

Virginia

§ 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 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](#).)