Lynchburg City Family Violence Fatality Review Team

Second Report
October 2008

A Review of Family Violence Related Fatalities
This project was supported by Grant No. 2004-WE-AX-0036, awarded to the Office of the Commonwealth’s Attorney, City of Lynchburg, by the Department of Justice, Office on Violence Against Women (OVW). This award provides the City of Lynchburg the opportunity to develop and strengthen effective responses to violence against women.

The printing of this project was supported by the Commonwealth and the Family and Children’s Trust Fund which is administered by a Board of Trustees appointed by the Governor of Virginia.
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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:

- Jennifer Bennett, Assistant Commonwealth’s Attorney, Domestic Violence Prosecution Unit
- Malcolm Booker, Officer, Lynchburg Police Department
- Susan Clark, Director, Victim Witness Program, Office of the Commonwealth’s Attorney, Domestic Violence Prosecution Unit
- Garry Davis, Senior Probation Officer, 24th Judicial District Court Services Unit
- Linda Ellis-Williams, Director, YWCA Domestic Violence Prevention Center
- Judy Gillispie, Victim Witness Program, Office of the Commonwealth’s Attorney, Domestic Violence Prosecution Unit
- Susan Hartman, Assistant City Attorney, City of Lynchburg
- Katherine Langlois, Probation and Parole Officer, District 13
- Honorable William Light, Judge, Juvenile and Domestic Relations District Court
- Donna Nash, Grants Administrator, Office of the Commonwealth’s Attorney
- Honorable John Payne, Chief Magistrate, 24th Judicial District
- Patricia Parrish, Magistrate, 24th Judicial District
- Cynthia Plummer, Agency Director, Lynchburg Community Corrections and Pretrial Services
- April Rasmussen, Forensic Nurse Examiner, Centra Health
- Todd Rodes, Investigator, Lynchburg Police Department
- Eugene Wingfield, Domestic Violence Investigator, Office of the Commonwealth’s Attorney, Domestic Violence Prosecution Unit

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

- Sheila Andrews, former Director, YWCA Domestic Violence Prevention Center
- Mary Basten, Chief Probation and Parole Officer, District 13
- Charles Bennett, Former Chief of Police, Lynchburg Police Department
- Chief Parks Snead, Chief of Police, Lynchburg Police Department
- Michael Doucette, Commonwealth’s Attorney, City of Lynchburg
- Walter Erwin, City Attorney, City of Lynchburg
- Janell Johnson, Senior Assistant Commonwealth’s Attorney, Supervisor, Domestic Violence Prosecution Unit
- Mark Johnson, Director, Department of Social Services, City of Lynchburg
- Lynchburg City Council
- Lisa Parks, Social Work Supervisor, Child Protective and Family Services, Lynchburg Department of Social Services
- Virginia Powell, PhD, Family Violence Surveillance Manager, Virginia Office of the Chief Medical Examiner
- Elizabeth Suydam, Assistant Administrative Director of Emergency Services, Centra Health
- Robert Wade, Probation Director, 24th Judicial District Court Services Unit
- The Coalition Against Domestic Violence for the 24th Judicial District, Inc.

*Special thanks to Robert Miller for granting permission to insert his beautiful picture of Lynchburg into this report (Page 2). Please visit the flickr website at http://www.flickr.com/photos/lynchburgvirginia/ to view more of his work.*
Welcome to Lynchburg!

Lynchburg is located in the Commonwealth of Virginia, in the foothills of the Blue Ridge Mountains, and along the banks of the James River. Classified as a central city of 50 square miles, Lynchburg is characterized by a blend of urban and suburban neighborhoods. Lynchburg is part of the Region 2000, 11th Virginia Planning District which includes the counties of Amherst, Appomattox, Bedford, and Campbell, and the cities of Bedford and Lynchburg. The City is home to five colleges and universities: Lynchburg College, Randolph College, Central Virginia Community College, Liberty University, and Virginia University of Lynchburg. Sweet Briar College is located just nineteen miles outside of the City limits in Amherst County.

Demographics (Weldon Cooper Center for Public Service)
- The current population is estimated at 69,579
- 68.03% white, 28.28% black, 0.28% American Indian, 1.94% Asian, 1.42% Two or More Races, 0.05% Native Hawaiian
- 54% female
- 46% male
- Median household income (two-person family): $35,744
- Persons below poverty: 21.4%

Other Interesting Facts (U.S. Census Bureau Lynchburg Fact Sheet, 2006)
- Compared to the rest of the country, Lynchburg’s cost of living is 21.8 percent lower than the U.S. average.
- For the population aged 25 years and over in Lynchburg, 80.1% completed high school or higher; 26.02% received a Bachelor’s Degree or higher; 9.5% received a graduate or professional degree; and 6.7% are currently unemployed.

Crime Statistics (2001—2007) (Lynchburg Police Department)

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<tr>
<td>Murders</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>1</td>
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<tr>
<td>Rapes</td>
<td>24</td>
<td>32</td>
<td>29</td>
<td>20</td>
<td>23</td>
<td>34</td>
<td>24</td>
</tr>
<tr>
<td>Robberies</td>
<td>83</td>
<td>87</td>
<td>72</td>
<td>63</td>
<td>76</td>
<td>90</td>
<td>82</td>
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<tr>
<td>Domestic Violence Related Assaults</td>
<td>751</td>
<td>736</td>
<td>711</td>
<td>733</td>
<td>701</td>
<td>706</td>
<td>823</td>
</tr>
<tr>
<td>Burglaries</td>
<td>453</td>
<td>425</td>
<td>429</td>
<td>410</td>
<td>418</td>
<td>440</td>
<td>479</td>
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<tr>
<td>Thefts</td>
<td>2,181</td>
<td>2,150</td>
<td>2,197</td>
<td>2,257</td>
<td>2,096</td>
<td>1,989</td>
<td>1,886</td>
</tr>
<tr>
<td><strong>Lynchburg Police Department</strong></td>
<td>2006</td>
<td>2007</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Number of Domestic Violence related arrests</td>
<td>451</td>
<td>503</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Number of calls for service classified as Domestic Violence</td>
<td>626</td>
<td>674</td>
<td></td>
<td></td>
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<tr>
<td>Number of calls for service classified as Domestic Dispute</td>
<td>903</td>
<td>881</td>
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<tr>
<th><strong>Magistrate</strong></th>
<th>2006</th>
<th>2007</th>
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<tbody>
<tr>
<td>Number of Emergency Protective Orders issued</td>
<td>560</td>
<td>562</td>
</tr>
<tr>
<td>Number of 18.2-57.2 warrants issued</td>
<td>540</td>
<td>537</td>
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<tr>
<th><strong>Forensic Nurse Examiners—Centra Health</strong></th>
<th>2006</th>
<th>2007</th>
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<tbody>
<tr>
<td>Number of Domestic Violence patients seen and reported to law enforcement</td>
<td>50</td>
<td>48</td>
</tr>
<tr>
<td>Number of Domestic Violence patients seen but not reported to law enforcement</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Percentage of Forensic Nurse Examiners cases classified as Domestic Violence</td>
<td>33%</td>
<td>30%</td>
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<tr>
<th><strong>Office of the Commonwealth’s Attorney</strong></th>
<th>2006</th>
<th>2007</th>
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<tbody>
<tr>
<td>Number of Domestic Violence cases opened and prosecuted</td>
<td>482</td>
<td>552</td>
</tr>
<tr>
<td>Number Dismissed (nolle prosequi, witness failed to appear, other case defects)</td>
<td>158</td>
<td>146</td>
</tr>
<tr>
<td>Number Deferred (First Offender 18.2-57.3 court took under advisement to be dismissed upon completion of noted conditions)</td>
<td>101</td>
<td>99</td>
</tr>
<tr>
<td>Number Convicted</td>
<td>160</td>
<td>216</td>
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<tr>
<td>Number Acquitted</td>
<td>63</td>
<td>91</td>
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<th><strong>YWCA Domestic Violence Prevention Center</strong></th>
<th>2006</th>
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<tbody>
<tr>
<td>Total Hotline Calls</td>
<td>2278</td>
<td>2538</td>
</tr>
<tr>
<td>Total Number of Families in Shelter</td>
<td>98</td>
<td>91</td>
</tr>
<tr>
<td>Number of Exit Plans Developed</td>
<td>60</td>
<td>58</td>
</tr>
<tr>
<td>Number of clients who returned home, abuser no longer present</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Number of clients who entered self-supported housing</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Number of clients who chose to stay at residence of a friend/relative</td>
<td>39</td>
<td>28</td>
</tr>
<tr>
<td>Number of clients who chose to enter transitional housing program</td>
<td>10</td>
<td>10</td>
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<tr>
<th><strong>Lynchburg Department of Social Services</strong></th>
<th>2006</th>
<th>2007</th>
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<tbody>
<tr>
<td>Number of Child Protective Services complaints involving Domestic Violence</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td>Percentage of cases/complaints involving Domestic Violence</td>
<td>4%</td>
<td>6%</td>
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2006—2007 Statistics Continued

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<tr>
<th>Court Services Unit</th>
<th>2006</th>
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<tr>
<td>Number of petitions filed against juveniles for violations of 18.2-57.2</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>Number of Preliminary Protective Orders filed (excludes child abuse and neglect protective orders sought by DSS)</td>
<td>188</td>
<td>226</td>
</tr>
<tr>
<td>Number of child abuse &amp; neglect protective orders sought by DSS</td>
<td>46</td>
<td>34</td>
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<tr>
<th>Community Corrections and Pretrial Services Agency</th>
<th>2006</th>
<th>2007</th>
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</thead>
<tbody>
<tr>
<td>Number of Domestic Violence cases referred to local probation</td>
<td>241</td>
<td>277</td>
</tr>
<tr>
<td>Number of referrals to Anger Management Program (Course)</td>
<td>54</td>
<td>55</td>
</tr>
<tr>
<td>Number of individuals completing the Anger Management Program</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>Number of referrals made to a certified Batterer’s Intervention Program</td>
<td>100</td>
<td>116</td>
</tr>
<tr>
<td>Number of individuals completing the Batterer’s Intervention Program</td>
<td>61</td>
<td>63</td>
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Definitions and References

Code of Virginia (1950)

§ 18.2-57.2 - Assault and battery against a family or household member; penalty.

A. Any person who commits an assault and battery against a family or household member is guilty of a Class 1 misdemeanor.

B. Upon a conviction for assault and battery against a family or household member, where it is alleged in the warrant, information, or indictment on which a person is convicted, that such person has been previously convicted of two offenses against a family or household member of (i) assault and battery against a family or household member in violation of this section, (ii) malicious wounding in violation of § 18.2-51, (iii) aggravated malicious wounding in violation of § 18.2-51.2, (iv) malicious bodily injury by means of a substance in violation of § 18.2-52, or (v) an offense under the law of any other jurisdiction which has the same elements of any of the above offenses, in any combination, all of which occurred within a period of 20 years, and each of which occurred on a different date, such person is guilty of a Class 6 felony.

C. Whenever a warrant for a violation of this section is issued, the magistrate shall issue an emergency protective order as authorized by § 16.1-253.4, except if the defendant is a minor, an emergency protective order shall not be required.

D. The definition of “family or household member” in § 16.1-228 applies to this section.


§ 18.2-57.3. - Persons charged with first offense of assault and battery against a family or household member may be placed on local community-based probation; conditions; education and treatment programs; costs and fees; violations; discharge. When a person who is no younger than 18 years of age or who is considered an adult at the time of the proceeding and who has not previously been convicted of any offense under this article or under any statute of the United States or of any state or any ordinance of any local government relating to assault and battery against a family or household member or has not previously had a proceeding against him for violation of such an offense dismissed as provided in this section, pleads guilty to or enters a plea of not guilty to a violation of § 18.2-57.2, the court, upon such plea if the facts found by the court would justify a finding of guilt, without entering a judgment of guilt and with the consent of the accused, may defer further proceedings and place him on local community-based probation upon terms and conditions.
Lynchburg’s Family Violence Fatality Review Team

I. Formation of the Lynchburg Team

In 2001, in accordance with the General Assembly’s 1999 enactment of § 32.1-283.3 of the Code of Virginia (see Appendix A), and in response to the growing number of family violence fatalities in Lynchburg and the concern for public safety, The Lynchburg City Family Violence Fatality Review Team was established. 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.

The idea to formulate a family violence fatality review team was enthusiastically embraced by the Coalition and by November 2001, ten agencies from the public health, social service, and public safety sectors had signed on to participate in this effort (see Appendix B). As part of an inter-agency 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 (see Appendix D). A resolution formally endorsing the formation of The Team was passed by Lynchburg City Council in June 2002.

The Team first set about defining its mission statement and establishing protocols for meetings and case reviews (see Appendix F). Meetings were initially devoted to sharing information about the roles and responsibilities of each agency at the table and their responses to incidents of domestic violence for both victims and offenders. Although it took more than several meetings to complete this process, the interaction served as an excellent base for the group’s work and was an invaluable process from an information-sharing and team-building perspective and in identifying gaps in services.

In January 2004, The Team commenced 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 change or improvement.

The Mission of the Lynchburg City Family Violence Fatality Review 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.

1 According to § 32.1-283.3(A) a “fatality 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.
and made the decision to produce a report that would document these recommendations so they could be shared among various partner agencies. In April of 2006, The Team released its initial report (copies may be obtained by contacting (434) 455-3770). The 2006 report includes the case review and subsequent findings, as well as recommendations for preventing future family violence related deaths. The Team has since reviewed three additional fatalities which are outlined in this report.

II. Purpose
The Team’s purpose is 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 the policies, procedures, and roles of those who intervene. The Team’s overall mission 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.

III. Goals and Objectives
The overall goal is to reduce future family and intimate partner violence fatalities through systematic change and response. The related objectives are as follows:

- To enhance awareness among the general public, community leaders, and policymakers as to the causes of family violence.

- To identify and describe the trends and/or patterns of behaviors associated with instances of family violence that have ended in fatalities in the City of Lynchburg.

- To identify and describe the high-risk factors associated with instances of family violence that have resulted in fatalities within the City of Lynchburg.

- To improve the methods by which data regarding instances of family violence is collected and disseminated.

- 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.

- To promote cooperation, communication, and coordination among agencies involved in responding to instances of family violence by recommending policies, practices, and services that will achieve this end.

- To promote and initiate local family violence prevention efforts.
IV. Case Selection and Review Process

In an effort to better understand the barriers, system responses, and overall impact of domestic violence, the Lynchburg Family Violence Fatality Review Team meets once per month to review domestic violence fatalities that occurred in the City of Lynchburg. The Team adheres to the guidelines outlined in the Code of Virginia § 32.1-283.3(E) which states that the review of a death shall be delayed until any criminal investigation or prosecution connected with the death is completed. The Lynchburg Team plans to review every family violence and intimate partner fatality that occurred from 1999 to the present that meets the criterion stated above. (Please refer to Appendix F)

V. Confidentiality Standards

Maintaining confidentiality is an essential part of The Team’s review process. In order to safeguard the records, reports, investigation material, and information that is shared during the fatality review process, each member of The Team is required to sign an agreement to maintain confidentiality. (Please refer to Appendix D - Lynchburg Family Violence Fatality Review Team—Agreement to Maintain Confidentiality.) All members are required to abide by the established confidentiality standards and procedures.

VI. Evaluation

To enhance future case reviews and the overall system response, a qualitative evaluation of the fatality review team process is conducted. A sub-committee of team members developed a questionnaire to assess the following team processes: case review, meeting logistics, team membership, reporting/team recommendations, and general feedback. The following questions are posed to Team members:

Case Review Process:
1. Do you have any suggestions for improving future case reviews?
2. Did you feel that too much, too little, or not enough time was spent on The Team’s case review? What amount of time would be appropriate for conducting future case reviews?
3. Was the assessment tool (Richmond case review form) a useful tool? Does it need to be revamped in any way to make it more user-friendly?

Logistical Issues:
1. Are you satisfied with the frequency of Team meetings and the current meeting time of 3:00 P.M., first Thursday of the chosen meeting month?
2. Are you satisfied with how team meetings are facilitated? If not, what could be done to improve the quality of team meetings?

Team Membership:
1. Does The Team need to expand its membership? If so, what agency members/representatives should be asked to join The Team?
2. Are you currently satisfied with your membership on The Team? Are there any other representatives from your agency that should consider joining the Team?

Initial Report/Team Recommendations:
1. Were you satisfied with the recommendations as outlined in The Team’s report?
2. Were you satisfied with the overall content of The Team’s report? What can be done to improve the quality of future reports?
Since the release of the April 2006 report, The Team has reviewed three domestic violence related fatalities that occurred in the City of Lynchburg. In keeping with the statutory mandate that both investigation and prosecution of the matters be concluded, these incidents were carefully chosen. The Team reviewed all available information about each fatality during its case review process, including the actions of the victim and perpetrator, and the various agency personnel who had contact with them on the day of the victim’s death and in the days immediately preceding the victim’s death. Each team member brought to the table the information available to their agency, and the circumstances around each fatality were thoroughly dissected by The Team.

Many researchers have identified circumstances that increase the likelihood of a domestic relationship turning violent. One of the cornerstones of domestic violence fatality review is analyzing these factors and the degree of awareness as to the dangerousness of the situation among the victim, family, friends, and system responders who became involved in the case.

Throughout the process of the case reviews, 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 identify some of the risk factors and factual similarities found in the three cases and to make recommendations it believes will assist in providing interventions to potential victims.

I. Trends — Factual Commonalities

Some of the risk factors and factual similarities found in the three cases reviewed are outlined below:

- Previous episodes of violence
- Threats of suicide/homicide (perpetrator)
- Substance abuse
- Mental health issues (perpetrator)
- Counseling referrals or attempts (victim and perpetrator)
- Previous separation
- Anger management classes ordered/attended (perpetrator)
- Friends/Relatives aware of violence

The Team’s analysis of these cases, and all the circumstances surrounding the domestic violence fatalities, led to some specific findings of fact and recommendations for change.
Findings and Recommendations

II. Findings and Recommendations

1. Finding: In all three case studies, it was apparent that there was a history of both acute and chronic mental health problems on the part of the victim and/or the perpetrator. While records indicate that referrals for treatment and other community interventions were made by mental health services or private physicians, there was no documentation that indicates if the victim or perpetrator followed through with the referrals.

The Team Recommends:

- Local criminal justice departments and emergency mental health professionals include in any existing protocols an additional directive to conduct danger assessments in any instances where dating/domestic violence is suspected or reported, especially in situations in which victims are seeking to obtain an Emergency Custody Order (ECO) on a suicidal or mentally unstable partner, to assess the potential risk of violence at the time.

- All agencies coming in contact with the victim offer resources/information to make her/him aware of the potential for future violence.

- Team members initiate the involvement and awareness of other mental health professionals in the community.

- Inviting a representative from Emergency Mental Health Services to serve on The Team to provide insight and perspective into the emergency mental health system processes, including post-discharge planning and follow-ups.

2. Finding: In two of the case studies, it was determined that there were attempts on the part of the victim to end the relationship. In one situation, the victim obtained a protective order, moved herself and her children to a local domestic violence shelter, but then reconciled with the perpetrator a short while later.

The Team Recommends:

- Developing a mechanism, utilizing members of The Team and the regional domestic violence coalition, to provide information to local agencies, employers, and the faith-based community, about the increased risk of danger to the victim, including death, that occurs at the time of separation.
3. **Finding:** In another case, the victim and perpetrator confided in family and friends, which included the church, that there were problems in the relationship and a separation was imminent. Although pastoral counseling was offered, there appeared to be a lack of awareness as to the seriousness of the situation on the part of the victim, the faith-based community, the professionals involved, and family and friends.

**The Team Recommends:**

- Developing and implementing public service announcements, in collaboration with the regional domestic violence coalition, that address various victim safety scenarios and provide options, hotline numbers, and area resources.
- Placement of domestic violence related literature in discreet locations, such as rest-rooms, local places of worship, and beauty salons.
- Reaching out to the faith-based community to alert them to the unique dynamics of domestic violence and ways to advise parishioners using Biblical principles (e.g., Biblical basis against domestic violence).

4. **Finding:** Two of the perpetrators had previously been court ordered into anger management classes as part of a sentence for a prior criminal domestic violence charge.

**The Team Recommends:**

- Tracking court ordered placements into anger management and batter’s intervention program’s to gain perspective on the utilization of these services in the community.
- Increasing awareness among criminal justice, public safety, public health, and social service agencies of the difference between anger management programs and certified batterer’s intervention programs to assure that perpetrators are ordered into the appropriate program.
III. Next Steps

Members of the Lynchburg City Family Violence Fatality Review Team, in collaboration with community partners, will strive to:

1. Review the current forms/instruments used by The Team to conduct fatality case reviews and develop new tools that are more adaptable to the cases reviewed by the Lynchburg Team.

2. Continue to evaluate and review The Team’s current protocols and processes to determine effectiveness and to implement recommended changes.

3. Appointment a subcommittee to work towards the development of 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

4. Share the findings and recommendations of this report with various service agency leaders and organizations within the City as well as other jurisdictions.

5. Invite additional agencies, that have been identified through the review process, that may be instrumental in implementing system change, to participate in a quarterly stakeholders meeting.

6. Continue to establish contact 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.

7. Register with the National Domestic Violence Fatality Review Initiative (funded through the U.S. Department of Justice, Office on Violence Against Women), as a means of utilizing resources and obtaining technical assistance.
IV. Accomplishments

The following changes and actions have been implemented by a variety of system responders based on the findings and recommendations outlined in the Lynchburg City Family Violence Fatality Review April 2006 initial report:

- In an effort to improve overall system response, case findings and recommendations for intervention and prevention strategies (no case specific information) were shared with a variety of community organizations City Council, criminal justice system, the media, the Virginia Office of the Chief Medical Examiner, and agency service leaders throughout the community.

- Information on domestic violence and available resources is distributed to new City employees during employee orientation. Presentations on domestic violence are offered periodically to all City employees. Information on domestic violence and available resources is posted on the City’s websites (under the Office of the Commonwealth’s Attorney and Lynchburg Police Department) and has been included in the “Changing Times” employee newsletter.

- Virginia’s domestic violence statute allows for cases involving a first-time offender to be taken under advisement for two years. In these cases, the court finds that the facts are sufficient to find the defendant guilty, but does not enter a finding of guilt. These cases are supervised by community-based probation for the first six months and the remaining eighteen months are unsupervised. In an effort to better monitor these offenders during unsupervised probation, the Commonwealth Attorney’s Office has initiated an internal “Probation Review”.
  One year from the sentencing, the defendant’s criminal record and local court records are reviewed to determine if they have incurred any new charges. If they have, the Commonwealth’s Attorney formally requests a hearing in front of the court, and asks for a guilty finding to be made. Probation Reviews are performed throughout the eighteen months of unsupervised probation to be certain the defendant is in continual compliance with the court order.

- The Magistrate’s Office instituted a requirement that all dating and domestic violence victims be advised to file a report with the Lynchburg Police Department, prior to the issuance of a warrant. This protocol was developed to ensure that citizen-initiated warrants received the same treatment and priority as officer-initiated warrants.

- Participating agencies conduct roll-call training and in-service training sessions to all law enforcement officers within the service area and to various localities throughout the State. Topics presented include an overview of domestic violence, the dynamics of domestic and dating violence, the use of innovative investigative techniques in handling domestic violence cases, legislative updates, protocols for responding to incidents of dating and domestic violence, identifying risk factors and conducting danger assessments.
Recommendation to Implementation!

- A risk and lethality assessment tool (Appendix G) developed by Jacquelyn C. Campbell, PhD, RN, FAAN was selected by team members for use in evaluating the dangerousness of a situation and for employing immediate interventions. Several participating members are certified and are currently utilizing this tool. Several other agencies, including first responders, were trained and certified in usage during the Annual Domestic Violence Conference (September 2008) sponsored by the Coalition Against Domestic Violence for the 24th Judicial District and the Families and Children’s Trust Fund of Virginia. The Team will continue to work to develop a process for communicating assessment results in a timely manner to all system responders.

- In response to the finding that the local police department’s standard operating procedure of mailing letters to perpetrators informing them of outstanding misdemeanor warrants against them actually places victims at greater risk for harm, the Lynchburg Police Department elected to do away with this policy. Instead, they have implemented the following new directive:
  
  Directive 81.2.14.82.3.8 (dated 03/21/07)
  “No notification shall be attempted under the following circumstances:
  (1) When the warrant is for an assault
  (2) For any J&D documents as these cases are usually family matters of a highly sensitive and emotional nature.”
  (Although there are other criteria, they do not pertain to domestic violence.)

- In response to the need for a single point of contact to assist victims in understanding and navigating the various aspects of the “system” (legal, medical, assistance/housing system, etc.) the Office of the Commonwealth’s Attorney and the YWCA Domestic Violence Prevention Center acquired funding to hire a full-time “Domestic Violence Community Advocate”. This coordinated advocacy program serves 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. It also provides integrated service referrals and standardized assistance for victims upon request/referral.

- The Team, in collaboration with the Coalition Against Domestic Violence for the 24th Judicial District, applied for and was awarded funding from the Families and Children’s Trust Fund of Virginia. The funding helped support the Annual Domestic Violence Conference, printing of user-friendly resource guides, and printing of the 2008 Lynchburg Family Violence Fatality Review report.

- The Team’s Chairperson, Susan Clark, was invited to serve on the Advisory Group for Best Practices in Domestic Violence Fatality Review. The Advisory Group is currently developing a resource manual for new and existing fatality review teams.

## V. Team Membership

**2005—2008 Lynchburg City Family Violence Fatality Review Team**

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Agency/Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>City Attorney</strong></td>
<td><strong>Assistant City Attorney</strong></td>
</tr>
<tr>
<td></td>
<td>• Susan Hartman</td>
</tr>
<tr>
<td></td>
<td><strong>City of Lynchburg</strong></td>
</tr>
<tr>
<td><strong>Community Corrections</strong></td>
<td><strong>Agency Director</strong></td>
</tr>
<tr>
<td></td>
<td>• Cynthia Plummer</td>
</tr>
<tr>
<td></td>
<td><strong>Lynchburg Community Corrections and Pretrial Services Agency</strong></td>
</tr>
<tr>
<td><strong>Court/Court Services</strong></td>
<td><strong>Judge</strong></td>
</tr>
<tr>
<td></td>
<td>• Honorable William R. Light</td>
</tr>
<tr>
<td></td>
<td><strong>Lynchburg Juvenile and Domestic Relations District Court</strong></td>
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<tr>
<td></td>
<td><strong>Probation and Parole Officer</strong></td>
</tr>
<tr>
<td></td>
<td>• Garry Davis, Senior Officer</td>
</tr>
<tr>
<td></td>
<td><strong>24th Judicial District Court Services</strong></td>
</tr>
<tr>
<td><strong>Law Enforcement</strong></td>
<td><strong>Investigations</strong></td>
</tr>
<tr>
<td></td>
<td>• Investigator Todd Rodes</td>
</tr>
<tr>
<td></td>
<td>• Officer Malcolm Booker</td>
</tr>
<tr>
<td></td>
<td><strong>Lynchburg Police Department</strong></td>
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<tr>
<td><strong>Medical</strong></td>
<td><strong>Forensic Nurse Examiner</strong></td>
</tr>
<tr>
<td></td>
<td>• April Rasmussen,RN</td>
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<td></td>
<td><strong>Centra Health</strong></td>
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<tr>
<td></td>
<td>(Chairperson for the Coalition Against Domestic Violence for the 24th Judicial District, Inc.)</td>
</tr>
<tr>
<td><strong>Magistrate</strong></td>
<td><strong>Chief Magistrate</strong></td>
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<tr>
<td></td>
<td>• Honorable John S. Payne</td>
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<tr>
<td></td>
<td><strong>24th Judicial District</strong></td>
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<tr>
<td><strong>Probation &amp; Parole</strong></td>
<td><strong>Probation Officer</strong></td>
</tr>
<tr>
<td></td>
<td>• Katherine Langlois</td>
</tr>
<tr>
<td></td>
<td><strong>District 13</strong></td>
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<tr>
<td><strong>Prosecution</strong></td>
<td><strong>Assistant Commonwealth’s Attorney</strong></td>
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<td></td>
<td>• Jennifer Bennett</td>
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<td></td>
<td><strong>Domestic Violence Investigator</strong></td>
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<td></td>
<td>• Eugene Wingfield</td>
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<td></td>
<td><strong>Office of the Commonwealth’s Attorney, City of Lynchburg Domestic Violence Prosecution Unit</strong></td>
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<td></td>
<td><strong>Victim Witness Program</strong></td>
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<td></td>
<td>• Susan Clark, Program Director</td>
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<td></td>
<td>• Judy Gillispie</td>
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<tr>
<td></td>
<td><strong>YWCA—Domestic Violence Prevention Center</strong></td>
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<tr>
<td></td>
<td><strong>Grants Administration/Program Development</strong></td>
</tr>
<tr>
<td></td>
<td>• Donna Nash</td>
</tr>
<tr>
<td></td>
<td><strong>Contractual position in partnership With the Domestic Violence Prosecution Unit</strong></td>
</tr>
<tr>
<td><strong>Victim Advocacy</strong></td>
<td><strong>Domestic Violence Program/Shelter</strong></td>
</tr>
<tr>
<td></td>
<td>• Linda Ellis-Williams, Program Director</td>
</tr>
<tr>
<td></td>
<td>• Betty Eley, Domestic Violence Community Advocate</td>
</tr>
<tr>
<td></td>
<td><strong>YWCA—Domestic Violence Prevention Center</strong></td>
</tr>
</tbody>
</table>
APPENDIX A

Code of Virginia (1950)

Title 21.1 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,
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 21 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.)
Lynchburg Fatality Review Team
Memorandum of Agreement

I agree for my organization to be a full participant of the Lynchburg Family Violence 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 Family Violence Fatality Review Team is to prevent domestic violence 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 Family Violence 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 the Memorandum of Agreement will be sent to all members of the Lynchburg Family Violence Fatality Review Team.

Signed:__________________________________________

Date:____________________
APPENDIX C

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 Michael R. Doucette   Chief Parks Snead
Office of the Commonwealth’s Attorney   Chief of Police
City of Lynchburg                  Lynchburg Police Department

______________________________________ _____________________________________
Honorable William R. Light   Walter C. Erwin, Esquire
Juvenile and Domestic Relations District Court   City Attorney for the City of Lynchburg
City of Lynchburg

______________________________________ _____________________________________
Mary Basten, Chief Probation and Parole Officer   Robert Wade, Director
Adult Community Corrections Program   Court Service Unit
District Thirteen                  Twenty-fourth Judicial District

______________________________________ _____________________________________
Cynthia Plummer, Agency Director   Linda Ellis-Williams, Director
Lynchburg Community Corrections and Pretrial Services Agency   YWCA—Domestic Violence Prevention Center

______________________________________ _____________________________________
Elizabeth Suydam, Assistant Director   Mark Johnson, Director
Emergency Department                  Department of Social Services
Lynchburg General Hospital            City of Lynchburg

______________________________________ _____________________________________
Honorable John S. Payne, Chief Magistrate   Patty Bumgarner, Director
24th Judicial District                 Emergency Department,
                                      Lynchburg General Hospital

Lynchburg City Family Violence Fatality Review Team, October 2008
APPENDIX D

Lynchburg Family Violence 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 Family Violence 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 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 materials 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
Resolution

June 11, 2002

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: June 11, 2002
APPENDIX F

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
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

DANGER ASSESSMENT

Jacquelyn C. Campbell, PhD, RN, FAAN
Copyright 2004 Johns Hopkins University, School of Nursing

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using a calendar, please mark the approximate dates during the past year when you were abused by your partner or ex-partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones, miscarriage
4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage
5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number.)

Mark Yes or No for each of the following.
(“He” refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

<table>
<thead>
<tr>
<th>Yes or No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>1.</em> Yes</td>
<td>Has the physical violence increased in severity or frequency over the past year?</td>
</tr>
<tr>
<td><em>2.</em> Yes</td>
<td>Does he own a gun?</td>
</tr>
<tr>
<td><em>3.</em> Yes</td>
<td>Have you left him after living together during the past year?</td>
</tr>
<tr>
<td>3a. (If have never lived with him, check here:__)</td>
<td></td>
</tr>
<tr>
<td><em>4.</em> Yes</td>
<td>Is he unemployed?</td>
</tr>
<tr>
<td><em>5.</em> Yes</td>
<td>Has he ever used a weapon against you or threatened you with a lethal weapon?</td>
</tr>
<tr>
<td>5a. (If yes, was the weapon a gun?__)</td>
<td></td>
</tr>
<tr>
<td><em>6.</em> Yes</td>
<td>Does he threaten to kill you?</td>
</tr>
<tr>
<td><em>7.</em> Yes</td>
<td>Has he avoided being arrested for domestic violence?</td>
</tr>
<tr>
<td><em>8.</em> Yes</td>
<td>Do you have a child that is not his?</td>
</tr>
<tr>
<td><em>9.</em> Yes</td>
<td>Has he ever forced you to have sex when you did not wish to do so?</td>
</tr>
<tr>
<td><em>10.</em> Yes</td>
<td>Does he ever try to choke you?</td>
</tr>
<tr>
<td><em>11.</em> Yes</td>
<td>Does he use illegal drugs? By drugs, I mean “uppers” or amphetamines, speed, angel dust, cocaine, “crack”, street drugs or mixtures.</td>
</tr>
<tr>
<td><em>12.</em> Yes</td>
<td>Is he an alcoholic or problem drinker?</td>
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<tr>
<td><em>13.</em> Yes</td>
<td>Does he control most or all of your daily activities? (For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? If he tries, but you do not let him, check here:__)</td>
</tr>
<tr>
<td><em>14.</em> Yes</td>
<td>Is he violently and constantly jealous of you? (For instance, does he say “If I can’t have you, no one can.”)</td>
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<td><em>15.</em> Yes</td>
<td>Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here:__)</td>
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<tr>
<td><em>16.</em> Yes</td>
<td>Has he ever threatened or tried to commit suicide?</td>
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<td><em>17.</em> Yes</td>
<td>Does he threaten to harm your children?</td>
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<tr>
<td><em>18.</em> Yes</td>
<td>Do you believe he is capable of killing you?</td>
</tr>
<tr>
<td><em>19.</em> Yes</td>
<td>Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don’t want him to?</td>
</tr>
<tr>
<td><em>20.</em> Yes</td>
<td>Have you ever threatened or tried to commit suicide?</td>
</tr>
</tbody>
</table>

Total “Yes” Answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.
ADDITIONAL COPIES OF THIS REPORT ARE AVAILABLE BY CONTACTING:

Susan Clark, Chair
Lynchburg City Family Violence Fatality Review Team
Office of the Commonwealth’s Attorney for the City of Lynchburg
901 Church Street
P.O. Box 1539
Lynchburg, Virginia 24505
www.ocalynchburg.com
(434) 455-3766