Domestic Violence Fatality Review in Nevada

Annual Report

November 30, 2014

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Message from the Nevada Attorney General Catherine Cortez Masto

Fatalities resulting from Domestic Violence are a serious concern in Nevada. In 2011, Nevada was ranked number one in the rate of women killed by men. While recent numbers indicate a declining rate in such fatalities, our Domestic Violence Fatality Review teams have worked hard to help expedite this decline.

The Domestic Violence Fatality Review is a multidisciplinary review team that compiles information to review deaths related to domestic violence. Through these reviews, teams identify red flags that may have indicated escalating levels of violence, and develop recommendations to improve systems designed to protect victims of domestic violence. The process is instrumental to reducing the number of deaths related to domestic violence. This report is intended to give an update on the work of Domestic Violence Fatality Review teams statewide since the last report in April 2013. The report also includes progress on existing recommendations as well as any new recommendations for prevention identified by each of the statewide, Clark and Washoe County teams.

As you might glean, eliminating fatalities related to domestic violence is an ongoing process, and one that is in need of great attention and effort. The Domestic Violence Fatality Review report will provide you with an assessment of the current process for assessing and enhancing multidisciplinary approaches of dealing with domestic violence fatalities in Nevada, and the work that is currently being done in order to combat domestic violence.

It is my hope that the report will bring valuable insight to social service providers, law enforcement, and stakeholders to continue to do great work in advocating for Nevada's vulnerable populations and work to end domestic violence.

Sincerely,

Attorney General Catherine Cortez Masto

I. INTRODUCTION

Domestic Violence Fatality Review is considered to be a best practice tool and is becoming increasingly utilized across the country. The process includes a multidisciplinary review team that compiles information to review deaths related to domestic violence. Through these reviews, teams identify red flags that may have indicated escalating levels of violence which enables the team to develop recommendations to improve systems designed to protect victims of domestic violence. In a 2011 report from the Violence Policy Research Center, Nevada ranked number one in the rate of women killed by men. While these numbers are trending down (the same report in 2013 ranked Nevada sixteenth nationally), domestic violence related fatalities are still a concern in Nevada. This review process is working to help identify areas in need of improvement, establish a formal mechanism to further examine those needs and allow agencies and organizations to work together to make improvements, thus reducing deaths related to domestic violence

This report is intended to give an update on the work of Domestic Violence Fatality Review teams statewide since the last report was released in April 2013. The report also includes progress on existing recommendations as well as any new recommendations for prevention identified by each of the teams.

II. DOMESTIC VIOLENCE FATALITY REVIEW TEAM ACTIVITIES 2013-2014

Attorney General Domestic Violence Fatality Review Statewide Team (AG-DVFRST)
Target Review Area: *15 Rural Counties in Nevada*

Since the last fatality review report in April 2013, the statewide team has conducted two more case reviews in rural jurisdictions: a case was reviewed in Silver Springs (Lyon County) and a case in Minden (Douglas County). Each review was conducted over two days and outcomes of the reviews are outlined in section V. 2014 Recommendations. The team also participated in a statewide meeting in June 2014 to discuss the review process, lessons learned, successes and challenges in conducting reviews and making recommendations. This meeting was well attended and helped build collaboration and information sharing between the three teams to create a more consistent statewide system for domestic violence fatality review in Nevada. A full summary of this meeting is included in this report under Appendix A.

Clark County Domestic Violence Fatality Review Team (CC-DVFRT)
Target Review Area: *Clark County, Nevada*

The Clark County review team has conducted four case reviews since the last report in April 2013. In addition to case reviews the Clark team spent time reviewing internal processes for team membership and case selection, making changes to the protocols to create more specificity in membership requirements, as well as establishing a concrete procedure for case selection. The case selection process now allows the Clark County Coroner's Office to identify domestic violence related fatalities and bring them to the team for review and selection, allowing for a centralized case identification process rather than relying solely on individual law enforcement jurisdictions to identify cases.

In addition, the Clark County team invited agencies to present to the group about their programming or systems in order to learn more about resources available to individuals in our community. The team heard presentations from Communities in Schools about programs available for families as well as from the Nevada Office of Suicide Prevention (OSP). The OSP presentation gave the team information on outreach activities related to suicide prevention as well as training opportunities for professionals to help identify and provide resources to those struggling with suicidal thoughts. This presentation was especially useful given that the team had reviewed a number of homicide and suicide cases.

Washoe County Domestic Violence Fatality Review Team (WC-DVFRT)
Target Review Area: *Washoe County, Nevada*

The Washoe County review team has conducted four case reviews since the last report. The team has focused on further developing their case review process by making some modifications. In the last year the Washoe County team has changed their process such that now when cases are selected, the information is sent to team members two months in advance of the meeting, then one month prior to the meeting, a core group of team members with case specific information meet to create the timeline for the review. Once the timeline is created, it is presented at the team's review meeting where members then engage during the meeting to identify red flags and generate recommendations for prevention.

III. STATEWIDE MEETING OF ALL TEAMS

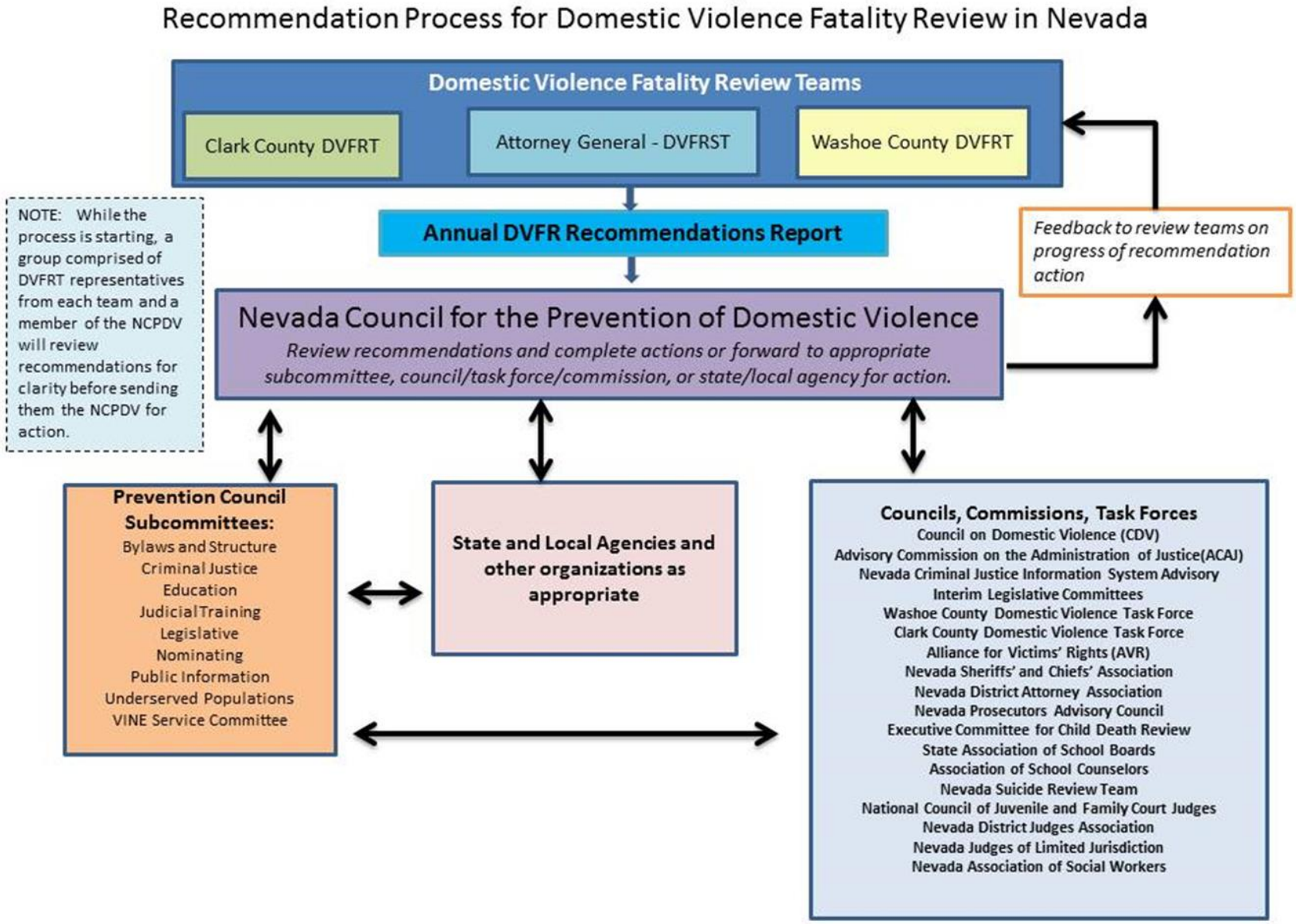
On June 3, 2014 members of the statewide domestic violence fatality review team as well as both local teams (Clark and Washoe) held a joint meeting to discuss the review process and identify both successes and challenges identified over the past two years. (Notes from this meeting are attached in Appendix B)

An outcome of this meeting was to create a "vetting team" that is responsible for the review, action, and follow-through on recommendations from the three review teams. A representative from each of the teams was requested to attend a meeting with the Attorney General and her staff to discuss the composition of this "vetting" team. This meeting was held on November 19, 2014 in Carson City, NV. Plans for this team are outlined in the next section of this report.

Domestic Violence Fatality Review in Nevada (DVFR) – Recommendation Process
As DVFR in Nevada has grown, teams have struggled to identify ways to make and implement effective recommendations for improvement. To streamline the process for receipt and review of recommendations from Domestic Violence Fatality Review Teams, the Attorney General and representatives from all three review teams met to discuss creating a process that establishes a central location for recommendations to be submitted, reviewed and acted upon.

During this meeting the Nevada Council for the Prevention of Domestic Violence (Council) was identified as an existing group that is well positioned to serve as the central depository for the review process. In the proposed plan, each review team would annually compile recommendations identified during case reviews and submit them to the Council. The Council would use their meetings to review and discuss these recommendations, and to identify an action plan to carry out the recommendations. This may be a referral to another agency, commission or task force in the state, or assignment to one of the Council's subcommittees. The Council would continue to work on the recommendations until they are considered complete and would update the team making the recommendation on the progress being made. Figure 1 below outlines the proposed process for making, reviewing, and implementing recommendations from DVFRTs.

Figure 1. Domestic Violence Fatality Review Recommendation Process



IV. 2013 DOMESTIC VIOLENCE FATALITY REVIEW RECOMMENDATIONS

Attorney General - Domestic Violence Fatality Review Statewide Team Recommendations

RECOMMENDATION #1:	ACTION TO DATE
Create policy, protocol, or other methods to ensure that agencies are submitting complete and accurate information to the Nevada Criminal Justice Information System (NCJIS). RATIONALE: **:** NCJIS – Nevada Criminal Justice Information System is a database for information sharing that contains all information on criminal activity, but is only as good as the agencies and individuals submitting the information. DAs, city attorneys, courts, and law enforcement should all have processes in place to ensure that full, accurate, and complete information is inputted into this system – including arrests, convictions, and Temporary Protection Orders	*The Nevada Department of Public Safety (DPS) is working on crafting regulations that specify exactly what information should go into NCJIS and when that information should be added.* *In addition, once regulations are completed, training will be developed and implemented for law enforcement to ensure they are aware of the new requirements.* Contact Person: Julie Butler, Department of Public Safety

RECOMMENDATION #2	ACTION TO DATE
Ensure that once a danger/lethality assessment is completed, the victim is referred for services and also follow up with the perpetrator. This could come in the form of the creation of high risk teams that place the focus on the prevention of crime and strengthen police response to high risk perpetrators. RATIONALE: Many agencies (law enforcement and other service providers) have implemented lethality assessments, but need more resources and guidance on how to use that information once the assessment is complete. The implementation of high risk teams would allow for specialized treatment of these cases to strengthen the ability for police to respond and prevent violent crimes.	*The Las Vegas Metropolitan Police Department (LVMPD) has created a process for administering lethality assessments that has been in place since 2009.* *A brief summary of the LVMPD lethality assessment and follow up process is provided in Appendix A of this report*

RECOMMENDATION #3	ACTION TO DATE
Provide support to agencies to allow them to achieve a level of capacity that will allow them to implement best practices in their field. RATIONALE: Best practices in many areas related to domestic violence treatment and prevention have been developed, but local agencies struggle to implement these processes because of high case loads and/or insufficient staffing levels.	*The Nevada Council for the Prevention of Domestic Violence has been identified to receive and take action on recommendations from all three DVFRTs in the state.* *The process was outlined and presented to the Council on December 8, 2014. This process will assist in developing interagency relationships statewide and facilitate building capacity in communities interested in implementing best practices.*

RECOMMENDATION #4	ACTION TO DATE
Explore the possibility of the creation and implementation of a process/procedure for instant Temporary Protection Orders (TPOs) at the time of arrest. RATIONALE: The Temporary Protection Order (TPO) at the time of the incident is often most valuable at the time of the incident and an instant system would prevent delays in protecting victims from additional abuse. This system may require on-call judges, and advocates that could be available immediately at the time of arrest. **NRS 33.017 Definitions.** As used in NRS 33.017 to 33.100, inclusive, unless the context otherwise requires: 1. "Extended order" means an extended order for protection against domestic violence. 2. "Temporary order" means a temporary order for protection against domestic violence. (Added to NRS by 1985, 2283; A 1997, 1808; 1999, 1372; 2001, 2128; 2003, 1754; 2007, 1275)	*Currently both Washoe County and Clark County have systems in place to issue emergency temporary protection orders.* *This recommendation will be referred to the Nevada Sheriffs' and Chiefs' Association as well as the District Attorneys' Association for review and assessment of the capacity issues that prevent this system from being implemented in rural jurisdictions.*

RECOMMENDATION #5	ACTION TO DATE
Work with judges and attorneys statewide to discontinue the practice of pleading down domestic violence cases. RATIONALE: When these cases are pled down to lower level offenses, sentencing is ineffective or even dangerous. For example, impulse control /anger management classes are not effective in domestic violence cases. In addition, this creates a system where future domestic violence incidents are treated as a first offense, and therefore the cumulative nature of domestic violence sentencing is ineffective.	*Resources for improvement in a community's response to domestic violence, including best practices for prosecuting domestic violence cases in Nevada are listed in Appendix A of this report.*

RECOMMENDATION # 6	ACTION TO DATE
Implement a regular review for the processes used when perpetrators are "Gone on Arrival." RATIONALE: In these circumstances, law enforcement may or may not follow up on locating these individuals. If 24 hours pass, then law enforcement can seek a warrant for their arrest, but this is not consistently done across jurisdictions.	*To better understand the current practices and available resources relative to Recommendations 6, 7, and 8, a brief online survey will be developed and disseminated to the Sheriffs' and Chiefs' Association, asking agencies to provide information on current practices.* *This information will be complied and then shared with the Association members so they can better address these recommendations by sharing processes in different jurisdictions to identify best practices for each community.*

RECOMMENDATION #7	ACTION TO DATE
Ensure that a language line or other reliable and certified interpretation services are available for 911 operators as well as law enforcement, and ensure staff are trained on when and how to use these services in the course of their job. RATIONALE: Interpretation services may not be available 24 hours a day in all jurisdictions and staff may not be aware of when and how to access these services. In DV cases, reporting abuse is a very important step, and if victims are not understood at the time of the call or law enforcement response, victims may become frustrated by the system and not use the systems that are there for their protection.	*See #6*

RECOMMENDATION #8	ACTION TO DATE
Review standard procedures for 911 operators in Public Safety Answering Point (PSAP) locations statewide to ensure that operators are trained using national best practices in how to respond to calls related to domestic violence. RATIONALE: When victims of domestic violence call 911 for help, operators should be trained to conduct a safety assessment of the caller to ensure their safety is secured before demographic information is collected. In some instances, valuable time is lost and victims remain at risk while the operator gets basic demographic information like name, address, etc.	*See # 6*

Clark County - Domestic Violence Fatality Review Team Recommendations

RECOMMENDATION #1:	ACTION TO DATE
Work with the Nevada Council for the Prevention of Domestic Violence's Education Committee to identify existing programs and best practices for increasing age appropriate education and awareness about domestic violence for children and youth in Nevada schools. *RATIONALE: In one of the cases reviewed by the team, the couple had children in the home that witnessed the abuse and in one case even made multiple calls to law enforcement when domestic violence occurred. The team identified a need to educate students about domestic violence so that they have tools and resources available if they recognize the signs in their own homes or dating relationships.*	*The Clark County team will review programs in other parts of the state (Child Assault Prevention, SHARE program, etc.). In addition the team will connect with individuals implementing the Clark County School District human trafficking curriculum to see if the messaging is also applicable to concepts around domestic violence prevention.*

RECOMMENDATION #2	ACTION TO DATE
Work with the Nevada Council for the Prevention of Domestic Violence's Public Information Committee to implement a broad public education campaign to recognize that even seemingly minor incidents in a relationship can be red flags that often escalate to more severe violence, power and control issues in a relationship. RATIONALE: In all of these cases in hindsight someone in the victim or perpetrator's family, their friend, neighbors or coworkers identified incidents of controlling behavior or violence, and if these earlier incidents (although perceived as minor or isolated) would have been taken more seriously the death may have been prevented.	*The Public Information subcommittee of the Nevada Council for the Prevention of Domestic Violence has created a plan to implement the national "No More" campaign in Nevada.* *http://www.nomore.org*

RECOMMENDATION #3	ACTION TO DATE
Create a subcommittee at the state level to review laws/policies related to the minimum age when a protection order may be requested without a parent or guardian to see if these restrictions can be changed to accommodate younger victims. RATIONALE: In some cases, the domestic violence or dating violence starts very young and victims may be too embarrassed to talk to their parents about their concerns, so requiring a parent or guardian for victims under age 18 may be a barrier to them seeking out these protections even when they have very serious concerns.	*In 2014 the Attorney General's Office and the National Council on Family and Juvenile Court Judges held two statewide meetings to better understand juveniles and domestic violence. One area of focus was on the relationship types most prevalent for juveniles and domestic violence. The Summary of these meetings were compiled into a report that will be shared with the Clark County team for possible action. The summary is also in Appendix C of this document.*

RECOMMENDATION #4	ACTION TO DATE
Amend NRS 202.360 so that persons convicted of a misdemeanor offense of battery constituting domestic violence are included in the list of persons prohibited from owning or possessing a firearm. RATIONALE: In two of the cases reviewed, the perpetrator used a firearm to commit the murder, and in both of those cases the firearm was owned by the perpetrator. In one of the cases reviewed the perpetrator had been previously convicted of domestic violence but still remained in possession of his firearms. This suggested change would bring Nevada state law more in line with federal law.	*Currently the Nevada Network Against Domestic Violence is exploring legislative options to address this issue.*

RECOMMENDATION #5	ACTION TO DATE
Work with the Nevada Council for the Prevention of Domestic Violence to identify existing resources or develop educational messaging or training about mental illness/substance abuse and the impact on victims of domestic violence to help professionals become more sensitive to these issues RATIONALE: In one of the cases reviewed, mental health issues of the victim may have led to chronic alcohol abuse which may have hindered her ability to advocate for herself, and may have impacted her credibility with law enforcement when reporting incidents of domestic violence. We know that victims may use substances as a coping mechanism to deal with the abuse, and their abusers may withhold treatment for mental illness to maintain control. Training for sensitivity to these issues may allow for better services to victims with these special needs.	*The Ombudsman for Domestic Violence in the Attorney General's Office is currently working on plans for a statewide training institute for sex trafficking/domestic violence/sexual assault. When this is created it would serve as a resource to provide this type of continuing education in Nevada.* *Currently the International Association of the Chiefs of Police has information on their website about improving officer response to people with mental illness. This information can be found at http://www.theiacp.org/responsetomentalill*

RECOMMENDATION # 6	ACTION TO DATE
Request that the Nevada Council for the Prevention of Domestic Violence and their Underserved Populations Committee could work with inpatient/outpatient mental health service providers as well as domestic violence shelters statewide to help address specific concerns for domestic violence victims with mental health diagnoses. RATIONALE: Historically, it has been difficult for victims of domestic violence with mental health or substance abuse issues to access domestic violence shelters. For the safety of all the women in the shelters, there are strict rules of conduct that must be followed and these can be difficult for victims with mental illness or those addicted to drugs or alcohol, but they could still benefit from the safety a shelter can offer. Currently there has been some work done to address these concerns, but it would be more beneficial if the issues were addressed on a statewide level.	*This recommendation will be forwarded to the Nevada Network for Domestic Violence as well as the Division of Public and Behavioral Health to identify existing outreach efforts to ensure that mental health concerns are addressed for victims of domestic violence.*

RECOMMENDATION #7	ACTION TO DATE
Identify existing training or develop training based on best practices, for medical providers on what to do after a lethality assessment or how to provide information discreetly if medical staff suspect that a patient is the victim of domestic violence. RATIONALE: In two of the cases reviewed, the team identified that the victim had been to the hospital for medical treatment after a violent incident and although a lethality assessment was completed, it was unclear what steps were taken after the assessment to help ensure the victim's safety. In addition, in these incidents even if the assessment wasn't done medical staff likely had a suspicion and could have provided resources or information even if the victim indicated that the injury was not a result of domestic violence.	*A request will be sent to a Clark County Traumatologist working out of the University Medical Center to better understand an existing program designed to provide case management for victims of violence. Once the information is compiled an informational letter will be sent to the Nevada Hospital Association to recommend best practices and existing resources for hospitals.*

Washoe County - Domestic Violence Fatality Review Team Recommendations

RECOMMENDATION #1:	ACTION TO DATE
Create policy, protocol and training to ensure that all Temporary Protection Order Offices within the courts have access and/or staff are bilingual to ensure that the victims applying for TPO's are afforded the opportunity to have all their questions, concerns and education explained to them in a language they understand. RATIONALE: Several of our previous cases over the past two years have involved immigrants from other countries who did not speak or understand English very well. There are international language services which provide bilingual speakers to assist in the interpretation and explanation of a TPO and would assist in ensuring the victim understands the TPO process and any fears or concerns they may have could be addressed at the time of application.	*See response to AG-DVFRST Recommendations #6, 7, 8 above.*

RECOMMENDATION #2	ACTION TO DATE
Provide statewide training to law enforcement personnel on domestic violence, signs of domestic violence and the TPO process. RATIONALE: Many agencies throughout the state have experienced an increase in the number of new officers on the street. This influx can partially be attributed to the early retirement age for law enforcement personnel (25 years of service). The basic law enforcement academy provides a very limited amount of domestic violence and TPO training to new officers. Nevada continues to lead the nation in domestic batteries, and we need to educate our first responders on identifying and addressing this issue. This training should also involve the best practices in the prevention and outreach resources available for victims.	*The practice and policy was created at the Reno Police Department and training was completed for all personnel.* *Currently, the Washoe County DVFRT is working on ensuring sustainability for this program.*

V. 2014 RECOMMENDATIONS

Attorney General-Domestic Violence Fatality Review Statewide Team

RECOMMENDATION #1:

Communities should implement a "Coordinated Community Response" to Domestic Violence to ensure communication between agencies and improved systems for prevention of domestic violence and protection of victims.

RATIONALE: Timeliness of response from law enforcement as well as continued communication and coordination of services between law enforcement and service providers in the community is crucial to the elimination of domestic violence and associated fatalities in Nevada. There is extensive research on this topic which continues to demonstrate that it is a model practice for communities. http://files.praxisinternational.org/ccrdv.pdf

RECOMMENDATION #2:

Efforts should be made for early and consistent contact with victims to ensure their safety and cooperation in apprehending and prosecuting the suspects.

RATIONALE: In domestic violence cases, victims will often recant their initial allegation for fear of additional abuse. Therefore law enforcement needs to ensure that in their system for response, they are working with victims immediately to ensure their safety and also develop a trusting relationship that will assist in the eventual prosecution of the case. This element should be a part of the coordinated community response noted in Recommendation #1.

RECOMMENDATION #3:

State leaders should explore options to develop a statewide data system that will identify and track domestic violence arrests, convictions, sentencing and recidivism.

RATIONALE: Currently there is no one data system that can be used to provide these metrics. This data is essential to understandthe scope of domestic violence statewide as well as our systems' response to it.

Clark County - Domestic Violence Fatality Review Team Recommendations

RECOMMENDATION #1:

Review policies related to minimum lengths of temporary protection orders. The timeframes should be a minimum of 5-7 days for emergency orders, and a minimum of 30-45 days for temporary orders.

RATIONALE: Judges have a lot of discretion when it comes to issuing protection orders, and the decisions are not always in the best interest of the victim's safety. Therefore required minimum standards would increase the likelihood that the order stays in place for as long as the victim needs it.

RECOMMENDATION #2:

Require that all judge pro-tems MUST have training on the dynamics of domestic violence before being allowed to preside over cases.

RATIONALE: This effort is underway through Judge Frank Sullivan (Eight Judicial District Court) and attorneys sitting in for Domestic Violence commissioners. They have received mandatory training and Judge Sullivan is also requiring that all hearing masters as well as attorneys sitting in for them have this training before they are allowed to sit on the bench for protective order hearings. This is a current practice but not an official "court rule." Also, the Clark County team is looking to review the content of the training curriculum to ensure it adequately covers the dynamics of domestic violence and not just the laws relative to domestic violence.

RECOMMENDATION #3:

Ensure that the health curriculum for K-12 students in Nevada includes relevant information regarding healthy relationships.

RATIONALE: Safe Nest and the Rape Crisis Center currently provide some training in Clark County, but not for all schools at all grade levels. This information could be included in the child sexual abuse prevention or sex trafficking prevention curriculums.

RECOMMENDATION #4:

Work with the Nevada Network Against Domestic Violence to provide training to nursing staff on screening for domestic violence/sexual assault during regular/annual visits. Request a letter from the AG's office to the Nevada Hospital Association and Nursing Boards regarding the importance of screening at visits as well as resources for screening tools to use and resources to provide if abuse is disclosed.

RATIONALE: Victims may be hesitant to come forward and report the abuse they are suffering. Many times medical appointments are the only time the victim is alone with a professional that could provide assistance in obtaining support and services. Therefore, it is crucial that medical professionals and especially nurses are trained to screen their patients for domestic violence and are able to provide resources for victims.

Washoe County-Domestic Violence Fatality Review Team Recommendations

RECOMMENDATION #1:

Include batterer information into Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups.

RATIONALE: The majority of the cases reviewed by the team have some element of alcohol or drug abuse by both perpetrator and/or victim. Including batterers' treatment information and resources to pre-exiting NA and AA groups would allow the information to reach the target audience.

RECOMMENDATION #2

Educate victims on the difference between a No Contact order and a Protection Order

RATIONALE: Victims often times do not understand the difference or more specifically their rights and the differences in protection and perpetrator restrictions between a no contact order and a protection order. Safety can be impacted based on what they believe each one will do.

RECOMMENDATION #3

Ensure that batterers are court ordered to attend groups while detained. Analyze what those groups specifically provide and how often and quickly they are offered.

RATIONALE: While a perpetrator is sitting in jail it is the perfect opportunity to order them to attend groups' specific to domestic violence. While there are currently groups offered, and credit given to offenders that attend, they are not court ordered.

RECOMMENDATION #4

Provide domestic violence information to weekly motels and apartment complexes.

RATIONALE: Many domestic violence homicides occur in weekly motels and apartment complexes, so it is important to have information in those complexes for tenants to access and to make sure the managers are made aware as well.

RECOMMENDATION #5

Bridges out of Poverty training for Law Enforcement

RATIONALE: There are huge dynamics around poverty and domestic violence. The *Bridges out of Poverty* training provides an opportunity for those that work with families living in poverty to help get a better understanding and perspective on why they make the decisions they make and how to be most effective when working with them.

RECOMMENDATION # 6

Strangulation training for first responders – educating them on the fact that there could be no visible injuries on the victim yet still be a strangulation. Better documentation of the event and other non-visible injuries. A checklist should be developed or first responders to use on scene.

RATIONALE: In strangulation cases there is a tendency for first responders to question the validity of the victims' story if there are no visible injuries to the neck, etc. If first responders could be educated that a lack of injury does not mean that a crime did not occur. Also, there are many other indicators of strangulation that they could be educated about. A checklist should be created as an educational tool.

RECOMMENDATION #7

More education on teen dating violence and healthy relationships for teens at the middle and high school level.

RATIONALE: Early education to teens is a huge preventative measure for both the batterers and the victims. Many programs will separate the boys and the girls and then teach specific to the batterers and victims in each grouping. This has shown to be very effective at the national level.

RECOMMENDATION #8

Improve documentation of victim injuries and Provide Training for law enforcement so they are more consistent with follow-up photos of victim injuries days after the event. In addition, add a BOLD clause on the law enforcement victim information sheet that encourages victims to take additional photos as their injuries progress or provide victims with a contact number for a specific agency (or reporting agency) to take those follow-up photos for them should be added by all three law enforcement jurisdictions in Washoe County.

RATIONALE: Many injuries in both domestic violence and strangulation cases get more pronounced and even appear days after the event. It is important to capture those images as they can often support the victims' statements even if at the time of the event there were no visible injuries.

VI. NEXT STEPS FOR DOMESTIC VIOLENCE FATALITY REVIEW IN NEVADA

The process for Domestic Violence Fatality Review in Nevada continues to be revised as we work to create a system that can help eliminate domestic violence fatalities in Nevada. In the next year, teams will continue to meet to review cases, identify red flags and recommendations, and work together to improve systems and services aimed at preventing and treating domestic violence.

In December 2014, all three DVFRTs in the state were invited to participate in training provided by the National Domestic Violence Fatality Review Initiative to assist teams in making better and more effective recommendations as well as learn new strategies for implementing recommendations statewide.

Teams plan to utilize the proposed recommendation process in 2015 and make adjustments as necessary. In addition, the teams will continue to hold an annual meeting to bring members of all three teams together to share lessons learned and identify ways to continually improve the fatality review process in Nevada. Information from these meetings, annual reports, as well as a domestic violence fatality review program manual will be located on the Nevada Attorney General's website in the domestic violence section.

APPENDIX A: SUCCESSFUL PROGRAMS AND BEST PRACTICE GUIDELINES IN NEVADA

In the process of conducting reviews and crafting recommendations for prevention teams have identified successful programs and model protocols that may be helpful for communities in thinking about how to make improvements. In the paragraphs below you will find a brief description of the program as well as a person to contact if you would like more information on the program.

1. COORDINATED COMMUNITY RESPONSE TO DOMESTIC VIOLENCE

Douglas County Special Victims Response Team (SVRT)

The Douglas County Special Victims Response Team (SVRT) is a coordinated community response designed to significantly improve the safety of victims of sexual assault, domestic violence and stalking by implementing protocols to ensure victims receive immediate access to victim services and the criminal justice system, and to ensure that offenders are held accountable. Both public and private agencies in Douglas County entered into a memorandum of understanding as to their respective roles.

The SVRT partners include: (1) the Douglas County District Attorney's Office (DCDA) acts as the sole public prosecutor and single point of contact through an investigator assigned full-time to investigating cases of sexual assault, domestic violence and stalking and ensuring that the protocols are followed on all cases; (2) the Douglas County Sheriff's Office (DCSO) is the primary law enforcement agency and is responsible for responding to all calls for service, public safety issues, reported crimes and the initial investigation of reported criminal activity; (3) the Douglas County Department of Alternative Sentencing (DAS) is responsible for supervising defendants who are placed on court ordered pretrial supervision based on conditions of release and for supervising probationers, who as a condition of a suspended sentence, are released under the supervision of DAS by the court; (4) the Family Support Council of Douglas County (FSC) is the non-profit domestic violence, dating violence, sexual assault and stalking victim service agency and shelter program providing 24/7 crisis hotline and victim advocacy in both English and bilingual/bicultural Spanish and provides access to victims 24/7 for advocacy, safety planning, shelter, transportation and accompaniment to court or hospital services, and provides weekly drop-in support groups and one-on-one peer counseling or therapy with a licensed marriage and family therapist; (5) the Douglas County Partnership of Community Resources is a non-profit substance abuse and wellness coalition that serves to strengthen collaborative projects in the community and serves as a technical assistance agency in collecting data, assisting in the preparation and submission of SVRT reports and identifying emerging community issues related to the SVRT, and; (6) the Douglas County Juvenile Probation Department is responsible for issues related to juveniles within the community.

Some of the key components of the SRVT protocol include: (1) contact with the victim within the first 12 critical hours following the crime to provide services and referrals within the scope of the SVRT; (2) provides for a single point of contact for all sexual assault, domestic violence and stalking cases; (3) weekly meetings with representatives from all of the partners of the SVRT to review the status of all ongoing cases and discuss new arrests and submissions from the previous week; (4) pretrial GPS monitoring of the offender as a condition of bail or as a condition of any additional suspended jail time after conviction; (5) and dedicated and thorough investigations of all cases, including listening to all non-privileged inmate recorded telephone calls and jail visits.

Contact: Mark Jackson, Douglas County District Attorney

2. LETHALITY ASSESSMENT

Las Vegas Metropolitan Police Department

The Las Vegas Metropolitan Police Department implemented the lethality Assessment Program in February, 2009 as a pilot project to address the increase in domestic violence homicides. This innovative program is based on collaboration and seamless services for victims who are determined to be at high risk for lethality. It is initiated when officers take a report for domestic violence. Victims are asked a series of questions to help assess the potential for escalating violence. Officers assist these victims to call the local domestic violence hotline to begin to formulate a safety plan, arrange for shelter or get more information about resources. While a majority of victims may not want to talk to an advocate immediately after talking to police, an advocate from the LVMPD Victim Services Unit will contact the victim within the first 24 hours to follow-up with resources, support and advocacy. When an arrest is made, the lethality assessment is included in the documents forwarded to the court for prosecution. While Southern Nevada saw a significant decrease in domestic violence homicides since 2010, the Las Vegas Metropolitan Police Department continues to expand proactive programs to support repeat victims, hold repeat offenders accountable and intervene before the violence escalates. Since January, 2014, LVMPD advocates have reached out to 4,356 victims at risk for escalating violence.

Contact: Elynne Greene, LVMPD Victim Advocate Supervisor

For more information about danger assessments please visit the Danger Assessment website from Johns Hopkins University at http://www.dangerassessment.org/

3. PROSECUTING DOMESTIC VIOLENCE IN NEVADA

The State of Nevada Advisory Council for Prosecuting Attorneys has recently produced two important documents for prosecutors of domestic violence in Nevada. These include the Domestic Violence Resource Manual as well as the Best Practices in Prosecuting Domestic Violence. Both of these resources can be found on the State of Nevada Attorney General's website at the link below.

http://ag.nv.gov/Hot_Topics/Victims/DV_Prosecuting/

4. MODEL POLICIES FOR DOMESTIC VIOLENCE

The International Association for Chiefs of Police (IACP) has many resources on their website including model polices for law enforcement for domestic violence. The information can be accessed at the link below.

http://www.theiacp.org/ViewResult?SearchID=797

APPENDIX B: JOINT MEETING OF DOMESTIC VIOLENCE FATALITY REVIEW TEAMS

Attendees:
Attorney General Domestic Violence Fatality Review Statewide Team (AG-DVFRST)
Clark County Domestic Violence Fatality Review Team (CC-DVFRT)
Washoe County Domestic Violence Fatality Review Team (WC-DVFRT)

June 3, 2014

Agenda:

1. **Welcome and Introduction – Attorney General Catherine Cortez Masto**

2. **Purpose and overview of the meeting and goals for the discussion**
   The purpose of this meeting is to have an open discussion between members of Nevada's DVFR teams, as well as the coalitions and task forces in the state working to prevent domestic violence and strengthen systems that work with victims, perpetrators and their families once violence has already occurred. The goal for today is to identify barriers to conducting effective case reviews and making recommendations for prevention as a result of those case reviews as well as discuss solutions to those barriers and gain some consensus about how the recommendation process can work for all DVFR teams to be most effective.

3. **Overview of purpose of DVFR and what work has been done over the past two years**

   The statewide team was established in 2012 and with that came work to establish a Clark County team as well as coordinate efforts between the two local teams (Clark and Washoe) and the statewide team. In April 2013 a report was published that outlined the work of the teams over the past year including a set of recommendations for prevention (see attached). During this time local teams as well as the statewide team started to identify barriers to conducting effective case reviews as well as struggling to identify where recommendations should be directed. Over the past two years the statewide team has convened to review three cases, the Clark team has reviewed six cases and the Washoe team has reviewed six cases.

4. **Identified barriers to conducting case reviews**
   - Access to criminal history record for perpetrators
   - Sometimes teams are not sure who should be contacted to participate in the review – how can we find more people to involve in the review that may have case specific information?
     - It was noted that the timelines that are created help to identify people that could participate in the review but this is done at the meeting
   - There are issues obtaining certain pieces of information because of confidentiality laws – the teams do not have subpoena power to compel agencies or organizations to provide information – this is particularly an issue with school information on any children involved
   - It is important to bring all information together in advance of the review and have the timeline drafted before the full team gets together to review – creating the timeline itself takes a lot of time and the group's time is better spent in discussion (for state team that meets only over 2 days – other local teams like creating the timeline together)
   - Local teams meet monthly and this can be a barrier because waiting a month for the next meeting breaks momentum in discussion of the case – the 2 day model is good but scheduling could be an issue for local groups
   - Finding family/friends to talk to the team about the case is a challenge – they are hard to locate and may not be interested in participating in the review
     - Friends/Family could be interviewed by one team member and information brought back to the team so that they don't have to attend the actual meeting itself

5. **Barriers to making recommendations**
    - There are questions about when does each team have responsibility to implement recommendations? Teams need the commitment of all stakeholders to work on implementing recommendations.
        - Teams need a list of entities that work on DV prevention – as well as additional prevention resources and then can funnel out recommendations or information to the appropriate place.
        - Some recommendations are local others are statewide – this should help guide where the recommendation goes
        - Whomever is working on the recommendation needs time to research and provide suggestions for implementation
        - If recommendations are directed to an agency – invite them to attend the meeting and discuss the recommendation then they could go back and work on it and report out to the team later
        - All members of the teams report learning from the reviews and using the information to improve their practice – team members need to regularly report back to the group any changes they made as a result of the reviews so that can be documented as an outcome of the review
    - Create a team made up of members from all over the state and all three review teams that can accept recommendations from DVFRTs and this group will identify the appropriate place to send the recommendation and will be responsible for follow up and reporting back to the team that originally made the recommendation.
    - Hold an annual meeting of all teams to discuss progress and work on improving the processes for case reviews – this meeting could also review and discuss the annual report before its release
    - Create a program manual for DVFR in Nevada – this could be reviewed at our next annual meeting
    - Create a structure/proposal to create the vetting team for recommendations.
    - Create a website for DVFR that would include recommendations, annual reports, membership lists, task forces, coalitions, etc – All DV groups that have webpages should be asked to also link to the DVFR page.

Barriers related specifically to the AG-DVFRST:

- Need a dedicated Case Agent – may be someone in law enforcement. When the team comes into a community for a review they don't know what the relationships are between agencies so may get conflicting information for the review.
- Identify cross-jurisdictional issues in advance (criminal history primarily in one county but fatal incident happens in another) – Decide how the team will handle those cases when this is identified in advance – where does the review take place?
- State team uses the NNADV report to select cases for review but that report may not have enough cases to choose from each year.
- Gathering information from shelters – maybe people as they enter shelter could designate a safe person to contact and the team can try to follow up with them

6. **Solutions (Group Discussion)– How to address the issues/redefine what fatality review is and what it's mission should be**
    - Hold a planning session in advance of the review meeting with only those with case specific information and talk to the homicide detectives to find additional friends/family that could be interviewed for the case review
    - Focus some reviews on cases with no documented history with law enforcement – these may give us more insight into why things go unreported – but a concern is who will track down information needed for the case review when there are no public records
    - Regarding the concerns about gathering confidential information – mental health records for the deceased can be accessed by this team under current law – need to develop a process for requesting these records and citing appropriate statute.
    - Address the Sheriffs' and Chiefs' Association and recommend a standard lethality assessment statewide and design a process for communication across jurisdictions to protect victims
    - Julie Butler is working on doing outreach to courts to help them fill in information in NCJIS – dispositions are missing in 800,000+ records statewide – courts are required to report this information to DPS but it's not being done – they are up to 56 courts consistently reporting but this should be higher (NOTE: In response to the notes – the Administrative Office of the Courts responded to report that their compliance check indicates 74 of 76 courts submitting records).
    - Create Best Practices for prosecuting DV cases and train and education law enforcement by promoting this best practices
    - Identify all community groups related to DV prevention/intervention and work with coordinate or combine efforts and ensure that they have representatives on the team – they may be best suited to carry out recommendations

7. **Next Steps**
    - Submit notes from the meeting to all attendees for review and feedback (Submitted on 7/29/14)
    - Create a Program Manual for DVFR in Nevada (In Progress)
    - Create an outline for the proposed team that could review recommendations and refer them out appropriate group for action (Meeting held on 11/19/14)
    - Draft the next Annual Report for DVFR (Complete)
    -

APPENDIX C: TEAM MEMBERSHIP

ATTORNEY GENERAL – DOMESTIC VIOLENCE FATALITY REVIEW STATEWIDE TEAM

NAME	ORGANIZATION/AGENCY
Catherine Cortez Masto	Nevada Attorney General
Darin Balaam	Reno Police Department
Julie Butler	Nevada Department of Public Safety
Karen Carey	Tahoe SAFE Alliance
Sandra Dieterich-Hughes	S.A.F.E. House
April Green	Legal Aid Center of Southern Nevada
Mark Jackson	Douglas County District Attorney
Brett Kandt	Council for Prosecuting Attorneys
Kathryn Baughman	Nevada Division of Public and Behavioral Health
Marla Morris	Nevada Division of Child and Family Services
Susan Meuschke	Nevada Network Against Domestic Violence
Leslie Preston	Newmont Mine
Team Facilitator	
Tara Phebus	UNLV Nevada Institute for Children's Research and Policy
Attorney General Staff	
Kareen Prentice	Domestic Violence Ombudsman
Heather Procter	Senior Deputy Attorney General

CLARK COUNTY - DOMESTIC VIOLENCE FATALITY REVIEW TEAM

NAME	ORGANIZATION/AGENCY
Magann Jordan	Clark County District Attorney's Office- Victim/Witness Assistance.
Tiffany Brown	Clark County Coroner's Office
Raeshann Canady	Clark County Family Court
Mayra Castro	Henderson City Attorney's Office - Criminal Division
Stephanie Charter	Clark County District Attorney's Office
Kimberly Del Rossi	Henderson Police Department
Brigid Duffy	Clark County District Attorney's Office
Tiffany Driscoll	Boulder City Police Department
Rachelle Ekroos	Center for Forensic Nursing International
Carol Ferranti	Las Vegas Metropolitan Police Department
Debora Flowers	Nevada Division of Child and Family Services
April Green	Legal Aid of Southern Nevada
Elynne Greene	Las Vegas Metro Police Department
Caroline Greene	Henderson City Attorney's Office - Criminal Division
Paula Hammack	Clark County Department of Family Services
Margaret King	District Court - Family Mediation Center
Vicki Kinnikin	Mojave Mental Health
Suzette Landholm	Las Vegas City Attorney's Office
Susie Lewis	Henderson Police Department
Renee Lightford	Community Member
Minddie Lloyd	Bamboo Bridges
Jan Lucherini	North Las Vegas Police Department
Carolyn Muscari	SAFE House
Kimberly Phillips	North Las Vegas City Attorney's office
Sharon Savage	Clark County Dept. Family Services.
Dana Seidlinger	Nellis Air Force Base, Family Advocacy and Treatment
Tami Utzig	SafeNest
Peggy Wellman	Las Vegas Metropolitan Police Department
Wendy Wilkinson	District Court - Family Division
Lourdes Yapjoco	Southern Nevada Health District
Team Coordinator/Facilitator	
Tara Phebus	UNLV Nevada Institute for Children's Research and Policy

WASHOE COUNTY - DOMESTIC VIOLENCE FATALITY REVIEW TEAM

NAME	ORGANIZATION/AGENCY
Darin Balaam	Washoe County Sheriff's Office
Rosie Basterrechea	Washoe County Social Services
Greg Blair	Reno Police Department
Joe Bowen	
Roni Branson	Committee to Aid Abused Women
John Etchemendy	Safe Embrace
Lori Fralick	Reno Police Department
Dr. Michael Freda	Ridgeview Counseling Group
Ken Harmon	Washoe County Sheriff's Office
Kasey Lafoon	Washoe County Sheriff's Office
Kim Meyer	Washoe County Sheriff's Office
Jennifer Olsen	Sparks Police Department
Stephanie O'Rourke	Department of Public Safety Parole and Probation
Dr. Melissa Piasecki	University of Nevada, Reno
Kareen Prentice	Nevada Office of the Attorney General
Kimberly Schweickert	Washoe County Social Services
Robert Smith	Washoe County Regional Animal Services
Alane Thomas	Washoe County Social Services
Debbie Titterington	Reno Police Department
Rocky Triplett	Sparks Police Department
Kelli Anne Viloria	Law Offices of Kelly Anne Viloria

APPENDIX D: Juveniles and Domestic Violence – Meeting Report from May 30, 2014

Summary of Community Dialogues regarding Juveniles & Domestic Violence

May 30, 2014

OVERVIEW

Over the past several years, a number of issues and concerns have arisen in Nevada about the handling of domestic violence incidents involving juveniles. These issues are partly due to the state's definition of domestic violence which includes acts against or upon "any other person to whom the person is related by blood or marriage." NRS 33.018. Amid stories that significant numbers of juvenile offenders were being improperly charged with domestic battery, the Nevada Attorney General, as chair of Nevada's Council for the Prevention of Domestic Violence, convened two community dialogues to explore concerns regarding the intersection of juveniles and domestic violence in the state's two most populous counties.

A Clark County dialogue was held in Las Vegas on March 10, 2014, and a Washoe County dialogue was held in Reno on March 14, 2014. Both information-gathering discussions were facilitated by Hon. Steven Aycock, (Ret.), Judge-in-Residence at the National Council of Juvenile and Family Court Judges (NCJFCJ). NCJFCJ was asked to provide facilitation as well as advice and support in developing the agenda for the meetings because of the organization's extensive experience with similar interdisciplinary and multi-jurisdiction discussions. NCJFCJ staff also took notes at the meetings and drafted this summary of the conversations.

Participants included a broad range of professionals including law enforcement, judges, prosecutors, public defenders, civil attorneys, advocates, juvenile services, and social service agencies. This wide array of interested individuals and stakeholders was encouraged to share their perspectives and concerns in order to better understand the numbers of juvenile offenders involved in incidences of domestic violence and how their cases are processed by the system. The general consensus from both community gatherings was that the opportunity to communicate provided needed clarity about processes in north and south and increased awareness and understanding about different roles within the system.

CLARK COUNTY DIALOGUE

The dialogue in Las Vegas started off with some statistics provided by Judge Voy, who said there were approximately 1,075 DV cases referred to the Juvenile Department in 2013. (See attached Exhibit 1.) About 60% of the referrals were male and about 40% were female. According to Judge Voy, very few of the cases involved intimate partner violence (only around 3.5%) and the great majority involved altercations between the juvenile and a parent, grandparent, sibling or other family member. These statistics were compared to national data which indicates a much higher percentage of abuse in teen relationships, and other participants stated that there was significant under-reporting of teen dating violence based on the number of calls received from concerned parents. Nonetheless, there was general agreement that a disproportionate number of the domestic violence cases in Clark County involved juveniles and other family members rather than intimate partners.

In further exploring the numbers, prosecutors explained that they filed formal petitions (charges) in only 361 cases in 2012 – probably about a third of the total referrals/arrests. Of those 361, prosecutors said that the great majority were settled/negotiated/dropped or reduced (to something not DV) and only about 60-65 cases were actually prosecuted. They explained that in juvenile matters, the law provides guidance but is not mandatory, so they have considerable discretion in adjudicating DV cases.

There was lots of discussion about the process involved in arrest, booking, filing of citations vs. petitions, intake by the department of Juvenile Services, detention or hold vs. release, and the involvement of social services. Participants generally agreed that proper assessment (including familial dynamics, substance abuse, mental health issues) and prompt services/intervention leads to the best results for the juvenile offender. There was also general consensus that resources were inadequate to address the needs identified during intake, with a particular lack of services and interventions focused on the needs of juvenile offenders and juvenile victims.

Participants also talked about several collateral consequences of domestic violence adjudications. Some noted that military service can be precluded, although it wasn't clear if that was due to firearms disabilities or to the fact that any crime of violence presents concerns. Others noted that there can be harsh immigration consequences due to a juvenile's status as a DV offender.

Another topic that arose throughout the dialogue concerned access to information – history of prior DV, history of child abuse/neglect, current or past involvement of the family with social services, etc. Juvenile services personnel and prosecutors were particularly troubled about recent changes in the UNITY database system and lack of access to relevant information that could improve intervention and services.

In corralling what was most needed at the end of the dialogue, participants focused on (1) better communication/information sharing within and between systems and (2) better access to community-based services, including comprehensive assessments; (3) more attention on prevention efforts (e.g., in schools); (4) cross training and/or multi-disciplinary training to increase awareness of roles and functions; and (5) better data on outcomes.

Attached as Exhibit 2 is a list of attendees at the Clark County meeting.

WASHOE COUNTY DIALOGUE

The community dialogue in Reno focused around identifying how cases involving juveniles and DV get processed. Christine Eckles of the Washoe County Department of Juvenile Services reported that there were 247 referrals in 2012, including 188 arrests and 59 citations. Similar to Clark County, Washoe County participants identified that the majority of the cases involving juveniles arrested for DV involve parent-child altercations, with only about 5% involving siblings and very few involving intimate partners.

Participants discussed the process involved in adjudicating DV cases concerning juvenile offenders, including detention hearings, release conditions, and referral to the DA for the filing of formal petitions. Of the 247 referrals in 2012, 74 petitions got filed by the DA (though not all were for DV charges). Once filed, a PD is appointed.

As in Clark County, prosecutors reported that all sorts of dispositions are available in juvenile matters, since they have broad discretion to decide how to best proceed in a particular case. Participants also said that the majority of citations involving juveniles arrested for domestic violence are resolved through informal probation services.

Referrals to Juvenile Services result in an assessment which includes questions about substance abuse, mental health issues, and violence/abuse in the home. It was noted that these assessment meetings occur with the parents present, so it can be some times be difficult to assess the history of family violence. Attached as Exhibit 3 is the screening checklist used by the Washoe County Department of Juvenile Services that was made available during the meeting.

There was discussion about the collateral consequences for a juvenile of a DV adjudication, with participants noting that some immigration proceedings may be affected, there can be firearms disabilities which could mean the youth is ineligible for military enlistment, and the adjudication can preclude getting into shelter or temporary

housing. Several participants pointed out that adjudication is not equal to a conviction, so some of these consequences may be less serious than in adult cases. In any case, even if the charge is dismissed, there is still an arrest on the juvenile's record (unless it is sealed).

The participants discussed challenges in sharing information between agencies and other actors in the system. Prosecutors and juvenile services both indicated that access to more information (prior history of DV, family history of social services involvement) is always preferable in determining the best intervention and treatment. The courts seem to have better access to inter-agency information, but most agreed that improvements in communication would be desirable.

As in Clark County, Washoe County participants identified a serious gap in services available, particularly for juvenile victims and also for DV offenders. They discussed the need for specialized programs for youth charged with DV. Also mentioned was the challenge and frustration of parents/families not accessing available services – parents need to *want* services for themselves and the juvenile in their household if intervention is to work. The general feeling was that there is a need for solutions focused on families, not on the individual.

In summarizing what participants believed was most important to addressing juveniles involved in domestic violence, participants said: (1) education on teen dating violence, in schools and the community, and corresponding services including access to safety planning; (2) improving communication between different agencies and actors in the process by addressing barriers to information sharing; (3) obtaining more resources for victims and families, and developing more programs/services for juvenile offenders; (3) earlier intervention with more and earlier screening and greater collaboration between social services and the school district; and (4) creative ideas for engaging the family unit because the problem is usually bigger than the juvenile offender.

Attached as Exhibit 4 is a list of attendees at the Washoe County meeting.

CONCLUSION

These community dialogues brought together two different sets of stakeholders from very different parts of the state with distinct judicial and case management processes, and enabled them to gain a greater understanding of how juvenile offenders of domestic violence are handled in their jurisdictions. There was general agreement that the dialogues provided an extremely useful opportunity to communicate between professionals engaged in working with juveniles involved in domestic violence.

In spite of some differences in how cases get processed and what resources are available in Clark and Washoe counties, the community discussions identified many common threads:

- the need for improvements in communication/information sharing between different agencies and actors in the system;
- the need for more resources for, and better access to, community-based services, especially programs geared toward juvenile offenders and services targeted specifically for juvenile victims;
- the importance of prevention and early intervention efforts, including education on teen dating violence and early screening and greater collaboration between social services and the schools;
- the need for better data gathering and for creative ideas for engaging the whole family; and
- the value of ongoing multi-disciplinary dialogue and cross training to strengthen the possibilities for collaboration.

Under the sponsorship of the Attorney General's office and through these community dialogues, the Nevada Council for the Prevention of Domestic Violence was able to enhance statewide communication about these important issues involved in addressing juveniles and their involvement in domestic violence.

DOMESTIC VIOLENCE CHARGES

2013 - 2014

I. DISTINCT YOUTH STATISTICS

A. By Year	2013	2014
Total	1,078	184

B. Gender by Year	2013	2014
Female	440	84
Male	638	100
Total	1,078	184

C. Ethnicity by Year	2013	2014
African American/Black	285	53
Asian/Pacific Islander	26	10
Hispanic	321	63
Other	61	5
White	385	53
Total	1,078	184

D. Age by Year	2013	2014
8	2	2
9	3	2
10	13	1
11	17	4
12	46	7
13	83	16
14	176	18
15	222	36
16	278	46
17	264	50
18+	7	2
Total	1,078	184

Exhibit 1 (2 pages)

II. DISTINCT ARREST STATISTICS

A. By Year	2013	2014
Total	1,251	193

B. Gender by Year	2013	2014
Female	505	87
Male	746	106
Total	1,251	193

C. Ethnicity by Year	2013	2014
African American/Black	333	55
Asian/Pacific Islander	30	10
Hispanic	373	66
Other	74	6
White	441	56
Total	1,251	193

D. Age by Year	2013	2014
8	2	2
9	3	2
10	14	1
11	22	5
12	62	7
13	99	17
14	196	19
15	251	39
16	300	49
17	295	50
18+	7	2
Total	1,251	193

Exh. 1, pg 2 of 2

III. TOP FIVE DV CHARGES BY DISTINCT YOUTH

	2013	2014
Battery	1,050	180
Assault with a Deadly Weapon	31	5
Battery by Strangulation	25	1
Battery with a Deadly Weapon	20	3
Assault	12	1

Monday, March 10, 2014
Clark County Dialogue

Hon. Steven Aycock (Ret.)
Ravi Bawa
Mary Berkheiser
Edwin Cirame
Summer Clarke
Liz Greb
Elynne Green
April Green
Nancy Hart
Kiande Jakada
Karen James
Michael Johnson
Magann Jordan
Brett Kandt
Susan Meuschke
Leisa Moseley
Michael Oh
Carlos Ponce
Frank Ponticello
Kareen Prentice
Shannon Richards
Justin Roberts
Pat Schreiber
Hon. Frank Sullivan
Hon. Willam Voy
Martie Washington
Daniel Tomaino
Debbie Goldner
Cheri Wright
Tara Phebus
Al Salinas
Jan Lucherini

EXHIBIT 2

Washoe County Department of Juvenile Services
Domestic Violence Case Screening Check List

TO BE COMPLETED BY ARRESTING OFFICER:

- ☐ **Name of Minor:** _____
- ☐ Relationship of the minor to the victim: _____
- ☐ Does the minor live with victim?: _____
- ☐ Any physical injuries to victim: **(Please explain)** _____
  _____
- ☐ Age of victim: _____
- ☐ Was youth under the influence of drugs/alcohol? _____

TO BE COMPLETED BY DETENTION STAFF *PRIOR TO CALLING PO*:

BOOKING STAFF INITIALS: _____ **CONTROL ROOM STAFF INITIALS:** _____

- ☐ **RAI score:** _____
- ☐ Prior Legal History - are there any other prior referrals for domestic battery?
  _____
- ☐ Are there any alerts in JCATS? _____
- ☐ Has the juvenile had prior incidences of violence at home? **(IF YES, ASK PARENT/GUARDIAN FOR DETAILS)**
  _____
- ☐ Are parents willing to accept custody? **(IF NO, ASK PARENT/GUARDIAN WHAT SPECIFIC CONCERNS ARE)**
  _____
  _____
- ☐ If not, is there an alternative family member / friend placement available at this time? _____
- ☐ Is juvenile willing to go home? **(IF NO, ASK JUVENILE WHAT SPECIFIC CONCERNS ARE)**
  _____
  _____

Duty PO authorizes: ☐ RELEASE ☐ DETENTION

Name of PO: _____

Exhibit 3

Revised: 4/19/2012

Friday, March 14, 2014

Washoe County Dialogue

Ross Armstrong
Hon. Steven Aycock (Ret.)
Jennifer Bascom
Tannan Birmingham
Christine Brady
Kristen Clements-Nolle
Christine Eckles
Hon. Sue Edmondson
Mary Encarnacion
Jessica Ernster
Elizabeth Florez
Jamie Gradick
Nancy Hart
Brett Kandt
Susan Meuschke
Suzanne Ramos
Cindi Smith
Ryan Sullivan
Jo Lee Wickes

EXHIBIT 4