

LYNCHBURG CITY FAMILY VIOLENCE
FATALITY REVIEW TEAM



**“Stop the Silence,
Stop the Violence!”**

Initial Report
April 2006

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ACKNOWLEDGEMENTS

The following people generously gave of their time and expertise by serving as members of the Lynchburg City Family Violence Fatality Review Team:

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Susan Clark, Director, Victim/Witness Program, Office of the Commonwealth's Attorney
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Carolyn Maples, Senior Social Worker, Child Protective and Family Services, Lynchburg
Department of Social Services
Cary Payne, former Deputy Commonwealth's Attorney and Lynchburg Fatality Review Team
Chairperson, City of Lynchburg
John Payne, Chief Magistrate, 24th Judicial District
Cynthia Plummer, Program Director, Lynchburg Community Corrections Program and
Pretrial Services
April Rasmussen, Forensic Nurse Examiner, Centra Health
Todd Rodes, Investigator, Lynchburg Police Department
Cindy Tolle, Grants Administrator, Office of the Commonwealth's Attorney

Further, this project has benefited from the vision, expertise, insight, and support of the following people:

Mary Basten, Chief Probation and Parole Officer, District 13
Charles Bennett, Chief of Police, Lynchburg Police Department
Jennifer Bennett, Assistant Commonwealth's Attorney, Office of the Commonwealth's Attorney
Joyce Coleman, Senior Assistant City Attorney, City of Lynchburg
Walter Erwin, City Attorney, City of Lynchburg
Renee Fluty, former counselor, Alliance for Families and Children
Susan Harrison, Director, YWCA of Central Virginia
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Medical Examiner
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HISTORY OF LYNCHBURG CITY FAMILY VIOLENCE FATALITY REVIEW TEAM

In 1999, the Virginia General Assembly enacted § 32.1-283.3 (see Appendix A) of the Virginia State Code, bestowing localities with the authority to create “family violence fatality review teams”¹ as a better means to understanding how and why some instances of domestic violence take a deadly turn. In 2001, with four domestic violence fatalities having occurred in the City of Lynchburg, Commonwealth’s Attorney William G. Petty spoke with the region’s Coalition Against Domestic Violence for the 24th Judicial District about developing a family violence fatality review team. This idea was enthusiastically embraced by the Coalition and by November 2001, ten agencies from the public health, social service, and public safety sector had signed on to participate in this effort (see Appendix B). As part of an interagency participation agreement (see Appendix C), each agency agreed to provide a representative to participate, on a regular basis, as a member of the Lynchburg City Family Violence Fatality Review Team (hereafter referred to as The Team) and to provide all necessary data to support its mission.² (see Appendix D)

Virginia Code § 32.1-283.3 requires family violence fatality review teams to have the endorsement of their local government. As the lead agency for this project, the Commonwealth’s Attorney’s Office worked closely with the City Attorney’s Office to draft a resolution (see Appendix E) for Lynchburg City Council’s approval officially sanctioning the formation of The Team. In June 2002, approval for The Team’s formation was given by City Council and over the next year, the newly-organized Lynchburg Family Violence Fatality Review Team met periodically to develop a mission statement and protocols for The Team’s fatality reviews (see Appendix F).

The Mission of the Team is to prevent domestic violence cases from escalating into murder by constructively examining the circumstances of past and future deaths by domestic violence, to make recommendations arising out of these fatality reviews for system response and improvement, and to increase coordination and communication between various agencies and systems.

Members of the Team work together to examine the circumstances preceding the family violence fatality in the hopes of achieving a better understanding of the events leading up to the death and a greater understanding of the policies, procedures, and roles of those who assist victims of family violence.

¹ According to § 32.1-283.3 (A) a “fatal family violence incident” means any fatality, whether homicide or suicide, occurring as a result of abuse between family members or intimate partners.

² Pursuant to § 32.1-283.3, all information, records, discussions, and opinions of Family Violence Fatality Review Team members disclosed during any closed meetings shall remain confidential.

From August 2003 to January 2004, the Team devoted its meetings to sharing information about the roles and responsibilities of each agency at the table and each agency's current response to incidents of domestic violence for both victims and offenders. Although it took more than several meetings to complete this process, this interaction served as an excellent base for the group's work and was an invaluable process from an information-sharing and team-building perspective. In January 2004, the Team began its first case review, meeting on five occasions over the course of the calendar year before its completion. By March 2005, the Team had finalized its recommendations for system improvement and began further discussion of how these recommendations could be communicated and implemented among various partner agencies.

Dr. Marcella F. Fierro, Chief Medical Examiner for the Commonwealth of Virginia, has stated that "Virginia is on the forefront as it is only one of a handful of states that has adopted legislation to support family violence fatality review teams."

The members of the Team are proud to accept a leadership role in the development of such a team in our community.

CASE-SPECIFIC FINDINGS AND RECOMMENDATIONS

The following findings and recommendations are based on The Team's extensive one year review of a domestic violence fatality that occurred in the City of Lynchburg. Throughout the process of the case review, the Team presented a series of questions and scenarios to assist in identifying interventions that might have allowed for the prevention of fatal injuries. By "brainstorming" these scenarios, the Team was able to make recommendations it believes will assist in providing interventions to potential victims.

The Team reviewed all available information about this fatality during its case review process, including the actions of the victim and perpetrator, as well as the various agency personnel who had contact with the victim and perpetrator on the day of the victim's death and in the days immediately preceding the victim's death. In reviewing this specific fatality, the Team utilized a tool that experts in the field of domestic violence refer to as a risk/lethality assessment.³ This tool identifies risk and lethality indicators to assist first responders, criminal justice agencies, social service providers, and domestic violence victims in evaluating the increased risk of a batterer killing his or her partner, other family members, and/or him/herself. The more indicators present in a relationship, the higher the risk that future violence or death may occur (FRT Protocol, 2nd Edition, Virginia Department of Health, Office of the Chief Medical Examiner, December 2002).

The following risk and lethality indicators were found in the case reviewed:

- Attempts to distance self from perpetrator
- Previous episodes of violence
- Possession of firearms (perpetrator)
- Stalking of victim
- Acts of property destruction (perpetrator)
- Threats of homicide or suicide (perpetrator)
- Rage (perpetrator)
- Public displays of violence toward victim
- Prior calls to police (victim and perpetrator)
- Sense of ownership of the victim by the perpetrator
- Obsessiveness about partner
- Access to victim
- Intimidation/threats (perpetrator)

³ A tool first responders and victim advocates can use to help a victim evaluate the degree of danger he/she faces in an abusive situation and to assess the most appropriate intervention or services to offer a victim.

These lethality indicators, among others, are all common amongst domestic violence-related fatalities (see Appendix G).

The Team's members have come to appreciate the importance that each of their respective agencies play in the protection of victims of domestic and dating violence. Throughout this process, the Team shared and clarified the specific roles of each participating agency. The knowledge gleaned from each agency's capabilities and resources proved to be tremendously valuable to all Team members. In the spirit of public health and public safety, the Team used these insights to generate the following recommendations. Each recommendation is described within the context of the Team's case-specific findings.

1. **Finding:** In this case, it became apparent that dating violence cases do not receive the same intensity of investigation, reporting, and sharing of information as do domestic violence cases.

The Team Recommends: That the Lynchburg Police Department and Commonwealth's Attorney's Office develop a protocol to screen dating and domestic violence cases to determine the dangerousness of a situation. The protocol should involve coordination between all appropriate agencies. The identification of serious cases, whether domestic or dating, would then require the same intensity of investigation, reporting, and information-sharing.

2. **Finding:** In this case, it became evident that the seriousness of the situation had not been recognized. Numerous incidents reported to the police, including assaults, vandalism and other suspicious activities, were not reviewed collectively by any agencies involved, to provide an adequate response to the seriousness of the situation and to ensure, as much as possible, the safety of the victim.

The Team Recommends: The Commonwealth's Attorney's Office continue to develop and organize annual in-service training curriculum/presenters for police officers and other first responders. The training should include: innovative investigative techniques, an overview of the dynamics of domestic and dating violence, protocols for responding to incidents of dating and domestic violence, and the importance of identifying risk factors and conducting lethality assessments. This training should also include an overview of any changes in laws regarding domestic and dating violence.

3. **Finding:** In this case, it was discovered that the victim sought the counsel of a co-worker and discussed her belief that she was being stalked and her property

was being vandalized. The victim wanted to know what else could be done to ensure her safety.

The Team Recommends: Major employers in the area, including the City of Lynchburg, make available to all employees information about the dynamics of domestic violence and the resources available to assist victims. Employers should also provide supervisors with additional training to assist them in seeking law enforcement assistance as well as making appropriate referrals for employees.

4. **Finding:** An assault and battery charge had been brought against the perpetrator three days preceding the fatality. The assault and battery had been reported to a police officer during an interview at the hospital. During the interview, the victim told the officer she would go to the magistrate to obtain a warrant.

The Team Recommends: The Magistrate's Office, the Lynchburg Police Department, and the Office of the Commonwealth's Attorney develop a protocol to address citizen-initiated domestic violence and dating relationship warrants, to ensure available safeguards are provided to victims and thorough investigation, reporting, and prosecution standards are implemented. This protocol would include field officers taking out these types of warrants themselves, whenever probable cause is determined through further investigation.

5. **Finding:** It was determined that after the assault, the victim had been examined by a forensic nurse. A risk/dangerousness assessment was completed, which indicated the victim may have been at an elevated risk of danger. There was no protocol in place to ensure that this vital information was communicated to other responding agencies in a timely manner.

The Team Recommends: That the Team spearhead the development of a uniform risk/lethality assessment tool that can be used immediately by first responders to determine the dangerousness of the situation; and thereafter by member agencies, as necessary, to determine recommended interventions. The Team should also develop a protocol to determine the best way to communicate the results of the lethality assessments to other agencies that may need to know the information in a timely manner. The Team will be responsible for training member agencies on the effective implementation of the risk/lethality assessment tool.

6. **Finding:** During the time of this fatality, the LPD, as standard operating procedure, mailed a letter to perpetrators informing them of any outstanding misdemeanor warrants, and requested they turn themselves in at the police department. Upon receiving such a letter, the perpetrator called the LPD complaint desk to get more information about the warrant. Complaint desk personnel informed the perpetrator that an outstanding warrant for assault and battery was on file for him and the warrant was sworn out by the victim. Upon learning this information, the perpetrator became outraged and later the same evening, the fatality occurred.

The Team Recommends: The LPD no longer mail letters to perpetrators referencing outstanding arrest warrants for dating and domestic violence offenses or offer any details about the nature of these warrants over the phone. It is recommended that the LPD continue its current policy of serving outstanding warrants on perpetrators in an expeditious manner, without alerting perpetrators in advance of an impending arrest.

7. **Finding:** The perpetrator worked in a neighboring county. The previous protocol for notifying other jurisdictions regarding warrants for perpetrators within their jurisdictions was to send the warrant through the U.S. Postal Service. This process was not timely and prevented the neighboring county from effectuating an arrest on the perpetrator while in their jurisdiction. Currently, LPD protocol calls for the warrants to be faxed to outside jurisdictions for service.

The Team Recommends: The LPD should continue improving upon its current policy of sharing arrest information with other jurisdictions, by immediately faxing warrants when it is learned the perpetrator is in another jurisdiction. This process decreases response time and ensures faster service on perpetrators, thereby providing additional protection for victims.

8. **Finding:** The victim in this case had made contact with numerous agencies for assistance. She sought medical attention for her injuries due to the assault she had sustained at the hands of the perpetrator and went to the magistrate to swear out a warrant. She also discussed the situation with her co-worker and made numerous criminal mischief reports to the LPD. There was no protocol in place for interagency communication that might have provided a coordinated effort to assist her. A coordinated response effort, spearheaded by a single point of contact, might have been beneficial in this case.

The Team Recommends: The Office of the Commonwealth’s Attorney and the YWCA Domestic Violence Prevention Center take the lead in developing a coordinated advocacy program to literally “walk” victims of dating and domestic violence through the maze of systems and services available to assist them in overcoming the circumstances of their abusive relationships. This program would provide integrated service referrals and standardized assistance, upon victim request and/or based upon a lethality assessment conducted by a first responder.

In addition, the Team recommends the Domestic Violence Coalition develop a user-friendly comprehensive resource guide that lists available services and contact persons by organization. This guide would be distributed to service agencies and community groups that may come into contact with domestic and dating violence victims.

9. **Finding:** Personnel within the Team’s agencies, as well as others who came into contact with the victim, were not knowledgeable of the dynamics of domestic violence and its potentially deadly results. Due to this lack of understanding, different agency personnel did not perceive the potential threat and therefore, services that may have assisted the victim in increasing her safety were not provided.

The Team Recommends: That all agency leaders represented on the Team encourage their personnel to take advantage of local and national training on domestic violence issues to become better equipped to address these serious situations.

LOOKING FORWARD: WHERE DO WE GO FROM HERE?

1. Share findings and recommendations with Lynchburg City Council, criminal justice, and service agency leaders.
2. Request written comments from agencies indicating acknowledgment of recommendations relating to that agency and willingness to implement recommendations, as well as identifying any roadblocks or assistance needed to address those recommendations.
3. Share recommendations with the Coalition Against Domestic Violence For the 24th Judicial District, Inc. (DVC), and request the DVC, as a registered 501(c)(3) organization, take on specific tasks as part of its mission. In addition to seeking grants and sponsorships, this would include the development of a speakers' bureau and a writers' bureau to present information to local citizens on domestic and dating violence through community groups, organizations, and employers.
4. Formally request that the City of Lynchburg include information on domestic violence and stalking in the workplace during new employee orientation. Request the City annually disseminate information to City of Lynchburg employees (provided by the Team and/or the DVC) on the prevention of domestic and dating violence and available resources to assist victims, through such mediums as the *Changing Times* employee newsletter, attachments to payroll slips, workshops, etc.
5. Appoint a subcommittee to outline clear procedures for domestic violence and stalking protective orders that can be easily followed by:
 - Victims seeking to obtain protective orders
 - Courts and Magistrates issuing protective orders
 - Police serving defendants with protective orders
6. In conjunction with the DVC Legislative Committee, investigate options for legislative changes to the definition of "domestic violence" to include dating relationships.
 - Obtain definitions used in other states.
 - Seek local legislative support to draft and sponsor changes.
7. Develop a procedure to follow up with agencies to determine progress in implementing recommended changes.
8. Prepare an annual report that includes any local family violence fatalities and cases reviewed by the Team. In addition, collect state and local family violence fatality statistics and other resource, response, and usage data as available for

team review and inclusion in the annual report. This will help put local data in perspective and assist the Team in identifying any trends. The report should also include an evaluation of any procedural changes related to domestic violence due to legislative or agency requirements or initiated as a result of the previous year's recommendations.

9. Establish contacts with other family violence fatality review teams, both in Virginia and out of state, to share and obtain information on new developments, trends, and best practices.
10. Develop a tool to evaluate the effectiveness of the Team and to measure whether or not the Team's work has influenced or led to any improvements in the system response to family violence.
11. Submit a copy of this report to the Virginia Office of the Chief Medical Examiner for review.

CONCLUSION

Throughout the course of this review, the Team was challenged by questions of which information to collect and how that information might help identify trends that could be addressed to effect positive change. Individual agencies had become aware of specific shortcomings in some of their procedures or protocols and had already taken the steps necessary to address those shortcomings in the years since this fatality. With this informal reform process already underway, the individual agencies were more than receptive to continue those efforts when the Team began its review process.

The Team has worked tirelessly to ensure that all possible services and resources would be provided whenever necessary to protect and serve domestic and dating violence victims and their families. Not only has the Team developed recommendations and suggestions to better protect those families affected by domestic and dating violence, but the Team is determined to continue in its efforts to reduce family violence and the number of domestic homicides in Lynchburg.

The victim of this review died tragically and senselessly, as a result of dating violence. The Team believes the lessons learned from this death and other victims of domestic and dating violence can be a catalyst for change. "Stop the Silence, Stop the Violence" has become The Team's motto. Its goal is to speak for victims who cannot speak for themselves, and to continue to search for ways to prevent these crimes from happening in the future. Perhaps, then, in some small way, those victims of dating and domestic violence fatalities will not have died in vain.

APPENDIX A

Text in effect from and after July 1, 1999:

Title 32.1 Health

Chap. 8 Postmortem Examinations and Services, §§ 32.1-277 – 32.1-309

Art. 1 Chief Medical Examiner and Postmortem Examinations, §§ 32.1-277 – 32.1-288

§ 32.1-283.3. Family violence fatality review teams established; model protocol and data management; membership; authority; confidentiality, etc. –

A. The Chief Medical Examiner shall develop a model protocol for the development and implementation of local family violence fatality review teams (hereinafter teams) which shall include relevant procedures for conducting reviews of fatal family violence incidents. A "fatal family violence incident" means any fatality, whether homicide or suicide, occurring as a result of abuse between family members or intimate partners. The Chief Medical Examiner shall provide technical assistance to the local teams and serve as a clearinghouse for information.

B. Subject to available funding, the Chief Medical Examiner shall provide ongoing surveillance of fatal family violence occurrences and promulgate an annual report based on accumulated data.

C. Any county or city, or combination of counties, cities or counties and cities may establish a family violence fatality review team to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities. The team shall have the authority to review the facts and circumstances of all fatal family violence incidents that occur within its designated geographic area.

D. Membership in the team may include, but shall not be limited to: health care professionals, representatives from the local bar, attorneys for the Commonwealth, judges, law-enforcement officials, criminologists, the medical examiner, other experts in forensic medicine and pathology, family violence victim advocates, health department professionals, probation and parole professionals, adult and child protective services professionals, and representatives of family violence local coordinating councils.

E. Each team shall establish local rules and procedures to govern the review process prior to the first fatal family violence incident review conducted. The review of a death shall be delayed until any criminal investigations or prosecutions connected with the death are completed.

F. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information

Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the review nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 22 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

G. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a family violence fatality review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports or records to review teams as part of such review, shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct. (1999, cc. 849, 868.)

Virginia Code § 32.1-283.3

APPENDIX B

Lynchburg Fatality Review Team Memorandum of Agreement

I agree for my organization to be a full participant of the Lynchburg Fatality Review Team. This participation will include providing an ongoing representative to participate on a regular basis as a member of the review team and providing the necessary data to support its operations.

I understand that the mission of the Lynchburg Fatality Review Team is to prevent domestic violation cases from escalating into murder by constructively examining the circumstances of past and future deaths by domestic violence, by making recommendations arising out of these deaths' reviews, and by increasing coordination and communication between agencies and systems. Operating guidelines and confidentiality procedures that govern the Review Team are to be established by the Lynchburg Fatality Review Team.

This agreement will be in effect as of _____. I can request a revision or review of this agreement within thirty (30) days of written notice. Notice of revision or termination of this Memorandum of Agreement will be sent to all members of the Lynchburg Fatality Review Team.

Signed

Date

**FAMILY VIOLENCE FATALITY REVIEW TEAM
FOR THE CITY OF LYNCHBURG, VIRGINIA**

INTER-AGENCY PARTICIPATION AGREEMENT

WHEREAS the City of Lynchburg has experienced family violence fatalities, four of such fatalities having occurred during the 2001 calendar year;

WHEREAS § 32.1-283.3 of the Code of Virginia bestows upon any city located within the Commonwealth of Virginia the authority to establish a family violence fatality review team to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities;

WHEREAS the undersigned parties are vested with the authority to promote and protect the public health and safety and to provide services which improve the well being of individuals and families residing within the City of Lynchburg;

WHEREAS the undersigned parties agree that they are mutually served by the establishment of a multi-agency, multi-professional family violence fatality review team and that the outcome of such reviews will be the identification of potentially preventable family violence fatalities and recommendations for intervention and prevention strategies;

WHEREAS the objectives of the Family Violence Fatality Review Team for the City of Lynchburg are agreed to be:

1. To enhance awareness among the general public, community leaders, and policy makers of the causes of family violence through the understanding of why individuals batter and why individuals remain in relationships and/or families in which violence occurs.
2. To identify and describe the trends and/or patterns of behavior associated with instances of family violence that have ended in fatalities within the City of Lynchburg.
3. To identify and describe the high-risk factors associated with instances of family violence that have ended in fatalities within the City of Lynchburg.
4. To improve the methods by which data regarding instances of family violence is collected and disseminated by developing

systems to share information between agencies and offices that work with victims of family violence.

5. To identify and describe the systemic responses to instances of family violence that have ended in fatalities which created barriers to the safety of individuals involved in family violence situations and that, when removed, will ultimately reduce the number of family violence fatalities.
6. To promote cooperation, communication, and coordination among agencies involved in responding to instances of family violence occurring within the City of Lynchburg by recommending policies, practices, and services that will achieve this end.
7. To initiate local prevention efforts designed to reduce the number of family violence fatalities occurring within the City of Lynchburg as indicated by team findings.

NOW THEREFORE, it is agreed that we, the undersigned parties, do hereby pledge our support for the creation of the Family Violence Fatality Review Team for the City of Lynchburg and do hereby agree to provide representatives from our respective agencies to serve on this team.

Honorable William G. Petty
Office of the Commonwealth's Attorney
City of Lynchburg

Charles W. Bennett, Chief
Lynchburg Police Department
City of Lynchburg

Honorable Kenneth Farrar
Juvenile & Domestic Relations District Court
City of Lynchburg

Walter C. Erwin, Esquire
City Attorney
City of Lynchburg

Mary Basten, Chief Probation & Parole Officer
Adult Community Corrections Program
District Thirteen

Robert Wade, Director
Court Service Unit
24th Judicial District

Cynthia Plummer, Director
Lynchburg Community Corrections &
Pre-Trial Services

Shelia Andrews, Director
YWCA Domestic Violence
Prevention Center

Elizabeth Suydam, Director
Forensic Nurse Examiner's Department
Lynchburg General Hospital

Mark Johnson, Director
Department of Social Services
City of Lynchburg

**Lynchburg Fatality Review Team
Agreement to Maintain Confidentiality**

By signing this form, I do hereby acknowledge and agree to the following:

I agree to serve as a member of the Lynchburg Fatality Review Team. I acknowledge that the effectiveness of the fatality review process is dependant on the quality of trust and honesty the team members bring to it. Thus, I agree that I will not use any material or information obtained during the Fatality Review meeting for any reason other than that which it was intended.

I further agree to safeguard the records, reports, investigation material, and information I receive from unauthorized disclosure. I will not take any case-identifying material from a meeting other than that which originated in the agency I represent. Thus, I will not make copies or otherwise document/record material made available in these reviews, including electronically. I will return all materials shared by others at the end of each meeting.

I understand and acknowledge that the unauthorized disclosure of confidential records, reports, investigation materials and information may result in civil or criminal liability and exclusion from the Lynchburg Fatality Review Team.

I agree to refrain from representing the views of Lynchburg Fatality Review Team to the media.

Printed name

Signature

Date

APPENDIX E

LYNCHBURG CITY COUNCIL: Agenda Item Summary

MEETING DATE: June 11, 2002

AGENDA ITEM NO.:

CONSENT: X

REGULAR:

CLOSED SESSION:

(Confidential)

ACTION: X

INFORMATION:

ITEM TITLE: Formation of a Family Violence Fatality Review Team for the City of Lynchburg

RECOMMENDATION:

Adopt resolution authorizing the formation of a Family Violence Fatality Review Team for the City of Lynchburg

SUMMARY:

In response to the growing number of family violence fatalities (four of which occurred in the City during 2001), and under the authority of Virginia Code Section 32.1-283.3, the Commonwealth's Attorney's Office, along with representatives from the public health and safety sector, have come together to form a multi-agency, multi-professional Family Violence Fatality Review Team for the City of Lynchburg. The formation of a Family Violence Fatality Review Team allows for a closer examination of instances of fatal family violence on an interagency level, creating a body of information, which can be shared, analyzed, and disseminated among participating members to promote a proactive response to the problem of family violence in Lynchburg. Membership on the team includes representatives from the following organizations: Commonwealth's Attorney's Office, Juvenile and Domestic Relations Court, Adult Community Corrections Program, Community Corrections and Pre-trial Services, Forensic Nurse Examiner's Department—Lynchburg General Hospital, Lynchburg Police Department, City Attorney's Office, Court Services Unit—24th Judicial District, YWCA Domestic Violence Prevention Center, and Department of Social Services.

PRIOR ACTION(S):

04/29/02: Commonwealth's Attorney's Office met with Walter Erwin and Nora Dunn to discuss the formation of a Family Violence Fatality Review Team

05/07/02: City Attorney's Office drafts a resolution authorizing the formation of the Family Violence Fatality Review Team for Council's review

FISCAL IMPACT:

N/A

CONTACT(S):

William G. Petty, Commonwealth's Attorney	847-1593, ext. 225
Teresa A. Polinske, Deputy Commonwealth's Attorney	847-1593, ext. 242

ATTACHMENT(S):

- Resolution
- Background Information
- Virginia Code Section 32.1-283.3
- Interagency Participation Agreement

REVIEWED BY:

Resolution

WHEREAS Section 32.1-283.3 of the Code of Virginia gives local governments in the Commonwealth of Virginia the authority to establish family violence fatality review teams to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities; and;

WHEREAS the City of Lynchburg has experienced family violence fatalities, four of such fatalities having occurred during the 2001 calendar year; and;

WHEREAS, the Lynchburg Juvenile and Domestic Relations District Court, the Commonwealth's Attorneys Office, the Adult Community Corrections Program, the Lynchburg Community Corrections and Pre-trial Services Program, the Forensic Nurse Examiner's Department at Lynchburg General Hospital, the Lynchburg Police Department, the Court Service Unit for the Twenty-fourth Judicial Circuit, the YWCA Domestic Violence Prevention Center, the Lynchburg Department of Human Services and the City Attorney's Office are vested with the authority to promote and protect the public health and safety and to provide services which improve the well being of individuals and families residing within the City of Lynchburg; and;

WHEREAS, the above-named parties agree that the City of Lynchburg would benefit from the establishment of a multi-agency, multi-professional Family Violence Fatality Review Team, have pledged their support for the creation of a Family Violence Fatality Review Team for the City and have agreed to provide representatives from their respective agencies to serve on the Family Violence Fatality Review Team;

NOW, THEREFORE, BE IT RESOLVED that the Lynchburg City Council pursuant to the authority given to it by Section 32.1-283.3 of the Code of Virginia does hereby create a Family Violence Fatality Review Team for the City of Lynchburg and the goals of the Team shall be as follows:

1. To enhance awareness among the general public, community leaders, and policymakers of the causes of family violence through the understanding of why individuals batter and why individuals remain in relationships and/or families in which violence occurs.
2. To identify and describe the trends and/or patterns of behavior associated with instances of family violence that have ended in fatalities within the City of Lynchburg.
3. To identify and describe the high-risk factors associated with instances of family violence that have ended in fatalities within the City of Lynchburg.

4. To improve the methods by which data regarding instances of family violence is collected and disseminated by developing systems to share information between agencies and offices that work with victims of family violence.
5. To identify and describe the systemic responses to instances of family violence that have ended in fatalities which created barriers to the safety of individuals involved in family violence situations and that, when removed, will ultimately reduce the number of family violence fatalities.
6. To promote cooperation, communication, and coordination among agencies involved in responding to instances of family violence occurring within the City of Lynchburg by recommending policies, practices, and services that will achieve this end.
7. To initiate local prevention efforts designed to reduce the number of family violence fatalities occurring within the City of Lynchburg as indicated by team findings.

BE IT FURTHER RESOLVED that membership on the Fatality Violence Review Team may include, but shall not be limited to, representatives from the Lynchburg Juvenile and Domestic Relations District Court, the Commonwealth's Attorneys Office, the Adult Community Corrections Program, the Lynchburg Community Corrections and Pre-trial Services Program, the Forensic Nurse Examiner's Department at Lynchburg General Hospital, the Lynchburg Police Department, the Court Service Unit for the Twenty-fourth Judicial Circuit, the YWCA Domestic Violence Prevention Center, the Lynchburg Department of Human Services and the City Attorney's Office.

Adopted:

Certified: _____
Clerk of Council

Lynchburg Fatality Review Team Protocol

I. Purpose

- Fatality review is a mechanism to create safer communities by establishing a multidisciplinary review team that will work to reduce future family and intimate partner violence fatalities.
- Fatality review identifies needed services and points of intervention and develops strategies for prevention.
- Fatality review is a powerful tool for responding to--not just reacting to--family or intimate partner fatalities.

II. Organization

- Teams are to be multidisciplinary and should consist of members who can create change and influence policy.
- Teams should focus on their mission and periodically review their goals.
- Teams must have the endorsement of local officials.
- Teams are to develop:
 - i. Purpose and functions
 - ii. Membership/Attendance
 - iii. Team chair or co-chair responsibilities and term of office
 - iv. Confidentiality
 - v. Ground Rules:
 - Upholding confidentiality
 - Monitoring “air time”
 - Respecting all options
 - Avoiding blaming
 - Maintaining a nonjudgmental process of fact-finding and information-sharing
 - Focusing on *how* it happened, not *why* it happened
- Team Members are encouraged to candidly assess their own ability to participate and to withdraw, if appropriate.
- Teams should provide different debriefing opportunities for the team.

III. Reports and Recommendations

- Recommendations are best reached by using a consensus decision-making process.
- Reports are to include aggregate information only.
- Recommendations should be directed to those who have the power to influence change.
- Send reports and recommendations to:

**Family Violence Surveillance Coordinator
Office of Chief Medical Examiner
400 E. Jackson Street
Richmond, VA 23219
Phone: 804-786-6044
Fax: 804-371-8595**

IV. Evaluation

- Teams should evaluate the review process on an ongoing basis.
- Teams are to follow up on recommendations.
- Team members should share information with their agency directors.
- Team members are to make suggestions for the next review.

APPENDIX G

RISK AND LETHALITY INDICATORS

The following are primary indicators in evaluating whether a batterer will kill his/her partner, other family members and/or him/herself. These indicators are not ranked; however, the more indicators present in a relationship, the higher the victim's risk that future violence or death may occur.

Threats of homicide or suicide	Stalking
Previous episodes of violence	Fantasies of homicide or suicide
Separation	Firearms
Rage	Access to victim
Public display of violence toward victim	Sexual violence
Timing, fear of losing a partner	Hostage taking
Drug or alcohol consumption	Depression
Prior calls to the police	Pet abuse
Sense of ownership of the victim by the batterer	Abuser's lack of respect for the law
Obsessiveness about partner or family	Intimidation/Threats
Isolation of victim, perpetrator or both	Acute mental health problems
Destruction of property	Cultural influences

*Used with permission from the Virginia Department of Health, Office of the Chief Medical Examiner.

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Office of the Commonwealth's Attorney for the City of Lynchburg
901 Church Street
P.O. Box 1539
Lynchburg, Virginia 24505
www.ocalynchburg.com

Lynchburg Police Department
905 Court Street
Lynchburg, Virginia 24504
www.lynchburgva.gov

YWCA Domestic Violence Prevention Center
626 Church Street
Lynchburg, Virginia 24504
www.lynchburgywca.org

ADDITIONAL COPIES OF THIS REPORT ARE AVAILABLE BY CONTACTING:

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