DOMESTIC VIOLENCE FATALITY REVIEW TEAM

WASHOE COUNTY DISTRICT COURT DEPARTMENT ONE ♦ 75 COURT STREET ♦ RENO, NEVADA, 89501
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Washoe County Domestic Violence Fatality Review Team

Five Year Report
1994-1999

Co-chairs
Judge Janet Berry
Joyce Burkholder, LCSW
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INTRODUCTION

In 1994 the Washoe County Adult Fatality Review Team, (WCFRT) was formed as a subcommittee of the Washoe County Task Force on Domestic Violence in Reno, Nevada. The WCFRT was created as an interdisciplinary, multi-agency collaborative to review adult domestic violence-related homicides and suicides in order to identify system failures and create recommendations that would enhance every system's response to victims.

Nevada has a high rate of abuse and homicide against women by their husbands, boyfriends or former intimate partners. Fatality review was a new concept in 1994, with the WCFRT being one of the first on-going teams in the nation. As a volunteer effort we began the tedious task of gathering team members, developing forms and addressing multiple issues as they surfaced such as victim and agency confidentiality.

Legislation formalized the team in 1997, defined team members and addressed confidentiality and immunity. To date, the team has reviewed cases primarily from Washoe County but may at any time review homicides and suicides from other Nevada counties upon request. We receive cases for review from the Washoe County coroner's office, newspaper clippings and suggestions from members of the team. Currently, the team reviews adult suicides and adjudicated domestic violence-related homicides with the option to review any death if requested by a team member or family member. We do not review all homicides and suicides, but take time to review cases systematically to identify "red flags" and look for ways to better serve the families. After a case is chosen for review, the process begins by looking at circumstances surrounding the death and working backwards, weaving our way through what was sometimes a complicated life. Some reviews brought to light women who were abused for years and isolated from family, friends and resources. Other cases revealed one batterer and multiple victims. Sadly, some cases involved children. Alcohol and drugs were involved in many of the cases. And through the review process, team members soon discovered that many agencies had contact with the victim or perpetrator prior to the homicide.

The team worked well together and learned that this review process was not about blame, but about understanding. Agency representatives shared their personal experiences of working with the victims and families prior to and after the homicide. We learned about different agency's responses to the families. Often voiced were the concerns that agencies don't communicate with each other, courts don't have access to the criminal and civil histories of perpetrators, and there is lack of funding for programs to assist victims of family violence. We offered suggestions for change in policy and procedure and, in one case, drafted legislation. Many issues arose and continue to arise, such as confidentiality, agency involvement, interviewing perpetrators and surviving family members.

The question, "What could we have done to prevent this from happening?" is one we continue to ask. As a community, what do we need to do so that no one in our community suffers at the hands of a batterer? The recommendations in this report will take time to implement. With this first report as a resource, it is our hope to assist service providers, the criminal justice personnel, law enforcement, social workers, health care providers and families to create a pro-active response for all perpetrators and victims of family violence.

DEFINITION OF FAMILY VIOLENCE

For the purposes of this work, we have defined family violence as outlined in Nevada Revised Statute 33.018. See Appendix.

SCOPE OF THE PROBLEM

The 1998 U.S. Department of Justice Bureau of Justice Statistics reported that between 1976-1996, intimate murders accounted for 30% of all female murders and 6% of all male murders. Of the 32,580 murdered spouses, six out of ten were women.

The Violence Policy Center (VPC) reported that in 1996 Nevada was ranked as the state with the highest rate of homicide among female victims by male offenders in a single victim/single offender incident – more than twice the national average. In 1997, VPC reported that Nevada ranked second in female homicide by male offenders.
Many of these homicides are domestic violence-related.

Nevada Office of the Attorney General's report "Domestic Violence in Nevada, Quarter 1 January – March 1999" using the Uniform Crime Reporting program reported that there were a total of 3,941 domestic violence incidents. Females were identified as the victim in 80.5% of reported cases and males were the offenders in 81.4% of the cases. In "Domestic Violence in Nevada Quarter 2 April – July 1999" a total of 4,431 domestic violence incidents were reported. Females were reported as the victim in 79.6% of the reported cases and males were the offenders in 80.7% of reported cases.

The Nevada Network Against Domestic Violence "Statewide Statistics" reports that first-time callers requesting assistance from domestic violence programs are:
1995: Statewide 24,641, Washoe County 6,570; 1996: Statewide 24,421, Washoe County 6,789; 1997: Statewide 27,713, Washoe County 7,949; 1998: Statewide 29,712, Washoe County 8,211.

CONFIDENTIALITY

Because of the sensitivity of this project, confidentiality is a concern for all team members. Respect, privacy and protection for the deceased and surviving family members and agency confidentiality are priorities. To address this, the team drafted two confidentiality forms.
All members signed a confidentiality form agreeing that any information shared at the fatality reviews was considered confidential. This form is kept on file. The other form is a sign-in sheet that each team members sign prior to each meeting. This form serves as a reminder to members of the importance of shared information remaining confidential. See Appendix.
Confidentiality also was addressed in Nevada Revised Statute 217.475 which states "Each organization represented on such a team may share with other members of the team information in its possession concerning the victim who is the subject of the review

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."
In addition, an Interagency Agreement was drafted to describe objectives, the team membership agreement to share information pertaining to the decedent, and confidentiality.

IMMUNITY

Nevada Revised Statute 217.475 addresses immunity by providing that each member of a team organized pursuant to the statute is immune from civil or criminal liability for an activity related to the review of the death of a victim. See Appendix.

PERTINENT BACKGROUND INFORMATION

CHILDREN

A concern for team members was the fact that children were involved in some of the cases reviewed. Perpetrators of domestic violence do not victimize adults only. As stated in *Effective Interventions in Domestic Violence and Child Maltreatment Cases Guidelines for Policy and Practice* p. 9, NCJFCJ. Nationally 30 to 60 percent of the cases where mothers were battered, their children also were maltreated. Some cases identified child abuse and intergenerational family violence. The effects of family violence on the children who witness domestic violence, who don't see but are aware of the violence in the home or were abused physically or sexually "tend to exhibit more developmental, cognitive, emotional and social behavior problems, including depression and increased aggression, than other children." *Effective Interventions in Domestic Violence and Child Maltreatment Cases Guidelines for Policy and Practice* p. 9 NCJFCJ.

HEALTHCARE

Research findings from a survey of 476 female patients seeking care at a family practice clinic in the Midwest, show that 22.7 percent said that they had been physically assaulted by their partners within the last year, and nearly 40 percent said they had been physically abused at least once in their lifetime. Yet only six patients said they had ever been asked about domestic violence by their physician. These rates demonstrate that spouse abuse is more common in family practice than most doctors believe. *Family Medicine* "Prevalence of domestic violence in community practice and rate of physician inquiry*"24 (4):283-287.*
Because the circumstances of the injury, the person causing the injury and the relationship of the victim to that person often are overlooked in medical evaluations, doctors fail to treat battered patients adequately. Furthermore, the risk of further abuse is rarely assessed. *JAMA* "Domestic violence intervention calls for more than treating injuries*"264(8):939-940*

Northern Nevada Medical Center, located in Sparks, Nevada, designed a simple domestic violence survey to interview women 18 years of age and older who entered the emergency room. In the first year of the project that began December 4, 1998, 932 women were interviewed. Of the 932 women who were interviewed, 456 stated that they had been a victim in the past, but were not being abused at the time of question. (See Appendix)

TEAM ACCOMPLISHMENTS

LEGISLATION

To address concerns regarding team membership, confidentiality and immunity we proposed and the 1997 Nevada Legislation passed NRS 217.475. (See Appendix) Nevada is one of five states that have a statute authorizing a domestic violence fatality review team. The other states are: California, Maine, Delaware and Virginia.

Additionally, the WCFRT proposed legislative changes to an already existing statute based on a case that was reviewed by the team. In this case, a battered mother was murdered by the children's father and custody of the children was given to the perpetrator's family. In the 1999 Nevada Legislature, NRS 432B.390 was amended to read: (See full statute Appendix A)

1. An agent or officer of a law enforcement agency, an officer of the local juvenile probation department or the local department of juvenile services or a designee of an agency which provides protective services
   (b) Shall place a child in protective custody upon the death of a parent of the child, without the consent of the person responsible for the welfare of the child, if the agent, officer or designee has reasonable cause to believe that the death of the parent of the child is or may be the result of an act by the other parent that constitutes domestic violence pursuant to NRS 33.018.
2. ***If there is reasonable cause to believe that the death of a parent of the child is or may be the result of an act by the other parent that constitutes domestic violence pursuant to NRS 33.018, a protective custody hearing must be held pursuant to NRS 432B.470, whether the child was placed in protective custody or with a relative. If an agency other than an agency which provides protective services becomes aware that there is reasonable cause to believe that the death of a parent of the child is or may be the result of an act by the other parent that constitutes domestic violence pursuant to NRS 33.018, that agency shall immediately notify the agency which provides protective services and a protective custody hearing must be scheduled.***

OTHER ACCOMPLISHMENTS

The review team developed protocols and forms necessary to review, record, and learn from fatalities in violent homes in Nevada. Much of this initial work served as a basis from which other communities now build and establish their own Domestic Violence Death Review Committees.

We have provided a venue for increased communication and collaboration among the various agencies that provide services for victims or sanctions for perpetrators of domestic violence. This increased communication is crucial to an honest evaluation of what we do well and what we can do better. Ideally, this process will lead us to a consistent, coordinated community response to domestic violence in Washoe County.

DATA COLLECTION AND ANALYSIS

Our initial data collection sheets were generated in the early days of the team, before any death reviews actually had taken place. The sheets were quite inclusive and have served as a generic basis from which other death review teams have developed their own data collection sheets. With changes in team membership the original data collection sheets were not always provided or used in every review. This resulted in inconsistency in the data outcomes, the most obvious of which is the variation in the questions asked in the reviews or questions that were never asked. Furthermore, the team did not attempt to review every domestic violence-related death in Washoe County, and in this sense alone, the data does not reflect the true impact of domestic violence in our community. As a team we chose to approach each case in a qualitative rather than quantitative manner, looking for patterns, flaws in our legal and community system of prevention, assessing the long-term effects on children and survivors of the fatalities, and making recommendations for change.

DATA OUTCOMES
Domestic Violence Fatality Reviews 1994-1999

We reviewed: 20 Deaths related to domestic violence.

County where death occurred:
Washoe = 18/20 = 90%
Elko = 1/20 = 5%
Nye = 1/20 = 5%

Overall:
12/20 deaths were female = 60%
8/20 deaths were male = 40%
12/12 females homicide victims = 100%
5/8 males were homicide victims = 62.5%
0/12 females were suicides = 0%
3/8 males were suicides = 37.5%
3/19 perpetrators were female = 15.79%
16/19 perpetrators were male = 84.21%

Age:
16 – 17 = 2/20 = 10%
18 – 29 = 7/20 = 35%
30 – 39 = 6/20 = 30%
40 – 49 = 3/20 = 15%
50 – 65 = 0/20 = 0%
65 and over = 2/20 =10%

Race:
Pacific Islander = 1/20 = 5%
Caucasian = 13/20 = 65%
Hispanic = 3/20 =15%
African American = 3/20 =15%
American Indian = 0/20 = 0%
Asian American = 0/20 = 0%

Homicides:
17/20 homicides 85%

Suicides:
3/20 suicides = 15%

Weapons;
Guns = 13/20 = 65%
Knives = 4/20 = 20%
Rope = 1/20 = 5%
Fists/feet = 2/20 = 10%

Relationship of victim to perpetrator:

Spouse = 8/20 = 40%
*Co-habitation boyfriend/girlfriend = 3/20 = 15%
Ex-husband/boyfriend = 2/20 =10%
Ex-wife/ex-girlfriend = 0/20 – 0%
Current boyfriend/girlfriend = 2/10 = 10%
Acquaintance = 1/20 = 5%
Child = 1/20 = 5%
Self = 3/20 = 15%
**No same sex partner cases were reviewed*

Temporary Protection Order (TPO):

- in effect at time of death
Yes = 2/20 = 10%
No = 16/20 = 80%
Pending = 1/20 = 5%
Unknown = 1/20 =5%

Domestic Violence History:

Perpetrator = 10/20 = 50%
Both victim/perpetrator = 2/20 = 10%
Unknown = 4/20 = 20%
No record = 3/20 = 15%

Alcohol and Illegal Drugs present at time of death:

Victim = 3/17 = 17.7%
Perpetrators = 6/19 = 31.57%

Illegal Drug Abuse History:

Victims = 4/17 = 23.53%
None = 4/17 = 23.53%
Unknown = 9/17 = 52.94%
Perpetrators = 8/19 = 42.11%
None = 3/19 = 15.79%
Unknown = 8/19 = 42.11%

Alcohol Abuse History:

Victims = 3/17 = 17.65%
None = 5/17 = 29.41%
Unknown = 9/17 = 52.94%
Perpetrators = 8/19 = 42.11%
None = 3/19 = 15.79%
Unknown = 8/19 = 42.11%

Pregnancy:

At time of death = 1/20 = 5%
Recent to time of death = 2/20 = 10%
Not at time of death = 14/20 = 70%
Unknown = 3/20 = 15%

Parent (at time of death):

Yes = 11/20 = 55%
No = 4/20 = 20%
Unknown = 5/20 = 25%
Children present at scene of death:
Yes = 5/20 = 25%
No = 14/20 = 70%
Unknown = 1/20 = 5%

Employed at time of death:

Yes = 2/20 = 10%
Retired = 2/20 = 10%
Student = 1/20 = 5%
Unknown = 15/20 = 75%

Workplace:

Casino = 2/20 = 10%
Soc. Sec. Retirement = 2/20 =10%
School = 1/20 = 5%
Unknown = 15/20 = 75%

Agency involvement (prior to death):

Law Enforcement = 7/20 = 35%
Social Services = 6/20 = 30%
CAAW/TPO = 4/20 = 20%
Hospitals = 5/20 = 25%
Unknown = 6/20 =30%
None = 2/20 = 10%

Animal Control (prior to death):

Yes = 2/20 = 10%
No = 15/20 = 75%
Unknown = 3/20 = 15%

Hospital contacts prior to death:

OB/GYN = 2/20 = 10%
Routine = 4/20 = 20%
DV = 1/20 = 5%
Mental Health = 1/20 = 5%
No record = 10/20 = 50%

Mental Health History:

Hospitalizations = 2/20 = 10%
None = 2/20 = 10%
Unknown = 13/20 = 65%
Contact (Outpatient) = 3/20 = 15%
Perpetrators –
Hospitalizations = 2/19 = 10.53%
Outpatient = 6/19 = 31.57%
Victims –
Hospitalizations = 1/17 = 5.88%
Outpatient = 0/17 = 0%

	A	B	C	D	E	F	G	H	I	J	K	L
1	CASE DEATH #	D/SEX/AGE	P/SEX/AGE	RACE	HOMICIDE	SUICIDE	WEAPON	RELATIONSHIP	CURRENT TPO	DV HX/ victim	ETOH/HX vic	DRUG HX/vic
2	1	female 22	male 24	Pac. Isl.	yes	no	gun	spouse	no	no	no	no
3	2	female 43	male 41	Caucasian	yes	no	shotgun	spouse	no	yes	yes	unknown
4	3	female 16	male 18	Hispanic	yes	no	shotgun	BF/ cohab.	no	no	unknown	unknown
5	4	female 38	male 30	Caucasian	yes	no	knife	boyfriend	no	no	no	no
6	5	female 84	male 91	Caucasian	yes	no	gun	spouse	no	unknown	unknown	unknown
7	6	female 36	male 38	Hispanic	yes	no	gun	spouse	no	no	unknown	yes
8	7	male 28	same	Caucasian	no	yes	rope	self	yes	n/a	n/a	n/a
9	8	male 22	female -	Caucasian	yes	no	gun	spouse	no	unknown	unknown	unknown
10	9	male 35	same	Caucasian	no	yes	gun	self	pending	n/a	n/a	n/a
11	10	female 23	male -	Caucasian	yes	no	hands/shoving	boyfriend	no	unknown	unknown	unknown
12	11	female 35	male 33	African Am.	yes	attempt/failed	knife	BF/ cohab.	no	no	unknown	yes
13	12	female 23	male 27	Caucasian	yes	no	fists/feet	spouse	no	no	unknown	unknown
14	13	female 41	male 33	Caucasian	yes	no	handgun	ex-husband	no	no	no	no
15	14	female 17	male 18	Caucasian	yes	no	knife	ex-boyfriend	no	no	no	no
16	15	female 30	male 28	Caucasian	yes	no	gun	spouse	unknown	unknown	unknown	unknown
17	16	male 28	male -	African Am.	yes	no	gun	acquaintance	none	no	no	yes
18	17	male 47	female 43	Caucasian	yes	no	gun	spouse	no	yes	yes	unknown
19	18	male 33	male 15	African Am.	yes	no	gun	son of GF	yes	no	unknown	unknown
20	19	male 28	female -	Hispanic	yes	no	knife	GF/cohab.	no	no	yes	yes
21	20	male 91	same	Caucasian	no	yes	gun	self	no	n/a	n/a	n/a
22												
23												
24	CASE DEATH #									DV/HX perp	ETOH HX/perp	DRUG HX/perp
25	1									yes	no	no
26	2									yes	yes	unknown
27	3									yes	unknown	unknown
28	4									yes	yes	yes
29	5									unknown	unknown	unknown
30	6									yes	unknown	yes
31	7									yes	yes	yes
32	8									yes	unknown	unknown
33	9									yes	yes	yes
34	10									unknown	unknown	unknown
35	11									unknown	no	yes
36	12									yes	yes	yes
37	13									yes	yes	yes
38	14									unknown	no	unknown
39	15									yes	unknown	unknown
40	16									unknown	unknown	yes
41	17									yes	yes	no
42	18									yes	unknown	unknown
43	19									yes	yes	no
44	20									unknown	unknown	unknown

	M	N	O	P	Q	R	S	T	U	V	W
1	PARENT	CHLD@SCENE	EMPLOYED/DEC	WORKPLACE	AGENCY INV.	HOSP.VISITS	M.H.TX / V	COUNTY	PREGNANCY	ANIMAL C./ HX	CRIM. HX/V
2	none	no	unknown	unknown	none	yes/OB	no	Washoe	yes	yes/perp	no
3	unknown	no	unknown	unknown	unknown	unknown	unknown	Nye	no	unknown	unknown
4	none	no	unknown	unknown	CPS,Tulare Co.	unknown	unknown	Washoe	yes	no	no
5	two	no	unknown	unknown	Ca.PD,UCDhosp,	yes/DV	unknown	Washoe	no	no	no
6	one	yes/adult child	retired	retired	Hosp,APS	yes	yes	Washoe	no	no	no
7	two	no	yes	casino	WCSS,CAAW,H	yes/MH	yes/inpatient	Washoe	no	no	no
8	unknown	no	yes	casino	RPD,TPO,hosp	multiple	n/a	Washoe	GF/perimortem	no	n/a
9	one	no	unknown	unknown	unknown	unknown	unknown	Washoe	no	no	no
10	two	no	unknown	unknown	RPD,NASAC	multiple	n/a	Washoe	no	no	n/a
11	unknown	no	unknown	unknown	unknown	unknown	unknown	Washoe	unknown	unknown	unknown
12	one	no	unknown	unknown	RPD	unknown	unknown	Washoe	no	yes/perp	no
13	two	no	unknown	unknown	DV/PlumasCo.	MD/OB O.V.	unknown	Washoe	yes	no	no
14	one	yes	unknown	unknown	RPD-911	unknown	no	Washoe	no	no	no
15	no	no	student	high school	none	none	no	Washoe	no	no	no
16	one	unknown	unknown	unknown	unknown	unknown	unknown	Washoe	unknown	unknown	no
17	no	no	unknown	unknown	unknown	unknown	no	Washoe	no	no	yes
18	one	no	unknown	unknown	RPD-911	YES/DV/perp	unknown	Washoe	unknown	no	no
19	unknown	yes	unknown	unknown	Elko Sheriff	unknown	unknown	Elko	no	no	yes
20	unknown	no	unknown	unknown	unknown	unknown	unknown	Washoe	no	no	unknown
21	one	yes/adult child	retired	retired	Hosp,APS	yes	n/a	Washoe	no	no	n/a
22											
23											
24							M.H. TX/P				CRIM.HX/P
25							unknown				yes
26							unknown				unknown
27							no				no
28							unknown				yes
29							referral				no
30							no				yes
31							yes				yes
32							yes				unknown
33							yes/ETOH				yes
34							unknown				unknown
35							unknown				unknown
36							yes				yes
37							yes				yes
38							referral				unknown
39							unknown				unknown
40							unknown				yes
41							unknown				yes
42							unknown				yes
43							unknown				unknown
44							n/a				no

RECOMMENDATIONS

As with all crime, it is not the responsibility of the victim to stop the violence. Law enforcement and the judiciary hold ultimate responsibility for holding batterers accountable for their actions, but the entire community needs to be involved in providing safety for victims and taking steps that lead to batterer accountability. The goal of the review process is to identify if, how, when and why victims sought assistance and what resources were provided, so the team may offer recommendations to better serve all victims and perpetrators of family violence. The following recommendations have been offered to assist with stopping the violence of one adult partner toward the other. These recommendations go beyond the fatality review multidisciplinary team because it takes an alignment of community resources with legal and judicial actions to end the cycle of violence. By subjecting the violent partner to civil and criminal sanctions, and offering protective services to the victim and child, the official response to domestic violence conveys the clear, consistent message that domestic violence will not be tolerated. Based on the committee's review of homicide and suicide cases over the past five years, we recommend that:

1) Law enforcement, the judiciary, prosecutors, parole board, child protective services, health care providers and other family service providers implement continuing education on the dynamics of domestic violence, behaviors of the victims and perpetrators, and the effects of domestic violence on children.
Rationale: As well-informed employees move on, new employees need to be trained. Ongoing training encourages consistent professional delivery of service to provide protection for victims and accountability for perpetrators.

2) All major employers in Washoe County implement domestic violence awareness training for management level employees and develop employee assistance programs with referrals and resources for victims including brochures or pamphlets with domestic violence information and referrals to resources.
Rationale: Employees in many fields often display behaviors at work that are a result of violence in the home. Often work quality and productivity decrease and may be a sign of problems in the home. Conveying an understanding and supportive work environment along with early identification and intervention may prevent future abuse and homicides.

3) All hospital, clinics and health care providers in Washoe County establish and implement domestic violence screening devices. Services should include resources and referrals for victim assistance.
Rationale: Screening patients who enter the hospital can offer immediate safety and prevent future abuse. It is well documented that many women who enter the hospital are there because of abuse from an intimate or former partner. See attachment.

4) Prosecutors develop and implement a "no-drop" policy in domestic violence cases.
Rationale: Prosecutors often see the victims as non-compliant because they recant their statement or do not show up for hearings. Often referred to as "bad witnesses," battered women are actually seeking safety by choosing not to be an active part of the

prosecution: dropping cases does not hold criminals accountable and sends the message that domestic violence is acceptable. If a no-drop policy is in effect, it shows that we as a community will not tolerate any form of abuse.

5) Child Protective Services develop and implement screening for domestic violence in all child abuse cases.
Rationale: In order to protect the children, we need to protect all victims in the home. In 50 to 70 percent of all child abuse cases, the mother also is being abused. In order to determine who the victims are, social workers must interview all adults separately and ask if they are being abused.

6) Child Protective Services and Adult Protective Services should hire experienced Domestic Violence Advocates as part of their investigative teams.
Rationale: The Child Protective Service Worker's job is to focus on the child. Experienced domestic violence advocates, whose expertise is in the area of adult violence, can provide useful information on family dynamics. In Adult Protective Services cases, domestic violence advocates can give useful input when domestic violence may be an unrecognized part of the problem. In both cases, domestic violence advocates are experienced at eliciting information clients initially may be unwilling to share.

7) Child Protective Services develop a long term follow-up procedure with children from violent homes.
Rationale: Because domestic violence is recurrent over time, children may continue to be at risk even when the immediate problem appears to have been resolved. Periodic follow-up reminds both victims and perpetrators that surveillance continues, potentially reducing future abuse and breaking the intergenerational family abuse.

8) State Mental Health Facilities implement a state certified batterers' treatment program for patients who have abused family members.
Rationale: A mental health facility often has batterers as patients (clients) providing an opportunity to intervene, educate and prevent future abuse.

9) The Parole Board request complete information about domestic and other violent patterns of behavior including felony and misdemeanor convictions, prior to any considerations for parole.
Rationale: Team reviews showed that batterers convicted of murdering their wives have been released from prison after serving minimal time. The Nevada Parole Board does not have information on the criminal history of the parolee, only what their behavior was in prison. A model prisoner may not continue model behavior outside the structured prison environment. Knowing a parolee's criminal history can help the parole board better assess the risks of release.

10) Nevada prisons implement a state certified batterers' intervention program as a requirement for violent offenders prior to release from prison.
Rationale: The Nevada legislature recognizes the need for batterers' treatment and

now mandates it for all convicted domestic violence offenders. Imprisonment should not invalidate that mandate. (Since the 1999 Nevada Legislature, batterers are mandated to attended state certified batterers' treatment programs)

11) The Washoe County School District develop a domestic violence awareness curriculum beginning in elementary grades and continuing through high school. **Rationale:** Knowledge and early intervention is the best way to prevent family violence. Teaching children of all ages about domestic violence will help them to seek help when there is violence in the home.

12) Limited jurisdiction courts should have formal probation departments in order to hold all spousal batterers accountable for their violent behavior. Specifically: all defendants convicted of domestic violence should be the subject of a written presentence investigation which outlines the criminal history of the defendant; the number of law enforcement responses to the defendant's home alleging a family disturbance; and a review of the health, welfare and safety of any child or children in the care, custody and control of the defendant. Judges should set sentencing out 30 days from the date of the defendant's entry of plea or conviction and be provided with a formal written report prepared by trained, POST certified probation officers detailing the nature of the offense, and recommended sentence and methodology for enforcement and accountability of the proposed sentence.
Rationale: Currently, the limited jurisdiction courts in the State of Nevada handle the majority of all family violence cases. The judges are provided limited criminal history and police reports. There are no trained probation officers to assist the judges in the enforcement of court orders nor are there consistent statewide policies to hold defendants accountable to meet the terms imposed by a court on a suspended sentence.

13)Law enforcement include on their reports the number of previous domestic violence calls to the residence that involves the same victim and perpetrator.
Rationale: This information will assist law enforcement and prosecutors with the homicide investigation. This information will be available and communicated to sentencing judges and others to enhance informed decision making.

APPENDIX

- **Mission Statement**
- **NRS 33.018**
- **NRS 217.475**
- **Domestic Violence Adult Fatality Review Team Washoe County, Nevada Procedures/Scope**
- **Interagency Agreement - Original 1994**
- **Interagency Agreement - 2000**
- **Confidentiality Agreement**
- **Confidentiality Agreement Meeting Sign-In**
- **Washoe County, Nevada Domestic Violence Fatality Review Fact Sheet**
- **Washoe County, Nevada Domestic Violence Fatality Review Team Data Collection form**
- **Senate Bill No.412**
- **Northern Nevada Medical Center Emergency Department Screening for Domestic Violence survey form and screening report**
- **Resources**

WASHOE COUNTY, NEVADA
DOMESTIC VIOLENCE FATALITY REVIEW COMMITTEE
MISSION STATEMENT

Domestic Violence Fatality Review Committee shall review deaths associated with domestic violence that occur in Nevada, focusing on decedents age 18 and above who fall within the criteria established by this committee.

We recognize the responsibility for responding to and preventing domestic violence fatalities lies with the community not with any single agency or entity. We recognize that promoting more accurate identification and reporting of domestic violence fatalities will result in the development of prevention strategies for all domestic violence injuries in the state of Nevada.

Finally, we recognize the implementation of domestic violence fatality panels will lead to improved coordination and services for families and children at the local level.

Revised 1/99

Statute

Statute: 33.018
Title: REMEDIES; SPECIAL ACTIONS AND PROCEEDINGS
Chapter: INJUNCTIONS (ORDERS FOR PROTECTION AGAINST
Article: ODERS FOR PROTECTION AGAINST DV

State: NV
Created: / /
Orginal Date: / /
Currency Date: 05/27/19

----Leadline:----
Acts which constitute domestic violence

----Body:----
1. Domestic violence occurs when a person commits one of the following acts against or upon his spouse, former spouse, any other person to whom he is related by blood or marriage, a person with whom he is or was actually residing, a person with whom he has had or is having a dating relationship, a person with whom he ha child in common, the minor child of any of those persons or his minor child:
(a) A battery.
(b) An assault.
(c) Compelling the other by force or threat of force to perform an act from which he has the right to refrain or t refrain from an act which he has the right to perform.
(d) A sexual assault.
(e) A knowing, purposeful or reckless course of conduct intended to harass the other. Such conduct may include, but is not limited to:
(1) Stalking.
(2) Arson.
(3) Trespassing.
(4) Larceny.
(5) Destruction of private property.
(6) Carrying a concealed weapon without permit.
(f) A false imprisonment.
(g) Unlawful entry of the other's residence, or forcible entry against the other's will if there is a reasonably foreseeable risk of harm to the other from the entry.
2. As used in this section, "dating relationship" means frequent, intimate associations primarily characterized the expectation of affectional or sexual involvement. The term does not include a casual relationship or an ordinary association between persons in a business or social context.

----Currency:----
Currency of Legislation: Current through 1997 Reg. Sess., adj. July 7, 1997. Baseline of Legislation: 1991 Cumulative Supplement.

Statute

Statute: **217.475**
Title: **CORRECTIONAL INSTITUTIONS; AID TO VICTIMS OF**
Chapter: **AID TO CERTAIN VICTIMS OF CRIME**
Article:

State: **NV**
Created: **06/17/1998**
Orginal Date: **/ /**
Currency Date: **06/1)8**

----Leadline:----
Team to review death of victim of domestic violence.

----Body:----
1. A court or an agency of a local government may organize or sponsor one or more multidisciplinary teams to review the death of the victim of a crime that constitutes domestic violence pursuant to NRS 33.018.
2. If a multidisciplinary team is organized or sponsored pursuant to subsection 1, the court or agency shall review the death of a victim upon receiving a written request from a person related to the victim within the third degree of consanguinity, if the request is received by the court or agency within 1 year after the date of death of the victim.
3. Members of a team that is organized or sponsored pursuant to subsection 1 serve at the pleasure of the court or agency that organizes or sponsors the team and must include, without limitation, representatives of organizations concerned with law enforcement, issues related to phsyical or mental health, or the prevention of domestic violence and assistance to victims of domestic violence.
4. Each organization represented on such a 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.
5. A team organized pursuant to this section may, upon request, provide a report concerning its review to a person related to the victim within the third degree of consanguinity.
6. Before establishing a team to review the death of a victim pursuant to this section, a court or an agency shall adopt a written protocol describing its objectives and the structure of the team.
7. A team organized pursuant to this section may, if appropriate, meet with a multidisciplinary team to review the death of a child organized pursuant to NRS 432B.405.
8. Each member of a team organized pursuant to this section is immune from civil or criminal liability for an activity related to the review of the death of a victim.
9. The results of the review of the death of a victim pursuant to this section are not admissible in any civil action or proceeding.

----Currency:----
Currency of Legislation: Current through 1997 Reg. Sess., adj. July 7, 1997. Baseline of Legislation: Through 1997 Reg. Sess., adj. July 7, 1997.

DOMESTIC VIOLENCE ADULT FATALITY REVIEW TEAM
WASHOE COUNTY, NEVADA

1) Procedures / Scope
   a) Team will meet monthly for a minimum of 60 minutes with the core team present.
   b) There will be systematic reviews of domestic violence - related fatalities for anyone over 18, as per approval of the team.
   c) The focus will be on Washoe County cases. Our team is available to review other Nevada cases as per NRS statutes.
   d) Ancillary team members may be invited to attend as their presence pertains to a specific case.
   e) In identified criminal cases, the case must be adjudicated prior to the review.
   f) Our case year will be a calendar year, January 1-December 31, and will end with the completion of an Annual Report.
   g) Documentation will occur with a secretary who takes minutes of the meeting, and adds a summary of the death review when a review is taking place. Co-chairmen will each alternate conducting the meeting and completing the fact sheet during the meeting.
   h) We plan to have only one central notebook which contains the specifics of each case and the outcome/recommendations of a review. As per the Confidentiality Agreement, disposal of all identifying information on each case will be the responsibility of each team participant. The notebook will be kept secure in an area accesible to the team for each meeting.

2) Review Process
   a) We receive cases by:
      1-coroner referral
      2-core team member referral
      3-media referral
      4-refer to NRS #217.475 addressing family member referral requests
   b) How we proceed:
      1-a list of possible cases is submitted monthly at a meeting
      2-core team agrees upon cases to be reviewed
      3-at the following monthly meeting, a fact sheet with narrative (supplied by referring member) is distributed to core team members
      4-core team members have until the NEXT meeting to obtain pertinent information through their respective agencies, to record it on the fact sheet, and present it at the case review. The team member, or the designated alternate, is responsible to see that the information gets to the death review. Chairmen are responsible for the monthly agendas for each meeting.

3) Goals
   To have an individual death review summary, with recommendations, completed at the end of each case review. In order to achieve this, attendance of core team members, or a designated alternate, will be essential.

APPROVED EFFECTIVE 1/99

INTERAGENCY AGREEMENT TO ESTABLISH THE MULTI-DISCIPLINARY DOMESTIC VIOLENCE FATALITY REVIEW COMMITTEE

This cooperative agreement is made this _____ day of _____, 1994 between the

_____

and the _____.

WHEREAS, the parties hereto are vested with the authority to promote and protect the public health and to provide services which improve the well-being of children and their families.

WHEREAS, under NRS _____, the Department of _____ has authority to investigate and determine the epidemiology of those conditions which contribute to preventable... death and disability, and also under NRS _____, to use Vital Records for research conducted in the public interest. NRS _____.

WHEREAS, under NRS _____, otherwise known as the Child Protection Act. ____ _____ has the responsibility to protect the well-being of children and their families.

WHEREAS, the parties agree that they are mutually served by the establishment of a Multi-disciplinary Domestic Violence Fatality Review Committee, and that the expected outcome of such review will be the identification of preventable deaths and recommendations for the intervention and prevention strategies.

WHEREAS, the objectives of the Review Committee are agreed to be:

1) To describe trends and patterns of domestic violence deaths in Nevada.
2) To identify and investigate the prevalence of a number of risks and potential risk factors in the population of domestic violence decedents.
3) To evaluate the service and system responses to families who are considered to be at high risk, and to offer recommendations for improvement in those responses.
4) To characterize high risk groups in terms that are compatible with the development of public policy.
5) To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.

WHEREAS, both parties agree that the membership of the Review Committee needs to be comprised of the following disciplines; law enforcement, judiciary, medical, public health, social services, law, coroners, and a legislator, with specific membership from designated agencies to include, but not limited to, the Washoe County Coroner's Office, Washoe County Medical Society, CAAW, American Academy of pediatrics, Washoe County Social Services Department.

WHEREAS, both parties agree that the review process requires case specific sharing of records and confidentiality is inherent in many of the involved reports, there will be clear measures taken to protect confidentiality.

NOW, THEREFORE, it is hereby agreed to establish a Multi-disciplinary Domestic Violence Fatality Review Committee subject to renewal of this Interdepartmental Agreement on the triennial basis. All members of the Domestic Violence Fatality Review Committee will sign

a confidentiality statement that prohibits any unauthorized dissemination of information beyond the purpose of the review process. Non-identified, aggregate data will be collected by the committee. The review committee shall not create any new files with specific case identifying information. Case identification will only be utilized in the review process in order to enlist interagency cooperation, and no material may be used for reasons other than that which was intended. It is further understood there may be individual cases reviewed by the committee which require a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on that agency's clear connection with the issue at hand.

INTERAGENCY AGREEMENT
WASHOE COUNTY DOMESTIC VIOLENCE FATALITY REVIEW TEAM

This cooperative agreement is made this ____ day of_____, 2000 between the Washoe County Domestic Violence Fatality Review Team and_____
_____.

WHEREAS, the parties hereto are vested with the authority to promote and protect the public health and to provide services which improve the well-being of children and families.

WHEREAS, under NRS 217.475, the Washoe County Domestic Violence Fatality Review team has the authority to investigate and determine the epidemiology of those conditions which contribute to preventable domestic violence related deaths and disabilities as described under NRS 33.018.

WHEREAS, the parties agree they are mutually served by the establishment of a Multi-disciplinary Domestic Violence Fatality Review Team, and the expected outcome of such review will be the identification of domestic violence related deaths and recommendations for intervention and prevention strategies.

WHEREAS, the objectives of the Fatality Review Team are agreed to be:

1) To describe trends and patterns of domestic violence deaths in Nevada.
2) To identify and investigate the prevalence of a number of risks and potential risk factors in the population of domestic violence decedents.
3) To evaluate the service and system responses to families who are considered at risk, and to offer recommendations for improvement in those responses.
4) To characterize high risk groups in terms that are compatible with the development of public policy.
5) To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.

WHEREAS, parties agree membership of the Washoe County Domestic Violence Fatality Review Team shall be comprised of and not limited to the following disciplines: Law Enforcement, Judiciary, Medical, Public Health, Victim Services Providers, a Domestic Violence Survivor, Prosecutors, Victim Advocates within Prosecution offices, Social Services, Child Protective Services, Medical Examiner, Educator, Mental Health Provider, Batterer Intervention, Parole and Probation, Clergy and Animal Control representatives.

WHEREAS, all parties agree the review process requires case specific sharing of records and confidentiality is inherent in many of the involved reports, there will be clear measures taken to protect confidentiality.

NOW, THEREFORE, it is hereby agreed to establish a Multi-disciplinary Domestic Violence Fatality Review Team subject to renewal of this Interdepartmental Agreement on a triennial basis. All members of the Washoe County Domestic Violence Fatality Review Team will sign a confidentiality statement that prohibits any unauthorized dissemination of information beyond the purpose of the review process. Non-identified, aggregate data will be collected by the team. Case identification will only be utilized in the review process in order to enlist interagency cooperation, and no material may be used for reasons other than that which was intended. It is further understood there may be individual cases reviewed by the team which require a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on that agency's clear connection with the issue at hand.

Signature Date

Signature Date

Signature Date

CONFIDENTIALITY AGREEMENT
WASHOE COUNTY DOMESTIC VIOLENCE
DEATH REVIEW COMMITTEE

The purpose of the Washoe County Domestic Violence Fatality Review Committee is to conduct a full examination of each domestic violence related death incident. In order to assure a coordinated response that fully addresses all systemic concerns surrounding domestic violence fatality cases, the Washoe County Domestic Violence Fatality Review Committee must have access to all existing records on each death. Every agency or its representative will disclose information pertinent to the death review, as permitted pursuant to NRS 217.475 et al.

With the 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 was intended. I also agree to protect confidentiality by disposing of any identifying data at the completion of the fatality review.

_____

Print Name

_____

Signature Date

_____

Witness Date

Judge Janet Berry, Washoe County District Court

DOMESTIC VIOLENCE FATALITY REVIEW COMMITTEE

12:00 NOON TO 1:00 PM

CONFIDENTIALITY AGREEMENT

The purpose of the Washoe County Domestic Violence Fatality Review Committee is to conduct a full examination of each domestic violence related death incident. In order to assure a coordinated response that fully addresses all systemic concerns surrounding domestic violence fatality cases, the Washoe County Domestic Violence Fatality Review Committee must have access to all existing records on each death. Every agency or its representative will disclose information pertinent to the death review, as permitted pursuant to NRS 217.475 et al.

With the purpose in mind, I, the undersigned agree that all information secured in this review will remain confidential and will not be used for reasons other than that which was intended. I also agree to protect confidentiality by disposing of any identifying data at the completion of the fatality review.

NAME	SIGNATURE

WASHOE COUNTY, NEVADA
DOMESTIC VIOLENCE FATALITY REVIEW
FACT SHEET

All cases reviewed by this committee are known domestic violence related deaths. All information is considered confidential.

Case Name_____ Coroner Number_____

Name of Decedent_____ Alias/Maiden_____

Source of Income_____ Employer_____

Address_____ Previous Address_____

Date of Death_____ Social Security Number_____
Date of Birth_____ Drivers License Number_____
Prison/Jail Inmate Number_____ Military Status (if applicable)_____
Education_____ Vehicle Description_____

Name of Perpetrator_____ Alias/Maiden_____

Source of Income_____ Employer_____

Address_____ Previous Address_____
Date of Birth_____ Drivers License Number_____
Prison/Jail Inmate Number_____ Military Status (if applicable)_____
Education_____ Vehicle Description_____

1. Is there evidence of prior domestic violence/sexual assault? ___ Yes ___ No ___ None Found
   ☐ Medical ☐ Social Services ☐ Employer ☐ Law Enforcement
   ☐ Family Court/TPO ☐ Domestic Violence Program ☐ Public Health Clinic ☐ Other
   If yes, specify what evidence indicated the existence of prior domestic violence: _____
   _____
   Please attach agency contact information to this report.

2. Had public or referral agencies been involved? (some may be unrelated to domestic violence)
   ____ Yes ____ No ____ Unknown
   If yes, please indicate which:
   ☐ Medical ☐ Social Services ☐ Employer ☐ Law Enforcement
   ☐ Family Court ☐ Public Health Agency ☐ Animal Control ☐ Other
   Describe_____

3. Were criminal domestic violence charges filed with this death? ____ Yes ____ No ____ Unknown
   Charges_____
   If yes, disposition:
   ☐ Acquitted ☐ Probation ☐ Jail ☐ Prison ☐ Case Pending

4. Was the history of the perpetrator obtained? ____Yes ____No ____None
   If yes, please list prior history:

WASHOE COUNTY FATALITY REVIEW
FACT SHEET
PAGE 2

5. Was the criminal history of the victim obtained? ____Yes ____No ____None
If yes, please list prior criminal history:_____

_____

6. What was the method or instrument with the death? _____

_____

7. Were drugs/alcohol associated with the death? ____Yes ____No ____Unknown

8. Did the decedent have a drug or alcohol problem in the past? ____Yes ____No ____Unknown
☐ Alcohol ☐ Drugs ☐ Prescription ☐ Other
At the time of death? ____Yes ____No ____Unknown
☐ Alcohol ☐ Drugs ☐ Prescription ☐ Other

9. Did the perpetrator have a drug or alcohol problem in the past? ____Yes ____No ____Unknown
☐ Alcohol ☐ Drugs ☐ Prescription ☐ Other
At the time of the death? ____Yes ____No ____Unknown

10. Where did the murder take place? _____

11. If different, where was the body discovered? _____

12. Were firearms or weapons kept in the house? ____Yes ____No ____Unknown

13. Household characteristics:

Number of children under 18 in the home: _____ Ages: _____
Relationship status: ___Boyfriend ___ Girlfriend ___Husband ___Wife ___Parent ___Other
Were there other relatives in the home? ____Yes ____No ____Unknown
Were there other unrelated persons in the home? ____Yes ____No ____Unknown
Major stressor? ____Yes ____No ____Unknown
If yes, please specify: _____

_____

NOTES:

WASHOE COUNTY, NEVADA
Domestic Violence Fatality Review Team
Data Collection

Homicide:

Victim Female ____ Male____
Perpetrator Female ____ Male____

Suicide: Female ____ Male____

Race:	**Victim**	**Perpetrator**	**Age:**
African American	_____	_____	Victim _____
Asian	_____	_____	
Caucasian	_____	_____	
Hispanic	_____	_____	Perpetrator_____
Native American	_____	_____	
Pacific Islander	_____	_____	

Weapons used:

Guns ____ Knives_____ Motor vehicle _____ Strangulation _____ Other_____

Relationship to perpetrator:

Spouse_____ Ex-spouse_____ Co-Hab _____ Boyfriend/Girlfriend_____
Child/ stepchild _____ Other_____

Protection Orders :

Current at time of death Yes _____ No _____
History prior to death Yes _____ No _____ If yes, how many?_____

DV History:

Perpetrator Yes _____ No _____ As a victim?_____
Victim Yes _____ No _____ As a victim?_____

Prior 911 calls: Yes _____ No_____ If yes, how many?_____

Alcohol abuse history:

Perpetrator Yes _____ No_____ ETOH present at death_____
Victim Yes _____ No_____ ETOH present at death_____

Drug abuse history :

Perpetrator Yes_____ No_____ Illegal drugs present at death_____
Victim Yes_____ No_____ Illegal drugs present at death_____

Pregnancy:

Perpetrator Yes_____ No_____ Recent_____At death_____
Victim Yes_____ No_____Recent_____At death_____

Animal abuse:

Perpetrator Yes _____ No _____ Recent_____ At death_____
Victim Yes _____ No _____ Recent _____ At death_____

Children:

Perpetrator Yes_____ No _____ How many children?_____
Victim Yes _____ No _____ How many children?_____

Children witnessed death: Yes_____ No _____ How many children?_____
Children at home/ nearby: Yes_____ No _____

Employed by:

Perpetrator Yes ____ No _____ Disability_____Unknown_____
Place of employment_____
Victim Yes _____ No _____ Disability_____ Unknown_____
Place of employment_____

Agency history:

Law enforcement No_____ Yes_____Branch:_____
Children's Protective Services Yes_____No_____Referral_____Contact___
Adult Protective Services Yes_____ No_____Referral_____Contact____
Hospital No_____Yes_____ DV related_____OB/GYN_____Substance Abuse_____Other_____
School Yes _____ No_____ Referral_____ Contact _____
Advocacy No_____Yes_____Agency_____

Mental Health:

Perpetrator No_____Yes_____Unknown_____ Inpatient_____
Outpatient_____Referral only_____Batterer's Intervention_____
Victim No_____Yes_____ Unknown_____Inpatient_____
Outpatient_____Referral only_____Batterer's Intervention_____

Criminal History:

Perpetrator Yes_____ No _____DV related_____ When/where_____
Victim Yes_____ No_____DV related_____ When/where_____

Information needed for completion:

Senate Bill No. 412–Senators Mathews, Rawson,

Amodei, Coffin and Washington

CHAPTER.....

AN ACT relating to children; providing for protective custody for children upon the death of a parent that is or may be a result of domestic violence; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 432B.330 is hereby amended to read as follows:

432B.330 1. A child is in need of protection if:

(a) He has been abandoned by a person responsible for his welfare;

(b) He is suffering from congenital drug addiction or the fetal alcohol syndrome, because of the faults or habits of a person responsible for his welfare;

(c) He has been subjected to abuse or neglect by a person responsible for his welfare;

(d) He is in the care of a person responsible for his welfare and another child has died as a result of abuse or neglect by that person; or

(e) He has been placed for care or adoption in violation of law.

2. A child may be in need of protection if the person responsible for his welfare:

(a) Is unable to discharge his responsibilities to and for the child because of incarceration, hospitalization or other physical or mental incapacity;

(b) Fails, although he is financially able to do so or has been offered financial or other means to do so, to provide for the following needs of the child:

(1) Food, clothing or shelter necessary for the child's health or safety;

(2) Education as required by law; or

(3) Adequate medical care; or

(c) Has been responsible for the abuse or neglect of a child who has resided with that person.

3. A child may be in need of protection if the death of a parent of the child is or may be the result of an act by the other parent that constitutes domestic violence pursuant to NRS 33.018.

Sec. 2. NRS 432B.390 is hereby amended to read as follows:

432B.390 1. An agent or officer of a law enforcement agency, an officer of the local juvenile probation department or the local department of juvenile services or a designee of an agency which provides protective services ~~[may]~~ *:*

(a) May place a child in protective custody without the consent of the person responsible for the child's welfare if he has reasonable cause to

believe that immediate action is necessary to protect the child from injury, abuse or neglect.

(b) Shall place a child in protective custody upon the death of a parent of the child, without the consent of the person responsible for the welfare of the child, if the agent, officer or designee has reasonable cause to believe that the death of the parent of the child is or may be the result of an act by the other parent that constitutes domestic violence pursuant to NRS 33.018.

2. If there is reasonable cause to believe that the death of a parent of the child is or may be the result of an act by the other parent that constitutes domestic violence pursuant to NRS 33.018, a protective custody hearing must be held pursuant to NRS 432B.470, whether the child was placed in protective custody or with a relative. If an agency other than an agency which provides protective services becomes aware that there is reasonable cause to believe that the death of a parent of the child is or may be the result of an act by the other parent that constitutes domestic violence pursuant to NRS 33.018, that agency shall immediately notify the agency which provides protective services and a protective custody hearing must be scheduled.

3. An agency which provides protective services shall request the assistance of a law enforcement agency in the removal of the child if it has reasonable cause to believe that the child or the person placing the child in protective custody may be threatened with harm.

~~[2.]~~ *4.* Before taking a child for placement in protective custody, the person taking the child shall show his identification to any person who is responsible for the child and is present at the time the child is taken. If a person who is responsible for the child is not present at the time the child is taken, the person taking the child shall show his identification to any other person upon request. The identification required by this subsection must be a single card that contains a photograph of the person taking the child and identifies him as a person authorized pursuant to subsection 1 to place a child in protective custody.

~~[3.]~~ *5.* A child placed in protective custody pending an investigation and a hearing held pursuant to NRS 432B.470 must be placed in a hospital, if the child needs hospitalization, or in a shelter, which may include a foster home or other home or facility which provides care for those children, but the child must not be placed in a jail or other place for detention, incarceration or residential care of persons convicted of a crime or children charged with delinquent acts.

~~[4.]~~ *6.* A person placing a child in protective custody shall:

(a) Immediately take steps to protect all other children remaining in the home or facility, if necessary;

(b) Immediately make a reasonable effort to inform the person responsible for the child's welfare that the child has been placed in protective custody;

(c) Give preference in placement of the child to any person related within the third degree of consanguinity to the child who is suitable and able to provide proper care and guidance for the child, regardless of whether the relative resides within this state; and

(d) As soon as practicable, inform the agency which provides protective services and the appropriate law enforcement agency.

~~[5.]~~ *7.* If a child is placed with any person who resides outside this state, the placement must be in accordance with NRS 127.330.

Sec. 3. NRS 432B.490 is hereby amended to read as follows:

432B.490 1. An agency which provides protective services:

(a) ~~[Shall,]~~ ***In cases where the death of a parent of the child is or may be the result of an act by the other parent that constitutes domestic violence pursuant to NRS 33.018, shall within 10 days after the hearing on protective custody initiate a proceeding in court by filing a petition which meets the requirements set forth in NRS 432B.510;***

(b) In other cases where a hearing on protective custody is held, shall within 10 days after the hearing on protective custody, unless good cause exists, initiate a proceeding in court by filing a petition which meets the requirements set forth in NRS 432B.510 or recommend against any further action in court; or

~~[(b)]~~ *(c)* If a child is not placed in protective custody, may, after an investigation is made under NRS 432B.010 to 432B.400, inclusive, file a petition which meets the requirements set forth in NRS 432B.510.

2. If the agency recommends against further action, the court may, on its own motion, initiate proceedings when it finds that it is in the best interests of the child.

3. If a child has been placed in protective custody and if further action in court is taken, an agency which provides protective services shall make recommendations to the court concerning whether the child should be returned to the person responsible for his welfare pending further action in court.

Sec. 4. This act becomes effective on July 1, 1999.

NORTHERN NEVADA MEDICAL CENTER

Emergency Department
Screening for Domestic Violence

Due to an increase in Domestic Violence in women's lives, Emergency Department Staff now asks every woman about Domestic Violence.

1. Have you ever been threatened or injured by any kind of abuse or violence?
   ☐ Yes ☐ No ☐ Not Sure ☐ Refused

   If yes, check one: By whom?
   - ☐ Husband
   - ☐ Boyfriend
   - ☐ Family member
   - ☐ Other

2. Is this happening now?
   ☐ Yes ☐ No

3. Has the violence increased in frequency and severity?
   ☐ Yes ☐ No

4. Are you afraid to go home today?
   ☐ Yes ☐ No

5. Do you know where you can get help?
   ☐ Yes ☐ No

Intervention:

Any *Yes* answer to questions will require documentation of findings and interventions in the patients medical record.

1. ☐ Documented on Medical Record
2. ☐ Follow-up with Social Worker if indicated ☐ Yes ☐ No By:_____
3. ☐ Shelter reference provided? ☐ Yes ☐ No
4. ☐ Educational material given:_____

R.N. Signature: _____ Date: _____ Time: _____

Please forward completed screening forms to the E.D. manager's mailbox. Thank you.

Patient ID Stamp

Total Patients seen during this time 17,854

Domestic Violence Re-Cap Sheet - for the year of the stud

Dates 12-4-98 - 12-4-99

Patients Interviewed ---------- 932

Never a Victim ---------- 459

Has been a victim, not now ---------- 456

Has been a victim, and is still a victim ---------- 17

Not able to be interviewed ---------- 76

Chart documentation ---------- 16

Domestic Violence information given ---------- 17 + 1 refusal

Do you know where to get help, or what number to call?

Yes ---------- 775
No ---------- 17
Prompted ---------- 123
Advised ---------- 1

Referrals to Social Service ---------- 9

Caaw ---------- 2

1. There had to be no mandatory reporting during the time of the study.
2. Study subjects were 18 years of age and older with no cut-off age.
3. The national average of victims vs. non-victims is 50-50, and our study reflects pretty much the same.
4. The study is going to be continued thru 2000, with the same criteria.
5. Domestic Violence screening is still not a standard of practice.
6. Attached are copies of the monthly reports and totals.

respectfully submitted,

M. J. Taylor, R. N.
Emergency Department, N.N.M.C.

Total Number of E.R. Patients during this time - 5665

Domestic Violence Re-Cap Sheet

Dates 12-4-98 --- 4-4-99

Patients Interviewed	319	
Never a Victim	184	
Has been a victim, not now	125	
Has been a victim, and is still a victim	10	
Not able to be interviewed	16	- Due to language hovering husban alzheimers & me condition
Chart documentation	12	- whether they ar still a victim rec'd info.
Domestic Violence information given	11	
Refused	1	

Do you know where to get help, or what number to call?

Yes	259	
No	7	
Prompted	36	- to recall "91
Advised	1	

Referrals to Social Service

Caaw

- 6 for those expressing a sire to have report & receive help.

1. The study is to be a 6 month study.
2. The stats are after 4 months (12-4-98 to 4-4-99).
3. Not all RN's are habitual about survey. Not yet a standard of care. copy of survey questions attached.
4. The survey form becomes part of the patients hospital record. It is reinforced with patient that it is strictly confidential.
5. Survey questions are brief and patients are always asked if they have objections to being asked the questions.
6. Survey patients are females 18 years and over --- no cut-off age.
7. Attached are the work products that we distribute --- both in English Spanish. We also have these on display in the bathrooms and in the P room.
8. Point of fact --- The spanish ones disappear the quickest and the fir
9. No mandatory reports during the period 12-4-98 to 4-4-99. 6 reports per patient request for information and help.

Respectfully Submitted

M. J. Taylor, R. N.
Emergency Dept. - N.N.M.C.

Total Number of E.R. Patients during this time - 5566

Domestic Violence Re-Cap Sheet

Dates 4-4-99 --- 8-4-99

Patients Interviewed	301	
Never a Victim	153	
Has been a victim, not now	147	
Has been a victim, and is still a victim	1	
Not able to be interviewed	29	Due to Sr Bridges-1 Mouth Injury 1 Suspect- Wont Par. ETOH 1 Hovering S.O. 2 No English 3 Membory Loss 1 = 29
Chart documentation	2	
Domestic Violence information given	2	

Do you know where to get help, or what number to call?

Yes	250	
No	6	
Prompted	45	to recall "911"
Advised	0	

Referrals to Social Service	0
Caaw	0

1. We've extended to 1 Year the study.
2. These stats are during the second part of the study.
3. Not all R.N.'s are habitual about the survey. Not yet a standard of ca Copy of survey questions attached.
4. The survey form becomes part of the patients hospital record. It is reinforced with the patient that this is strictly a confidential survey
5. Survey questions are brief and patients are always asked if they have a objections to being asked the questions.
6. Survey patients are females 18 years and over --- no cut-off age.
7. There were no mandatory reports during the above period, and no patient request reports.

Respectfully Submitted

M. J. Taylor, R. N.

Emergency Dept. - N.N.M.C.

Total number of E.R. Patients during this time ------ 6025

Domestic Violence Re-Cap Sheet

Dates 8-5-99 to 12-4-99

Patients Interviewed	280
Never a Victim	107
Has been a victim, not now	167
Has been a victim, and is still a victim	6
Not able to be interviewed	30
Chart documentation	2
Domestic Violence information given	4

Do you know where to get help, or what number to call?

Yes	238
No	4
Prompted	38
Advised	0

Referrals to Social Service ---------- 3 - 2 already going & 1 in Calif

Caaw ---------- 2 - 1 here and 1 in calif.

1Patients not able to be interviewed - 1 Aphasic, 2 Sr. Bridges, 1 Anxiety, 3 refuses, 10 hovering s.o's, 5 medical problems, 2 intubated, 2 don't understand, 2 confused, 1 no English, 1 Alzheimers.. = 30

2 We've extended the study

3 Not yet a standard of care

4 N ot all R.N.'s habitual about the survey

5 The suvey form becomes part of the patients hospital record. It is re-inforced with the patient that this is strictly a confidential survey.

6 Survey patients are females 18 years and over --- no cut-off age.

7 There were no mandatory reports during the above period, and no patient requests to report.

8 These stats were during the 3rd part of the study - the last 4 months.

Respectfully Submitted

M. J. Taylor R. N.
Emergency Dept. N. N. M. C.

RESOURCES

Battered Women's Justice Project: (800) 903-0111 Civil Ext.1, Criminal Ext.2

Center for the Prevention of Sexual and Domestic Violence: (Resources for Clergy) (206) 634-1903

Domestic Abuse Intervention Project: (218) 722-2781

Health Resource Center on Domestic Violence: (888) Rx-ABUSE (792-2873)

National Clearinghouse for the Defense of Battered Women: (215) 351-0010

National Domestic Violence Hotline: (800) 799-SAFE (7233) TTY (800) 787-3224

National Resource Center on Domestic Violence: (800) 537-2238 TTY (800) 553-2598

National Resource Center on the Link Between Violence to People and Animals: (877) LINK-222 (546-5222)

National Resource Center to End Violence Against Native Women – Sacred Circle: (877) 733-7623

National Training Center on Domestic and Sexual Violence: (512) 407-9020

Nevada Network Against Domestic Violence: (775) 828-1115

Resource Center on Domestic Violence: Child Protection and Custody: (800) 52PEACE (527-3223)