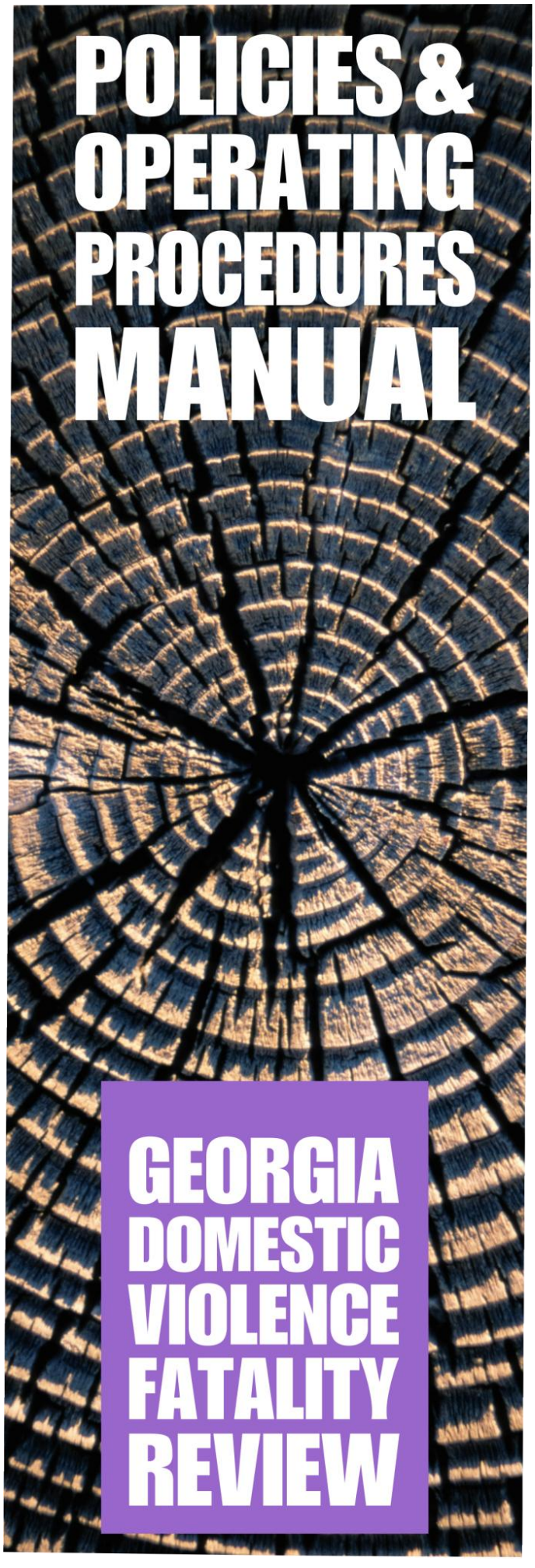
POLICIES & OPERATING PROCEDURES MANUAL



GEORGIA DOMESTIC VIOLENCE FATALITY REVIEW

Georgia Commission on Family Violence

GCADV

Acknowledgements

The Georgia Commission on Family Violence (GCFV) and the Georgia Coalition Against Domestic Violence (GCADV) are grateful to the many individuals who continue to make Georgia's Fatality Review Project possible. To learn more about GCFV, please visit www.gcfv.org. To learn more about GCADV, please visit www.gcadv.org.

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Special Thanks

We are thankful for *Nancy Dickinson, LMSW*, who provided creative direction and editing for this manual.

Fatality Review Teams and Family Violence Task Forces

We acknowledge the commitment of the Fatality Review Team participants and Family Violence Task Forces from around the state who devote their time, energy, and expertise to work towards creating safer communities in Georgia. We hope this Polices and Operating Procedures Manual will assist Teams that have already conducted fatality reviews in continuing their invaluable work and provide new and developing Teams with the information and tools necessary to successfully conduct fatality reviews in their communities.

Dedication

This manual is dedicated to all those who have lost their lives to domestic violence and to their family members, friends, and surviving children who must go on without them. It is our goal to learn from their untimely deaths and implement changes in communities across Georgia to prevent future domestic violence-related fatalities from occurring.

Financial Support

The Georgia Fatality Review Project is funded by the Criminal Justice Coordinating Council through Violence Against Women Act funds. We are grateful for the grant which allows our state to join many others around the country in conducting fatality reviews. This Project was supported by subgrant no. W10-8-052, awarded by the state administering office for the STOP Formula Grant Program. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the authors and do not necessarily reflect the views of the state or the U.S. Department of Justice, Office on Violence Against Women.

contents

domestic violence in georgia

Domestic Violence in Georgia is a devastating reality. According to our report generated via media monitoring services, over 100 Georgia citizens lose their lives annually to domestic violence. Most of these are individuals killed by an intimate partner, but the number also includes children, family members, perpetrators and others who lost their lives during the course of domestic violence-related incidents.

Since the beginning of the Fatality Review Project (the Project) in Georgia in 2004, Georgia has consistently ranked in the top 20 states for the rate at which men kill women. Most disturbingly, Georgia has risen to one of the top 10 states for this rate in the most recent years. Please visit the Violence Policy Center at http://www.vpc.org for up-to-date information on Georgia's domestic violence homicide rates and other current trends in domestic violence in the United States.

participation in the georgia domestic violence fatality review project

We invite you and your community to join in the effort to understand domestic violence fatalities and work to keep victims and survivors of domestic violence safer in Georgia.

By agreeing to participate in the Project, you are agreeing to follow the fatality review model put forth by GCADV and GCFV as the lead coordinators of this statewide initiative. This model, developed in consultation with nationally recognized fatality review experts, has been modified over the course of the Project to reflect lessons learned. While we are constantly refining our model and processes and we are open to input about new and better ways of doing things, we do require that Fatality Review Teams (Teams) coordinate with the Project Coordinator(s) to follow this model in order to ensure that participating Teams operate in a uniform manner across project sites.

The work of local Teams fits into a larger, statewide effort to review fatalities and make recommendations for change. All of the information included in the Georgia Domestic Violence Fatality Review Project Annual Reports comes directly from the work of local Teams. After all cases are reviewed in a calendar year, the Project Coordinators work diligently to synthesize the information collected from around the state, analyze and aggregate the data, and write detailed summaries of areas identified for change. All of this information is included in the Annual Report which is then disseminated across the state and is intended to be a road map for change. A Project Coordinator from GCADV or GCFV will be designated as your liaison for the Project

and will provide you with guidance and technical assistance throughout the process. This close partnership allows us to assist you in your local community fatality review process while gathering the information we need to write the Annual Report.

The Project is generously supported by Georgia's Criminal Justice Coordinating Council and the U.S. Department of Justice, Office on Violence Against Women. These funding sources require certain deliverables at the end of each calendar year. Typically, Teams review cases from January through October, submit their case reviews to the Project Coordinator(s) on November 1st of that year, and the Annual Report is written in December and disseminated the following year. It is expected and necessary that the Teams operate within these parameters and comply with this timeline.

We hope that your community will join us in this effort and will choose to participate in the Project. Please contact one of the Project Coordinators listed in the Assistance Section at the end of this manual to further discuss Project participation.

Thank you for the hard work you do to stop domestic violence in Georgia.

how to use this manual

This manual was created by GCADV and GCFV to help communities and Family Violence Task Forces develop Fatality Review Teams in order to analyze system responses to intimate partner violence by the relevant agencies, institutions, and organizations involved with victims and perpetrators of domestic violence. Investigating domestic violence fatalities and the events leading up to a fatality in a nonjudgmental, fact-finding fashion, Teams work to create a greater understanding of policies and procedures currently in place, to enhance cooperation among systems and agencies, and to reform systems in an effort to prevent future fatalities.

This manual is an overview of how to coordinate a successful Team to review domestic violence fatalities in your community. While every effort has been made to include all the information you will need, this manual is not intended to replace the technical assistance provided to local communities through the Project Coordinators for the Project. Please reference the Assistance Section at the end of this manual for their contact information.

the mission of fatality review in georgia

The Georgia Domestic Violence Fatality Review Project seeks to enhance the safety of victims and the accountability of batterers. The Project does this by conducting detailed reviews of fatalities and near-fatalities and by preparing, publishing, and disseminating objective information gained from these reviews. The resulting information is used as a tool for identifying gaps in system responses, improving statewide data collection, and implementing recommendations to create a coordinated community approach to ending domestic violence through enhancing efforts to train systems on better responses, identifying critical points for intervention and prevention, and providing a forum for increasing communication and collaboration among community agencies.

the purpose of the fatality review in georgia

To raise awareness and promote critical thinking about the problem of domestic violence as a means of fostering conversation and collaboration statewide.

To give a voice to the victims and their loved ones so that we may learn from their experiences as we seek to prevent future tragedies.

To expose and explore the dangers created when individuals or systems engage, consciously or unconsciously, in victim-blaming. Understanding how a culture of victim-blaming can be fatal for victims of domestic violence is essential to promoting safety and justice for victims and accountability for perpetrators.

To serve as a practical tool for all those who wish to eliminate this violence in Georgia. By providing current data and analysis, mapping trends, summarizing recent history, and exposing barriers to safety and survival, our intention is that this tool will inspire and drive changes in our systems and our culture.

the history of the georgia domestic violence fatality review project

The Project is a collaborative partnership between GCADV and GCFV. Initiated in 2004, the Project operates under grants awarded by Georgia's Criminal Justice Coordinating Council with funding from the U.S. Department of Justice, Office on Violence Against Women.

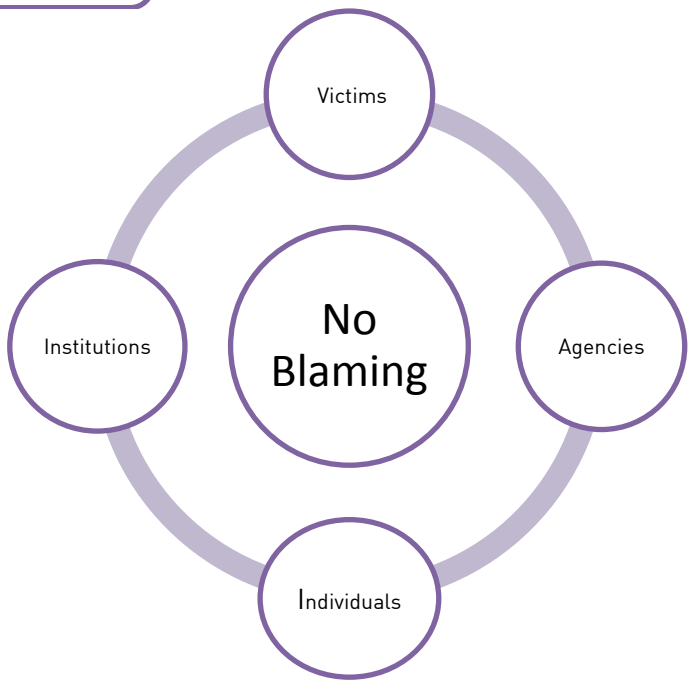
Through Georgia's Fatality Review Teams, several themes and gaps in services have been identified in the lives of victims of domestic violence and the systems that are in place to help them. The information that has been collected, coupled with the implementation of recommendations by Teams, has led to an increase in intentional and effective partnerships, system collaboration, and sincere effort to reduce the amount of complicated barriers that victims face when seeking to escape violence at the hands of their abusers in Georgia.

A goal of this project is to reduce domestic violence-related fatalities by using information learned from past fatalities. Each Annual Report builds on the last and contains data and analysis related to the year just prior to the published report.

Through the publishing of Annual Reports containing the critical findings and crucial recommendations for change, the Project directs the lessons learned to individuals and agencies poised to affect meaningful change. The Annual Reports, though diverse in design, contain researched findings regarding carefully selected fatalities that meet review criteria. Each report provides useful information for use in local communities. Whether frontline responders, justice system personnel, advocates or family and friends of those affected by domestic violence, the reports seek to provide information that might be used to prevent future domestic violence incidents and related deaths.

the guiding principles of fatality review

Respect	•The Team will respect victims and their family and friends as well as their team members and other community agencies.
Honesty	•Team members will be honest with one another and trust one another.
Confidentiality	•The Team will respect all agreements of confidentiality, both within the group and with community members.
No Blame	•The Team will not assign blame to victims, individual service providers, agencies or institutions.
Victim Sensitivity	•The Team will be sensitive regarding a victim's personal decisions and life experiences.
Collaboration	•Team members will uphold a collaborative atmostphere.
Accountability	•Team members will analyze their own system's response to domestic violence and work towards implementing recommended changes.



the methodology of fatality review

There are several components that comprise a successful fatality review. These components include forming strategic Teams of representatives from community agencies to work together to prevent fatalities from domestic violence and hold perpetrators accountable. The Teams select fatality cases that are currently closed and collect as much pertinent information as possible regarding the victim and perpetrator. A chronology is then developed by the Team, which documents all known instances of abuse between the victim and perpetrator and their involvement with any agencies or systems. Information is collected from a variety of sources, including open records from district attorney's offices and interviews with family and friends of the victim. The Teams then review the chronology, critically examining the events leading up to the homicide and identifying gaps in community service delivery. Recommendations are then developed to create a system of community agencies that can best serve victims of domestic violence and prevent future fatalities. Teams and Family Violence Task Forces then focus on implementing their recommendations to effectively bring about meaningful change in their communities. Please see Appendix A for a step by step guide to fatality review.

1. Team Formation and Member Roles
2. Case Selection
3. Case Information Collection
4. Case Chronology Development
5. Family & Friend Interviews
6. Fatality Review Meetings
7. Development & Implementation of Findings & Recommendations
8. Submitting Case Information to Project Coordinators
9. Evaluation

1. team formation & member roles

The Family Violence Task Force in each participating community will form a multi-disciplinary Team to function as a sub-committee to review domestic violence-related fatalities in their community. Teams generally meet 4-6 times per year. The meeting schedule consists of organizational meetings, 1 or 2 review meetings, and follow-up or implementation meetings.

Depending on a community's resources, the Team will create a structure that suits its unique needs. Teams often have a Chair and Co-Chair who lead the group and a core group of committed members from the community who are involved with the ongoing processes of fatality review and attend most meetings. All of the below-mentioned individuals have the task of helping the group maintain a respectful tone and stay purposeful during meetings.

Once a core group of members has been assembled, meetings should be held to present basic information about the purpose, mission, principles and benefits of fatality reviews to interested representatives from appropriate community agencies. **The Project Coordinator(s) can assist with presenting this information to interested community members.**

How Teams assign titles and roles within the group will vary widely and will evolve as the Team progresses. Evaluations of Team positions, processes, and abilities are recommended. Please see the Evaluation Section at the end of this manual.

Common Titles and Roles in a Fatality Review Team

Chair – The Chair is often comprised of an individual from the community who has a history of involvement in the field of domestic violence. The Chair performs the following functions: serves as the primary contact with the Project Coordinator(s) by communicating regularly about meeting schedules, agendas and community updates, schedules fatality review meetings, attends and chairs all meetings, creates agendas for all meetings, identifies, recruits and cultivates potential fatality review committee members, encourages members by keeping them informed of meetings and urging them to fully participate in the review process, coordinates case selection and data collection for the committee, and facilitates forwarding that information to the Project Coordinator(s).

Co-Chair – The Co-Chair shares responsibilities with the Chair. The division of labor between the two positions should be determined based on availability, personality, professional strengths and communication skills of each member.

Project Coordinator – Both GCADV and GCFV employ a full time Project Coordinator. Their responsibilities include training Teams on the fatality review process and the model used for this Project, helping Teams identify cases for review and identifying sources of information for data collection, providing guidance as Teams write the chronology, conducting family and friend interviews, assisting with the case review, forming of recommendations and the implementation of those changes, serving as a networking agent to other Teams, and providing information and guidance based on National best practices and trends.

Team Member – Team members will honor confidentiality and group agreements, attend meetings on a regular basis or send a designated representative when they are unable to attend, identify, recruit and cultivate potential fatality review committee members, promote collaboration across agencies and disciplines to increase safety for victims and accountability for perpetrators of domestic violence, focus on identifying gaps in services and formulating recommendations to improve systemic response, participate in implementation strategies, and promote the work of the Team overall.

Case Specific Member – Case specific members are representatives from a particular system who are invited to join the Team temporarily due to their expertise or direct involvement with a particular case. An example of this would be inviting a law enforcement officer who responded to calls for help prior to the homicide. Another example is inviting local "experts" who can bring expertise from their field. For example, if you are reviewing a case involving a same-sex couple, you may consider inviting someone who works with the Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and Intersex (LGBTQQI) community who can shed light on unique barriers faced by this population.

Representatives from the following systems are invited to join the Teams

Community and prosecution-based advocates	Alcohol and drug counseling providers
Judicial	Legal service providers
Corrections	School systems
Prosecution	Animal welfare and animal control agencies
Law Enforcement	Military service
Family Violence Intervention Programs (FVIPs)	Culturally specific organizations
Department of Family and Children Services (DFCS)	Employers
Faith-based organizations	Housing Authority
Mental health providers	Council on Aging
Child Care providers	Hospitals and medical providers
Sexual Assault and Child Advocacy Centers	Other social service organizations

things to consider when selecting team members	
Ability to Commit to Meeting Times	Fatality Review Teams require time and commitment to the Project. Members must be able to commit to consistent participation. Meeting times should be held on a habitual basis and all Team members should commit to regular attendance.
Non-Defensive Approach	Team members should come to the Fatality Review Team with an open-mind and a commitment to analyzing agency responses in an effort to prevent future fatalities.
Front-Line Experience	While not necessary, first-hand experience with survivors of domestic violence allows Team members to critically examine barriers and availability of agency services. These members will have a clear understanding of how agency policy and agency practice may differ.
Ability to Influence Policy	Team members should be able to implement recommendations and changes to policy or influence decision makers who have the ability to do so.

Adapted from Norling (2009), Figure 1: Selecting the Right Team Members

The Importance of Creating a Diverse Team

Teams are most effective when their membership includes representatives from all systems involved with victims and perpetrators of domestic violence fatalities. The Team should include a diverse array of individuals from the community with respect to ethnicity, gender and race.

Developing an Understanding of Community Resources

Teams may wish to compile a database of available services within their community and the methods by which community agencies interact with one another when they are working with a victim or perpetrator of domestic violence. Identifying which services an agency provides, who is eligible for services, and what sort of information they collect will help your Team understand the unique system of services within your community and where to locate information (Norling 2009).

Confidentiality Agreements and Group Agreements

Team members are asked to adhere to the confidentiality standards of their individual professional position and to know what information they can and cannot share with the Team. Team members are never asked to share information that is confidential. Team members are asked to sign a confidentiality agreement stating that they will keep the work product of the Team confidential. See Appendix B for a sample confidentiality agreement. Further, a group agreement should also be signed regarding the group environment, working assumptions and behavior expectations. See Appendix C for a sample group agreement form.

2. case selection

The Teams select domestic violence-related homicide cases for review with 3 criteria in mind:

1. All civil and criminal proceedings have been closed with no pending appeals related to the victim and the perpetrator.
2. The perpetrator has been identified by the criminal justice system.
3. When possible, the date of the homicide does not extend beyond 3-5 years.

Homicides are defined as domestic violence-related if the victim and perpetrator were current or former intimate partners. Teams are encouraged to include a range of deaths that are related to domestic violence. Cases involving the homicide of a secondary victim such as a friend, current partner, child or family member of the domestic violence victim are also considered domestic violence-related. Near-fatalities and suicides are also examples of cases that can be considered for review.

A Word on Near-Fatality Cases

Your Team may encounter a near-fatality case that they are interested in reviewing. While there are many benefits that can come from allowing a survivor to speak for themselves regarding the systems that they encountered that could have better helped them through their experiences, reviewing the case can also be further emotionally painful and traumatic for the survivor. These cases are unique and require further training and assistance from the Project Coordinator(s) at GCADV or GCFV. A specific methodology has been especially developed for reviewing near-fatality cases and is available upon request from the Project Coordinator(s).

3. case information collection

Once the case is selected, the Team gathers all public records pertaining to the case. The majority of the information can be located in the prosecutor's file and/or the homicide file.

Only information that can be obtained pursuant to the Open Records Act (O.C.G.A. § 50-18-70) is to be collected. The Open Records Act requires that all documents, papers, letters, maps, books, tapes, photographs, computer-based or computer-generated information, or similar material maintained, prepared, or received by a state agency, staff or department in the course of their operations be open for personal inspection by any citizen of the state at a reasonable time and place. Once a written or oral request is made, the agency has 3 business days to reply with copies of the records or to provide the specific authority for claiming that the records are exempted from disclosure. While most agencies are more than willing to allow Teams to review their records and documents, you may need to make an official Open Records Request to gain access to certain documents for the fatality review. Please see Appendix D for a sample letter requesting Open Records be made available to the Team. The Team's Project Coordinator can assist with this process, as well.

Useful information can be found through the following systems:

Police
Homicide report
Transcripts of interviews
911 calls to the residence
911 tapes
On scene investigation reports
Copies of evidence collected at the scene (diaries, letters, and other items)
Police reports where no arrest was made
Police reports involving prior partners of the perpetrator or secondary victims

Courts
Civil filings such as TPOs, divorces, custody
Criminal case files (pay close attention to continuances)
Prior sentences
Sentencing sheet for homicide
Photos from prior difficulties
Booking and release dates from the jail for charges prior to the fatality
Sex offender registry

Probation

Sentencing requirements
Completion of probation
Warrants for probation revocation

Medical

Admittance dates
Complaint dates
Was the victim screened for domestic violence?
If she was determined to be a victim, was a proper referral made?
Was anyone with the victim when she sought medical treatment?
What was the outcome of this hospital/doctor visit?

Workplace

Were there domestic violence resources available at the victim's and/or perpetrator's place of employment?
If there was an Employee Assistance Program, were they prepared to offer resources to victims and perpetrators of domestic violence?

Other Agencies and Resources

Places of worship
Substance abuse providers
Mental health providers
Community service boards
Other local service providers
Family Violence Intervention Providers (FVIP)
Dispute Resolution Centers
Family's First visitation centers
Humane Societies
Legal Services

Important Questions to Ask When Locating Case Information

Where else might the victim or perpetrator sought help or disclosed abuse?
What other agencies might serve victims and/or perpetrators in some capacity?

4. case chronology development

The Team will develop a chronology for each case with a focus on all prior significant events leading up to the death. These include prior acts of violence perpetrated by the person who committed the homicide (whether against this victim or another individual), previous attempts by the victim to seek help, previous criminal and civil history, etc. A completed chronology is distributed to each Team member. Please refer to Appendix F for the chronology form.

Guidelines for Writing the Chronology

Write a summary to tell the story briefly. In the summary, include relevant personal details including employment, length of relationship, where they lived, faith community membership, connection to other support networks, etc., as well as the history of the relationship, abuse, and a description of contacts that the victim and the perpetrator had with formal and informal systems.

Integrate information received from Open Records and interviews with family, friends, neighbors, coworkers, clergy, etc. into the summary and chronology of events.

Don't be afraid of the chronology of events section being too long. Get as much detailed information in as you can (within limits – see below). For example, a traffic ticket could be relevant if the perpetrator had outstanding warrants.

Include information related to informal systems: Employment, involvement in faith community, neighborhood associations, and other social systems.

Include relevant personal information. Options include race, class, gender, age, ethnicity, religion/faith status, ability/disability status, education level, employment status and income, neighborhood, and sexual orientation. When in doubt, discuss with others which of these elements are relevant and why before you include them.

Remember

- Don't include repetitive witnesses. Summarize.
- Don't focus too much on the crime scene details or details of the killing itself. We are interested in the events leading up to the homicide, not the homicide itself.
- Don't include salacious details that are not relevant.
- Don't include crime scene photos.

5. family and friend interviews

When applicable and appropriate, Teams seek out interviews with surviving family and friends of the victim who, in turn, provide incredible insight not gleaned from the public documents. The discussions are open-ended, with family members and friends invited to share what they want the Team to know about their loved one, the steps the victim took to achieve safety, and the victim's perceptions of the options available in the community.

The purpose of interviews with family and friends of the victim are to humanize the person(s) who lost their life, to gain a better understanding of the victim's perceptions of their choices, and to fill in a few key gaps in information collected from files. Please refer to Appendix G for a sample list of interview questions to use with family and friends.

Who Should Be Interviewed?

Family and friend interviews may include the victim's family, friends, clergy, faith leader or fellow congregant, new partner, coworkers, employers, or neighbors. Teams usually identify these individuals through victim advocates in prosecutors' offices, court records and law enforcement reports. Once you talk with a family member or friend, that person may refer you to someone else to interview.

As a general rule, family and close friends should not be interviewed until 1 year after the homicide. Family members who witnessed the homicide, or who were very close to the victim, such as the victim's mother, should not be interviewed until 2 years after the homicide. There may be exceptions to these guidelines. Please talk to your Team Chair and the Project Coordinator(s) if you have questions.

While other states vary in their policies, Teams participating in Georgia's Project do *not* interview the perpetrator or the perpetrator's family. We also do *not* interview minor children. If these issues arise within your Team, please feel free to contact the Project Coordinator(s) for further discussion.

Family members, friends, clergy, neighbors, and others who had a close personal relationship with the perpetrator or the victim may not attend the review itself. Also, no specific information about the case should be shared with family or friends before or after the review.

Who Should Conduct the Interview?

Teams should carefully select one or two Team members to conduct the interview. Interviewers should have experience with supportive interviewing, crisis counseling, and victim advocacy. Ideally, interviewers will have experience in helping family members of homicide

victims. Domestic violence advocates from the District Attorney's (DA) office or the local domestic violence agency may have these skills. Some Division of Family and Children's Services (DFCS) workers and therapists may have experience and skills in this area as well.

In addition, a therapist with expertise in trauma care should be selected to participate with the interview team. The therapist will meet with the surviving family members before the interview and will conduct a de-briefing with the surviving family members after the interview. The therapist will address multiple safety and process issues with family members, including mandatory reporting laws and self-care before and after the interview. To prepare for the de-briefing, the therapist will consult with the Project's contract therapist about the process. Please contact one of the Project Coordinator(s) for more information on this important process. In certain circumstances, the requirement for a therapist may be waived by the Project Coordinator(s) in consultation with the team.

Team members should write as much of the chronology as possible before the interview. Interviewers should be knowledgeable about the case in advance.

Interviewers should make sure that they have a lot of time available for the interview. Some interviews will be short, but others may be hours long. Interviewers should set aside appropriate time for the interview. Generally, the family member should decide how long the interview will go. Family members may end the interview at any time.

Before the Interview

The victim's family has a right to know that their loved one's case is being reviewed. They should be given the opportunity to share information prior to the review.

If an advocate from the prosecutor's office or the domestic violence agency has a relationship with the family, that advocate should call the family and make the initial contact. They should explain the process and ask if any family members would like to be interviewed. It is totally up to the family as to whether or not they will participate, and in what manner. An in-person interview is ideal, but the family member may also choose to be interviewed by phone or to submit information in writing.

If there is no existing relationship with an advocate, the Team may reach out to the family member or friend by letter and follow-up phone call or by phone. See Appendix E for a sample letter to send to family members and friends. Please do not use e-mail for this contact.

In most cases, the initial contact will be to set up a time for the interview, rather than for the interview itself. Family members should be given the option of talking with someone who lives outside their local community if that is more comfortable for them.

During the Interview

Interviewers should ask open-ended questions rather than pursuing a fact-finding check-list. The primary purpose is to gain a broader understanding of the victim through the eyes of the person you are listening to. The interview should be more about memories, feelings, and impressions than data. Discussion should go where the person you are interviewing wants it to go. This is their opportunity to talk and to share what they want to.

Interviewers should convey the following tone and message throughout the interview: *We're not trying to blame you or question your choices. We're trying to change us – the community – to stop this from happening again to someone else.*

Use the victim's name often in the interview. Ask the family member for an "in-life" photo that you can share with the Team. Avoid professional terms like "victim," "domestic violence," and "systems."

Have resources and referrals ready for the family.

- Know about the offender's status on probation or parole. Advise the family on how to register with parole for release information.
- A copy of the Georgia Department of Corrections Crime Victim Notification Request Form can be found at http://www.dcor.state.ga.us/pdf/NOTIFY.pdf
- Be prepared to advise the family about Crime Victim's Compensation options and provide a referral to Georgia Criminal Justice Coordinating Council.
- Information on Crime Victim's Compensation as well as the application form can be found at http://www.cjcc.ga.gov
- Have referrals for counseling options in your community available, as well

Leave your contact information with the family member. Say, "Please call me if you have any questions or if you think of anything else you'd like to share." Ask whether it is okay to contact them again if you have additional questions.

Ask if there is anyone else they think you should interview. Would they be willing to reach out to that person and ask them if they would like to be interviewed?

After the Interview

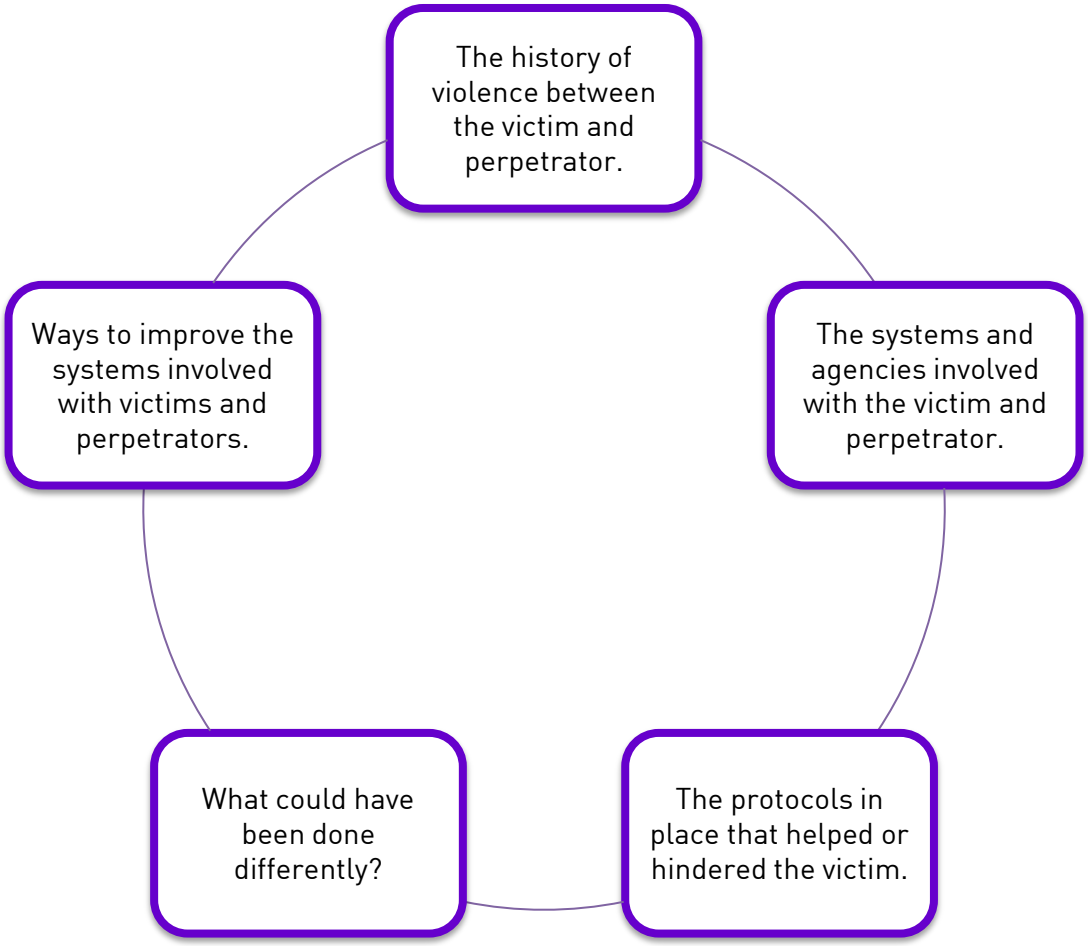
Send a Thank You note after the interview. Published reports of fatality reviews should be dispersed to family and friends who were interviewed. A courtesy phone call should be placed to family and friends prior to mailing the Annual Report.

If the Project Coordinator was not present for the interview, type up your notes from the interview and send them to the Project Coordinator.

6. fatality review meetings

The fatality review meeting is when the Team, along with any other invited guests and case specific members, comes together to review the chronology and formulate their recommendations. These meetings generally last about 3 hours and include the following steps: signing of the confidentiality agreement (see Appendix B), filling out the sign-in sheet (see Appendix I), having a moment of silence for the victim(s), and conducting an oral reading of the chronology. The Team will then go item by item through the chronology to see where the community could have stepped in and how the system response could have been stronger. With a strong trust in each other and a commitment not to blame one another, each Team identifies gaps in local response, areas where practice did not follow protocol, and innovative ideas to make the system response more effective in increasing victim safety and offender accountability. Please refer to Appendix H for a sample meeting agenda.

The Teams discuss the following areas:



7. development & implementation of findings & recommendations

The Teams then make findings about the factors in each case that appeared to contribute to the death, or conversely, actions which, if taken, might have prevented the death. Teams are always focused on reviewing the systems' responses: what types of resources were available in each system for victims and offenders, what the policies and protocols for responses were, whether they were followed or not, and what monitoring, training and accountability existed in each system for workers who responded to families. From the findings, each Team makes recommendations about changes to systems that would improve victim safety and offender accountability.

Policy and Protocol Questions

What do the reviews of agency policies, trainings, records, and practices reveal?
Are there written policies and procedures in place?
Were all current written policies and procedures followed?
What are the best practice procedures available and how do they compare with current practice procedures?
Are current policies and procedures adequate?
Were statutes regarding family abuse, protective orders, stalking, firearms, etc. enforced?

Service Questions

What services were offered, provided, or declined by the victim or perpetrator?
When did services and interventions occur?
What other services could have been utilized?

Outcome Questions

What were the barriers to obtaining services for the victim or perpetrator?
What were the institutional barriers? (language, cultural, social costs)
Were statutes a barrier to assistance or prevention?
Were there any barriers to interagency communications?
What specific interventions could have resulted in better outcomes?
Are there any significant recommendations?
Does the review Team have all of the information it needs to complete the review?
(Virginia Department of Health, 2001)

Areas of Recommendations

- Education
- Training
- Policy
- Practice
- Networks or collaborations
- Resources
- Funding
- Services
- Legislation (Norling, 2009)

Focus on Implementation

Appendix J is designed to guide Teams from findings and recommendations to implementation. Please build into your fatality review process ample time to focus on implementation in the months after the review. Please see Appendix K for tips on implementing Team recommendations.

A few recommendations include:

1. Teams should present their recommendations from the review (minus identifying information) to the local Family Violence Task Force. Ideally, the Task Force will deliberate and form a committee to focus on implementing one or two key findings from the review.

2. When thinking about implementation, focus on concrete and manageable changes. Momentum builds as Task Forces and Teams successfully complete small but important changes in their community. Don't try to implement too much too soon.

3. Teams don't need to review a case every year. Take a year off to focus on implementing findings from previous years. Fatality review is hard work! Your Team members may need a break. And implementation can be energy-producing rather than energy-draining.

8. submitting case information to project coordinators

The following items are to be submitted to the Project Coordinator(s) for the case your community reviewed to be included in the Annual Report:

- Meeting Sign-in Sheets
- Meeting notes
- Chronologies
- Other relevant documents and notes related to the case review
- Summary of issues identified and recommendations for change
- Summary of areas of focus you have identified
- Changes you have made in your community

As a general guideline, these documents should be submitted no later than November 1st of that year.

After Teams submit their case information to the Project Coordinator(s), the data is entered into an electronic database designed for this Project and adapted from the work of data collection tools used around the country. The data is then aggregated and comprises the data findings in the Fatality Review Annual Report.

All of the information contained in the Annual Reports comes directly from the work of local Teams. It is imperative that we collect this information from your Team so we can make sure the Annual Report is an accurate reflection of trends in Georgia.

9. evaluation

Teams should conduct ongoing evaluations regarding the process and outcome of their fatality review. Teams should follow up on recommendations that have been made through the fatality review process.

Attention should be paid to the potential traumatic experiences and stress that Team members may experience during the fatality review process.

See Appendix L for a Sample Evaluation form.

assistance

Please contact the Georgia Domestic Violence Fatality Review Project Coordinators, Taylor Tabb or Jenny Aszman, if you need any assistance.

Taylor Tabb
Fatality Review Project Coordinator
Georgia Coalition Against Domestic Violence
404-209-0280 ext. 17
ttabb@gcadv.org
www.gcadv.org

Jenny Aszman
Fatality Review Project Coordinator
Georgia Commission on Family Violence
404-657-3412
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references

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Virginia Department of Health. (2001). Family and intimate partner violence fatality review team protocol. 2nd Edition. Virginia Department of Health, Office of the Chief Medical Examiner. Retrieved from http://www.ndvfri.org/wp-content/uploads/ndvfri/28865.pdf

appendices

Appendix A – Step-by-Step Guide to Fatality Review

Appendix B - Confidentiality Form

Appendix C – Group Agreement Form

Appendix D – Sample Open Records Request Letter

Appendix E – Sample Letter for Interview

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Appendix I – Match Sign-In Sheet

Appendix J – Fatality Review Form

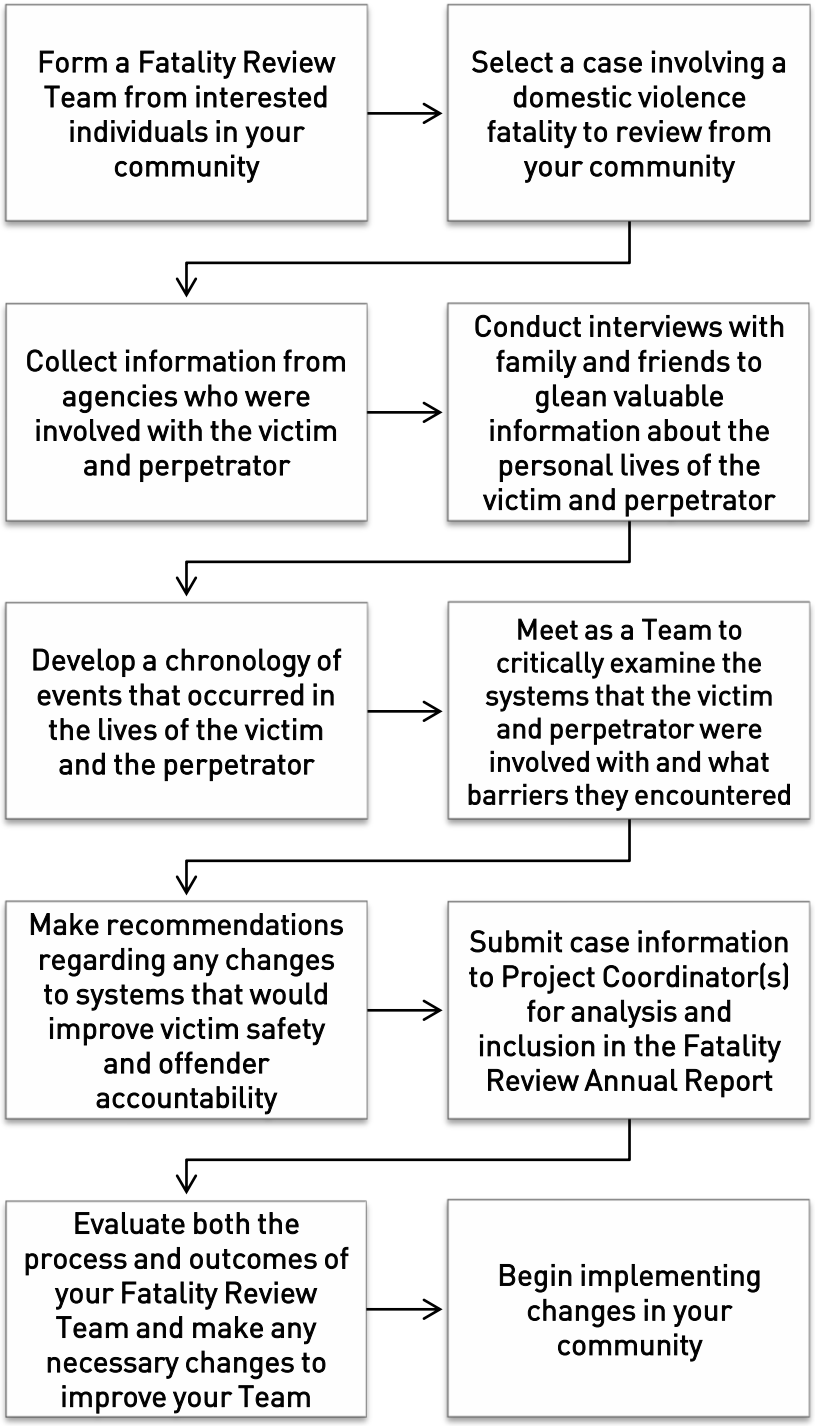
Appendix K – Tips for Implementing Recommendations

Appendix L - Sample Evaluation Form

Appendix A

georgia domestic violence fatality review project

Step-by-Step Guide to Fatality Review



Appendix B

georgia domestic violence fatality review project

Agency Representative Agreement to Confidentiality

Name and title: _____

Designated representative to the [Judicial Circuit]

DV Fatality Review Committee for Agency: _____

Through the process of conducting a formal review of selected fatalities in which domestic violence is considered a significant factor, the Georgia Domestic Violence Fatality Review Project will:

1. Work to increase safety for victims and accountability for perpetrators of domestic violence by cooperation and communication among agencies investigating and intervening in domestic violence and identifying gaps in services and accountability structures and formulating recommendations for policies, services and resources to fill those gaps.
2. Through research (including the fatality review committees) and data collection, identify and describe patterns in domestic violence investigation, intervention and prevention.
3. Document these patterns in an annual report, which also contains recommendations for collaboration on domestic violence investigation, intervention and prevention.

The effectiveness of the Domestic Violence Fatality Review Committee's work is conditioned upon the confidentiality, cooperation and communication, in good faith, of the review process and information shared within it.

- I understand that I am not being asked to disclose any information on individuals or cases that is not subject to open records by anyone participating or facilitating the fatality review project.
- I understand that some of the information obtained through fatality reviews originates in the public record (information regarding charges and sentencing, for example) and that material originating in public records is not confidential.
- However, I the undersigned, as a representative of _____, I agree to maintain the confidentiality of information discussed during the review process and not use any information discussed for any reason other than that which it was intended.
- However, recommendations from the reviews may be discussed minus personal identifiers. I agree to immediately notify the Georgia Commission on Family Violence or the Georgia Coalition Against Domestic Violence if I am subpoenaed for information obtained or discussed via the review committee.
- I agree not to release information about individual cases outside of committee meetings, and instead to discuss the findings of the Domestic Violence Fatality Review Committee in terms of trends and aggregate findings. I understand and acknowledge that the unauthorized disclosure of confidential information discussed in the reviews may result in exclusion from the Domestic Violence Fatality Review Committee.
- I agree that I will not represent the views of Domestic Violence Fatality Review Committee or Project to any media or any other publications such as agency newsletters.
- I agree to take clear measures to understand the limits of what I may reveal during reviews in my capacity as a representative of _____.

_____Signature_____Date

Title

Georgia Domestic Violence Fatality Review Project

This form was adapted from the Washington State Coalition Domestic Violence Fatality Review Project

Appendix C

georgia domestic violence fatality review project

Working Assumptions and Group Agreement for Domestic Violence Fatality Reviews

Domestic Violence Fatality Review Team members should agree to each of the following:

1. Honor all signed confidentiality agreements.
2. Keep in mind each participant brings important knowledge and expertise to the team, and each participant can learn from others on the team.
3. Maintain professionalism: Focus discussion on issues of policy, practice and accurate information about domestic violence, not on personalities or individuals. Avoid taking discussion personally.
4. Assume that each person on the Domestic Violence Fatality Review Team has a sincere interest in:
    - Increasing domestic violence victim safety and domestic violence perpetrator accountability
    - Improving collaboration amongst agencies coming into contact with domestic violence victims, domestic violence perpetrators and their children
    - Accurately identifying trends and patterns in domestic violence fatalities.
5. Keep in mind that the purpose of the Domestic Violence Fatality Review process is *not* to assign blame for the fatality. The purpose of reviews is to improve understanding of the circumstances leading up to the fatality in order to gain the knowledge necessary to track trends, improve safety and accountability and create recommendations for collaboration, training and policy change. No person in any agency represented on the review panel should be held responsible for a person's death.
6. Some reviews will include a critical examination of how agency/institution practices, policies and procedures figured into the circumstances leading up to a fatality. Such examination will take place in order to consider recommendations for changes, which will increase domestic violence victim safety and domestic violence perpetrator accountability in the future, and not for the purpose of assigning blame. In some cases, the team may come to the conclusion that an agency's policies were not adequate or were not adequately followed. In these cases, the panel may ask that agency to review its mechanisms for ensuring the consistent realization of its policies or to review its policies.
7. Avoid victim blaming. No person deserves or wants to be abused or die at the hands of another. Interpretation of data from reviews should not imply that victims of domestic violence are responsible for or deserves their victimization or death.

Signature:_____Date:_____

Appendix D

georgia domestic violence fatality review project

Sample Open Records Request Letter

Month Date, Year

Dear _____,

Pursuant to the Open Records Act, O.C.G.A. § 50-18-70, you are hereby requested to make available for review and copying all files, records and other documents in your possession that refer, reflect or relate to the homicide investigation and prosecution of *(insert perpetrator's name)*.

I am requesting these records as part of a local Fatality Review Project working with the local Family Violence Task Force *(insert Task Force)*. The mission of this project is to enhance the safety of victims and accountability of batterers by conducting detailed reviews of fatalities and near-fatalities and disseminating objective information gained from these reviews as a tool for identifying gaps in system response. Through this process, we hope to enhance system responses, identify critical points for intervention and prevention, and increase collaboration among those involved in a coordinated community response to domestic violence.

The Open Records Act requires that all documents, papers, letters, maps, books, tapes, photographs, computer-based or computer-generated information, or similar material maintained, prepared, or received by you, your staff or your department in the course of your operations shall be open for personal inspection by any citizen of the state at a reasonable time and place. It is my belief that none of the materials I am requesting are currently exempted from release under the Open Records Act. If you disagree with this assessment, please provide a detailed written description of the authority, including Code Section, subsection and paragraph that you claim exempts the records from disclosure.

Pursuant to the 1999 amendments to the Open Records Act, you have 3 business days to provide copies of the records or to provide the specific authority for claiming that the records are exempted from disclosure. Pursuant to the Open Records Act, failure to comply with the requirements of the Act can result in civil and/or criminal penalties.

The Open Records Act guarantees the right of citizens to reproduce records, subject to a payment of costs based upon the most economical means available for providing copies of records. Please waive any costs associated with this request or advise me of any costs that you will assess and state the basis for computing the charges utilizing the method specified in O.C.G.A. § 50-18-71.

Thank you for your immediate attention to this request. I hope to receive notification of the availability of these records within three business days, as required by law. If you have any questions, you may contact me via telephone at *(insert phone number)*. Thank you for your help.

Respectfully,
(Insert name and affiliation)

Appendix E

georgia domestic violence fatality review project

Sample Letter for Interview

Month Date, Year

Dear _____,

First, I want to say how sorry I am about the loss of your loved one, *(insert victim's name).* Her death was tragic and I am so sorry for your loss.

My name is *(insert name)* and I work for the *(insert agency name).* My role here is to help communities review deaths that resulted from domestic violence. Our goal is to learn from these tragedies and make changes to improve safety for other women and children who are currently being abused. In the hope of improving safety for other women like *(insert victim's name)*, I am wondering if you would be willing to talk with me about your loved one's life and the circumstances surrounding her death.

Your participation is completely voluntary. If you choose to talk with me, your responses will be shared with a team of people who are reviewing your loved one's death in order to make life better for others. If we talk, here are some of the questions you might choose to respond to:

- What would you like us to know about *(insert victim's name)* life? What was she like as a person?
- What would you like us to know about *(insert victim's name)* relationship with (insert perpetrator's name here)?
- Do you know who *(insert victim's name)* turned to for help as she suffered abuse?
- Did she try to talk to you or anyone else about the abuse she was suffering?
- What kind of community support might have been helpful to *(insert victim's name)* as she tried to stay safe?
- Is there anything else you would like us to know about *(insert victim's name)* life and death?

I understand that you may be feeling deep sadness, grief, and a sense of injustice about *(insert victim's name)* death. These are normal reactions that you may be having now and they could be intensified by this process. Please know that I will help support you in any way that I can whether or not you choose to participate.

Thank you for considering this difficult request. If you or any other family members or friends of (insert victim's name here) have any questions or are willing to be interviewed please contact me at *(insert phone number).* You may also share information with me by letter or e-mail. I will follow-up with you by telephone in the next week to see if you are interested in talking with me.

Respectfully,
(Insert name and affiliation)

Appendix F

georgia domestic violence fatality review project

Chronology

Persons involved:

Name	Role	Date of birth

Addresses:

	Note

Summary:

Chronology of events:

Date	Agency	Type of incident	Summary

Appendix G

georgia domestic violence fatality review project

Sample Interview Questions for Family and Friends

Tell me about _____.

What would you like us to know about _____'s life? What was s/he like as a person?

What would you like us to know about _____'s relationship with _____?

Were there any good times in the relationship?

Do you know who _____ turned to for help as s/he suffered abuse?

Did she try to talk to you or anyone else about the abuse s/he was suffering?

Were you aware of the abuse? When/how did you become aware?

How did your relationship with _____ (the victim) change over the years?

How did your relationship with _____ (the perpetrator) change over the years?

What kind of community support might have been helpful to _____ as s/he tried to stay safe?

Is there anything else you would like us to know about _____'s life and death?

What message would you give to other families who are experiencing violence?

How would you like _____ to be remembered?

Remember

This is a sample list of questions. Interviewers will not ask all of these questions. Instead, interviewers will pick a few that are relevant and then allow the family member or friend to share whatever they are comfortable with sharing.

Appendix H

georgia domestic violence fatality review project

Fatality Review Committee Meeting Agenda

Fatality Review Committee

Meeting Agenda

9:00am-12:00pm

General Business

- Introductions
- Review and sign Confidentiality Statement and Group Agreement
- Sign in sheet
- Distribution of additional copies

Who is this Victim?

- Moment of Remembrance
- Notes from Family and Friend Interviews are Read

Reading of Chronology

Sharing of Additional Information

System Review

- What systems were involved?

Findings

Recommendations

Implementation

Appendix I

georgia domestic violence fatality review project

Sign-In Sheet

Georgia Fatality Review Project Sign in Sheet

Circuit: _____Page:_____ of:_____

Location:_____Date: _____Time:_____

Name	Is your position Federally funded? Yes or No	Organization	Title	Phone	Email

*Georgia Commission on Family Violence and Georgia Coalition Against Domestic Violence Fatality Review Project

Appendix J

georgia domestic violence fatality review project

Fatality Review Form

Fatality Review

Date:

Team:

Case:

Staff:

1. Initial Assessment of System Involvement: Who was involved?

System	Very Involved	Minimally Involved	Not Involved
Clergy			
DFCS			
Employer			
Family & Friends			
Health Care			
Judge			
Law enforcement			
Probation			
Prosecution			
VWAP			
DV Shelter			
FVIP			
Other			

2. What were the 3 most important factors that impacted *batterer accountability*?

1)

2)

3)

3. What were the 3 most important gaps in response and information for the *victim*?

1)

2)

3)

Appendix J (Sample Fatality Review Form cont.)

4. Of the barriers to access and response issues, what 3 things would the review committee *wish most would have been different* in this family's life?

1)

2)

3)

5. Of the problems and barriers that most impacted this victim and offender, what 3 recommendations can the committee make of *changes to policy and practice*?

1)

2)

3)

6. Of the problems and barriers that most impacted this victim and offender, what 3 recommendations can the committee make for *changes to training and public awareness*?

1)

2)

3)

7. <u>Implementation</u>

Recommendation	Who would need to agree this is a problem?	Is that person here, or who here knows that person?	What specific steps will the team make to contact this person/system?	What specific outcome will we ask for?
1.				
2.				
3.				

8. By what date will the committee come back together to monitor implementation progress?

_____.

Appendix K

georgia domestic violence fatality review project

Tips for Implementing Recommendations

Implementing Recommendations:
13 Ways for Fatality Review Teams to Effect Social Change

1. **Highlight and Include** survivor and victim voices and perspectives in work and reporting.
2. **Trumpet** the differences you've made.
3. **Communicate** in a clear, simple, and straightforward way.
4. **Prioritize and limit** recommendations.
5. **Stress** accountability.
6. **Make** products (reports) useful to the field.
7. **Follow up** regularly on recommendations and implementation.
8. **Work** with the media: establish credibility and relationships.
9. **Reality-test** your work with survivor and community members.
10. **Have** a long term vision – this won't happen overnight.
11. **Link** findings and recommendations to reviewed cases.
12. **Designate** outreach persons to: talk to media, do training and technical assistance (both to state and to board members constituent groups).
13. **Stay informed** of others' work statewide and nationally – findings and recommendations have greater impact when they align and complement.

Prepared by Robin H. Thompson, JD, National Domestic Violence Fatality Review Initiative

Appendix L

georgia domestic violence fatality review project

Fatality Review Team Evaluation Form

Fatality Review Team Evaluation Form

Please rate how much you agree with each of the following statements.

Team Process	*Strongly Disagree*	*Disagree*	*Agree*	*Strongly Agree*
Team members talk openly, share skills and knowledge, and learn from one another	1	2	3	4
Team members have a shared sense of purpose and direction	1	2	3	4
Team members feel equally responsible for the team's functioning and outcomes	1	2	3	4
The Team uses the consensus process adequately to draw conclusions	1	2	3	4
Team members draw on the resources and talents of all members	1	2	3	4
All team members actively participate in the process	1	2	3	4
Team members resolve disagreements effectively	1	2	3	4
The meeting atmosphere is informal, comfortable, relaxed	1	2	3	4
Team Members are genuinely engaged in the process	1	2	3	4

Comments on Team functioning as a whole:

FATALITY REVIEW TEAM EVALUATION FORM (CONT.)

TEAM COORDINATION	*Strongly Disagree*	*Disagree*	*Agree*	*Strongly Agree*
Team facilitator is effective in guiding the team through the case review process	1	2	3	4
Meeting materials are acceptable in content and form	1	2	3	4
The coordinator effectively works toward accomplishing the original mission of the team	1	2	3	4
Meetings are well planned and executed to accomplish the goals of the Team	1	2	3	4
The coordinator consistently works within the protocol established by the Team	1	2	3	4
The coordinator keeps me informed of issues relevant to fatality review	1	2	3	4
The coordinator responds appropriately to suggestions for improvements by Team members.	1	2	3	4

COMMENTS ON THE COORDINATION OF THE TEAM'S WORK:

FATALITY REVIEW TEAM EVALUATION FORM (CONT.)

MY ROLE ON THE TEAM	*Strongly Disagree*	*Disagree*	*Agree*	*Strongly Agree*
I am comfortable sharing my thoughts and concerns with the Team	1	2	3	4
I am happy with the direction in which the Team is moving	1	2	3	4
I am pleased with the accomplishments of the Team so far	1	2	3	4
I think the pace of the Team's work is appropriate	1	2	3	4

COMMENTS ON HOW I FEEL ABOUT MY ROLE ON THE TEAM:

THE ONE THING I WISH I COULD CHANGE ABOUT THE TEAM IS:

THE ONE THING I WISH I COULD TELL THE COORDINATOR IS:

Fatality Review Team Evaluation Form (cont.)

Fatality Review Team members are exposed to emotionally difficult material. How are you taking care of yourself as a Team member? Anything you need from the Project or the Team in this regard?

Have you or your Team implemented any changes based on the Fatality Review Findings? How can the Project support your Team and you in working towards implementation of one or more of your findings?

Adapted from the Virginia Maternal Mortality Review Team.
From Family and Intimate Partner Violence Fatality Review Team Protocol and Resource Manual (Nordling, 2009)

Distributed December 2011