for other crimes.	As complete information as possible on inmate's medical condition when released from medical facility.		Get victim's phone #. Info re: inmate's drug/alcohol use & behavior at arrest. Get police reports to D.A. ASAP		Victim advocates can come to jail to support domestic violence victims incarcerated for other crimes.
Victim-Witness Advocate		Cooperation and coordination with our agency. 24-hour response	Cooperation and coordination with our agency.	Knowledge of mandatory reporting laws.	Sensitive, empathetic listening to victim and children.	Better evidence so victim may not have to be the only one who testifies.	Notify victim of release.	

Column A	Prosecutor	Judge-Criminal Court	Probation Officer	Treatment Program	Indian Tribe or Rancheria	Civil Law Victim Advocate	Child Welfare Services	Judge-Family Court
Victim	Needs to know the status of the case in the court system.	Needs to know the status of the case in the court system.	What are the conditions of probation?	What are the requirements to satisfy compliance with the treatment order?		Help with court forms and procedures.		
Shelter Victim Advocate	What are the charges? What is the role of the victim?	Any orders such as probation, treatment, etc., now & in past.	Is abuser on probation now or in past? Why? How is compliance monitored; for felons & misdemeanors?	Progress, attendance, compliance. How is confidentiality kept when both partners have same treatment provider?				Divorce & custody information. Any orders now or filed in the past, such as kick-outs?
Rape Crisis Team Victim Advocate	Case status. Offer of NCRCT services. Access for advocacy.	Issuance of stay-away orders.	Conditions of probation. Release & compliance status.	Compliance status. Referrals to NCRCT for survivors. Residential treatment options.	Info & inservices on resources & responsibilities. Enforcement of restraining orders, etc.	Assistance with forms.	Access to clients in shelter wishing NCRCT services. Response for children who witness DV.	Issue restraining orders. Awareness of DV/ Intimidation re:custody & visitation decisions in Family Court.
Medical Provider	Type of evidence needed. Effective reporting/charting. Keep MD out of court if possible. Legal updates.	Type of evidence needed. Effective reporting/charting. Keep MD out of court if possible. Legal updates.			Awareness & brochures of resources available to tribal members. New laws/other rules pertaining to DV/child abuse.		Timely response. What support available. Check kids safety. Brochure/form, phone #'s. Evidence needed.	Have clients keep medical providers informed of custody agreements.
9-1-1 Police Dispatch	When requesting 911 tape for prosecution, ask for what you want specifically, with a time frame.		Make CLEWS entry ASAP. Put more I.D. info on forms. Include all pertinent charges on restriction screens.				Operators won't have most needed info. Officer has info. Operators just relay info via radio from officer.	
Police Officer	Wants early intervention with accountability for abusers. Don't dismiss ans/or reduce pleas if possible.	Minute orders.	Release status. Conditions of probation.	Is abuser in compliance with treatment requirements?				
Jail Correctional Officer	Call law enforcement agencies ASAP to get police reports in time for arraignment in 48 hours.			Treatment programs can bring their programs to the jail rather than wait to see them when they are released.				
Victim-Witness Advocate	Listen to victim. Respect her even if she goes back to defendant.	Issue Stay-Away Orders, if requested.	Better supervision of batterers.	Possible residential treatment options.	Safety for victim. Contingencies if defendant doesn't abide by the order.	More help with family law forms.	More follow-up on children who witness violence.	Clarify orders and the process if they are disobeyed.

Column A	Victim	Shelter Victim Advocate	Rape Crisis Victim Advocate	Medical Provider	9-1-1 Police Dispatch	Police Officer	Jail Correctional Officer	Victim-Witness Advocate
Prosecutor	Help in building the prosecution's case against the abuser.	Support for victim in criminal court. Help filling out restraining orders.	Support for victim in criminal court.	Medical records and testimony at trials.	Copy of 9-1-1 call tape. History of DV calls. Were weapons used?	Accurate evidence collection: Written or taped statements; photos, videos of injuries. Hx of DV.	Any history of violelnce with the involved parties. Any threats toward the victim while in custody.	Support for victim in criminal court. Help filling out restraining orders.
Judge-Criminal Court	At arraignment and bail/OR hearings, it is important to know the alleged victim's position; any history of violence.	At the time of sentencing it is important to know if the alleged victim is safe?	At the time of sentencing it is important to know if the alleged victim is safe.	What is alleged to have occurred? As complete information as possible.		What occurred? As complete info as possible. At arraignment/ O.R. hearings, any hx of violence.		Assisting alleged victim with court procedures. Safety issues at sentencing. Their position stated to the court.
Probation Officer	Statements re: offense & sentencing for pre-sentencing investigation. Info on compliance of probation orders.	Phone number.				Police report. Statements from arresting officer. Hx of DV or other known problems.		
Treatment Program	Is she safe? Are minors safe? Is there a TRO or DVRO? Hx of DV in relationship. Victim view of events. Safety concern.	Concerns re: individual survival. Offender risk factors. Overall concerns. Myths & misconceptions. Communication.				Copy of police report. Is there a TRO or DVRO? Hx of DV calls, arrest/charges. Report reofFenses ASAP.		
Indian Tribe or Rancheria	Response to follow-up-contacts. Direction on nature & extent of assistance desired. Consent to info access.	Cooperation with/referral to Indian/Tribal Programs. Info re: services provided, contacts. Cultural sensitivity.	Cooperation with/referral to Indian/Tribal Programs. Info re: services provided, contacts. Cultural sensitivity.	Know the mandated reporting laws, including any required reporting to Tribal authorities.		Police reports. RO/TRO info. Enforce tribal RO's. Cultural sensitivity re: primary aggressor assessments.		Know Tribal Programs/personnel. Cultural sensitivity. Know Indian laws, e.g. ICWA & info re: services/contacts.
Civil Law Victim Advocate	Complete information re: children, income, property, history, etc.	Support for victim in gathering information.	Support for victim in gathering information.					Support for victim in gathering information.
Child Welfare Services	Situation & child safety info. Are children abused? If in shelter w/o her children, are they in abuser's care?	Shelter mom & children. Assess her ability to protect children. Inform CWS if children are abused by her abuser.	Age of victim. Is the victim safe? Is there support (emotional & protective) for the victim?	Reports of injuries to children resulting from DV incident. Report of children in care of abuser while victim @ hosp.	Info from responding officer re: parents, children's age, gender, special needs, & if they need shelter.	Police report. Hx of DV & other problems. Children's name/ age gender, special needs. If they need shelter.	Notification when abuser will be released.	Support for victim. Assistance in applying for claim.
Judge-Family Court & Court Investigator Services	Legible, factual info with dates on fully completed TRO-DVRO applications. Follow thru on hearing appearances.	Assistance & support for victim at court hearings. Individualized response which best meets victim's needs.	Assistance & support for victim at court hearings. Individualized response which best meets victim's needs.	Clear, accurate records. Court appearances when subpoenaed. Know mandated reporter laws.	If there is litigation, hang on to 9-1-1 tapes for at least 3 months.	Complete case information in reports. Appear if subpoenaed. Contact CWS if children present. Hx of DV.	Court Investigative Services needs abuser release date.	Assistance to victim to help understand court processes.

Column A	Prosecutor	Judge-Criminal Court	Probation Officer	Treatment Program	Indian Tribe or Rancheria	Civil Law Victim Advocate	Child Welfare Services	Judge-Family Court
Prosecutor		Restraining order violations. Know new laws re: evidence for DV. Be sensitive to victims who are scared.	Written report with lethality index. Notification of failure to complete treatment requirements. Accountability.	Progress, attendance, compliance, etc.				
Judge-Criminal Court	What occurred? As complete information as possible. At arraignment/OR sentencing, any history of violence?		Does the defendant have the ability, wherewithal, finances to abide by probation terms, e.g. batterer's treatment, etc?	Is the defendant attending and completing the batterer's treatment program?				
Probation Officer				Progress, attendance, compliance, etc. Written documentation of violations or success.			Reunification plan requirements, and status of changes.	
Treatment Program	Charges and treatment requirements. History of DV?	Charges and treatment requirements. History of DV? Sentencing protocols. How decisions are made.	Charges and treatment requirements. History of DV? Wants PO's to take time to get more information.	Release information to share about clients.				
Indian Tribe or Rancheria	Consistency in Indian and non-Indian prosecution & clarification in criteria for exercise of prosecution discretion.	Familiarity with Tribal Programs/ personnel. Cultural sensitivity, e.g. subsistance hunting. Know Indian laws.	Familiarity with Tribal Programs/ personnel. Cultural sensitivity, e.g. subsistance hunting. Know Indian laws.	Outcome information. Familiarity with Tribal Programs/ personnel. Cultural sensitivity. Know Indian laws.	Clarity re: tribal affiliation & capacity of involvement. Cooperation re: intertribal service delivery. Info exchange.	Familiarity with Tribal Programs/ personnel. Cultural sensitivity, e.g. subsistance hunting. Know Indian laws.	Cultural sensitivity. Compliance with ICWA when children involved. Cooperation with tribal Program.	Familiarity with Tribal Programs/ personnel. Cultural sensitivity, e.g. subsistance hunting. Know Indian laws.
Civil Law Victim Advocate							Support for victims in obtaining benefits in a timely fashion.	
Child Welfare Services	Charges of child abuse included when applicable.	Restraining orders regarding victim and children.	Abuser's treatment in progress. Copy of treatment plan. Info re: is abuser returning home? If DV history, is there child abuse?	Info on treatment progress, attendance, compliance, written documentation of violations or success.				Information re: abuse reports. Custody/visitation orders if d.v. abuser is child abuser. Contact order to be supervised.
Judge-Family Court & Court Investigator Services	Proceed criminally on every case that has a legal basis. If dismissing case, get TRO in place first.	If dismissing case, put criminal RO in place or postpone dismissal until DVRO is in place. Coordinate orders.	Access to records and history of dom-estic violence.	Provide accurate compliance information to the court & Center for Child Advocacy. Access to records & history.		Assist in custody/ divorce hearings. Hire document reviewer to help review applications for mistakes.	Respond when children are at risk. Act on behalf of the child. Use Juvenile Court for more oversight for CWS.	Court Investigator Services needs time to complete reports.

Appendix D

CONFIDENTIALITY AGREEMENT

HUMBOLDT COUNTY
DOMESTIC VIOLENCE DEATH REVIEW TEAM

The purpose of the Humboldt County Domestic Violence Death Review Team is to conduct a full examination of each death incident. In order to assure a coordinated response that fully addresses all systemic concerns surrounding domestic violence death cases, the Humboldt County Domestic Violence Death Review Team must have access to all existing records, autopsy reports, mental health records, hospital or medical related data, and any other information that may have a bearing on the involved decedent and family.

As a member of the Humboldt County Domestic Violence Death Review Team, I understand that all information shared regarding reviewed cases is confidential and may be used only for the purpose of a team review. Information that is to be considered confidential is any information that is specific to an individual, but not limited to: their name, identifying characteristics which in the absence of a name might serve to identify them; prior and/or current drug use; mental health and health information; personal criminal and/or legal information.

With this purpose in mind, I, the undersigned, as a representative of

_____

agree that all information secured in this review will remain confidential and will not be used for reasons other than that which it was intended. No material will be taken from the meeting with case identifying information.

_____

Print Name

_____

Signature Date

_____

Witness Date

Appendix E

OMI ID#: _____ **Date Collected:** _____

Collected By: _____

CHART INCLUDES: _____

Autopsy _____

Toxicology _____

App to Crime Vict Rep _____

Other _____

STUDY:

Intimate Partner _____

Family Member _____

Stranger _____

Unknown _____

Control: Medical _____ Injury _____

I. DEMOGRAPHICS

Victim's full name: _____

Victim's age/Date of Birth: _____

VICTIM'S RACE:

☐ Anglo ☐ Hispanic ☐ Native American ☐ African American ☐ Asian American

☐ Other: _____

II. INJURIES/AUTOPSY FINDINGS

CAUSE OF DEATH RECORDED IN THE AUTOPSY REPORT: _____

_____

WHAT INJURIES DID VICTIM SUFFER? *(check all that apply)*

☐ gunshots ☐ stab/incised wounds ☐ broken bones/cartilage ☐ burns ☐ strangulation

☐ cuts/abrasions ☐ lacerations/slashes/gashes ☐ asphyxiation

☐ punctured/lacerated organs/vessels/muscles/nerves ☐ bruises/contusions/hematomas

☐ smoke inhalation ☐ unknown ☐ other _____

# of wounds? _____ Time of injury: _____ ☐ unknown

ISS Score: _____ Date of injury: ___/___/_____ ☐ unknown

AIS Score: _____ Date and Time pronounced dead: _____

LOCATION OF CRIME OR WHERE BODY WAS FOUND: *(check all that apply)*

☐ victim's apartment/house ☐ street/sidewalk ☐ workplace ☐ bar/club

☐ park/playground ☐ schoolyard ☐ parking lot ☐ motel

☐ store/restaurant ☐ highway ☐ desert ☐ alley

☐ arroyo ☐ car ☐ other (specify) _____

COMMENT: _____

WAS VICTIM PREGNANT AT TIME OF DEATH? ☐ yes ☐ no Trimester: 1 2 3

WAS THERE EVIDENCE OF PREVIOUS INJURY? ☐ yes ☐ no

IF YES, NATURE OF INJURIES AND ESTIMATION OF WHEN INJURIES OCCURED: _____

_____

_____

Chronic Medical Conditions ☐ yes ☐ no ☐ unknown Type _____

Medications ☐ yes ☐ no ☐ unknown Type _____

Medical History ☐ yes ☐ no ☐ unknown Type _____

_____

_____

Mental Health History ☐ yes ☐ no ☐ unknown Description _____

_____

III. HOMICIDE METHODS/WEAPONS

WHAT METHOD(S) WAS/WERE USED? *(check all that apply)*

☐ gunshot ☐ stabbing ☐ bludgeoning ☐ strangling ☐ burning ☐ beaten
☐ smoke inhalation ☐ asphyxiating ☐ pushed/jumped from height ☐ unknown
☐ other _____

WHAT WEAPON(S) WAS/WERE USED: *(check all that apply)*

☐ gag ☐ knife or other pierce/cut instrument ☐ blunt instrument ☐ machete/ax ☐ ligature
☐ arson ☐ rifle ☐ handgun ☐ shotgun ☐ machine gun ☐ hands ☐ feet
☐ unknown other _____

BULLET CALIBER/MM: ☐ .22 ☐ .25 ☐ .32 ☐ .357 ☐ .38 ☐ .40 ☐ .45
☐ 9mm ☐ .38/gm ☐ mac 10 ☐ 12 g.
☐ small ☐ medium ☐ large ☐ unknown

RANGE: ☐ close (contact w/body; soot present)
☐ intermediate (stippling)
☐ distant (2-3 feet or greater; absence of soot) ☐ unknown

IV. SEXUAL ASSAULT

WAS A SEXUAL ASSAULT ANALYSIS PERFORMED? ☐ yes ☐ no ☐ unknown
If yes: ☐ negative ☐ positive

V. POLICE INFORMATION

AGENCY: ☐ APD ☐ Bernalillo ☐ BIA ☐ State Police
☐ Other _____

FULL NAME OF OFFICER/DEPUTY ASSIGNED TO CASE: _____

RESTRAINING ORDERS: ☐ yes ☐ no ☐ unknown How Recent: _____
Comments: _____

_____

WERE THERE VIOLATIONS OF ORDER: ☐ yes ☐ no ☐ unknown How many: _____
By Whom: ☐ perpetrator ☐ victim
What was the result of violation: _____

_____

STALKING: ☐ yes ☐ no ☐ unknown ☐ conviction

VI. OTHER SERVICES

☐ D.V. SHELTERS USED ☐ NONE USED _____

HOW MANY TIMES? WHAT TIME FRAME? _____

Comments: _____

VII. MORE DEMOGRAPHICS/INFORMATION

WHO REPORTED DEATH:
- ☐ Stranger
- ☐ Intimate Partner - Relationship _____
- ☐ Family Member - Relationship _____
- ☐ Unknown

WITH WHOM DID THE VICTIM LIVE? *(include foster/adopted/step/half; check all that apply)*

☐ husband (including common-law) ☐ intimate partner ☐ roommate/friend

☐ child(ren)<18 ☐ child(ren)>18 ☐ parent(s) ☐ alone

☐ unknown ☐ other family member _____

other *(specify)* _____

IF VICTIM LIVED WITH CHILDREN<18, HOW MANY? _____

IS ALLEGED PERPETRATOR FATHER OF CHILDREN<18? ☐ yes How many _____ ☐ no ☐ unknown

VICTIM'S COUNTY OF RESIDENCE: _____

VICTIM'S TRIBAL AFFILIATION: _____ ☐ NOT APPLICABLE

DID VICTIM LIVE ON RESERVATION/PUEBLO? ☐ yes ☐ no ☐ unknown

IF YES, INDICATE: _____

IF OTHERS DIED WITH VICTIM, INDICATE RELATIONSHIP *(Exclude alleged perpetrator suicides):*

☐ intimate partner ☐ child/grandchild ☐ parent/grandparent

☐ other family member: _____ ☐ non-family member _____

DID CHILD(REN)... ☐ find body ☐ witness murder/present at time of murder ☐ unknown ☐ no

WHAT WERE CIRCUMSTANCES SURROUNDING DEATH: _____

_____

_____

DID THE VICTIM HAVE A PRIOR POLICE RECORD? ☐ yes ☐ no ☐ unknown

Nature _____

_____

VIII. ABOUT THE ALLEGED PERPETRATOR\

WHAT IS THE ALLEGED PERPETRATOR'S RELATIONSHIP TO THE VICTIM

☐ husband (include common-law) ☐ ex-husband ☐ boyfriend/partner
☐ ex-boyfriend/ex-partner ☐ friend ☐ family member _____
☐ neighbor ☐ stranger ☐ employment related _____
☐ other _____

Length of relationship: _____ Length of separation: _____

WHAT WAS MOTIVE FOR HOMICIDE? *(check all that apply)*

☐ alcohol ☐ drug related ☐ gang ☐ dispute/argument
☐ robbery ☐ burglary ☐ sexual assault ☐ self-defense
☐ homicide/suicide ☐ separation ☐ unknown ☐ anger ☐ rejection
☐ other _____

DID PERPETRATOR HAVE A PRIOR POLICE RECORD? ☐ yes ☐ no ☐ unknown
Nature _____

IF ALLEGED PERPETRATOR(S) IS/ARE DEAD, WHY?

☐ suicide ☐ killed by police
☐ killed by other ☐ not applicable OMI ID # _____

ALLEGED PERPETRATOR GENDER(S): ☐ male ☐ female ☐ unknown

ALLEGED PERPETRATOR RACE(S):

☐ Anglo ☐ Hispanic ☐ Native American ☐ Asian American
☐ African American ☐ Other _____

ALLEGED PERPETRATOR AGE(S): _____

CASE DISPOSITION: _____

_____

IX. SUMMARY

AT RISK IDENTIFIERS:

_____
_____
_____
_____

SYSTEM INTERVENTIONS/FAILURES:

_____
_____
_____
_____

PREVENTION ISSUES:

_____
_____
_____
_____