

Attachment 3

**Contra Costa Country DVDRT
Data Collection Form**

Contra Costa County Domestic Violence Death Review Team Data Collection Form

DVDRT # _____
Date Case Review Completed _____

Team Members Contributing Information:

BWA Children & Family Services
 Contra Costa Crisis District Attorney
 Family Court Services
 Hospitals & Health Centers Kaiser
 Mental Health Probation
 Public Health Sheriff
 Substance Abuse
 Other _____

CONFIDENTIALITY

All information contained herein is collected and documented pursuant to California Penal Code Sections 11163.3-11163.6, the legislation that allowed for the creation of Domestic Violence Death Review Teams. This information is confidential, and to be shared among team members only.

Circumstances of Death

1. Decedent: _____ AKA: _____
2. Responsible for death: _____ AKA: _____
 Referred to as "Responsible" throughout the remainder of form
3. Coroner Case #: _____
4. Police Jurisdiction: _____ Report #: _____
5. Location of DV Incident--Address: _____
 Description (decedent's residence, public, etc): _____
6. Location of Death--Address: _____
 Description: _____
7. Manner: suicide homicide accident undetermined
8. Method: Weapon: _____ Other: _____
9. Decedent intoxicated at time of death? Y N Unknown
 Toxicology Screen Results: _____ Not Tested
10. Responsible intoxicated at time of death? Y N Unknown
 Toxicology Screen Results: _____ Not Tested

11. Adults present at incident

	Name	Relationship to Decedent?	Relationship to Responsible?	Witness?
1.	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
2.	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
3.	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
4.	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown

12. Children present at incident

	Name	Relationship to Decedent?	Relationship to Responsible?	Witness?
1.	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
2.	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
3.	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
4.	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown

Decedent Information

- 1. Name: _____ AKA: _____
- 2. Date of Birth: ___/___/___ Date of Death: ___/___/___ Age at Death: _____
- 3. Gender: M F Trans
- 4. Pregnant: Y N Expected Date of Delivery: ___/___/___
- 5. Race/Ethnicity (check all that apply):
 - African American Asian Black Caucasian East Indian Filipino
 - Latin American Native American Pacific Islander Other _____
- 6. English speaker: Y N Unknown Primary Language: _____
- 7. Home Address: location of incident location of death
 Other: _____

Others living at this address:	Name	Relationship to Decedent?	Relationship to Responsible?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

- 8. Current Intimate Partner(s): _____
- 9. Past Intimate Partner(s): _____

10. Dependents/Parents:

Name	Relationship to Decedent	Birth Date	Living with Decedent?	
1. _____	_____	___/___/___	<input type="checkbox"/> Y	<input type="checkbox"/> N
2. _____	_____	___/___/___	<input type="checkbox"/> Y	<input type="checkbox"/> N
3. _____	_____	___/___/___	<input type="checkbox"/> Y	<input type="checkbox"/> N
4. _____	_____	___/___/___	<input type="checkbox"/> Y	<input type="checkbox"/> N
5. _____	_____	___/___/___	<input type="checkbox"/> Y	<input type="checkbox"/> N

- 11. Employed: Y N Unknown
- 12. Occupation: _____ Retired Disabled, unable to work
- 13. Abuse History: None Unknown (check all that apply)

- | | | |
|---|--|--|
| <p>As a Victim</p> <ul style="list-style-type: none"> <input type="checkbox"/> DV-current partner(s) <input type="checkbox"/> DV-past partner(s) <input type="checkbox"/> DV-Childhood home <input type="checkbox"/> Childhood sexual abuse <input type="checkbox"/> Childhood physical abuse <input type="checkbox"/> Adult Physical Abuse <input type="checkbox"/> Adult Sexual Abuse/Rape | <p>As a Perpetrator</p> <ul style="list-style-type: none"> <input type="checkbox"/> DV-current partner(s) <input type="checkbox"/> DV-past partner(s) <input type="checkbox"/> Child sexual abuse <input type="checkbox"/> Child physical abuse <input type="checkbox"/> Adult physical abuse <input type="checkbox"/> Adult Sexual Abuse/Rape <input type="checkbox"/> Abuse of animals/pets | <input type="checkbox"/> Family Violence in childhood home |
|---|--|--|

Dates/Details: _____

- 14. Mental Health History (check all that apply):
 - None Unknown Affective Disorder-Bipolar Aggressive Behavior/Impulse Disorder
 - Anxiety Disorder Attention Deficit Disorder Depression Developmental Disorder
 - Eating Disorder Organic Mental Disorder Psychosis Suicide Attempt(s)
 - Other _____

Dates/Details: _____

15. Substance Use History (check all that apply):

- None Unknown Alcohol Amphetamine Cocaine Heroin IVDU
 Marijuana Prescription medications Tobacco Other _____

Abuse/Addiction Issues: Y N Unknown

Dates/Details: _____

16. Stressors (check all that apply):

- None Unknown Chronic disease/disability Death of loved one Divorce/Break-up
 Family Financial Immigration Legal Major changes in social environment
 Onset of psychiatric illness Recent illness/injury Recent move Un/underemployment
 Other _____

Dates/Details: _____

17. Counseling/Treatment: Was treatment voluntary? Yes No Unknown

Length of time in treatment: _____

Agencies: _____

Dates/Details: _____

18. Known contact with:

- Children & Family Services Court Services DV Services Hospitals & Health Centers
 Law Enforcement Mental Health Probation Work Force Services
 Substance Abuse Treatment Other _____

Was contact voluntary? Y N Unknown

Dates/Details: _____

19. History of criminal record? Y N Unknown

Dates/Details: _____

Additional comments (use back if further space needed): _____

DVDRT # _____

Intimate Partner Information

Responsible? Y No (Use this space for parent if decedent is child)

Relationship to decedent: Current partner Past partner Parent Other: _____

1. Name: _____ AKA: _____

2. Date of Birth: ___/___/___ Age at time of decedent's death: _____

3. Gender: M F Trans

4. Pregnant: Y N Expected Date of Delivery: ___/___/___

5. Race/Ethnicity (check all that apply):

- African American Asian Black Caucasian East Indian Filipino
- Latin American Native American Pacific Islander Other _____

6. English speaker: Y N Unknown Primary Language: _____

7. Home Address: location of incident location of death decedent's home address
 other: _____

Others living at this address:	Name	Relationship to Decedent?	Relationship to Suspect?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

8. Current Intimate Partner(s): _____

9. Past Intimate Partner(s): _____

10. Dependents:

Name	Relationship to Decedent	Birth Date	Living with Intimate Partner?	
1. _____	_____	___/___/___	<input type="checkbox"/> Y	<input type="checkbox"/> N
2. _____	_____	___/___/___	<input type="checkbox"/> Y	<input type="checkbox"/> N
3. _____	_____	___/___/___	<input type="checkbox"/> Y	<input type="checkbox"/> N
4. _____	_____	___/___/___	<input type="checkbox"/> Y	<input type="checkbox"/> N
5. _____	_____	___/___/___	<input type="checkbox"/> Y	<input type="checkbox"/> N

11. Employed: Y N Unknown

12. Occupation: _____ Retired Disabled, unable to work

13. Abuse History: None Unknown (check all that apply)

- | | | |
|--|---|---|
| <p>As a Victim</p> <ul style="list-style-type: none"> <input type="checkbox"/> DV-current partner(s) <input type="checkbox"/> DV-past partner(s) <input type="checkbox"/> DV-Childhood home <input type="checkbox"/> Childhood sexual abuse <input type="checkbox"/> Childhood physical abuse <input type="checkbox"/> Adult Physical Abuse <input type="checkbox"/> Adult Sexual Abuse/Rape | <p>As a Perpetrator</p> <ul style="list-style-type: none"> <input type="checkbox"/> DV-current partner(s) <input type="checkbox"/> DV-past partner(s) <input type="checkbox"/> Child sexual abuse <input type="checkbox"/> Child physical abuse <input type="checkbox"/> Adult physical abuse <input type="checkbox"/> Adult Sexual Abuse/Rape <input type="checkbox"/> Abuse of animals/pets | <p><input type="checkbox"/> Family Violence in childhood home</p> |
|--|---|---|

Dates/Details: _____

Additional Information (use back if necessary):

DVDRT# _____

14. Mental Health History (check all that apply):

- None Unknown Affective Disorder-Bipolar Aggressive Behavior/Impulse Disorder
- Anxiety Disorder Attention Deficit Disorder Depression Developmental Disorder
- Eating Disorder Organic Mental Disorder Psychosis Suicide Attempt(s)
- Other _____

Dates/Details: _____

15. Substance Use History (check all that apply):

- None Unknown Alcohol Amphetamine Cocaine Heroin
- IVDU Marijuana Prescription medications Tobacco Other _____

Abuse/Addiction Issues: Y N Unknown

Dates/Details: _____

16. Stressors (check all that apply):

- None Unknown Chronic disease/disability Death of loved one
- Divorce/Break-up Financial Immigration Major changes in social environment
- Onset of psychiatric illness Recent illness/injury Recent move Un/underemployment
- Other _____

Dates/Details: _____

17. Counseling/Treatment: Was treatment voluntary? Yes No Unknown

Length of time in treatment: _____

Agencies: _____

Dates/Details: _____

18. Known contact with:

- Children & Family Services Court Services DV Services Hospitals & Health Centers
- Law Enforcement Mental Health Probation Work Force Services
- Substance Abuse Treatment Other _____

Was contact voluntary? Y N Unknown

Dates/Details: _____

19. History of criminal record? Y N Unknown

Details: _____

Issues for follow-up at next meeting

	Issue	Responsible Agency	Completed
1.			<input type="checkbox"/>
2.			<input type="checkbox"/>
3.			<input type="checkbox"/>
4.			<input type="checkbox"/>
5.			<input type="checkbox"/>
6.			<input type="checkbox"/>
7.			<input type="checkbox"/>
8.			<input type="checkbox"/>
9.			<input type="checkbox"/>
10.			<input type="checkbox"/>
11.			<input type="checkbox"/>
12.			<input type="checkbox"/>
13.			<input type="checkbox"/>
14.			<input type="checkbox"/>
15.			<input type="checkbox"/>

Additional Risk Factors

Characteristics Of Abuse

This section refers to (check all that apply): <input type="checkbox"/> decedent <input type="checkbox"/> intimate partner <input type="checkbox"/> responsible <input type="checkbox"/> parents Names of two people in relationship referred to in this sections:	During year prior to death			More than 1 year prior to death		
	Yes	No	Unknown	Yes	No	Unknown
1. Did the abuse occur more frequently?	Yes	No	Unknown	Yes	No	Unknown
2. Did the abuse become more severe?	Yes	No	Unknown	Yes	No	Unknown
3. Did the responsible threaten to kill the decedent?	Yes	No	Unknown	Yes	No	Unknown
4. Did the decedent threaten to kill the responsible?	Yes	No	Unknown	Yes	No	Unknown
5. Did the responsible threaten to hurt the decedent's children or other family members?	Yes	No	Unknown	Yes	No	Unknown
6. Did the decedent threaten to hurt the responsible's children or other family members?	Yes	No	Unknown	Yes	No	Unknown
7. Did the responsible threaten to &/or actually abduct the decedent's children?	Yes	No	Unknown	Yes	No	Unknown
8. Did the decedent threaten to &/or actually abduct the responsible's children?	Yes	No	Unknown	Yes	No	Unknown
9. Did the responsible have homicidal ideation?	Yes	No	Unknown	Yes	No	Unknown
10. Did the decedent have homicidal ideation?	Yes	No	Unknown	Yes	No	Unknown
11. Did the responsible force sex on the decedent?	Yes	No	Unknown	Yes	No	Unknown
12. Did the decedent force sex on the responsible?	Yes	No	Unknown	Yes	No	Unknown
13. Did the responsible stalk the decedent?	Yes	No	Unknown	Yes	No	Unknown
14. Did the decedent stalk the responsible?	Yes	No	Unknown	Yes	No	Unknown
15. Was there physical &/or sexual abuse during pregnancy?	Yes	No	Unknown	Yes	No	Unknown
16. Was the decedent seriously injured so as to require medical treatment during prior events?	Yes	No	Unknown	Yes	No	Unknown
17. Was the responsible seriously injured so as to require medical treatment during prior events?	Yes	No	Unknown	Yes	No	Unknown
18. Did the decedent apply for a restraining order against the responsible?	Yes	No	Unknown	Yes	No	Unknown
A. Was the restraining order in effect at the time of death?	Yes	No	Unknown	Yes	No	Unknown
B. Had the restraining order been violated?	Yes	No	Unknown	Yes	No	Unknown
19. Did the responsible apply for a restraining order against the decedent?	Yes	No	Unknown	Yes	No	Unknown
A. Was the restraining order in effect at the time of death?	Yes	No	Unknown	Yes	No	Unknown
B. Had the restraining order been violated?	Yes	No	Unknown	Yes	No	Unknown
20. Did the responsible threaten the decedent regarding immigration issues?	Yes	No	Unknown	Yes	No	Unknown
21. Did the decedent threaten the responsible regarding immigration issues?	Yes	No	Unknown	Yes	No	Unknown
22. Did the responsible threaten &/or injure or kill family pets?	Yes	No	Unknown	Yes	No	Unknown
23. Did the decedent threaten &/or injure or kill family pets?	Yes	No	Unknown	Yes	No	Unknown
24. Did the responsible destroy personal property?	Yes	No	Unknown	Yes	No	Unknown
25. Did the decedent destroy personal property?	Yes	No	Unknown	Yes	No	Unknown
26. Did the responsible have a history of committing other types of violence?	Yes	No	Unknown	Yes	No	Unknown
27. Did the decedent have a history of committing other types of violence?	Yes	No	Unknown	Yes	No	Unknown

Characteristics of Relationship Dynamics and Control

DVDRT#

This section refers to (check all that apply): <input type="checkbox"/> decedent <input type="checkbox"/> intimate partner <input type="checkbox"/> responsible <input type="checkbox"/> parents Names of two people in relationship referred to in this sections:	During year prior to death			More than 1 year prior to death		
	Yes	No	Unknown	Yes	No	Unknown
28. Did the responsible try to control the decedent's daily activities?	Yes	No	Unknown	Yes	No	Unknown
29. Did the decedent try to control the responsible's daily activities?	Yes	No	Unknown	Yes	No	Unknown
30. Did the responsible exhibit obsessive, possessive beliefs/behaviors?	Yes	No	Unknown	Yes	No	Unknown
31. Did the decedent exhibit obsessive, possessive beliefs/behaviors?	Yes	No	Unknown	Yes	No	Unknown
32. Did the responsible perceive that he/she had been betrayed by the decedent?	Yes	No	Unknown	Yes	No	Unknown
33. Did the decedent perceive that he/she had been betrayed by the responsible?	Yes	No	Unknown	Yes	No	Unknown
34. Was the decedent in the process of leaving the responsible &/or had he/she left the relationship?	Yes	No	Unknown	Yes	No	Unknown
35. Was the responsible in the process of leaving the decedent &/or had he/she left the relationship?	Yes	No	Unknown	Yes	No	Unknown
36. Did the responsible control the decedent's finances &/or access to income?	Yes	No	Unknown	Yes	No	Unknown
37. Did the decedent control the responsible's finances &/or access to income?	Yes	No	Unknown	Yes	No	Unknown

Weapons

This section refers to (check all that apply): <input type="checkbox"/> decedent <input type="checkbox"/> intimate partner <input type="checkbox"/> responsible <input type="checkbox"/> parents Names of two people in relationship referred to in this sections:	During year prior to death			More than 1 year prior to death		
	Yes	No	Unknown	Yes	No	Unknown
38. Did the responsible possess and/or have firearms in the home?	Yes	No	Unknown	Yes	No	Unknown
39. Did the decedent possess and/or have firearms in the home?	Yes	No	Unknown	Yes	No	Unknown
40. Did the responsible threaten the decedent with weapons?	Yes	No	Unknown	Yes	No	Unknown
41. Did the decedent threaten the responsible with weapons?	Yes	No	Unknown	Yes	No	Unknown
42. Did the responsible use weapons during prior DV incidents?	Yes	No	Unknown	Yes	No	Unknown
43. Did the decedent use weapons during prior DV incidents?	Yes	No	Unknown	Yes	No	Unknown