VIRGINIA DVFR GUIDANCE DOCUMENT: CASE SELECTION

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What Kinds of Cases Can Be Reviewed by DVFRTs?

Any Virginia community considering forming a Domestic Violence Fatality Review (DVFR) Team (also referred to as Teams or DVFRTs) or updating their existing Team's protocol should consider which types of cases will be reviewed by their Teams.

Virginia law provides the legal framework—including responsibilities and protections—for DVFRTs "to examine fatal family violence incidents." But how are such incidents defined?

> *"A 'fatal family violence incident' means any fatality that occurred or that is suspected of having occurred in the context of abuse between family members or intimate partners."*
> -Code of Virginia § 32.1-283.3

This language was updated effective July 1, 2016 to broaden the scope of fatalities that are eligible for review by DVFRTs. Teams may now review a range of fatalities beyond homicides and suicides. The new law gives teams latitude to examine fatal domestic violence however it manifests in their communities.

"Family members" and "intimate partners" are not clearly defined in this or other statutes. The closest reference is to "family and household members" in Code of Virginia § 16.1-228, which include the following:

- Current or former spouses
- Parents, stepparents, children, stepchildren, brothers, sisters, half-brothers, half-sisters, grandparents, grandchildren, and in-laws
- Any individual who has a child in common with the person
- Any individual who cohabits or who, within the previous 12 months, cohabited with the person, and any children of either of them

These categories are not exhaustive of the relationships that can be and are impacted by domestic violence in Virginia. Other relationships involving domestic violence include but are not limited to dating partners; boyfriends and girlfriends; non-family caretakers of children or dependent adults; same-sex partners; foster family members; and stalking perpetrators (where an offender is pursuing or perceives a romantic relationship with the victim). The spirit of the law, therefore, is to cast a wide net that extends beyond statutory definitions to encompass all possible aspects of domestic violence that impact Virginia communities. The Office of the Chief Medical Examiner (OCME) recommends DVFRTs use this broader definition. This will help Teams to identify and address the full breadth and scope of fatal domestic violence in their communities. With this in mind, the following types of deaths may be reviewed by Virginia DVFRTs:

Homicides: In Virginia, nearly one in three homicides (29%) is related to family or intimate partner violence.[1] All Teams in Virginia consider cases determined to be homicides by the OCME for review. These include cases where a person is killed by an intimate partner or family member, or in the crossfire or while trying to intervene in a domestic violence incident. Family and intimate partner (FIP) violence associated homicides may also involve persons outside the family or intimate partner relationship to whom the violence is directed, such as in cases of jealousy toward a new intimate partner.

Suicides: More than a third of intimate partner homicides in Virginia are followed within one week by the suicide of the alleged offender.[2] Many Teams include homicide-suicides in their reviews, although less information may be available due to limited criminal investigation and the inability to prosecute the offender. Other suicides that may be related to domestic violence include those that involve an attempted homicide of a family member or intimate partner, or a problem or conflict involving such a relationship. From 2003-2012, 32.4% of suicides in Virginia were known to be precipitated by a problem or conflict with an intimate partner.[3] Few Teams include suicides in their review, but there is growing interest as communities gain a greater understanding of the role of suicide in domestic violence. For example, Fairfax County Domestic Violence Fatality Review Team recently conducted a review of intimate partner violence related suicides.

Other Manners of Death: "Any fatality" may also include other manners of death, namely natural, accidental, and undetermined deaths. Where the Team has reason to believe the death "occurred in the context of abuse between family members or intimate partners," these cases are eligible to be reviewed under Virginia law. However, identifying these cases may pose a challenge. Natural and accidental deaths are less likely to involve criminal investigation and prosecution. And because many Teams rely on law enforcement or prosecu-

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tion to identify cases for review, these cases are more likely to go unexamined by DVFRTs.

While many of these cases come under the jurisdiction of the OCME as sudden or unexpected, the OCME does not conduct routine surveillance of natural, accidental, or undetermined deaths for the involvement of family or intimate partner violence. For these reasons, the process of identifying cases such as these for review will require input and insight from local agencies or team or community members who have knowledge of a context of domestic violence surrounding the death. This can include a history of calls for service or death cases involving Child or Adult Protective Services (see text box on page 4 for more information about how teams identify potential cases for review).

Determining Context

With the broadening of the types of fatalities that can be reviewed by Virginia DVFRTs in 2016, the task of identifying potential cases for review expands from examining manner of death and the relationship between the decedent and the alleged offender to include the more nuanced exercise of determining the context within which the person's life ended.

The most obvious way abuse between family members or intimate partners creates context for a fatality is when the death is the result of fatal violence. But what about a death that does not involve fatal violence? What is the potential role of domestic violence in those cases, and why would DVFRTs be interested in reviewing them?

Domestic Violence in Non-Violent Deaths. Exposure to domestic violence may increase risk of injury, illness, and premature death. Individuals who experience domestic violence report higher rates of chronic conditions such as asthma, headaches, chronic pain, diabetes, and digestive disease.[4] People who experienced adverse childhood experiences (ACEs) such as child abuse and witnessing domestic violence die nearly 20 years earlier on average than people who did not experience ACEs.[5] Half of all victims of domestic violence also have a substance abuse disorder, placing them at risk for fatal overdose.[6] In each of these cases, domestic violence may have played a role in the victim's death as a life stressor that contributed to a potentially fatal health condition. In the case of a child or older adult who is ill, abuse or neglect by a caregiver may have prevented them from receiving medical treatment that might otherwise have prolonged their life.

The Mission of DVFR: Prevention. The purpose of fatality review is to prevent future deaths. With this in mind, domestic violence is a relevant factor in a natural, accidental, or undetermined death when the availability or coordination of community services (for victims and perpetrators of domestic violence) contributed to the cause of death, such that a reasonable intervention might have prevented the death. Because the Team's focus is on the full spectrum of domestic violence in their community, the question of preventability should be centered on whether and how service providers may have interacted with the involved parties and the domestic violence.* For example, someone who died of natural disease may have been receiving medical treatment, but did their medical providers screen or make referrals for domestic violence services? Would receiving such services have changed the course of their disease?

Sample Cases. An example of a case which might come to the attention of a DVFRT is one in which a family member or intimate partner is convicted of wrongdoing in connection to the death (e.g., neglect leading to death, murder, manslaughter, etc.), when the OCME has ruled out homicide. Other examples of potentially eligible cases include:

- An elderly person is found to have died of a natural disease process, but there is evidence of neglect by the elder's family caretaker such as not providing adequate food, water, or medical care. (Natural)
- A woman being abused by her spouse dies from complications of her diabetes. She had not been following medication treatment or seeing her doctor regularly due to her abuser's controlling behaviors, such as not allowing

If a person is killed by the friend of a family member during the course of a robbery, is this death domestic violence related, or was the victim simply one of convenience? When there is no other history to suggest motive, try framing the case using the question "If the family or intimate partner relationship had not existed, would the death still have occurred?" Perhaps the alleged offender could have robbed a stranger, but they chose the family acquaintance because their relationship afforded them information such as the location of valuables and how to access the home.

* *With the expansion of the types of cases a Team chooses to review, the Team may also need to broaden their understanding of what makes up the domestic violence response system in their community and adjust their team members accordingly.*

her access to transportation. (Natural)

- During a heated and physical argument between two intimate partners, one tries to get away but trips and falls down a flight of stairs, causing his/her accidental death. (Accident)
- A six year old child is hit by a car in a cross-walk. The investigation by Child Protective Services reveals that the parents were acting negligently in allowing the child to walk home alone from school. (Accident)
- A child dies from an injury while in the father's care, which is reported by the father as an accidental fall. Law enforcement identifies a history of calls for service regarding domestic disturbances at the home and a history of CPS contact with the family. The medical examiner is unable to determine through a medicolegal death investigation whether the injury was caused by a fall, as the father claims, or by intentional actions that would constitute a homicide. (Undetermined)
- Skeletal remains of a dependent person who was cared for by relatives is found inside a storage shed on his/her property. The family claims the person died from natural causes and they stored the body due to not having funds for burial. The Medical Examiner was unable to determine cause of death. (Undetermined)

The review of any death that fits the above criteria is protected by current Virginia statute. However, not every Team can or should review every eligible case. See below for guidance on what types of cases your Team should review.

Which Types of Cases Should Our DVFRT Review?

All Virginia DVFRTs review homicides where the victim was killed by an intimate partner. However, Teams vary on whether their reviews encompass other types of cases. Each Team should consider their capacity and resources as well as the characteristics of their community when determining which types of cases to review. Virginia DVFRTs have a responsibility to identify and respond to the problem of domestic violence, however that might manifest in their community. Ideally, each DVFRT conducts an exhaustive review of all deaths related to domestic violence in their community; however, many Teams face limited time and resources. To maximize the ability of DVFR to provide insights and improvements to the local response system, Teams may consider the following ways to focus their review.

Teams should specify in their written procedures which types of cases will be considered for review and how those cases will be identified and selected.

How many? The number of domestic violence related deaths occurring in your Team's locality or region every year may help determine your Team's scope of review. Data on FIP homicides and suicides specific to a locality or region are available by request from the OCME. These data from the Family and Intimate Partner Homicide Surveillance Project and the Virginia Violent Death Reporting System can assist communities in getting a more complete portrait of their unique experience of fatal violence.

For a community with relatively few deaths each year, it may be feasible for even a small Team that meets quarterly to review every eligible death as it occurs. For a community with especially small numbers, the Team may be convened as needed when a case becomes available for review. For example, the Mathews County Family Violence Fatality Review Team operates on an as needed basis, and meets annually to stay prepared for potential future reviews.

If your community experiences a large number of fatalities, or your Team is small and/or meets infrequently, it may not be practical to review all eligible cases. In this case, the Team should make a strategic decision about which cases are reviewed by the Team.

What are your priorities? As mentioned above, many Virginia DVFRTs limit their review to intimate partner homicides. This is a logical place to begin DVFR, since intimate partner homicides accounted for 42.9% of domestic violence related homicides in Virginia in 2014.[7] Some Teams also choose to focus on fatalities involving intimate partner violence because that issue is a priority to their community stakeholders and/or because there are existing systems and services which can respond to Team findings and recommendations. The greater availability of domestic violence resources, services, and research that are specific to intimate partner violence creates an opportunity for DVFRTs focusing on intimate partner violence-related deaths to guide how such resources and information are used in their community for the greatest impact.

Most Teams also prioritize fatal violence that occurs directly between family members or intimate partners before extending their review to associated violence that may involve bystanders and other victims who are third parties to the relationship.

In 2014, the majority (75.1%) of FIP homicide victims were killed by a family member or intimate partner, compared to 28.7% who died in associated violence.[8] Similar to the availability of resources specific to intimate partner violence, prevention and response mechanisms tend more often to focus directly on interpersonal violence than on bystander safety or other issues that are unique to domestic violence associated fatalities. Teams may also prioritize violent death cases before reviewing cases involving natural, accidental, or undetermined causes, especially if identifying such cases proves difficult for the Team.

Where and when to start? An understanding of current law and procedure impacting your community response to domestic violence and how those have changed or been updated over time may also help your Team narrow its focus or find its starting place. For example, when the Henrico County Family Violence Fatality Review Team formed in 2001, they chose to start with July 1997 to limit their review to cases that occurred after mandatory arrest laws were passed in Virginia.

"The DVFRT began its fatality reviews in 2009. While recognizing the statutory requirement to review only closed cases, the Team wanted to ensure that the cases it reviewed occurred recently enough that the solutions to any identified problems would still be relevant. Therefore, the Team decided to begin its review with fatalities that occurred in 2005." - Norfolk Family Violence Fatality Review Team 2012 Report

Often, a prominent case will spark the formation of a new Team and serve as the catalyst for determining the Team's focus. Wherever your Team may start, consider how far back in time your review should reach. The most important consideration in retrospective case review is the relevance of your Team's recommendations when they are based on events from the past.

Addressing bias in case selection. Whichever criteria your Team uses to determine the types of cases it will review, the relevance of your Team's findings and recommendations will be impacted by any apparent bias in your case selection strategy. To avoid "cherry picking" cases, such as those that received a lot of media attention or were prosecuted, choose a time period and case type(s) that are relevant and manageable for your Team then review all eligible cases that fit those criteria.

[1] Virginia Office of the Chief Medical Examiner. (2015). *Family and intimate partner homicide: A descriptive analysis of the characteristics and circumstances surrounding family and intimate partner homicide in Virginia, 2014.*

[2] Ibid.

[3] Virginia Office of the Chief Medical Examiner. (2015). Virginia Violent Death Reporting System, unpublished data.

[4] Black, M.C., et al. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

[5] Brown, D.W., et al. (2009). Adverse Childhood Experiences and the Risk of Premature Mortality. *American Journal of Preventive Medicine*, 27(5): 389-396

[6] Soper, R.G., (2014). Intimate Partner Violence and Co-Occurring Substance Abuse/ Addiction. *American Society of Addiction Medicine Magazine.* http://www.asam.org/magazine/read/article/2014/10/06/intimate-partner-violence-and-co-occurring-substance-abuse-addiction. Retrieved: June 13, 2016.

[7] Virginia Office of the Chief Medical Examiner. (2015). *Family and intimate partner homicide: A descriptive analysis of the characteristics and circumstances surrounding family and intimate partner homicide in Virginia, 2014.*

[8] Ibid.

How Do Domestic Violence Fatality Review Teams Identify Cases for Review?

Once a Team has identified which types of cases it will review, it will have to agree on a mechanism or method for identifying these cases when they occur. The most common way that DVFRTs identify cases for review is by partnering with a local law enforcement agency or prosecutor's office. These agencies collect much of the information needed to identify whether domestic violence was a factor in a death being investigated by their offices. They can also be consulted to identify any pending investigation, prosecution, or appeals to ensure that a case has been closed and is eligible for review under state law.

Other possible sources of information on potential cases include news articles and team members who have had direct contact with a victim or a perpetrator. It is also possible for a local agency or community member who is not a member of the Team to bring a case to the attention of the DVFRT for review.

Lastly, the OCME can be of assistance in identifying domestic violence related homicides and suicides that have occurred in each Team's jurisdiction.

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