CALIFORNIA
DEPARTMENT OF JUSTICE

CALIFORNIA DOMESTIC VIOLENCE INCIDENT REVIEW TEAM PROTOCOL

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INTRODUCTION

In 1995, California state law authorized counties to establish interagency domestic violence death review teams ("Review Teams").[1] The law authorizes such Review Teams to identify and review domestic violence deaths, facilitate interagency communications, and develop recommendations for prevention and intervention policies and protocols with the objective of reducing and eradicating incidences of domestic violence.[2] In 2022, the legislature amended the law to authorize Review Teams to also review "near-death" incidents (in addition to deaths), and directed the Office of the Attorney General to develop by January 2025 a protocol ("Protocol") "for the development and implementation of interagency domestic violence death review teams for use by counties."[3] There are currently twelve Review Teams active in California, a list of which can be found at Appendix B on page 53.

In the last twenty-five years, California has reduced the number of domestic violence fatalities, due in part to the enactment of gun control laws.[4] However, significant work remains. Domestic violence incidents increased during the COVID-19 pandemic and continue at rates higher than pre-pandemic levels.[5] In its 2021 analysis of the state's response to domestic violence, the Little Hoover Commission, a bi-partisan government oversight agency, concluded that California focuses primarily on crisis management and "does not have a substantial prevention or early intervention program."[6] The bi-partisan commission also concluded that the "state does not have a firm grasp of the full scope and impact of intimate partner violence on Californians who are not cisgender white women and whether it is meeting their needs – though conversations with advocates from those communities suggest it is not."[7]

Because facilitating agency responses requires deep relationship building, the most successful domestic violence death and near-death case reviews are likely to be local.[8] Due to the great geographic and cultural diversity of California's communities, this Protocol describes how different domestic violence review teams across the state, the country, and the world approach key decisions and facilitate communication among the various persons and agencies involved in domestic violence cases. This Protocol highlights emerging practices and presents their potential advantages and disadvantages, and it also focuses on remedying the California-specific problems identified by the Little Hoover Commission.

Box 1: What is a Review Team?

A Domestic Violence Death Review Team is a county-level multidisciplinary team authorized by the California Penal Code to:

- **IDENTIFY domestic violence death and near-death cases;**
- **REVIEW death and near-death incidents;**
- **FACILITATE agency responses; and**
- **DEVELOP prevention and intervention recommendations**

The Office of the Attorney General urges Review Teams to adopt their own localized protocol based on the various options presented by this Protocol, and to post their localized protocol online to build trust among community members.[9]

The Establishing a Review Team section discusses the basics of setting up a Review Team, including funding, team structure and membership, and training. This section also discusses how Review Teams can set guiding principles and establish an agreed upon framework, which experts and Review Team chairs consistently identify as an essential element of success. The Confidentiality and Ethics section discusses the various confidentiality laws and ethical rules that bind the Review Team as a whole and its members as individuals. The Near-Death Incident Review section highlights the ethics, safety, survivor support, and other considerations that differ when a Review Team broadens its practice to include near-death case reviews. The Marginalized Populations section focuses on special considerations necessary when engaging with marginalized populations, particularly as Review Teams aim to remedy the kinds of problems identified by the Little Hoover Commission.

The Reviewing Cases section describes steps undertaken by Review Teams that conduct detailed case reviews. The Issuing Conclusions and Recommendations section presents the different approaches Review Teams take to crafting recommendations to ensure the best chance of implementation. Finally, the Appendix includes sample documents that may help existing and developing Review Teams engage in their work.

Box 2: Review Team Step by Step

1. Establishing a Review Team
    a. Identify and invite members (See page 6)
    b. If possible, find funding to hire a coordinator (See page 7)
    c. Train members (See page 12)
    d. Adopt a confidentiality protocol (See page 14)
    e. Adopt a guiding principle (See page 4)
2. Reviewing Cases
    a. Adopt a methodology (See page 30)
    b. Identify domestic violence related deaths and near deaths (See page 31)
    c. Choose cases for review (See page 32)
    d. Collect information (See page 34)
    e. Build a timeline (See page 37)
    f. Identify risk markers (See page 39)
    g. Identify agencies and stakeholders involved (See page 40)
    h. Assess how agencies and stakeholders involved worked together (See page 40)
    i. Identify and prioritize recommendations (See page 42)
    j. Track the implementation of recommendations (See page 44)

Methodology

This Protocol was developed following a comprehensive review of published scholarship, Review Team protocols and reports, a commissioned California Partnership to End Domestic Violence ("the Partnership") survey of service providers and Partnership led survivor listening sessions, and over 50 hours of live interviews and case review observation.

The Office of the Attorney General reviewed scholarly articles published in peer-reviewed journals and books and consulted the protocols and reports of approximately 30 teams from California, the United States, and the world.

As directed by statute, the Office of the Attorney General contracted with the Partnership, the state domestic violence coalition, to conduct a survey of domestic violence service providers statewide and to hold domestic violence survivor listening sessions.[10]

The survey asked domestic violence service providers about how to engage survivors, whether the providers have served on Review Teams and if they have done so, what their experience was like, and whether or not their communities would benefit from a Review Team, if no team exists in their county. Seventy-nine representatives responded on behalf of organizations serving 46 counties.[11]

The Partnership conducted three listening sessions between 60 and 90 minutes with a total number of 14 participant survivors of domestic violence. Based on survivor self-identification and request, one listening session only included survivors who identified as Black, Indigenous, or People of Color (BIPOC), and one only included survivors who identified as LGBTQ+. The third listening session did not specialize in a particular subgroup.

Survivors were compensated for their time. These listening sessions focused on the subject of survivor participation in case reviews of near-death incidents, and included question prompts related to safety, consent, and confidentiality.

The Office of the Attorney General interviewed: representatives from all 12 active California Review Teams; representatives from the state teams of Delaware, Georgia, Illinois, Montana, New Jersey, New York, Vermont; the chair of the Louisville, Kentucky team; and experts at the National Domestic Violence Fatality Review Initiative at the Family Violence Center at Arizona State University, and the Quattrone Center at the University of Pennsylvania. We attended virtual and in person case reviews in California.

We sent requests for information to all 58 California counties. Of the 41 counties who responded, 24 counties reported never having had a team, and three reported having had a Review Team in the past that was no longer active, due to the challenges of the COVID-19 pandemic. Of the 15 counties reporting that a Review Team would be useful, 12 cited lack of funding as an obstacle. Other barriers included: low population/low incidence of domestic violence deaths; lack of staff, subject matter expertise, or stakeholder buy-in; or conflicts between stakeholders.

There is no one-size-fits-all model to the work of a Review Team. No empirical studies related to the effectiveness of any one approach have been published.

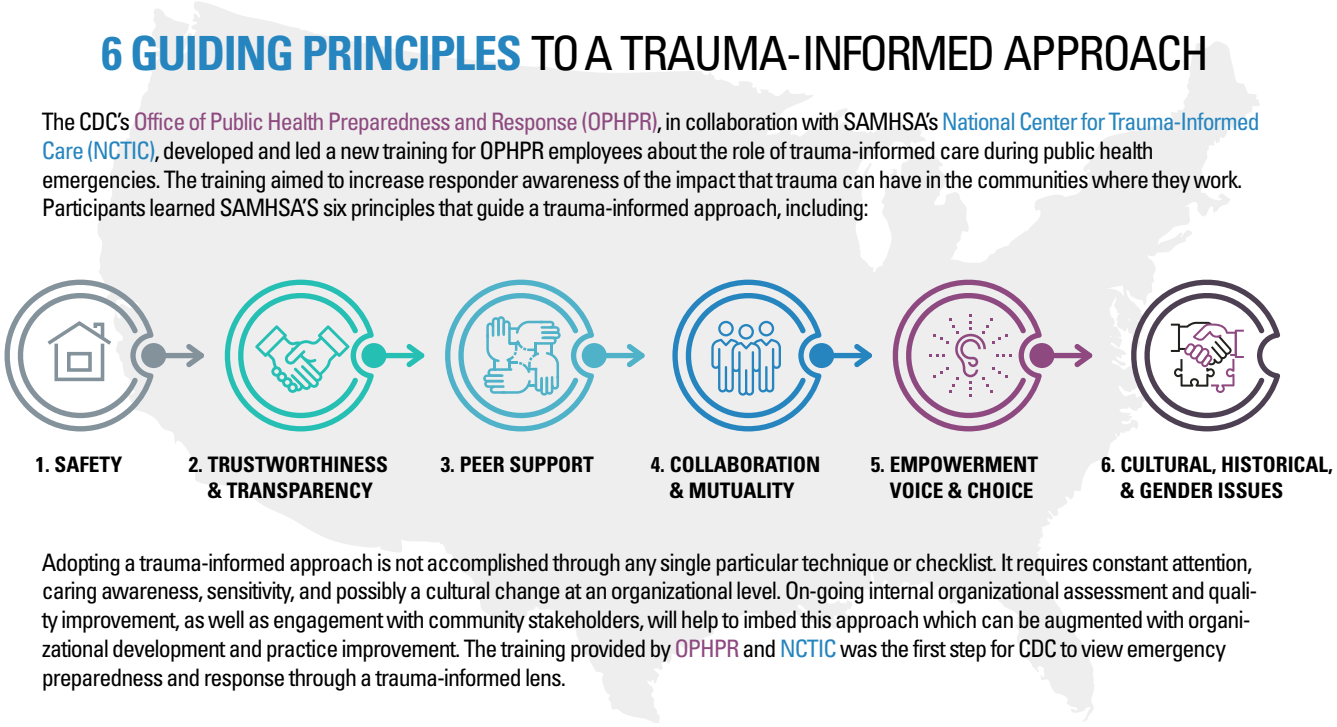
Review Teams identify gaps in the services provided by medical, law enforcement, legal, and social services establishments, and develop recommendations to improve prevention and reduce domestic violence incidents.[12] Some teams, like Alameda County, accomplish this through data analysis of all qualifying cases that occur each year. Other teams, like the ones found in San Diego County, Contra Costa County, Vermont, and Montana, conduct in depth case reviews of two or three cases a year. Many Review Teams, like Orange County, take a hybrid approach by conducting individual case review while also conducting some data analysis.

Adopting a Guiding Principle

Several survey respondents stated that their Review Team lacked purpose. Adopting a guiding principle can help teams make difficult decisions during their work. The following are examples of guiding principles adopted by teams in California and elsewhere. A Review Team may adopt one or more, or craft their own from these or other ideas. No one approach is correct. The more important issue is that all team members agree to whatever guiding principle the Review Team chooses. "When you get strangers in a room, and they come up with their own set of rules, that they individually agree on, it's like a magic trick. Suddenly, these strangers become a team," said John Hollway, Executive Director of the Quattrone Center for the Fair Administration of Justice.

- **No Blame, No Shame:** The National Domestic Violence Fatality Review Initiative recommends that all Review Teams adopt this approach in order to foster honest information sharing, build trust, and avoid perpetuating a manipulation tactic used by abusers.[13] The San Diego team has adopted this approach and gives a reminder to the entire team at the beginning of each meeting. This approach meets each agency, stakeholder, community member, victim/survivor, and perpetrator where they are. The criminal and civil justice systems examine past actions to determine culpability. By contrast, Review Teams examine past actions, only to improve future responses without blame.
- **Trauma-Informed:** Research has shown that victim/survivors can experience trauma from organizations intending to provide them with services and supports, like seclusion and restraints in the mental system, family separation in the child welfare system, or systemic racism or intimidating practices in the criminal justice system.[14] These practices alienate victim/survivors and sometimes perpetrators from the help.[15] A trauma-informed approach combats the "risk of blaming victims for not taking advantage of or appreciating the progressive services and shaming, silencing, and [harming] victims/survivors who are told that their needs are met when in fact they are not."[16] The CDC and the Substance Abuse and Mental Health Services Administration has laid out six guiding principles to a trauma informed approach.[17]
- **Do No Harm:** The National Domestic Violence Fatality Review Initiative advocates for this approach, where Review Teams make decisions to avoid harming any parties, including perpetrators or third parties.[18] Under this approach, Review Teams recognize that perpetrators have a right to confidentiality, and avoid decisions that may undermine victim confidence in service providers.[19]

- **Survivor-Led or Victim-Centered:** This approach is centered in the belief that autonomy in decision-making heals the victim/survivor's experience of powerlessness and helplessness experienced at the hands of the perpetrator.[20] This can translate to requesting consent from the victim/survivor to review their case, even where they do not participate, or other priorities.[21]
- **Community Repair:** The New Zealand Review Team aims to dismantle systemic bias in agency responses by incorporating frameworks developed by indigenous people historically marginalized by colonization and racism.[22] The team aims to accurately report domestic violence statistics through prioritizing culturally appropriate interpretations and centering the individual and community experience of racism and colonization.[23]



Courtesy of Stephen B. Thacker CDC Library collection.

Funding

No specific federal or California appropriations fund the operation of domestic violence death review teams. Most teams rely on the agency of the Review Team chair to perform their administrative work, often with help from seasonal interns.

Some teams are funded from other sources. The Contra Costa Board of Supervisors specifically funds a full-time coordinator position to provide administrative support to several multi-disciplinary teams, including its domestic violence death review team. The City and County of San Francisco received grants from the U.S. Department of Justice to develop a pilot domestic violence death review, including funding from the Sentinel Event National Demonstration Project and from the Office on Violence Against Women generally.[24] The grant paid for the Quattrone Center for the Fair Administration of Justice to conduct witness interviews, develop factual narratives, and moderate case review discussion.[25] Alameda has received funding from the Advancing the Use of Technology to Assist Victims of Crime Grant

from the U.S. Department of Justice[26] to help build and serve as one of four pilot counties for an integrated data collection and communication platform. The U.S. Department of Justice has identified the grants to improve the criminal justice response (ICJR) program as a grant that it often awards to domestic violence death review teams.

Team Structure

Review Team Chairs

No one agency is the best home for a Review Team.

Review Teams in California and around the country are chaired by district attorney's offices, domestic violence service providers, law schools (Orange County), public health departments (Stanislaus), judges[27] (Louisville, Kentucky), coroner's offices (San Mateo), and other county departments that do not engage directly with the victim-survivor or perpetrator. The organization that chairs the Review Team usually, but not always, facilitates discussion at each meeting. The chair organization provides administrative support out of its general operations budget, and, if the team meets in person, may provide a physical meeting space.

Several Review Teams identified the advantages of a team chaired by a neutral perspective. The Contra Costa team is led by the Contra Costa Alliance to End Abuse, a division of the county's employment and human services department, and the Quattrone Center at the University of Pennsylvania facilitated the most recent San Francisco case review. In San Diego, one of the California teams conducting in-depth case reviews, is chaired by the District Attorney's office, but case reviews are led by a coordinator who is a social worker.

Each host and chair presents advantages and disadvantages, depending on the goal of the Review Team, and the perspective of the chair can heavily influence the work of the Review Team. For example, case reviews chaired by district attorney's offices may focus primarily on the issue of prosecution. Several service providers explained in their responses to the Partnership survey that their District Attorney-led case reviews sometimes felt like a trial. **Carolyn Hanson, who was a criminal prosecutor before becoming the coordinator and chair of the Vermont team, noticed the challenge of pivoting to the different mindset for case review. "It was a struggle for me to let things not be linear, but that's an impulse to pull back on because sometimes people remember really important things when they meander," said Hanson.**

Some experts suggest rotating the chair to take advantage of different perspectives[28] and prioritize marginalized communities. For example, the New Jersey Domestic Violence Fatality and Near Fatality Review Board appoints ad hoc members who belong to the same community as the parties to chair the meetings involving their community members.[29]

Box 3: Review Team Website

What to Include:

- Past and Current Members
- Mission Statement
- Guiding Principle
- Contact Information
- Review Team Protocol
- Confidentiality Protocol
- Confidentiality Agreement
- Consent Form
- Frequently Asked Questions, including an explanation of what domestic violence death and near-death review is, and what it is not
- Past, current, and future case selection process or criteria
- A method for the public to submit requests for the team to review a case[30]
- Previously published reports
- Success stories, if any that can be shared, of systems changes that came from Review Team work

Team Coordinators

Where funding is available, some teams hire a full-time paid coordinator to collect information and case files from member agencies, schedule team meetings, and follow up with members to ensure participation.[31] If the coordinator is a licensed therapist or social worker, they may conduct interviews with victim/survivors, perpetrators, and community members and report back to the team.[32] Some teams, like those in San Francisco and Montana, have hired independent facilitators to lead team meetings, encourage productive disagreements, and reach consensus.[33]

Based on information the Office of the Attorney General gathered in interviews with Review Teams, a coordinator has strong stabilizing effects on the few California teams that have been able to make this happen. Regardless of the chairing agency, a neutral coordinator can ensure that no single voice or opinion dominates the process. The coordinator engages in relationship building and has preliminary conversations with team members before particularly emotional case reviews to ensure that team discussions are as productive as possible. The coordinator also can track and follow up with individual agencies on whether or not recommendations are implemented and report back to the team. Coordinators can also open up discussions with questions to redirect the conversation. See “Reviewing Cases” starting on page 30 for further discussion.

Other Logistics

According to experts and Review Teams, no ideal meeting frequency or length exists. Some counties, like Orange County, meet once every two months for one hour to review several cases. The San Francisco team conducted five two-hour meetings to review one case only.[34] Case reviews can be emotionally draining and labor and time intensive. Team members’ time and energies are finite, so Review Teams should collectively decide their focus.

Flexibility is key for small counties with fewer resources. Review Teams from counties with sporadic fatalities may meet irregularly, as needed, or operate one team to review multiple types of fatalities, including domestic violence, suicide, and elderly abuse.

Cross-county teams can offer stability and identify regional trends, particularly for rural counties with shared resources like trauma centers, rape crisis services, or other service providers. In Illinois, for example, regional teams are organized by circuit court boundaries and may include one or more counties.

Reporting to the County Board of Supervisors or other elected officials provides a mechanism for political buy-in. For example, in Sacramento County, the Domestic Violence Death Review Team reports its recommendations out to the Board of Supervisors annually. While the Board does not have direct authority over all member agencies, it has funded an intervention program, discussed in the Reviewing Cases section, which was recommended by the Team.

Membership

There is no ideal number of Review Team members. For example, while the Quattrone Center recommends Review Teams of approximately twelve individuals for a deep discussion, other effective, long-standing teams conduct case reviews with as many as nineteen members.

Which Organizations Should Participate?

Under California law, certain organizations must provide participants for a Review Team. If a county has multiple agencies or organizations that fit into the legally mandated categories, Review Teams should prioritize organizations that are open to dialogue and compromise and/or have a history of successful working relationships across the political spectrum. Different organizations can also serve for rotating time-limited terms to maximize community engagement and obtain a variety of perspectives.

Box 4: Mandatory Team Members

Under Pen. Code 11163.3(a), Review Teams Must Include:

1. Experts in the field of forensic pathology
2. Medical personnel with expertise in domestic violence abuse
3. Coroners and medical examiners
4. Criminologists
5. District attorneys and city attorneys
6. Representatives of domestic violence victim service organizations, as defined in subdivision (b) of section 1037.1 of the Evidence Code
7. Law enforcement personnel
8. Representatives of local agencies that are involved with domestic violence abuse reporting
9. County health department staff who deal with domestic violence victims' health issues
10. Representatives of local child abuse agencies
11. Local professional associations of persons described in paragraphs (1) to (10), inclusive

Beyond these mandatory members, the experts and Review Teams we interviewed recommended an expansive and flexible approach.[35] Certain organizations may be regular members who attend every case review, while other organizations or categories of individuals can attend on an ad hoc or case by case basis.[36]

In order to ensure trust by the public, participating agencies, victim/survivors, and the community, Review Teams should publicly state on a web page or a report which agencies are represented, how members are selected, and note how the absence of representation may affect their recommendations.[37] For example, Review Teams in counties with a large Native American population may acknowledge that certain tribal representatives are in the process of being invited but have not yet participated in a case review.

Box 5: Potential Team Members[38]

In addition to the team members mandated by law listed in Box 4, the following are ideas for additional members.

- Victim-survivor who is not reviewing their own case (See page 10 for further discussion)
- Court administrators
- Defense attorneys
- Nurses
- Teachers and school administrators
- Therapists, psychiatrists, social workers
- Probation officers
- Religious and community leaders
- Culturally specific service providers or community organizations
- Restorative or transformative justice practitioners
- Housing department representatives and landlords
- Perpetrator intervention treatment providers, mental health counselors for violent offenders
- Researchers
- Children's and parents' attorneys practicing in family or dependency court
- Retired judges[39]
- Professors
- Tribal liaisons
- Batterer intervention program representatives
- Emergency medical services personnel
- Childcare providers[40]

Review Teams should include whoever is necessary to best understand the experience of the victim/survivor and perpetrator.[41] The Georgia statewide team concluded after conducting in-depth case reviews for fifteen years that improvements to the traditional systems of response—police, courts,

shelters—are not enough to prevent domestic violence deaths, as victims and perpetrators do not always share their stories with prosecutors, police officers, social workers, or even shelter staff.[42] For example, the Montana Domestic Violence Fatality Review Commission discovered that some victim/survivors were more likely to share their stories of abuse with their pastors, and so the Commission included a pastor on certain case reviews.[43]

We recommend that Review Teams include a survivor as a permanent member, albeit one who does not review their own case. Survivors who attended the Partnership's survivor listening session overwhelmingly agreed that an individual who survived domestic violence should be at every case review to represent a victim/survivor perspective.

The Louisville Review Team has found survivor participation to be essential in helping team members understand why victims may behave in ways that seem counter intuitive to people who have not experienced domestic violence and abuse. This Review Team's work resulted in a training for state judges on why survivors should not be punished for staying in abusive relationships, especially when there are children involved, because sometimes staying may be a safer option than trying to leave. The Louisville team also reported that their case reviews have found that in some cases, prosecution of the perpetrator may further endanger the victim and any children involved.

Scholars who study domestic violence identified perpetrators as an understudied area. A single perpetrator can have dozens of victims in their lifetime, said Carolynn Brooks, the Georgia team coordinator, so Review Teams should respectfully but in good conscience examine the perpetrator's role in the story.

Scholars who study domestic violence identified perpetrators as an understudied area.[44] A single perpetrator can have dozens of victims in their lifetime, said Carolynn Brooks, the Georgia team coordinator, so Review Teams should respectfully but in good conscience examine the perpetrator's role in the story. As such, the National Domestic Violence Fatality Review Initiative highly recommends that Review Teams include defense attorneys who were not involved in the case being reviewed. In Illinois, public defenders are part of the regional teams that conduct localized reviews to ensure that teams are truly multidisciplinary. The Contra Costa team has also considered including attorneys and peer advocates representing parents in child welfare proceedings, in order to represent similar perspectives.

Teams serving rural counties should ensure the participation of resources shared across other counties to maximize impact. For example, Shasta County is home to Mercy Medical Center, which is the only hospital serving rape crisis victims for eleven nearby counties.

Finally Review Team members should reflect the communities in which the deaths or incidents occurred so that recommendations are tailored to California's diverse communities, which can help address California's historical gap in serving marginalized victims/survivors.[45] (See page 24 for further discussion.) Over a third of survey respondents stated that their counties' diverse communities are not represented on their Review Teams.

Who Attends on Behalf of the Organization

Several Review Teams emphasized that actively recruiting the right individuals to attend on behalf of their organizations can determine a Review Team's success. The best individuals are experienced, dedicated, line staff with institutional knowledge. It is not necessary for the participating individuals to be high ranking in their organizations' hierarchies, although they should be knowledgeable about organizational capacity and resources.[46] Organizational leaders and elected officials can engage with teams periodically to demonstrate support and improve morale.

The most important criterion for selecting team members is that the person be a highly motivated but disciplined individual who balances objectivity with empathy and energy for the work. These individuals will naturally fight for change within their own agencies and can commit their agencies to change during Review Team meetings.[47] (For more strategies about effective implementation, see page 44.) Several Review Teams advised that in addition to being able to commit their organizations to such changes, team members who have significant experience are also less defensive and more willing to engage in difficult but illuminating conversations.

A Review Team does not need to include an organization's top leaders to be successful and implement reform. Individuals in leadership may have less insight into day-to-day operations. The Santa Clara team includes retired members with institutional knowledge. **Tara Anderson, one of the architects of the San Francisco Review Team, recommends spending time to identify and build relationships with key mid-ranking law enforcement officers by educating them about the importance of the Review Team's work. These individuals may not serve on Review Teams, but nonetheless affect the Review Team's work by carving out department time and resources.** Several teams recommend creating a succession process to remedy the problem of turnover. The outgoing team member selects the incoming team member weeks or months before leaving, and the two members overlap for several case reviews, to ensure a seamless transition.

Changes in organizational leadership can also bring uncertainty to Review Teams, and many of the Review Teams we interviewed recommend taking every opportunity to educate new police chiefs and district attorneys about the Review Team's work. Teams have found success in framing the Review Team's work as, for example, finding ways to help prosecutors or service providers understand how best to support first responders, including improving officer safety. For example, Carolyn Hanson, the Vermont team's coordinator, recalls a case in which a woman was killed by her husband. The Review Team interviewed family members and discovered that on a prior occasion when police had responded to a domestic violence call, the husband, who had access to a gun, had been hiding in the closet, listening, while police officers were trying to convince the woman and other family members to press charges.

In a survivor's own words

"I always think it's really important to have victims and survivors and thrivers present at the table."

Once individuals have been selected to participate in a Review Team, several Review Teams recommend sending formal invitation letters. These letters are useful for members' professional development and incentivize participation.

Training Members

Several Review Teams identified a need to train members on how to conduct a case review, the legal confidentiality mandates of each participating organization, the effects of trauma, anti-bias, restorative or transformative justice, and other topics. Review Teams should not assume that team members are already sufficiently trained in such topics, even if they are experts in the field of domestic violence. Review Teams are invited to contact the National Domestic Violence Fatality Review Initiative at Arizona State University for in-depth, free online and in person training and technical assistance on how to conduct case reviews.[48] The Quattrone Center for the Fair Administration of Justice is also a resource for effective case review.

It is essential that case reviews avoid re-traumatizing participants, including victim/survivors, and their family members.[49] Service provider respondents to the Partnership survey and survivors themselves repeatedly identified a need for training in trauma-informed responses. Trauma training can help Review Teams identify instances in which a victim/survivor's and a perpetrator's past traumatic experiences prevented them from engaging with services.[50]

Training on the effects of trauma not only improves the quality of case review work, but also builds team resilience. Training on vicarious and secondary trauma can help reduce high turnover, which can result from case review related emotional burnout.[51] The Illinois Statewide Fatality Review Committee recommend training sessions on vicarious trauma and intimate partner induced traumatic brain injury for newly established teams.[52] The entities that provide these trainings are included in the resources in Appendix F on page 64.

Trainings on implicit bias and cultural competency can help team members learn to recognize their own limitations, and trainings on restorative justice practices are necessary to remedy California's failures to serve marginalized populations, as identified by the Little Hoover Commission's 2022 report, and discussed in detail on page 24.[53] A list of organizations that conduct such trainings, their contact information, and other resources are available in Appendix G on page 68.

Box 6: Common Challenges and Potential Solutions

Frequent team member turnover

- Conduct training on vicarious and secondary trauma to avoid burnout (see page 12).
- Create a clear succession plan so the outgoing member can train the new member from their agency (see page 11).
- Adopt an incremental approach and focus on a small number of recommendations to focus resources and reduce frustration and burnout (see page 42).

Limited funding and resources

- Teams may choose to apply for direct grants from the federal Department of Justice. The Quattrone Center and the National Initiative have received funding to support Review Teams (see page 5).
- Teams may choose to appeal to the county board of supervisors for financial support. The Contra Costa County team is funded directly through the county's general fund. Contact information can be found at Appendix B (see page 53).

Low attendance at team meetings

- Rely on the help of Review Team members who regularly work together to encourage attendance (see page 11).
- Recruit individuals passionate about domestic violence prevention within their respective organizations and agencies (see page 11).
- Issue formal letters of invitation to team members (see page 11).
- Issue letters of commendation for inclusion in personnel files, which help with team members' professional development (see page 11).
- Invest time and energy in discussing the team's work and successes with agency leaders and mid-level managers, who can help carve out time for members to attend (see page 11).

One dominant perspective during case review

- See Box 8 on page 29.

Low trust/suboptimal information sharing

- See Box 8 on page 29.

Inconsistent or absent implementation (see page 42)

- Adopt a multi-year strategy of incremental reform.
- Choose informal and formal published recommendations based on team resources.
- Create an action plan to track the status of recommendations and assign action items to team members.
- If possible, appoint a coordinator to support team operations.
- Set aside dedicated meeting time for implementation.

This section discusses the legal and ethical practice of adopting and using confidentiality protocols and confidentiality agreements and, when necessary, obtaining informed consent. This section also explains the complex privacy laws that bind the Review Team and its members as individual professionals[54] and employees of their respective agencies, and how these laws impact information sharing and publication of the Review Team's work. California law states that no organization or individual shall be required to disclose requested information.[55] Whether a Review Team shares its findings either publicly or with member agencies and stakeholders, it must ensure that no privacy laws are violated, and it should carefully review its presentation or publication to ensure that it is consistent with the Review Team's adopted guiding principles.[56]

Confidentiality Protocol

The use and adoption of confidentiality protocols establish information-sharing guidelines to protect individual privacy rights. Confidentiality agreements define a team member's individual responsibilities.[57] Adopting such protocols and making them public will help create trust with the community and may lead to greater participation from victim/survivors and identification of near-death reviews. A sample confidentiality protocol and confidentiality agreement are provided in Appendix D on page 60 and Appendix E on page 63.

A confidentiality protocol explains the steps that the Review Team will take to ensure that the Team does not violate California law, which prohibits the disclosure of any verbal or written communication or document shared or produced by a Review Team that is related to a domestic violence death or near-death.[58]

A confidentiality protocol should state:[59]

- That all members and participants must sign the agreement before engaging in any work related to the Review Team;[60]
- That each meeting should begin with a review of the confidentiality protocol;[61]
- That all data and documents—including personal notes—created or circulated must be stored in a secured setting, such as with encryption, password protection, or two-factor authentication;[62]
- The approved methods of data collection, use, and storage, which may be regulated by local, state, and federal confidentiality policies;[63]
- That all data and documents, including personal notes, should be destroyed after every case review, unless retained for the purpose of analysis;[64] Review Teams may choose a designated note taker to minimize the chances of disclosure of individual notes;
- That meetings will not be recorded without a confidentiality protocol and secure data storage policy to ensure that no one outside the team can access the information;
- That members cannot and will not share any information or documents outside the team, including with colleagues at their respective agencies, unless otherwise obligated by law, such as in the case of *Brady* disclosures;[65]
- That during virtual meetings, members must confirm they are alone in the room while participating in the meeting, and that any screenshots must be treated as notes and be destroyed after case review;[66] and
- The consequences if a participant is found to be in violation of the confidentiality protocol or agreement, including removal of the member from the Review Team.[67]

Review Teams that review death cases pending prosecution (Review Teams are not authorized to review near-death cases pending prosecution) choose additional protections. For example, the confidentiality agreement of the Santa Clara County team prohibits anyone who attended a case review from working as an expert in the criminal or civil case related to that incident.[68] And the Riverside County Review Team confidentiality agreement states that any new information reviewed by the district attorney during case review must be disclosed to the defense.

Informed Consent

To facilitate the victim-survivor's healing process, the victim-centered, trauma-informed approach is for Review Teams to obtain written, informed, and time-limited consent from a victim-survivor to review their case, regardless of whether or not they participate in the review. Review Teams should also obtain informed consent for interviews from all case-related participants, including the victim's family and friends, or the perpetrator, in order to respect individual autonomy and promote healing.[69] Review teams must provide appropriate referrals for any unmet need of a victim/survivor or a family member.[70]

In a survivor's own words

"The biggest obstacle is how are you going to ensure that the victim is not getting any repercussions for sharing their story, or for trying to make a change, because I don't want to be a martyr when my kid is on the line."

Teams reviewing near-death cases must take extreme care to avoid inflicting continued trauma on the victim-survivor, which is counterproductive to the Review Team's mission. Survivors, service providers, and mental health experts emphasize that a victim/survivor's priority is processing the trauma of their experience and protecting their own safety and the safety of their children.[71] A survivor's ability to regain a sense of control over their environment, emotions, and the way their story is told is a key element of healing that enables a survivor to disengage from cycles of abuse and move toward thriving.[72]

Before a case review or witness interview, a Review Team representative, ideally a coordinator who is a mental health professional, should meet with case-related participants to explain:

- The Review Team's goals, what will and will not be accomplished during the case review, and realistic expectations of change. The representative should be transparent about how the individual's information will be used in the review and whether it may be included in any public reports;[73]
- That the individual's participation is always voluntary;[74] that they may withdraw it at any time, and that the Review Team may request their consent again after a period of time;
- That there is an imbalance inherent to the case review, as the Review Team may receive valuable insight from the participant, but the participant may have less to gain from their participation;[75]
- That if during a review, unreported incidents of child abuse or other potential harms are discovered, these incidents must be reported by law; and
- That despite best efforts, a Review Team interview may re-traumatize participants as they relive their violent experience.[76]

After this initial conversation, the team representative can present an informed consent for participation for the participant to sign. A sample consent form is available in Appendix F on page 64. **Although this document can help the participant determine what information to disclose to the Team, it is not legally sufficient to release medical information to the Review Team under federal and state laws[77] or to release information held by agencies funded by VAWA, VOCA, or FVSPA.[78] See page 17 for a detailed discussion of these laws.**

In their analysis, Review Teams should discuss how the use of informed consent may impact their conclusions.

Information Sharing

Some Review Teams require all participating organizations to sign a memorandum of understanding to participate on the Team, to ensure that all members understand their duties and that member organizations commit to the Review Team's information sharing practices. Regardless of such agreements and the legal protections in California for Review Teams, Review Team members may also be prohibited by law from sharing information held by their organization with other Review Team members without an individual's consent, even if the information is only used for case review purposes.[79]

As discussed below, each statute's requirement for legally sufficient consent is different, and under several of these laws, an individual's consent is only legally sufficient if it is given for each specific instance of use, for a specific purpose, and for a specific amount of time.[80] The laws surrounding confidentiality and privacy are complicated, and Review Teams and individual members should consult with attorneys for advice when issues related to information sharing arise.

Box 7: Engaging Survivors and Family

- Make the first contact in person but defer to the victim/survivor or family member as to the preferred manner and frequency of communications.[81] Victim/survivors should not be approached by anyone associated with the perpetrator.
- Always prioritize the victim/survivor's safety, including from the perpetrator, family members and community who do not agree with the victim/survivor.
- Consider and disclose all potential actions from government agencies such as child protective services.
- Arrange for an interviewer ideally with social work or other clinical experience to meet separately with the witness and report back to the Review Team unless the witness expresses a wish to speak to the Team as a whole.[82] However, any team member who is trauma-informed, empathetic, and has good emotional intelligence may conduct interviews.
- Clearly communicate expectations about the process from the start and throughout the review.[83]
- Ensure support from an advocate or therapist through a service provider during the review process.[84] Members of the Review Team should not be the advocate, as the Review Team needs to be fully independent and may reach conclusions that the interviewee disagrees with.[85]
- Provide logistical supports including transportation, childcare, and compensation for their time, without which a large population of victim/survivors will not be able to participate, as shared in the survivor listening sessions conducted by the Partnership.
- Provide a list of the questions in advance of the interview. Defer to them as to what they choose to share. Permit them to review notes to allow more control over the narrative.[86]
- Update them on the progress of the review.[87]
- Enable them to choose a pseudonym for themselves or the deceased victim, or to anonymize certain details in any public reports.[88]
- Be respectful and make every attempt to accommodate religious, cultural, linguistic, and other particular needs.[89]
- Give them enough time and privacy to review draft public reports and record their areas of disagreement but be transparent that their disagreement may not be incorporated into any public report.[90]
- Inform them of any report publication and potential media attention. Be mindful of key dates, such as birthdays or anniversaries.[91]
- Invite them to help implement recommendations.[92]

Entities Subject to Confidentiality

Generally, the following entities are subject to confidentiality and privacy laws that may prevent them from sharing information with Review Teams.

- Entities that receive funding under the Violence Against Women Act (VAWA), Family Violence Prevention Services Act (FVPSA), and Victims of Crime Act (VOCA) are subject to certain requirements.[93] These entities may include community-based organizations, victim services divisions of

law enforcement agencies, tribal representatives, women's shelters, institutes of higher education, medical clinics, and legal services organizations. Specific law enforcement divisions that receive VAWA funds may not disclose any personally identifying information with other divisions of their organization without the appropriate release.[94]

- Entities that maintain medical information protected by the federal Health Insurance Portability and Accountability Act (HIPAA) and the California Confidentiality of Medical Information Act (CMIA) are subject to varying requirements.[95] These include medical providers, staff of medical facilities and county health offices, insurance providers, and health care service plans.[96] These providers are also subject to the California Unfair Competition law, which protects patients from unfair business practices including unlawful disclosure of patient medical information.[97]
- Educational entities must protect student and staff institutional files under the Family Educational Rights and Privacy Act (FERPA) which applies to all public and private elementary, secondary, and post-secondary schools, and any state or local education agency that receives federal funding.[98]
- Public and private employers must protect the employment records of their employees pursuant to the California Constitution and as supported by case law.[99] Federal law limits what information federal agencies and the military may maintain for their employees.[100]

The Violence Against Women Act (VAWA), Family Violence Prevention Services Act (FVPSA), and the Victims of Crime Act (VOCA) prohibit funded agencies from disclosing personally identifying information of the victim/survivor.[101] Identifying information of a victim-survivor includes their name, current address or location, date of service request, names and ages of their children, and current address or school enrollment data.[102]

These entities, many of which participate as permanent members of Review Teams, may share aggregated, non-identifying information without the specific consent of the victim/survivor. They may also share information generated by courts, law enforcement, or prosecuting attorneys, for protective order and prosecution purposes only.[103] **However, if the entity cannot obtain the informed consent of a survivor-victim, then they cannot disclose identifying information to the Review Team, regardless of whether all members or participants have signed a confidentiality agreement.[104]**

Even if the victim is deceased, VAWA-funded entities are nonetheless prohibited by law from sharing the personal information of a deceased victim, unless all of the following conditions are met:[105]

1. The underlying objectives of the fatality review are to prevent future deaths, enhance victim safety, and increase offender accountability;[106]
2. The review includes "policies and protocols to protect identifying information, including details about the victim's children, from further release outside the fatality review team";[107]
3. The entity makes a reasonable effort to obtain a release from the victim's personal representative (if one has been appointed), and from any surviving minor children or the guardian of the children (but not if the guardian is the abuser of the deceased parent), by sending the release by mail to their home address;[108] and
4. The information released should be limited to what is necessary for the review.[109]

If the entity does not have the contact information of the victim's personal representative, surviving minor children, or their guardians, then the entity may be prohibited by federal law from sharing any information with the Review Team, even if the victim is deceased.[110]

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that protects the privacy and security of an individual's health information, and the California Confidentiality of Medical Information Act (CMIA) is its state law counterpart, which offers additional protections.[111] HIPAA applies for 50 years after the death of the individual, so the same protections apply to a deceased victim as to victim-survivors.[112] A medical provider may obtain a release from the deceased victim's personal representative – an executor, administrator, or person with statutory authority to act on behalf of a decedent or decedent's estate.[113]

A patient's consent is necessary for health providers to share information with Review Teams, unless very specific conditions are met.[114] Releasing information without a patient's consent may also violate California's Unfair Competition Law and subject a medical provider to civil penalties and injunctive relief.[115]

The Family Educational Rights and Privacy Act (FERPA) protects all students and staff institutional files, including health information, immunization records, medical test results, and medical evaluations.[116] The parent or an eligible student must consent to the release of records, although there are narrow exceptions.[117]

Finally, an individual's personal information is protected by the California Constitution, and these privacy rights include the ability to dictate whether personal information is shared.[118] It is unlawful to misuse sensitive and confidential information, which may occur when information is used for purposes other than the specific cause it was collected to serve or when dissemination leads to unjustified embarrassment or indignity.[119]

Public Presentations

When Review Teams share case review information with the public, they must also abide by the laws discussed above, which protect the privacy rights of living and deceased individuals.[120] Under various federal privacy and confidentiality laws discussed above, consent to release information must be for specific purposes and for a specific amount of time. Just because consent is provided for case review does not mean it has been obtained for report publication.

Publication of private information may lead to legal consequences. Under the California Constitution, individuals may file lawsuits against public or private entities for the dissemination or misuse of sensitive and confidential information.[121] Various government agencies may also investigate and assess penalties for violations of privacy laws.[122]

Review Teams can best abide by their legal obligations by obtaining consent from case-related participants who specifically allow Review Teams to publish their information.

Ethical Considerations

In addition to these legal mandates, Review Teams must act ethically.[123] Participation in a review is voluntary, so teams should ensure that their policies seek to uphold trust in their member agencies and representatives.[124] Although a Review Team's members may share information with one another (subject to the limits discussed above) and may discuss certain information such as mental health diagnoses and treatment or requests for legal services, Review Teams should not use that information in a way that could undermine a victim-survivor's confidence in engaging with services.[125]

Several Review Teams emphasized that no information shared during the Review Team's work has resulted in a new criminal case. *However, survivors repeatedly emphasized their fear that participating in*

case reviews may lead to systems actions, such as child protective services investigations. **Review Teams should be transparent about team members' mandatory reporting obligations**, while also adopting guiding principles to address these top-of-mind survivor concerns. The adoption of guiding principles, discussed in the Establishing a Review Team section, will aid Review Teams in discussing these topics and making these difficult decisions.

Review Teams should share details, such as relationship history or drug use, and discuss these details in a way that contributes to systemic reform.[126] Review Teams should avoid victim-blaming tropes or sharing and discussing details out of prurient interest.[127]

NEAR-DEATH INCIDENT REVIEWS

In 2022, the California Legislature changed the law to authorize Review Teams to conduct near-death reviews.

Near-death reviews are not conducted in a substantively different manner than death reviews. However, unlike death reviews, Review Teams are not authorized to conduct near-death reviews where prosecution is pending.[128] **Near-death incident reviews must be done with the utmost care and consideration for the safety of the survivor. Distance from the incident is essential, so that the victim/survivor has dealt with the immediate impact of the incident and has healed enough to be able to think and speak about what happened without concerns about immediate survival predominating.** Survivors and service providers defined readiness to engage as a state of stability, mental health, and the existence of a strong support system, rather than a specific amount of time. If the individual participates prematurely out of a sense of obligation or pressure, they may be retraumatized by the process. The decision about whether or not to participate must be the victim/survivor's choice to make, free of pressure or fear of consequences for choosing not to participate.

Given the potential for re-traumatizing and out of respect for the victim/survivor's experience, Review Teams should not review near-death cases until the team establishes consensus around the goals of a near-death review.

Teams should request informed consent from victim/survivors to review their case, even if the victim/survivor declines to be interviewed, unless the case review can be done in a completely anonymous way. This will also improve case review. One service provider stated in the Partnership survey that in one case review in which they participated, a survivor's consent to share information would have helped the Review Teams identify barriers. Without that survivor's consent, the Review Team was not able to access certain protected information.

A Review Team's confidentiality protocol, confidentiality agreement, and informed consent forms should state that when there is a criminal matter associated with a case, the prosecution may be legally obligated to turn over any new information discovered during the case review to the defense, even though prosecution has concluded.[129]

What should the team do with the information that it learns?

"If they attend various death reviews and it's the same thing that they're mentioning that's failing every time, then what is the purpose of attending or having these meetings?"

Experts and Review Teams that have conducted near-death reviews strongly advise that victim/survivors should not attend the case review. However, an individual who survived domestic violence should be at every case review, to represent a victim/survivor perspective. The following are priorities identified by survivors and service providers through the survey and listening sessions conducted by the Partnership, and through reviews and interviews of teams that have conducted near-death reviews. [130]

Review Priorities

Protecting the survivor's safety.
A near-death incident review is safest and most ethical if the perpetrator is deceased.[131] Where the perpetrator is incarcerated, even with a sentence of life without parole, the Review Teams should consider the potential negative impacts on the survivor, including:

- The incarcerated perpetrator learns of the survivor's participation and sends a third party to intimidate or act violently against the survivor;
- The incarcerated perpetrator attempts to retaliate against the survivor through the perpetrator's continued contact with their child;
- The incarcerated perpetrator is unexpectedly released and retaliates against the survivor many years in the future.

Teams should be aware that a survivor's sources of harm may include the perpetrator, the family of the perpetrator or survivor, and their community, who may not agree with the survivor's choices.

Teams should assign an advocate to the victim/survivor to review their rights, to discuss safety planning, and to help determine whether they feel safe to engage in the process and whether they are receiving adequate support during and after their participation.[132]

Teams should be aware that a survivor's sources of harm may include the perpetrator, the family of the perpetrator or survivor, and their community, who may not agree with the survivor's choices.

Healing emotional and psychological trauma.
It is imperative that sufficient time has passed for the victim/survivor to heal from their trauma and to ensure that they are no longer in crisis. The Partnership recommends a range between two and five years.

Teams should approach the victim/survivor through an individual specialized in trauma and to whom the victim/survivor feels comfortable to say "no." Teams should make clear that participation is completely voluntary, and that participation does not change whether or not the victim/survivor can receive services. **During listening sessions, some survivors stated that no one associated with law enforcement, child protective services, or the perpetrator should ask a victim/survivors for permission to review their near-death case.**

Review Teams should create a safe, comfortable, and empowering space for victim/survivors to tell their story outside of the criminal justice system.[133]

Review Team members should display compassion, cultural awareness, and genuine interest in survivor experiences, even where those experiences may include missteps or systemic racism at member agencies, or where members do not agree with the survivors' decisions. Team members should demonstrate understanding that it takes time, support, finances, and sometimes multiple attempts to leave a violent relationship.[134]

Avoiding alienating the survivor from a system they may later need.

Survivors often live in the communities in which they were abused. A request for the survivor to give feedback about how agencies function in those communities may alienate them.[135] In order to avoid these negative consequences, the Georgia Team did not share all case information with all team members, especially where team members personally knew the survivor or there was reason for other confidentiality concerns.[136]

What supports, processes or team qualities are important in a Review Team reviewing your near-death case?

"I would want them to be well informed, trauma informed, so that I'm walking into a safe space where I ...[do] not feel judged or be victim blamed. It should be a space for me to also be encouraged and empowered [to] heal."

Teams should adopt guiding principles in order to balance the victim/survivor's privacy rights against the goal of identifying insights that may uncover new incidents of domestic violence.[137]

Potential legal issues

Before reviewing near-death cases, teams should discuss how to proceed if the review uncovers unreported crimes and decide how to weigh the benefits of review against this potential risk.[138] Previously unreported incidents disclosed by a victim-survivor could give rise to mandatory reporting by members of a review team, as required by law.[139]

The Little Hoover Commission, a non-partisan, independent investigative state agency, concluded in 2021 that "California lacks a coordinated, cohesive strategy" to prevent domestic violence and provide survivors with long-term support.[140] The Commission found that California agencies and services have not met the needs of communities with language, cultural, and geographic barriers.[141] The Commission recommended that the State develop a domestic violence reduction plan that prioritizes "often overlooked groups."[142] This section summarizes the challenges and suggested remedies in prioritizing marginalized communities for Review Teams.

Challenges

Underreporting

Although domestic violence is under-reported in the population as a whole, it is particularly under-reported in marginalized communities for numerous reasons. **One California study reported that Black women avoid calling the police due to the risk that the police may mistake them as the perpetrator, separate them from their children,[143] or harm or kill their partner or themselves.[144] These fears are supported by other research, which shows that compared to white parents, Black parents are more likely to be reported and investigated by state welfare agencies, and to have their parental rights terminated.**[145] A 2008 study found that compared to white children in child welfare investigations with similar facts, Black children were 77 percent more likely to be removed from their homes.[146] The proportion of Black youth placed in foster care is four times higher than their proportion in the California population, a figure similarly experienced by Native children.[147] Native children are overrepresented in foster care in California at a rate twice their proportion in the general population, which may contribute to under-reporting, despite high rates of domestic violence.[148] Immigrant victim/survivors may avoid reporting due to fears of deportation, or a general distrust of authorities instilled by experiences of state-sponsored violence or harassment in their home countries.[149]

A 2008 study found that compared to white children in child welfare investigations with similar facts, Black children were 77 percent more likely to be removed from their homes.

Victim/survivors may also decline to report based on past experiences with services that did not meet their needs. Law enforcement and domestic violence service providers may lack adequate interpretation services or other resources for victim/survivors with disabilities.[150] The effects of these barriers are intensified as some victim/survivors develop disabilities as a result of the injuries inflicted by their abuser, and the disability prevents the victim/survivor from seeking help and accessing services.[151] Although women with disabilities are 40 percent more likely to experience domestic violence, research has found that police are less likely to respond to reported violence against victims with disabilities than victims without disabilities.[152]

Services sometimes do not have sufficient resources to help victim/survivors who lack money to leave a relationship, an experience which may be more likely in rural and other marginalized communities.[153] A lack of cultural responsiveness when interacting with law enforcement or social services may lead victim/survivors to conclude they will not receive help when reaching out to these institutions.[154]

LGBTQ+ victims/survivors may decline to report because few shelters, support groups, hotlines, and services are trained in and comfortable working with LGBTQ+ individuals and family structures.[155] LGBTQ+ victim/survivors fear being inadvertently outed and risk greater harm as a result.[156]

Fear of loss of community may deter members of tight-knit communities from reporting. LGBTQ+ victim/survivors may lose community if it includes their abusive partner, which is especially painful if they are estranged from their unaccepting biological family.[157] Loss of community may result from cultural norms of non-reporting for immigrant survivors or other close-knit cultural communities.[158] Victim/survivors from these communities may reach out for help from friends, relatives, or religious or other cultural institutions.[159]

Misidentification

Where reporting does occur, research has revealed that government agencies and service providers disproportionately misidentify domestic violence incidents in marginalized communities, both leading to and resulting from errors during investigations.[160]

Domestic violence data gathering is incomplete. Surveys often track race but not ethnicity, which can lead to the inaccurate characterization of some individuals (e.g. Latinx, Indigenous) as white.[161] Law enforcement officers may also misidentify the race or ethnicity of perpetrators or victims. **The Alameda County team tracked down the birth certificates of all decedents in its reviewed cases and identified many errors in police reports.** The Centers for Disease Control does not track level of urbanization in its reports and therefore its data does not consider how the experiences of rural victim/survivors differs from other populations.[162]

California currently does not track Native American domestic violence incidents or deaths, and one study of California crime databases showed errors in racial classification in one third to over half of cases involving Indigenous victims.[163] Native communities report heightened levels of missing and murdered women and girls, and failures of record keeping and resources mean that there is no accurate count of the number of such cases in California.[164] Only nine percent of murders involving indigenous women and girls in California are solved, compared with a state-wide homicide clearance rate of over sixty percent. [165] **Many cases involving Indigenous people are characterized as disappearances, accidents, or suicides even when friends and families believe these characterizations to be false.**[166]

Native children are overrepresented in foster care in California at a rate twice their proportion in the general population, which may contribute to under-reporting, despite high rates of domestic violence.

Government agencies and social services sometimes overlook deaths that do not conform to the social expectations. LGBTQ+ domestic violence incidents do not conform to the expectation of a male perpetrator harming a female victim.[167] **The Alameda County team reported instances in which law enforcement failed to notice or record the presence of a same-sex intimate relationship between a victim and perpetrator, such that the death was only recorded as a domestic violence case due to the team's work.** Elder domestic violence deaths are sometimes assumed to arise from natural causes, leading to an incomplete postmortem examination or lack of autopsy.[168]

Agencies and service providers sometimes do not characterize individuals who fight back against their perpetrators as victim/survivors,[169] and Native American and Black women have higher rates of killing

their perpetrators than Caucasian and Latina women.[170] Racial stereotypes of Black women as more violent may lead to their mischaracterization as a co-perpetrator or main aggressor.[171] In case reviews, California Review Teams stated that they have struggled with lack of expertise and community understanding in cases where both domestic violence and gang relationships are present. Research has also shown that medical providers tend to underestimate or minimize their assessment of Black women's pain or injury, which may lead to further misidentification of cases.[172]

Remedies

Review Teams should aim to remedy these issues through every step of their work from selecting a guiding principle to choosing and implementing recommendations. To start, Review Teams may choose to adopt community repair as a guiding principle.

Review Teams should be annually trained on implicit bias and cultural competence, even where members already receive training through their organizations. These trainings teach team members to practice self-awareness and cultural humility during case reviews, which is necessary to recognize how a victim/survivor or perpetrator's culture is central to how they interact with law enforcement, service providers, or other stakeholders.[173] These skills can guide teams on how to discuss the trauma experienced by a community, how that affects patterns of domestic violence and interactions with government agencies, or how cultural beliefs influence survivors' decision-making.[174]

Review Teams should aim to better serve marginalized communities through every step of their work from selecting a guiding principle to choosing and implementing recommendations.

A Review Team should include permanent and/or ad hoc members of the diverse community that it serves.[175] For example, a representative from the Deaf community is necessary for case reviews that include the impact of injuries related to domestic violence like loss of hearing. Victim/survivors from certain communities may rely more on faith leaders or informal networks of support instead of reporting to law enforcement.[176] These networks are therefore a potential point of intervention, especially if they can help to avoid family separation.[177] The San Diego team includes representatives from Native American and military communities and the San Francisco review team partnered with Black Women Revolt Against Domestic Violence and La Casa de las Madres to provide outreach and assistance with case identification. Community members help improve case identification and witness participation, and lend expertise to case reviews so that recommendations are effective.[178] The Alameda team reported one case in which a community representative helped improve services provided to their community by explaining to the Review Team how cultural perceptions of the perpetrator's mental health disorder may have complicated earlier interventions. In another case, the Review Team relied on a community representative to develop a culturally tailored Mommy & Me group to create a supportive space that previously did not exist.

Community input is essential, as remedies to these problems are not always simple. One California county reported that although its agencies hired bilingual staff to support one specific immigrant community that spoke an uncommon language, one year after hiring, the agency still had not served any member of that community. Since then, the county has focused on increasing awareness of its services and expanding resources to serve that community.

Review Teams may intentionally choose to review cases from communities that have been overlooked to fill the gaps identified by the Little Hoover Commission: "[t]he state does not have a firm grasp of the full scope and impact of intimate partner violence on Californians who are not cisgender white women and whether it is meeting their needs – though conversations with advocates from those communities suggest it is not."[179] When county data indicates elevated levels of domestic violence and/or related deaths in a given population, this information can serve as a signal that a Review Team should dedicate time to investigating why. In doing so, a Review Team may choose to gather representative organizations and community members for a single review or limited series of reviews with the aim of gaining an in depth understanding of the nuances of domestic violence for that community in that jurisdiction.

Such a focus can be temporary or permanent depending on the specific features and needs of the county. For example, several teams, including New Mexico, Arizona, and Montana, created subcommittees or separate committees to review Native American cases on an ongoing basis to ensure continued attention to the unique needs of this community.[180]

The work of a truly collaborative Review Team creates personal relationships that improve interagency cooperation, separate from developing recommendations.[181] **Numerous Review Teams reported, and research shows, that building trust to support honest and difficult conversations is fundamental to a Review Team's success and longevity.**[182] Without buy-in from team members, some counties in California have struggled to form teams at all. Several respondents to the Partnership survey stated that the Review Team on which they participate does not operate well. One respondent stated that they faced "a lot of victim-blaming and/or saying we did not do enough to support the victim from some of the other partners."

Ensuring buy-in from all members is particularly important given the diverse disciplines and professional and personal backgrounds that are necessary to ensure an insightful case review.[183] Several long-running Review Teams advised that trust takes time to build, and it may take several years before all team members consistently participate.

Team members like defense attorneys, prosecutors, restorative or transformative justice advocates, law enforcement agencies, and community faith leaders may have spent years on opposing sides of public debates, especially in marginalized communities. Review Teams need not resolve these different perspectives, as that may not be possible.[184] Instead, it is essential that the Review Team agree as a whole to invest time and care to acknowledge these differences, but also each other's shared dedication to the reduction of domestic violence incidents.[185]

Review Teams may choose to engage in trust building separately from case reviews at a first team meeting, at an annual planning session, or at a dedicated time during each team meeting. These discussions can include collaborative decision-making related to Review Team operations, like choosing a guiding principle, applying for grants and other funding opportunities, selecting or rotating a chair, or choosing trainings for Review Team members, discussed further below. Teams may also choose to first discuss a fictional case in order to identify potential areas of tension.

For example, when the San Francisco team reconvened after receiving additional funding in 2018, it dedicated its first meetings to discussing and committing to guiding principles.[186] In Contra Costa, the Team engages in a restorative justice exercise at the beginning of each meeting, and in San Mateo, the Team discusses different meanings of "prevention[,]" which may evolve as team members conduct case reviews. "We hardly in law enforcement ever find out the reason 'why' for crimes," said Craig Campbell, a retired police officer, in speaking about his experience as a member of the Montana Domestic Violence Fatality Review Commission.[187] His work on the Commission allowed him to see the factors that led to the crime.[188]

Building personal relationships between Review Team members is an important objective of the Review process.[189] The chair or coordinator should create space and invite comment from Review Team members who may historically hold opposing perspectives.[190] This productive disagreement broadens the perspectives of participants. While their work on the Review Team hasn't "changed the world," said Julie Falkenstein, who serves on the Stanislaus team, the team's work has "changed the people who sit in that room[,]" which has led to improved community responses to domestic violence.

Productive disagreement allows team members to recognize the limitations of their own organizations, and humanizes both victims and perpetrators.[191] "The Domestic Violence Fatality Review Team has allowed me to become a better investigator," said FBI agent Brandon Walter. "There's more consideration

on my mind than just the collection of evidence."[192] This type of collaborative approach can reduce turnover, a challenge identified by nearly all Review Teams interviewed by the Office of the Attorney General.

Discussing difficult topics in an inclusive and compassionate way improves trust between team members and reduce tension when team members, such as domestic violence service providers, are not able to share information due to legal confidentiality mandates. (See Confidentiality and Ethics section.)[193]

Box 8: How to Build Trust

Below are techniques to build trust and facilitate productive disagreement among team members.

- Discuss and adopt guiding principles and refer back to these principles regularly during meetings and discussions.
- Use a neutral facilitator during case review or rotate the agency that chairs the team.
- Conduct trainings on the confidentiality requirements that apply to each team member.
- Discuss and collectively make foundational team decisions by consensus, like co-creating confidentiality protocols (see page 14), applying for grants (see page 4), setting up rotating chairs (see page 4), and pursuing or not pursuing review of near-death cases (see page 21).
- Sending the confidentiality protocol and agreement to members to allow their attorneys to review.
- Set aside dedicated time for trust building, like engaging in restorative justice exercises, both as a matter of course at the outset of reviews and as disagreements arise. (Teams may reach out to the Contra Costa team for advice on this process. Contact information for all Review Teams in California is available starting on page 53.)
- Acknowledge each Review Team member's deep dedication to reducing domestic violence incidents at the beginning of each meeting.
- Collaboratively build a factual timeline (see page 30).
- Limit the Use of Professional Jargon: legal jargon, like using "TRO" for temporary restraining order; law enforcement slang, like using "perp" for perpetrator; medical abbreviations, like using EMS instead of emergency medical services; and service provider terms like "deficit model" may make it difficult for members from other professions to engage in the discussion.
- Actively note who has spoken and invite those who have not spoken to provide input during case reviews so that no perspectives dominate. Acknowledge differences in perspectives by using phrases such as "this is a public health or law enforcement, or prosecutor's focus."
- Use active listening phrases like: "What I'm hearing you say is this, is that right? What do others think about that idea?"
- Use roundtable discussions instead of simply relying on knowledgeable team members to give presentations and answer questions. Law enforcement and prosecution representatives naturally give more information as the team discuss the crime itself. (See page 30.)

Review Teams across the country conduct case reviews differently, and teams should choose what works best for their resources, team dynamics, political realities, and needs. Review Teams have changed their methodology, focus, and goals over time.

Methodology

Some Review Teams choose to review all domestic violence deaths in their county. One methodology uses data analysis to identify large scale trends on an annual basis. This allows the team to be responsive to changing needs of the county, as data is continually updated. The Alameda team, led by its public health department, uses an epidemiological analysis and does not conduct in-depth individual case reviews.

Some teams conduct in-depth reviews of only a select number of fatalities, which may or may not have occurred during that year. Teams that only review cases after the conclusion of prosecution will review cases that are several years old. This approach has been adapted by both small counties like Sonoma, which reviews every domestic violence fatality in the county, and large counties like Los Angeles, which selects a handful of fatalities among all occurrences within its jurisdiction to review. Some teams, like Orange County, conduct case reviews and data analysis on every fatality. These teams believe that a combination of data analysis and in-depth review identifies not only changing needs as data is continually updated, but also practical policy improvements.

An in-depth case review is not an inquiry into the cause of death, who is culpable, or how the investigation or prosecution could have been different.

Other teams change methodology over time. From 2004 to 2018, teams in Georgia conducted 128 in-depth case reviews. Since 2019, the Georgia state team has focused on data analysis to be more responsive in a timely way to large scale trends.

An in-depth case review is not an inquiry into the cause of death, who is culpable, or how the investigation or prosecution could have been different.[194] The Review Team should treat every case review as unique and try to uncover as much information as possible about relationships, events, and factors leading up to the incident. Several survey respondents reported that their team needed to review cases in more detail.

Case review should not focus only on the crime, investigation, and prosecution, but describe how violence in the relationship may have escalated over time. In this way, the Review Team can identify community recommendations to intervene before a death or a near death incident occurs. Some research has found that while it is essential to hold perpetrators accountable, "focusing primarily on the arrest and prosecution may actually create more harm than good for some victims."[195] For example, one study researched the correlation between non-injury domestic violence calls and differences in long term health risks to victim/survivors whose perpetrator was arrested versus given a warning. In the 20 years after their abusers were arrested, victims were 64 percent more likely to die of any cause when compared to victims whose abusers were given a warning.[196] The risk of death was concentrated for African

American victims, whose risk of death was twice as high when their partners were arrested than when their partners only received a warning.[197] The increase in risk for white victims was only 9 percent.[198]

A thorough and systematic case review can be divided into eight steps. The first steps occur before any individual case review. First, Review Teams should decide how broadly or narrowly to define domestic violence deaths. Second, out of an identified pool of domestic violence deaths, the team may choose to further narrow case review. Third, Review Teams gather information.

What should the team seek answers to?

"Look at the system to see how it further victimizes us when we seek help...Because that's what's killing us. When you finally speak out, all these other things happen that [do] not help us."

The next steps occur during the case review. Depending on the Review Team, each case review may last twenty minutes to several days. The Montana team meets twice a year for three days to review only one case.[199] The team will collaboratively build a timeline (step four) and identify potential risk markers (step five) and the agencies and stakeholders involved in the case (step six). **As discussed in detail below, experts advise that the identification of risk factors, or trends, is only a preliminary step in case review. It is not the entirety of the case review, or even the main step of case review.[200]**

After the Review Team has agreed upon a set of facts, it analyzes how various agencies and stakeholders worked together (step seven), identifies gaps in resources and barriers to access, and considers how these factors affected the behavior of both victim and perpetrator and contributed to the incident. Finally, the Review Team considers recommendations (step eight).

The manner in which Review Teams conduct robust, honest discussion while acknowledging all disagreements is as important as the approach that is ultimately adopted by the Review Team. See "Building Trust and Productive Disagreement" starting on page 28 for further focus on how to create conditions for this type of discussion.

Identifying Cases

By California law, a Review Team may review deaths or near-deaths "related to domestic violence[.]"[201] Domestic violence is defined as abuse between spouses, cohabitants, parents and children, individuals in romantic relationships or who have previously been in romantic relationships, or individuals who are "related by consanguinity or affinity within the second degree."[202] Abuse includes bodily injury, attempts to or threats to cause bodily injury, sexual assault, and non-physical acts such as harassment or stalking.[203] A near-death incident is defined as an incident during which the victim "suffered a life-threatening injury, as determined by a licensed physician or licensed nurse, as a result of domestic violence."[204]

This broad legal authority includes deaths or near-deaths that are indirectly related to domestic violence, including an individual who commits suicide to exit a relationship, or first responders or bystanders killed by a perpetrator.[205] This definition of domestic violence deaths or near-deaths is broader than the criminal law definition, which more narrowly refers to violence committed against a current or former intimate partner or certain unrelated adult cohabitants.[206]

Review Teams identify deaths in different ways. The entire Alameda team spends one to two full days

a year reviewing coroner's reports of every death in the county that was due to homicide, suicide, accident, or unknown causes, and follows up with approximately five additional afternoons reviewing police reports and other agency files for any case where domestic violence cannot be ruled out as a causal or contributing factor. This has led the team to identify a number of domestic violence deaths that were initially mislabeled. Other teams deputize select team members or the team coordinator to identify domestic violence deaths. In Contra Costa, the team coordinator develops a list of all domestic violence deaths in consultation with the coroner's office, then supplements this list with outreach to service providers and internet and media searches for officer involved shootings. Contra Costa has considered developing a protocol to remedy misidentification of victims from marginalized communities. See above Marginalized Populations section for further discussion on remedying the harm to marginalized populations. Carolyn Hanson, the Vermont coordinator, recalls reviewing a case of two male roommates, where one killed the other. Team members did not agree that the death was domestic violence related until after the case review concluded.

To identify near-death incidents, teams may wish to work with their team members who represent domestic violence shelters and medical providers to develop a protocol. Due to the confidentiality laws discussed above in the Confidentiality and Ethics section, this protocol must include informed consent from the victim/survivor before any legally protected information can be shared with the Review Team. **In Contra Costa, the same county agencies run several multi-disciplinary review teams, including the domestic violence high-risk team and the death review team. With consent after a victim/survivor is no longer in crisis, Review Teams may choose to follow up with victims/survivors whose cases have been reviewed by the high-risk team to request permission for a near-death case review.** See the Building Trust and Productive Disagreement section for further discussion on the necessary supports and resources to engage with victims/survivors.

Although Review Teams are authorized to review a broad number of cases, Review Teams may choose to review a small subset of cases if that is the way their community can be best served.

Choosing Cases

Although Review Teams are authorized to review a broad number of cases, Review Teams may choose to review a small subset of cases if that is the way their community can be best served. Dr. Neil Websdale, the Director of the National Domestic Violence Fatality Review Initiative, argues that a thorough review of one case can be as useful in identifying gaps in the system as a cursory review of ten cases. **In Georgia, although approximately 130 domestic violence related deaths occur per year, the state's in-depth case review teams reviewed on average only eight cases a year.[207] Nonetheless, between 2012 and 2018, the state passed twelve pieces of legislation based on the recommendations from these reviews.** These successes included legislation allowing early termination of residential leases without financial penalty in circumstances involving domestic violence and allowing courts to delay a dismissal of a petition for a temporary protective order for an additional 30 days if a party is avoiding service to delay a hearing.[208]

However the Review Team chooses to proceed with case selection, it is important to make the decision collaboratively. The case selection protocol should allow the Review Teams to review a sample of cases that accurately reflects the county in which each Review Team sits.[209] Review Teams should take particular care to consider how their work impacts communities that California has failed to adequately

serve, as identified by the Little Hoover Commission report.[210] See the Marginalized Populations section above for further discussion.

Review Teams should clearly and publicly define their case selection process and criteria to team members, agencies, and community stakeholders to establish trust and avoid misunderstandings.[211] Dr. Websdale recounted an instance in which the chair of a California Review Team worked alone to choose cases for the team's review with the well-intentioned goal of minimizing delay and red tape. However, the chair did not clearly state this reasoning to the rest of the Review Team. As a result, other members believed that the chair had chosen cases that made the chair's agency look good, leading to resentment and accusations.

Review Teams may also broaden their reach by taking case review referrals from the public. The New York State Domestic Violence Fatality Review includes a referral form on its website,[212] and while it exercises discretion regarding which cases to pursue, it gives some priority to cases received by public request.

A case selection protocol should state the factors that the Review Team considers when selecting the cases and, if applicable, whether any factors are weighed more heavily than others. For example, the Florida Domestic Violence Fatality Review considers the following factors when selecting cases for review:

- The impact of the case on the community;
- Whether or not there are any legal difficulties involved in case review;
- Whether or not the team has adequate resources to review the case;
- Whether or not the death may have been mischaracterized by media, law enforcement, or social service providers, such as later in life homicide/suicides; and
- What type of preventive strategies might be identified.[213]

Review Teams may choose to rotate their focus depending on the type of preventive strategy a case may identify.[214] For example, the risk factors and significant events leading up to familicide (murder of an entire family by one parent) may be different from the predictors of intimate partner violence.[215] The perpetrators in these cases are less likely to interact with the criminal justice system, so these cases are more likely to reveal gaps in the mental health system.[216]

Teams in California review cases both before and after the conclusion of prosecution. Review Teams are not authorized by law to review near-death cases where prosecution is pending.[217] Some Review Teams reported that reviewing cases before the conclusion of prosecution allows the team to be more responsive to changing trends. The Santa Clara team reported that their pre-prosecution case review has not impacted the ongoing criminal case. Other Review Teams reported that their practice is to review cases after the conclusion of prosecution to support the safety and healing of the victim/survivor and family. Waiting to conduct the review also ensures that it will not impact the legal case. However, it is important to note the pros and cons of both approaches; prosecution can take years to resolve, and waiting will result in reviewing older cases and risks the loss of witnesses, evidence, and the ability to deeply evaluate the current conditions of the relevant agencies. Accordingly, some Review Teams take a hybrid approach; for example, the Contra Costa Review Team takes a case-by-case approach, depending on the circumstances and needs of each incident.

Box 9: Case Review Ideas:

- Reviewing cases in pairs or small groups to compare and contrast complementing facts to highlight certain issues.
- Reviewing cases with particular facts, like strangulation;[218] bystander deaths, surviving child witnesses;[219] victim suicide;[220] death of the aggressor by the domestic violence survivor; or presence of an active restraining order.
- Reviewing cases in a particular geographic region, or of a particular demographic.
- Reviewing cases in which the parties had deep contact with various systems, or where the parties had little or no contact with government agencies and systems.[221]
- Reviewing cases in locations that have not been previously examined, or multiple cases in one particular location.[222]
- Reviewing non-intimate partner homicides, including siblings killing another sibling or a child killing a parent.[223]
- Reviewing cases that initially present as suspicious deaths, accidents, or disappearances.[224]
- Reviewing near-deaths.

Information Collection

Document Collection

Once a case is selected for review, the next step is information collection. Who collects the information and the breadth of the information collected will depend on the Review Team's available time and resources.

Review Teams ask member agencies to search their files for documents related to the case.[225] Each team member must ensure that by sharing information with the Review Team, its organization is not violating any privacy laws. Each team member is independently responsible for ensuring that any information shared with the Review Team is consistent with the team's adopted guiding principles and confidentiality protocol and agreement. If an organization, regardless of whether it is a Review Team member, declines to provide any information to a team, California law states that they shall not be required to disclose the requested information.[226]

Some teams use the administrative staff or the interns of the Review Team chair to take notes or compile case files to distribute among the team members. Review Teams with resources can hire a coordinator to collect documents and conduct witness interviews in a trauma-informed way. Some teams meet in person at the medical examiner's office to review hardcopy case files together during team meetings. The Riverside District Attorney's office created a separate space in its secure case management software for use exclusively by Review Team members. **However it takes place, it is essential that Review Teams have confidentiality protocols in place so that this information sharing can take place.**

All relevant information should be collected, organized, and distributed to all Review Team members before a case review meeting. Whether or not something is relevant should include consideration of ethics and secondary and vicarious trauma. See Confidentiality and Ethics section above on discussion of ethics. As one example, the Santa Clara team no longer shares medical examiner and crime scene

photos, unless they provide critical context that cannot be found elsewhere. The Team had found routine sharing of these photos to be distracting and counterproductive.

Box 10: Case Documents[227]

Not every review will have access to the following documents, as some of these documents are confidential by law. Consent of the victim/survivor or other parties may therefore be necessary for review.

- Coroner reports and investigator narratives
- Law enforcement reports/records
- Emergency Call records
- Arrest records
- Weapon confiscation or relinquishment
- Crime scene reports
- Medical examiner report/autopsy
- Court records, including:
  - Civil protective orders
  - Divorce and child support cases[228]
- Criminal protective orders, criminal case disposition
- Dependency court records[229]
- Family/Child Protective services reports
- Service provider files (victim/survivor consent needed)
- Media coverage
- School data (parental consent needed)
- Hospital emergency room protocols/procedures
- Shelter and advocacy information

Witnesses Interviews

We recommend that witnesses not attend case reviews. One California team reported that inviting family members directly to case reviews was ineffective and emotionally draining. Witnesses may also personally know team members from their involvement with the victim/survivor's systemic support network, which may impact their ability to be forthcoming in the interview. The coordinator of New York's Review Team described this as a particular problem in rural settings where people are more likely to know each other. **Instead of having the witness attend the full case review, an experienced coordinator or single team member—ideally one with a mental health background—should conduct the interview and bring information back to the team without filter or interpretation.[230]**

Witness interviews help focus the case review on the victim/survivor's and perpetrator's perspectives, rather than prosecutor, law enforcement, physicians, or children and family services views, which are necessarily incomplete.[231] Experts advise that this adjustment of perspective is essential in an effective case review process.[232]

For example, in one case review detailed in the 2018 Georgia statewide report, the Review Team interviewed friends of the victim and discovered new facts. Friends of the victim, Linda, told the Review Team that her husband, Roger, often brought home beer to sabotage Linda's sobriety.[233] Although the police were often called about Roger abusing Linda, when the officers responded, Roger appeared calm and concerned, while Linda appeared frantic and inebriated.[234] The Review Team found that this dynamic contributed to Linda's death.[235] The interview led to the Review Team recommending training for first responders on how substance abuse, mental health crises and domestic violence issues combine in real world situations. **If interviews are conducted with adequate preparation, empathy, and with space for the interviewee to speak freely and calmly, these interviews will not only yield unparalleled information about prevention practices and systems improvement, but also create an opportunity to heal.**[236]

Where a victim/survivor never received (or declined) support, witness interviews can reveal why this happened and how to improve the system so that it does not happen again.[237] Review Teams have noted witness interviews are crucial to revealing prejudices or biases on the part of the service agencies.[238] Survivors stated in listening sessions that they would participate in case reviews of their own cases only if the Review Team were open to hearing about how their agencies may have contributed to the harm.

In a survivor's own words

"When you're able to finally tell your story, and you're not in that space [of victimhood and crisis], you're in a good space. I want to tell you my story."

For all teams, but especially for teams speaking with victim/survivors, the confidentiality protocol, confidentiality agreement, and informed consent forms should state that the prosecution may be legally obligated to turn over any new information discovered during the case review to the defense, even if prosecution has already concluded.

Even if a Review Team does not wait for prosecution to conclude before conducting its death review (Review Teams are not authorized to review pre-prosecution near-death cases), it may wish to wait before interviewing witnesses. For example, the Georgia state protocol advises that a Review Team wait one year from the homicide before interviewing family and friends, unless they witnessed the incident, in which case the Team should wait two years.[239]

The Georgia Review Team also recommends that interviewers express that "[w]e're not trying to blame you or question your choices. We are trying to change us—the community—to stop this from happening again to someone else."[240] Interviewers should ask open ended questions, allow the interviewee to lead, and focus on memories rather than data.[241] **"This is a complete change from a prosecutor's method of interviewing," said Carolyn Hanson, the Vermont team chair and former prosecutor. "We aren't presenting a case for a courtroom. I'll go to meet with [a witness] and they'll ask "What do you want to know?" and I will say "[…] What is important to you? […] Tell me what this person meant to you."** For further assistance on witness interviewing, teams should contact the National Initiative. See Appendix G on page 68.

Under California law, Review Teams must be prepared to direct participating victim/survivors and family members to available mental health services.[242] The Georgia Domestic Violence Fatality Review makes a therapist available before and during the interview process.[243] One Review Team in Arizona meets multiple times over four to six months to review the same case, which allows for follow up interviews to address unanswered questions.[244]

Some teams, like New York, interview or receive written information from perpetrators if they are incarcerated.[245] **Teams should ensure safety by assigning an advocate to make a safety plan with the victim's family or a survivor before considering engaging with the perpetrator, or the perpetrator's family or representative, especially where "honor-based" violence is suspected.[246]** New York also conducts interviews of identifiable past partners of the perpetrator, which has uncovered helpful information and can also potentially provide prior survivors an opportunity for healing.

Teams should avoid engaging with the perpetrator in near-death cases, due to safety concerns. As discussed above, scholars and advocates note that little is known about perpetrators, and increased information collection can lead to new prevention practices.[247] The New Zealand team in case reviews found that perpetrators were often child victims of trauma and violence and never received the support necessary to cope and heal from these experiences.[248] The perpetrator need not be remorseful or sincere for the interview to be useful. Interviews may reveal critical information like how the perpetrator discovered the victim's address or other ways the perpetrator evaded victim protections to commit the violence.

Children are rarely involved in the review process, but involving them in a limited way, with support, can highlight gaps in support services, such as practitioners' failure to listen to children's concerns about domestic violence.[249] If the Review Team engages with any children, it must obtain parental or guardian informed consent, and the consent of the child.[250] The interviews should be conducted by experienced child mental health professionals.

Building the Timeline

Before the case review meeting, Review Team members should review all information distributed and prepare their own notes and analyses. Several teams announce content warnings to give individual members options to choose their level of involvement based on their own mental health. Some teams also maintain a list of mental health resources for members.

Box 11: Difficult Cases

Review Teams will come across difficult cases in which an entity decision appears to have contributed to a death in hindsight. Teams recommend the following to help navigate those case reviews.

- If resources allow, the facilitator should meet with that entity before the case review to learn context, so that the facilitator can direct the case review in the most productive way.
- At the case review, the facilitator should openly acknowledge the decision and that clarity only comes with hindsight.
- The facilitator can begin discussion by inviting the entity representative to discuss the challenges of how the organization operates in general, and to explain the context of why polices are in place. This initial, general discussion can diffuse strong emotions before the team moves on to case specifics.

Teams should begin the meeting by reading the confidentiality agreement, guiding principles, or other team agreements, depending on the teams' needs. Contra Costa Review Team begins with a restorative justice exercise. The Montana Native American team begins each meeting with an elder telling the history of their community.[251]

The first main task of a case review meeting is for team members to work collaboratively on a timeline of events from the perspective of the victim and the perpetrator.[252] **Some teams invite the responsible law enforcement officer or prosecutor to present their knowledge of the case, then allow for questions or additions by other team members. However, some teams avoid this practice because they feel that such an approach creates the perception that the case "belongs" to that agency and encourages defensiveness, as the presenter may feel that identifying improvement reflects badly.**

Every member of the Contra Costa team identifies events to create a timeline based on the documents and information circulated before the meeting. Building a timeline together as a team accomplishes the second goal of the Review Team as identified by California law: facilitating agency responses.[253] Dr. Websdale explains that the collaborative act of assembling two human lives from available facts is an emotional bonding exercise and through this, team members build personal relationships, leading to better teamwork on future cases.[254] As such, the timeline should not be written by one person, and circulated for team edits, even though this approach is more efficient.[255] Instead, team members should sort through details, and decide by consensus which facts are most important.[256] The New York team uses a hybrid approach where a neutral coordinator assembles a skeleton of the timeline, due to the large volume of case files, and the team spends a day together in person completing it by consensus.

In this way, no perspective dominates the discussion, even though prosecution and law enforcement representatives may naturally speak more during the discussion of the investigation and prosecution. "If everyone is participating, no one is more important than anyone else, so even if the head district attorney themselves are at the meeting, they have the same input, they have the same contribution to the process as every other person in that space, including the DV case worker or advocate," said Natalie Oleas, coordinator of the Contra Costa team. This creates a supportive and trusting atmosphere that is conducive to identifying improvements.

A timeline is more than a catalogue of events, but uses the broader circumstances, the experiences of both the victim and perpetrator and the dynamics of the relationship in order to understand the compromises made by the parties. The timeline may begin and end with whatever the team collaboratively decides is appropriate for its review. Some teams choose to begin the timeline with the birth of both the victim and the perpetrator.[257] Other teams have gathered enough facts to reconstruct key events in the victim/survivor and perpetrators' parents or grandparents' lives.[258] Research shows that the roots of domestic violence begin long before the first violent incident, with a series of experiences, decisions and interactions that increase or decrease the risk of future violence.[259] Building a timeline identifies these risks by understanding the victim/survivor and the perpetrator as whole human beings and their reasons for making decisions leading to the death or near-death incident.[260]

Law enforcement, criminal justice, medical, and child welfare systems only have knowledge of specific incidents, which do not show the full picture. By building longer timelines, Georgia Review Teams identified the need for early prevention and developed state and local strategies to increase awareness of healthy relationships to prevent dating violence.

Research shows that children who are exposed to domestic violence are more likely to become victims or perpetrators of domestic violence themselves.[261] A timeline that includes events that occur after the

death or near-death incident may offer insights into cycles of violence experienced by victim/survivors, child witnesses and other surviving family members.[262]

The work of other Review Teams and research has identified the need to gather information and recommend services for surviving family members.[263] The Sacramento team identified the significant impacts on children exposed to domestic violence in the home. In response, its Family Justice Center implemented a program called Camp CATCH, which allows underserved youth who have experienced trauma from domestic violence to participate in an evidence-based camp intervention.

Identifying Risk Markers

After the team has agreed upon a timeline, the next step is to identify red flags that may occur before a death or a near-death incident, which might, for example, include prior strangulation, weapons use, and forced sex.[264] If local law enforcement agencies, service providers, medical personnel, school officials, or children and family services already have protocols in place to use certain red flags to identify "high-risk" scenarios, then these local red flags should be included in this analysis.[265] Review Teams should assign different weights to risk factors, as not all risk factors are equally important.[266]

"If everyone is participating, no one is more important than anyone else, so even if the head district attorney is at the meeting, they have the same input, the same contribution to the process as every other person in that space, including the DV case worker or advocate," said Natalie Oleas, coordinator of the Contra Costa team. This creates a supportive and trusting atmosphere that is conducive to identifying improvements.

Experts warn that teams should not focus for too long on the risk markers themselves: case review is not a box checking exercise.[267] Doing so can oversimplify the lives of victim/survivors and fail to acknowledge that external factors like access to affordable housing, childcare, shelter and advocacy affect the likelihood of re-victimization.[268] Overreliance on risk markers can also lead to stereotyping the victim/survivor or perpetrator, which prevents the team from identifying gaps in the government agency response to domestic violence and how victims navigated or experienced those gaps.[269] For example, given that African American men are disproportionately affected by the racist effects of mass incarceration, risk markers based on carceral involvement will be similarly biased and therefore unhelpful in accurately identifying gaps in agency response.[270]

The objective of identifying risk markers is to ask and answer the following questions:

- What did agencies and stakeholders, like law enforcement agencies, service providers and medical personnel, know about the level of risk as it relates to the victim/survivor, the perpetrator and their children?[271]
- If they did not know about the risk, or if the level of risk was misjudged, why?[272]
- How did the victim/survivor perceive their own risk vis-à-vis the perpetrator?

- How did the victim/survivor perceive their own risk as it relates their continued involvement with the criminal justice system? The child welfare system? The medical system?[273]
  For example, why did the victim/survivor get a restraining order and then rescind it?

This analysis requires Review Team members to "flip the logic" that they use in their day-to-day work.[274] This can be challenging unless Review Teams cultivate a robust discussion and productive disagreement among members with different perspectives.[275] See Building Trust and Productive Disagreement section on steps to cultivate productive disagreement.

Identifying Stakeholders Involved

After the risk marker identification process, Review Teams should identify:

- What government agencies and community-based organizations were involved?[276]
- What entities were not involved with the case but might have been expected to come into contact with the victim/survivor or perpetrator?[277]
- What information was known to each entity?[278]
- What decision and actions did each entity take?[279]
- What services were offered and provided?[280]
- What trainings and supervision did individuals involved in the case receive?[281]

Experts advise that a successful case review should avoid focusing on the conduct of individuals and evaluate whether or not the policy or procedure of the entity should be adjusted to operate in the best interest of the victim/survivor.[282] Through its case review, the Santa Clara team identified that law enforcement did not have sufficient trainings on the LGBTQ+ community, and planned to conduct outreach training to law enforcement to ensure that LGBTQ+ relationships are not treated differently and so that investigators would not struggle with how to approach and/or discuss an LGBTQ+ relationship.

Assessing How Stakeholders Worked Together

After the Review Team has identified the government agencies, service providers, community-based organizations, and other stakeholders that were involved in the case, the next step is to assess how they worked together. **What degree of communication, coordination, and collaboration existed between these entities in this particular case?[283]**

In incidents of domestic violence that resulted in a death or near-death, the victim/survivor and perpetrator may have had minimal involvement with government agencies and service providers, or there may have been a great amount of involvement.[284] Scholars have found that in both sets of circumstances, there is likely a minimal amount of entity collaboration.[285] Case review should try to identify reasons for lack of communication and miscommunication.

Teams should ask:

- What do the reviews of agency policies, trainings, records, and practices reveal?
- Were all current written policies and procedures followed?
- What are the best practice procedures available and how do they compare with current practice procedures? How do we know what best practices are?

- Are current policies and procedures adequate?
- Were statutes regarding family abuse, protective orders, stalking, firearms, etc. enforced?
- Were statutes a barrier to assistance or prevention?
- 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?
- What were the barriers to obtaining services for the victim or perpetrator?
- What were the institutional barriers (language, cultural, social costs)?
- Were there any barriers to interagency communications?
- What specific interventions could have resulted in better outcomes?

Box 12: Review Questions for Marginalized Communities.[286]

In order to remedy California's failure to provide domestic violence services to marginalized communities, as identified by the Little Hoover Commission Report, Review Teams should ask the following questions when reviewing a case or engaging with marginalized communities:[287]

- What is the story of this community and its past engagement with law enforcement, service providers or other government agencies?
- What harms have government agencies caused this community?
- How did the community story influence the victim/survivor, perpetrator or other individual's engagement with government agencies or service providers?
- How can Review Team members make efforts to establish an equal, trusting relationship with the community when engaging with survivors and other community members?
- Are members of the community represented on the Review Team?
- What efforts can Review Team members make to establish equal trusting relationships with members of the community who are also Review Team members?
- How can Review Team members model the acknowledgement that community partners are equal and essential to the prevention of domestic violence?
- In conducting the case review, has the government agency or other organization prioritized its own needs over the needs of the victim/survivor?
- Do Review Team members have a clear understanding of how current processes may reinforce the experience of violence?

The final step in the case review process is to issue formal, published recommendations, unpublished, informal recommendations, or both.[288] The Montana team only makes recommendations every two years directly to the legislature, but smaller, local level recommendations are implemented by the agencies and stakeholders who sit on the Review Team.[289] Some teams publish reports, or, like the Orange County team, conduct trainings. The Louisville Fatality Review Committee has tracked its recommendations issued on the local level to the state level with recommendations for training and policy changes up to the Administrative Office of the Court and the Kentucky Supreme Court. Some teams do neither, but report successes in implementing informal recommendations.

Crafting and Prioritizing Recommendations

After assessing how entities worked together, the Review Team should identify a list of opportunities for improvement. Most Review Teams operate through informal discussion and building consensus, which California teams report helps build camaraderie and keeps the teams flexible, which experts advise is key to a Review Team's success.[290]

From this preliminary list, experts advise Review Teams to choose a small handful to prioritize.[291] Teams can build momentum over time as the team begins with smaller, community based changes.[292] **It is not realistic or effective for a Review Team to track and implement two dozen recommendations at the same time, each of which takes a considerable amount of time and resources to implement.**[293] Prioritization also helps Review Teams reduce member turnover due to individual frustrations and burnout.[294] For further advice on prioritization, Review Teams should reach out to the National Domestic Violence Fatality Review Initiative.

Guiding principles will help teams with prioritization. Teams should also prioritize remedying the California's failure to serve victim/survivors of color and LGBTQ+ victims/survivors identified by the Little Hoover Commission.[295] All recommendations should take into consideration the effects of trauma on the victim/survivor, acknowledge that the cycle of violence takes time to break, and respect the victim/survivors' autonomy in making their own choices.[296]

Informal Recommendations

Informal recommendations are not public and do not need legislative change. **Some Review Teams have reported more success implementing informal recommendations by collaborating with local officials rather than pursuing publicized, formal recommendations that may run into legislative roadblocks.**[297] Voluntary changes in practice allow entities to tailor reforms to the unique needs of their own organizations and communities, whereas legislative reforms must be generally applicable statewide.[298]

For example, a Contra Costa case review revealed that county social workers did not understand the domestic violence restraining order process, so the Team recommended and implemented training social workers to support victim/survivors through the process. The Montana team found that when a perpetrator was arrested with family member assault on a Friday, that individual spent the weekend in jail but was released on bond at 8:30 am on Monday morning. As a result, a service provider did not have time to speak with the victim/survivor before the perpetrator went home. The team included a judge, who moved such initial court appearances to Monday afternoon, so that the service provider would have Monday morning to connect with the victim/survivor.[299]

Through case review work, the Riverside Sheriff's Department implemented a checklist for sheriff's deputies to identify high risk factors, like signs or history of strangulation and/or presence of a weapon in the household, to use when responding to domestic violence calls. Team members also coordinated a training for all officers so that they would be equipped to share information about resources like local shelters, counseling services, relocation funding, and the steps to pursue a temporary restraining order while responding to an incident call.

Voluntary policy reforms can be challenging to implement if they require major resource investments.[300] It is therefore essential that Teams include individuals with enough institutional knowledge of their organizations to understand what is necessary to commit their organizations to voluntary reforms.[301] This is also why it is essential that the Review Team receive true buy-in from all members, instead of forced consensus.[302]

Report Publication and Issuing Formal Recommendations

Review Teams may choose to publish reports that summarize their work and/or issue formal recommendations. Published reports can contain information on how the team functions, the number of deaths reviewed, findings and recommendations after the reviews, and the overall data regarding domestic violence deaths.[303] Reports should transparently state which agencies or organizations are represented and how the absence of certain agencies or organizations may affect recommendations.[304] Some Review Teams target recommendations to specific agencies, while others do not.[305] Some teams make formal recommendations to policymakers only every few years.[306] San Mateo reports are published every five years to allow the team to use its resources towards case review.

Teams report that publishing can be a way of showing respect for and building trust with community partners and offer public acknowledgement of systems weaknesses as accountability.

Some teams report that publication can sometimes improve the likelihood of implementation. However, teams also report that other times, publication can make member agencies feel more defensive, prevent certain agencies from serving on the Review Team, or lead to watered down recommendations. Review Teams should consider what type of process and outcomes they aim to have when deciding whether publishing a report is right for their county.

What should the team do with the information that it learns?

"Educate everybody all around – judges, lawyers, police officers, CPS workers, just educate them. Have them listen to these cases and what can be done to prevent it."

After publishing reports, some teams, like Orange County, conduct trainings with judges, law enforcement and other organizations, and present the findings at conferences.[307] Scholars also recommend that teams conduct outreach and education to community organizations, including those that do not focus on domestic violence, to build awareness and support victim/survivors informally.[308] New York aims to publish reports on a three-year cycle and conduct a presentation circuit during non-publication years to train law enforcement and social welfare agencies on their findings. Review Teams should consider translating the report, executive summary, and/or recommendations into different languages, especially where the fatality occurred in a non-English speaking community.[309]

Implementation and Accountability

Scholars have found that the process of implementing recommendations is incremental; some recommendations may not be completely implemented.[310] It is important to keep in mind that making and implementing recommendations is only one of two goals of the Review Team, as building personal relationships may also improves agency coordination.

Some teams set aside team meetings focused only on implementation.[311] Teams should create an action plan for implementing formal or informal recommendations by detailing who will do what, by when, with what intended outcome, and clearly describe how improvements will be made in practice and systems will be monitored and reviewed.[312] Some teams publish a monitoring table of recommendations in its reports, including the details of the extent to which its previous recommendations have been implemented.[313] In Contra Costa, the team coordinator tracks informal recommendations and follows up with individual members regarding the status of action items. Other jurisdictions assign specific Review Team members to present recommendations to an agency or track recommendations for completion, and conduct follow up for six months to one year after the recommendations are made.[314]

Some teams set aside team meetings focused only on implementation.[317] Teams should create an action plan for implementing formal or informal recommendations by detailing who will do what, by when, with what intended outcome, and clearly describe how improvements will be made in practice and systems will be monitored and reviewed.

Tangible incentives, such as positive media coverage or winning grant funding, may help agencies implement voluntary recommendations.[315] Several teams hold annual public events to spotlight their work. Santa Clara County holds a Valentine's Day press conference to publicly present its report from the prior calendar year to publicize its findings and highlight the Team's work and proposals. Alameda County reports its results to the District Attorney in preparation for an annual day of remembrance. These public events can include appearances or support from elected officials or organizational leaders, which can lead to implementation efforts.[316] Where Review Teams identify a need for statewide legislative change, it may be helpful to coordinate case review topics with other California Review Teams to identify the issue in each county and to build evidence and momentum.

APPENDIX A: Quick Reference Guide

What is a Review Team?

A Domestic Violence Death Review Team is a county-level multidisciplinary team authorized by the California Penal Code § 11163.3(a) to:

- IDENTIFY domestic violence death and near-death cases;
- REVIEW death and near-death incidents;
- FACILITATE agency responses; and
- DEVELOP prevention and intervention recommendations

Review Team Step by Step

1. Establishing a Review Team
   a. Identify and invite members (See page 6)
   b. If possible, find funding to hire a coordinator (See page 7)
   c. Train members (See page 12)
   d. Adopt a confidentiality protocol (See page 14)
   e. Adopt a guiding principle (See page 4)
2. Reviewing Cases
   a. Adopt a methodology (See page 30)
   b. Identify domestic violence related deaths and near deaths (See page 31)
   c. Choose cases for review (See page 32)
   d. Collect information (See page 34)
   e. Build a timeline (See page 37)
   f. Identify risk markers (See page 39)
   g. Identify agencies and stakeholders involved (See page 40)
   h. Assess how agencies and stakeholders involved worked together (See page 40)
   i. Identify and prioritize recommendations (See page 42)
   j. Track the implementation of recommendations (See page 44)

Review Team Website:

- Past and Current Members
- Mission Statement
- Guiding Principle
- Contact Information
- Review Team Protocol

- Confidentiality Protocol
- Confidentiality Agreement
- Consent Form
- Frequently Asked Questions, including an explanation of what domestic violence death and near-death review is, and what it is not
- Past, current, and future case selection process or criteria
- A method for the public to submit requests for the team to review a case[318]
- Previously published reports
- Success stories, if any that can be shared, of systems changes that came from Review Team work

Mandatory Team Members:

- Experts in the field of forensic pathology
- Medical personnel with expertise in domestic violence abuse
- Coroners and medical examiners
- Criminologists
- District attorneys and city attorneys
- Representatives of domestic violence victim service organizations, as defined in subdivision (b) of section 1037.1 of the Evidence Code
- Law enforcement personnel
- Representatives of local agencies that are involved with domestic violence abuse reporting
- County health department staff who deal with domestic violence victims' health issues
- Representatives of local child abuse agencies
- Local professional associations of persons described in paragraphs (1) to (10), inclusive

Potential Team Members[319]

- Victim-survivor who is not reviewing their own case (See page 10 for further discussion)
- Court administrators
- Defense attorneys
- Nurses
- Teachers and school administrators
- Therapists, psychiatrists, social workers
- Probation officers
- Religious and community leaders
- Culturally specific service providers or community organizations
- Restorative or transformative justice practitioners
- Housing department representatives and landlords
- Perpetrator intervention treatment providers, mental health counselors for violent offenders

- Researchers
- Children's and parents' attorneys practicing in family or dependency court
- Retired judges[320]
- Professors
- Tribal liaisons
- Batterer intervention program representatives
- Emergency medical services personnel
- Childcare providers[321]

Common Challenges and Potential Solutions

Frequent team member turnover

- Conduct training on vicarious and secondary trauma to avoid burnout (see page 12).
- Create a clear succession plan so the outgoing member can train the new member from their agency (see page 11).
- Adopt an incremental approach and focus on a small number of recommendations to focus resources and reduce frustration and burnout (see page 42).

Limited funding and resources

- Teams may choose to apply for direct grants from the federal Department of Justice. The Quattrone Center and the National Initiative have received funding to support Review Teams (see page 5).
- Teams may choose to appeal to the county board of supervisors for financial support. The Contra Costa County team is funded directly through the county's general fund. Contact information can be found at Appendix B (see page 53).

Low attendance at team meetings

- Rely on the help of Review Team members who regularly work together to encourage attendance (see page 11).
- Recruit individuals passionate about domestic violence prevention within their respective organizations and agencies (see page 11).
- Issue formal letters of invitation to team members (see page 11).
- Issue letters of commendation for inclusion in personnel files, which help with team members' professional development (see page 11).
- Invest time and energy in discussing the team's work and successes with agency leaders and mid-level managers, who can help carve out time for members to attend (see page 11).

One dominant perspective during case review

- See Box 8 on page 29.

Low trust/suboptimal information sharing

- See Box 8 on page 29.

Inconsistent or absent implementation (see page 42)

- Adopt a multi-year strategy of incremental reform.
- Choose informal and formal published recommendations based on team resources.

- Create an action plan to track the status of recommendations and assign action items to team members.
- If possible, appoint a coordinator to support team operations.
- Set aside dedicated meeting time for implementation.

Engaging Survivors and Family

- Make the first contact in person but defer to the victim/survivor or family member as to the preferred manner and frequency of communications.[322] Victim/survivors should not be approached by anyone associated with the perpetrator.
- Always prioritize the victim/survivor's safety, including from the perpetrator, family members and community who do not agree with the victim/survivor.
- Consider and disclose all potential actions from government agencies such as child protective services.
- Arrange for an interviewer ideally with social work or other clinical experience to meet separately with the witness and report back to the Review Team unless the witness expresses a wish to speak to the Team as a whole.[323] However, any team member who is trauma-informed, empathetic, and good emotional intelligence may conduct interviews.
- Clearly communicate expectations about the process from the start and throughout the review.[324]
- Ensure support from an advocate or therapist through a service provider during the review process.[325] Members of the Review Team should not be the advocate, as the Review Team needs to be fully independent and may reach conclusions that the interviewee disagrees with.[326]
- Provide logistical supports including transportation, childcare, and compensation for their time, without which a large population of victim/survivors will not be able to participate, as shared in the survivor listening sessions conducted by the Partnership.
- Provide a list of the questions in advance of the interview. Defer to them as to what they choose to share. Permit them to review notes to allow more control over the narrative.[327]
- Update them on the progress of the review.[328]
- Enable them to choose a pseudonym for themselves or the deceased victim, or to anonymize certain details in any public reports.[329]
- Be respectful and make every attempt to accommodate religious, cultural, linguistic, and other particular needs.[330]
- Give them enough time and privacy to review draft public reports and record their areas of disagreement but be transparent that their disagreement may not be incorporated into any public report.[331]
- Inform them of any report publication and potential media attention. Be mindful of key dates, such as birthdays or anniversaries.[332]
- Invite them to help implement recommendations.[333]

How to Build Trust

Below are techniques to build trust and facilitate productive disagreement among team members.

- Discuss and adopt guiding principles and refer back to these principles regularly during meetings and discussions.
- Use a neutral facilitator during case review or rotate the agency that chairs the team.
- Conduct trainings on the confidentiality requirements that apply to each team member.
- Discuss and collectively make foundational team decisions by consensus, like co-creating confidentiality protocols (see page 14), applying for grants (see page 4), setting up rotating chairs (see page 4), and pursuing or not pursuing review of near-death cases (see page 21).
- Sending the confidentiality protocol and agreement to members to allow their attorneys to review.
- Set aside dedicated time for trust building, like engaging in restorative justice exercises, both as a matter of course at the outset of reviews and as disagreements arise. (Teams may reach out to the Contra Costa team for advice on this process. Contact information for all Review Teams in California is available starting on page 53).
- Acknowledge each Review Team member's deep dedication to reducing domestic violence incidents at the beginning of each meeting.
- Collaboratively build a factual timeline (see page 30.)
- Limit the Use of Professional Jargon: legal jargon, like using "TRO" for temporary restraining order; law enforcement slang, like using "perp" for perpetrator; medical abbreviations, like using EMS instead of emergency medical services; and service provider terms like "deficit model" may make it difficult for members from other professions to engage in the discussion.
- Actively note who has spoken and invite those who have not spoken to provide input during case reviews so that no perspectives dominate. Acknowledge differences in perspectives by using phrases such as "this is a public health or law enforcement, or prosecutor's focus."
- Use active listening phrases like: "What I'm hearing you say is this, is that right? What do others think about that idea?"
- Use roundtable discussions instead of simply relying on knowledgeable team members to give presentations and answer questions. Law enforcement and prosecution representatives naturally give more information as the team discuss the crime itself. (See page 30.)

Case Review Ideas:

- Reviewing cases in pairs or small groups to compare and contrast complementing facts to highlight certain issues.
- Reviewing cases with particular facts, like strangulation;[334] bystander deaths, surviving child witnesses;[335] victim suicide;[336] death of the aggressor by the domestic violence survivor; or presence of an active restraining order.
- Reviewing cases in a particular geographic region, or of a particular demographic.
- Reviewing cases in which the parties had deep contact with various systems, or where the parties had little or no contact with government agencies and systems.[337]
- Reviewing cases in locations that have not been previously examined, or multiple cases in one particular location.[338]

- Reviewing non-intimate partner homicides, including siblings killing another sibling or a child killing a parent.[339]
- Reviewing cases that initially present as suspicious deaths, accidents, or disappearances.[340]
- Reviewing near-deaths.

Case Documents[341]

Note that some of these documents are confidential by law and consent of the victim/survivor or other parties may therefore be necessary for review.

- Coroner reports and investigator narratives
- Law enforcement reports/records
- Emergency Call records
- Arrest records
- Weapon confiscation or relinquishment
- Crime scene reports
- Medical examiner report/autopsy
- Court records, including:
  - Civil protective orders
  - Divorce and child support cases[342]
- Criminal protective orders, criminal case disposition
- Dependency court records[343]
- Family/Child Protective services reports
- Service provider files (victim/survivor consent needed)
- Media coverage
- School data (parental consent needed)
- Hospital emergency room protocols/procedures
- Shelter and advocacy information

Difficult Cases

Review Teams will come across difficult cases in which an entity decision appears to have contributed to a death in hindsight. Teams recommend the following to help navigate those case reviews.

- If resources allow, the facilitator should meet with that entity before the case review to learn context, so that the facilitator can direct the case review in the most productive way.
- At the case review, the facilitator should openly acknowledge the decision and that clarity only comes with hindsight.
- The facilitator can begin discussion by inviting the entity representative to discuss the challenges of how the organization operates in general, and to explain the context of why polices are in place. This initial, general discussion can diffuse strong emotions before the team moves on to case specifics.

Review Questions for Marginalized Communities.[344]

In order to remedy California's failure to provide domestic violence services to marginalized communities, as identified by the Little Hoover Commission Report, Review Teams should ask the following questions when reviewing a case or engaging with marginalized communities:[345]

- What is the story of this community and its past engagement with law enforcement, service providers or other government agencies?
- What harms have government agencies caused this community?
- How did the community story influence the victim/survivor, perpetrator or other individual's engagement with government agencies or service providers?
- How can Review Team members make efforts to establish an equal, trusting relationship with the community when engaging with survivors and other community members?
- Are members of the community represented on the Review Team?
- What efforts can Review Team members make to establish equal trusting relationships with members of the community who are also Review Team members?
- How can Review Team members model the acknowledgement that community partners are equal and essential to the prevention of domestic violence?
- In conducting the case review, has the government agency or other organization prioritized its own needs over the needs of the victim/survivor?
- Do Review Team members have a clear understanding of how current processes may reinforce the experience of violence?

APPENDIX B: List of Active Domestic Violence Death/Fatality Review Teams by County in California and Contact Information

Active DVDRTs and Contact Information
SB 863 Domestic Violence Death Review Protocol

Alameda

Hillary Larkin
Clinical Director, Sexual Assault Response Team/Domestic Violence Service
Alameda County Medical Center (Highland Hospital)

Alameda Health System | 1411 East 31st Street | Oakland, CA 94602
Office: (510) 437-8396 | hlarkin@alamedahealthsystem.org

Contra Costa

Natalie Oleas
Director Central Justice Alliance and
Contra Costa County's Domestic Violence Death Review Team Coordinator

Central Contra Costa Family Justice Center | 2151 Salvio Street, Suite 201 | Concord, CA 94520
Office: (925) 521-6366 | natalie@cocofamilyjustice.org

Mélody Saint-Saëns
Division Manager, Contra Costa Alliance to End Abuse

Contra Costa County, Employment & Human Services Department
1470 Civic Court, Suite 200 | Concord, CA 94520
Office: (925) 608-8821 | mssaens@ehsd.cccounty.us

Los Angeles

Janis Johnson
Head Deputy District Attorney, Family Violence Division

Los Angeles District Attorney's Office | 211 Temple Street, Rm 9-980A | Los Angeles, CA 9001
Office: (213) 257-2185 | jjohnson@da.lacounty.gov

Orange

Jane K. Stoever
Clinical Professor of Law | Director, Initiative to End Family Violence | Director, Domestic Violence Clinic

UC Irvine School of Law | 401 East Peltason Drive | Irvine, CA 92697
Office: (949) 824-3418 | jstoever@law.uci.edu

Riverside

Daima Calhoun
Chief Deputy District Attorney

Riverside County District Attorney's Office | 3960 Orange Street | Riverside, CA 92501
Office: (951) 955-5400 | DCalhoun@RivCoDA.org

Sacramento

Dawn Bladet
Assistant Chief Deputy District Attorney, Sex Crimes and Family Violence Bureau

Sacramento District Attorney's Office | 901 G Street | Sacramento, CA 95814
Office: (916) 874-5258 | bladetd@sacda.org

San Diego

Terra Marroquin
Senior Analyst, San Diego County District Attorney's Office

Hall of Justice | 330 West Broadway | San Diego, CA 92101
Office: (619) 531-4040 | Terra.Marroquin@sdcda.org

San Francisco

Rebecca D. Wagner
Managing Attorney, Domestic Violence, Stalking and Child Abduction

San Francisco District Attorney's Office | 350 Rhode Island, Suite 400N | San Francisco, CA 94103
Office: (628) 652-4165 | rebecca.wagner@sfgov.org

San Mateo

K'Lynn Weber
Chief Deputy Coroner

Office of the Coroner, San Mateo County | 50 Tower Road | San Mateo, CA 94402
Office: (650) 312-5295 | kweber@smcgov.org

Santa Clara

James Gibbons-Shapiro
Assistant District Attorney

Santa Clara District Attorney's Office | 70 West Hedding Street, West Wing | San Jose, CA 95110
Office: (408) 792-2985 | jgibbonsshapiro@dao.sccgov.org

Sonoma

Andrew Lukas
Chief Deputy District Attorney

Sonoma County District Attorney's Office | 600 Administration Drive, Rm 212J | Santa Rosa, CA 95403
Office: (707) 565-3885 | Andrew.Lukas@sonoma-county.org

Stanislaus

Beverly Van Ruler
Senior Nurse Manager, Public Health Director of Nursing

Stanislaus County Health Services Agency, Public Health Division
917 Oakdale Road | P.O. Box 3271 | Modesto, CA 95353
Office: (209) 558-4804 | bvanruler@schsa.org

APPENDIX C: Penal Code Section 11163.3

State of California

PENAL CODE

Section 11163.3

11163.3. (a) A county may establish an interagency domestic violence death review team to assist local agencies in identifying and reviewing domestic violence deaths and near deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. Interagency domestic violence death review teams have been used successfully to ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives to reduce and eradicate the incidence of domestic violence.

(b) (1) For purposes of this section, "abuse" has the meaning set forth in Section 6203 of the Family Code and "domestic violence" has the meaning set forth in Section 6211 of the Family Code.

(2) For purposes of this section, "near death" means the victim suffered a life-threatening injury, as determined by a licensed physician or licensed nurse, as a result of domestic violence.

(c) A county may develop a protocol that may be used as a guideline to assist coroners and other persons who perform autopsies on domestic violence victims in the identification of domestic violence, in the determination of whether domestic violence contributed to death or whether domestic violence had occurred prior to death, but was not the actual cause of death, and in the proper written reporting procedures for domestic violence, including the designation of the cause and mode of death.

(d) County domestic violence death review teams shall be comprised of, but not limited to, the following:

(1) Experts in the field of forensic pathology.

(2) Medical personnel with expertise in domestic violence abuse.

(3) Coroners and medical examiners.

(4) Criminologists.

(5) District attorneys and city attorneys.

(6) Representatives of domestic violence victim service organizations, as defined in subdivision (b) of Section 1037.1 of the Evidence Code.

(7) Law enforcement personnel.

(8) Representatives of local agencies that are involved with domestic violence abuse reporting.

(9) County health department staff who deal with domestic violence victims' health issues.

(10) Representatives of local child abuse agencies.

(11) Local professional associations of persons described in paragraphs (1) to (10), inclusive.

(e) An oral or written communication or a document shared within or produced by a domestic violence death review team related to a domestic violence death review is confidential and not subject to disclosure or discoverable by a third party. An oral or written communication or a document provided by a third party to a domestic violence death review team, or between a third party and a domestic violence death review team, is confidential and not subject to disclosure or discoverable by a third party. This includes a statement provided by a survivor in a near-death case review. Notwithstanding the foregoing, recommendations of a domestic violence death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the domestic violence death review team.

(f) Each organization represented on a domestic violence death review team may share with other members of the team information in its possession concerning the victim who is the subject of the review or any person who was in contact with the victim and any other information deemed by the organization to be pertinent to the review. Any information shared by an organization with other members of a team is confidential. This provision shall permit the disclosure to members of the team of any information deemed confidential, privileged, or prohibited from disclosure by any other statute.

(g) Written and oral information may be disclosed to a domestic violence death review team established pursuant to this section. The team may make a request in writing for the information sought and any person with information of the kind described in paragraph (2) may rely on the request in determining whether information may be disclosed to the team.

(1) An individual or agency that has information governed by this subdivision shall not be required to disclose information. The intent of this subdivision is to allow the voluntary disclosure of information by the individual or agency that has the information.

(2) The following information may be disclosed pursuant to this subdivision:

(A) Notwithstanding Section 56.10 of the Civil Code, medical information.

(B) Notwithstanding Section 5328 of the Welfare and Institutions Code, mental health information.

(C) Notwithstanding Section 15633.5 of the Welfare and Institutions Code, information from elder abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.

(D) Notwithstanding Section 11167.5 of the Penal Code, information from child abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.

(E) State summary criminal history information, criminal offender record information, and local summary criminal history information, as defined in Sections 11075, 11105, and 13300 of the Penal Code.

(F) Notwithstanding Section 11163.2 of the Penal Code, information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or of persons suffering physical injury where the injury is a result of assaultive or abusive conduct, and information relating to whether a physician referred the person to local domestic violence services as recommended by Section 11161 of the Penal Code.

(G) Notwithstanding Section 827 of the Welfare and Institutions Code, information in any juvenile court proceeding.

(H) Information maintained by the Family Court, including information relating to the Family Conciliation Court Law pursuant to Section 1818 of the Family Code, and Mediation of Custody and Visitation Issues pursuant to Section 3177 of the Family Code.

(I) Information provided to probation officers in the course of the performance of their duties, including, but not limited to, the duty to prepare reports pursuant to Section 1203.10 of the Penal Code, as well as the information on which these reports are based.

(J) Notwithstanding Section 10850 of the Welfare and Institutions Code, records of in-home supportive services, unless disclosure is prohibited by federal law.

(3) The disclosure of written and oral information authorized under this subdivision shall apply notwithstanding Sections 2263, 2918, 4982, and 6068 of the Business and Professions Code, or the lawyer-client privilege protected by Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code, the physician-patient privilege protected by Article 6 (commencing with Section 990) of Chapter 4 of Division 8 of the Evidence Code, the psychotherapist-patient privilege protected by Article 7 (commencing with Section 1010) of Chapter 4 of Division 8 of the Evidence Code, the sexual assault counselor-victim privilege protected by Article 8.5 (commencing with Section 1035) of Chapter 4 of Division 8 of the Evidence Code, the domestic violence counselor-victim privilege protected by Article 8.7 (commencing with Section 1037) of Chapter 4 of Division 8 of the Evidence Code, and the human trafficking caseworker-victim privilege protected by Article 8.8 (commencing with Section 1038) of Chapter 4 of Division 8 of the Evidence Code.

(4) In near-death cases, representatives of domestic violence victim service organizations, as defined in subdivision (b) of Section 1037.1 of the Evidence Code, shall obtain an individual's informed consent in accordance with all applicable state and federal confidentiality laws, before disclosing confidential information about that individual to another team member as specified in this section. In death review cases, representatives of domestic violence victim service organizations shall only provide client-specific information in accordance with both state and federal confidentiality requirements.

(5) Near-death case reviews shall only occur after any prosecution has concluded.

(6) Near-death survivors shall not be compelled to participate in death review team investigations; their participation is voluntary. In cases of death, the victim's family members may be invited to participate, however they shall not be compelled to do so; their participation is voluntary. Members of the death review teams shall be prepared to provide referrals for services to address the unmet needs of survivors and their families when appropriate.

(Amended by Stats. 2022, Ch. 986, Sec. 1. (SB 863) Effective January 1, 2023.)

APPENDIX D: Sample Confidentiality Protocol

On [DATE], the [COUNTY] Domestic Violence Death/Fatality Review Team ("Review Team") adopted this confidentiality protocol, including the attached Confidentiality Agreement, by [unanimous/majority] vote. This protocol shall govern all functions of the [COUNTY] Domestic Violence Death/Fatality Review Team. The attached Confidentiality Agreement shall govern the actions of all individuals who participate or aid in the Review Team's work.

Confidentiality of Communications and Documents

Pursuant to Penal Code § 11163.3, subd. (e), all verbal communications and documents shared within or created by the Review Team related to a domestic violence death review are confidential and cannot be shared or given to anyone outside the team.

All verbal communications and documents given by a third party to the Review Team as part of a review are also confidential and cannot be shared or given to anyone outside the team. This includes a statement provided by a survivor in a near-death case, unless otherwise mandated by law.

The Review Team will publicly share recommendations from a review after removing any identifying information only if a majority of the team agrees to do so.

Application of the Confidentiality Agreement

Before any individual participates in or aids the [County] Domestic Violence Death/Fatality Review, including Team members, their staff, or guest attendees, they must sign the Confidentiality Agreement. By signing the Confidentiality Agreement, each individual agrees to comply with all of its terms. If an individual declines to sign the Confidentiality Agreement, they shall not have access to any confidential communications or documents.

The Review Team shall review the agreement and this protocol at the beginning of each meeting to ensure that all attendees understand and agree to comply with its terms.

The duty to maintain confidentiality continues even after the conclusion of a case review or the end of an individual's participation on the Review Team.

Voluntary Disclosure

The Review Team acknowledges that under Penal Code § 11163.3, subd. (f), each organization with a representative participating in a domestic violence death review team may share information in its possession about the victim or survivor with the Review Team, which shall remain confidential under this Protocol.

The Review Team acknowledges that some Review Team members are subject to federal laws mandating that these team members protect certain information from disclosure, even where state law would allow sharing this information with the Review Team. For example, the Review Team acknowledges that under the confidentiality provisions of the Violence Against Women Act, a survivor's informed written consent may be needed before domestic violence victim service organizations can share certain confidential information with the Review Team.

The Review Team acknowledges that under Penal Code § 11163.3, subd. (g)(1), an individual or agency ***shall not be required to disclose information***.

Brady Disclosures

The Review Team acknowledges that pursuant to the Due Process Clause of the U.S. Constitution, that it is the policy of the District Attorney's Office, including the Victims Services Division, [describe the District Attorney' Office's policy to abide by the duty described in *Brady v. Maryland* (1963) 373 U.S. 83, 87].

Data Sharing and Storage

All documents associated with the Review Team's work shall be stored by [organization or individual]. [Organization or individual] shall be the only repository of the Review Team's documents. No individual Review Team member shall store documents associated with a case review after the review concludes.

Individuals are prohibited from printing or creating any new files, documents or records using any review team materials, unless they are necessary for case analysis. Individual members shall destroy all handwritten notes and printed materials and delete electronic notes at the conclusion of a case review.

All Review Team electronic documents shall be protected by encryption, password, and two factor authentication. Only [organization or individual] shall store physical documents, which shall be stored in a locked file cabinet, with a key maintained by [name].

Review Team files shall be stored for [XX] years, after which they shall be destroyed.

The Review Team shall only use [name of a secure document sharing portal or document management system] to access confidential documents associated with the Review Team's work. Confidential documents shall only be accessed on computers systems or shared over applications that are protected by encryption, password, and two factor authentication.

Members and guests are prohibited from sharing any information from the secure portal or their passwords with anyone outside the team, including non-team members from their respective agencies/employers.

Any notes created during the team meetings shall be collected by [name or position of a designated member of the team] and maintained securely in [name or description of document management system].

If a team member leaves the Review Team, their access to all confidential documents shall immediately terminate.

Remote Meetings

The Remote Team shall only use [name of application that is secured by encryption and password] to conduct remote meetings. Meeting attendees shall not share their password or access with anyone, including other individuals in their organization.

Meetings shall not be recorded.

Meeting attendees must be joining the meeting from a room where no one else is present.

Meeting attendees shall use earphones, unless they can ensure that no one will overhear the virtual meeting.

Meeting attendees are prohibited from taking screenshots, except for the designated note taker, but only if necessary for the review team's analysis. Screenshots shall be secured in the same manner as other confidential documents.

Team members shall not take screenshots unless necessary for case analysis. Screenshots shall be destroyed at the conclusion of a case review.

Any notes, screenshots, or other documents created during the meeting shall be securely stored, which individuals shall destroy at the conclusion of the case review.

Breach of Confidentiality

A violation of the Confidentiality Agreement may result in removal from the team.

If a breach is discovered, the Review Team may create an ad hoc subcommittee to investigate the matter. The involved member will be suspended from Review Team work and from accessing confidential documents pending review.

If there is a finding that a member intentionally disclosed or circulated confidential information, they shall be removed from the team.

APPENDIX E: Sample Confidentiality Agreement

I, _____ a member/guest of the _____ [County] Domestic Violence Death/Fatality Review Team, understand that:

Pursuant to Penal Code § 11163.3, subd. (e), all verbal communications and documents shared within or created by the Review Team related to a domestic violence death review are confidential. In addition to this legal mandate, confidentiality is indispensable to the function of the Review Team. Confidentiality fosters trust among team members and the community. It facilitates the honest and meaningful discussions necessary to accomplish the Review Team's goals of identifying systemic gaps and barriers in the County's domestic violence response. It also encourages survivors and witnesses to share their insights with the Review Team.

To accomplish this goal, I agree that:

- I will not share any communication, document, or fact related to the Review Team's work with anyone who has not signed this Confidentiality Agreement, including individuals in my own organization, unless otherwise mandated by law.
- I will not print or create any new files, documents, or records using any review team materials, unless they are necessary for case analysis.
- I will securely store all case review related documents, including my own notes, by storing them on a computer or computer system that is protected by encryption, password, and two factor authentication. I will store all physical documents in a locked location.
- I will not share any information from the secure portal or my password with anyone outside the team, including non-team members from my organization.
- I will not share my password or access to any remote meetings with anyone else. I will not record meetings. I will join a remote meeting from a room where no one else is present and use earphones so that no one overhears the meeting.
- I will destroy all handwritten notes and printed materials and delete electronic notes and screenshots at the conclusion of a case review. I will not store any documents associated with a case review after the review concludes.
- I will not work as an expert in any criminal or civil case in which I participated as part of the work of the Review Team.

I understand that a violation of this agreement may result in my removal from the Review Team and subject me to additional action as required or permitted by law, including personal civil or criminal liability. I agree to abide by this Confidentiality Agreement even after my work with the Review Team ends.

Name: _____ Signature: _____

Date: _____

APPENDIX F: Sample Informed Consent for Survivor Case Review

[Based on interviews with Review Teams that conduct survivor near-death case reviews, surveys of service providers, and survivor listening sessions conducted by the California Partnership to End Domestic Violence, the Office of the Attorney General recommends that the informed consent of survivors be renewed after a certain amount of time has passed. We recommend that one team member reach out to the survivor, and—in a trauma informed way—conduct a full discussion with that survivor regarding the work and consequences of giving the Review Team consent to review their case. The survivor should have every opportunity to ask questions. This document should be presented to the survivor once the survivor has verbally given their consent. The Review Team should not present this document without first providing a conversation with a team member and the opportunity for a survivor to ask questions. See section [XX] for further discussion.]

[X] County operates the [name of team] to review incidents of domestic violence that have resulted in near-death injuries. The team consists of [X] members, including: [identify members].

Your consent will be active for [amount of time], after which a member of the Review Team will contact you again to renew your consent to allow the Review Team to actively review your case. Actively reviewing your case means [describe how the Review Team actively reviews cases.]

If at any time prior to or after providing your consent, you have any questions about the process or your information, you can contact:

[NAME]

[Phone number]

[Email address]

What is a Case Review?

On __[DATE]___, I discussed with [NAME] the following:

As part of the review, I understand that the team members listed above and other potential experts and community members, as needed, will review facts related to what happened on [date and short description of the incident].Team members may also review information about my life, the life of the person who committed the abuse, and the lives of other family members, including my children, if this information helps the Review Team understand what happened, and how systems could have responded to prevent this from occurring.

As part of the review, I understand that:

- The team may review records and documents related to both me and the perpetrator including criminal history, calls to first responders, dependency cases, police reports, and probation records;
- If the Review Team requests my medical records, the school records of my children or myself, records held by a DV counselor or service provider, or other records protected by law, I will separately sign other written documents to give consent;

- The team may conduct witness interviews;
- The team will review information to determine how representative agencies and systems could have handled my situation and other similar situations differently to better serve survivors and their families; and
- I will not be contacted or asked to provide any other information, unless I also agree to be interviewed.

Confidentiality and Limited Circumstances of Disclosure

On __[DATE]___, I discussed with [NAME] the following:

I understand that information about my life and my case will generally not be shared with anyone who is not a member of the Review Team and that any information that identifies me, my children (if applicable), and other impacted individuals will not be made public.

HOWEVER:

- I understand that under the United States Constitution, a prosecutor must share exculpatory information with the defense team of the perpetrator that has not previously been discovered. Exculpatory evidence is evidence that shows that the person is not guilty of the crime they are accused of. [Add to or correct this sentence based on the District Attorney team member's approach to Brady disclosures.] If this were to occur, I understand that I will be informed.
- I also understand that under the Child Abuse and Neglect Reporting Act, Penal Code section 11164 subsection (a), previously unreported incidents of child abuse or other threats to the well-being of any involved children must be immediately reported to the appropriate agencies for further investigation.

I understand that the team may publish recommendations in a report based on a review of my case. I understand that any report will not contain any information that would identify me or my family.

Safety Planning

On ___[DATE]___, I met with [NAME] to discuss what I need to feel safe during this case review. I understand that the team will do the following during my case review:

[List the requests, which may include, for example, that the Review Team not contact certain witnesses associated with the perpetrator or that the Review Team not include certain members of a community due to the survivor's fears of retaliation, ostracization, or further emotional or physical abuse.]

My Participation is Completely Voluntary

I understand my participation is completely voluntary and I have the right to revoke my consent and decline participation at any time. I understand that my decision to participate or not participate in this case review will not affect my ability to access or receive services.

I understand that the Review Team has no power to change any criminal, civil, or dependency proceeding.

CONSENT TO REVIEW INCIDENT

I, _____ agree that the [County and Team Name] can review my case.

Signed: _____ Date: _____

*A copy of this signed consent form will be provided to you and shared in a confidential database maintained by the Review Team.

Informed Consent for Witness Interview

On __[DATE]___, I discussed with [NAME] the following:

[X] County operates the [name of team] to review incidents of domestic violence that have resulted in deaths and near-deaths in order to understand how to prevent future incidents and how to better serve victims/survivors of domestic violence. The team consists of [X] members, including: [identify members] who will review details about the domestic violence incident [which resulted in the death or serious injury to NAME on DATE].

I understand that detailed information about the Review Team can be found [on the website? In a previously published report?].

I understand that I will speak to [name of the member of the team] about my experience. I understand that [name] will take notes and share this information with the rest of the Review Team, which will use this information to understand what happened, and how systems could have responded to prevent what happened to me from occurring in the future to others. I understand that the Review Team will not share this information (or any other case information) with anyone else who is not a member of the Review Team, including other individuals at their organizations. For example, I understand that any prosecutor who sits on the Review Team will not share case information with other prosecutors who do not work on the Review Team, unless that information must turned over to the defense team, as described above.

I understand that:

- I will receive a set of standard questions in advance of any meeting. I have the option to choose which questions I want to answer and may end the interview or meeting at any time;
- I [will or will not] be compensated for my time. The information I provide will allow me to share my experience and allow for agencies and their representatives to learn from and better serve other survivors;
- Any information shared in my interview will be shared with the team but cannot be shared outside of the team or the review;
- I understand that the Review Team has no power to change any criminal, civil, or dependency proceeding; and
- Previously unreported incidents of child abuse or other threats to the well-being of any involved children must be immediately reported to the appropriate agencies for further investigation under the Child Abuse and Neglect Reporting Act, Penal Code section 11164 subsection (a).

If I have any questions, I can contact:

[NAME]

[Phone number]

[Email address]

I _____, agree to speak to a representative of the [County and Team Name] regarding my experience.

Signature: _____ Date: _____

*A copy of this signed consent form will be provided to you and shared in a confidential database maintained by the Team.

APPENDIX G: Resource List

Charitable organizations registered in California are noted with an asterisk (*) and are current as of November 2024. Charities operating in California must register and renew their registration annually with the California Attorney General's Registry of Charities and Fundraisers. To check the registration status of a charity, use the Registry Search Tool. For information on registration and registration renewal requirements, visit the Attorney General's website.

California Partnership to End Domestic Violence*

www.cpedv.org

1215 K Street Suite 1850 | Sacramento, CA 95814 | (916) 444-7163

The California Partnership to End Domestic Violence (the Partnership) is California's recognized domestic violence coalition, representing over 1,000 survivors, advocates, organizations, and allied individuals across the state. Working at the local, state, and national levels for nearly 40 years, the Partnership has a long track record of successfully passing over 200 pieces of legislation on behalf of domestic violence victims and their children. The Partnership believes that by collectively working with our diverse membership, advocates, and state policy makers, we can deepen the process of healing and restoration by identifying and addressing the underlying and contributing factors.

Find domestic violence organizations in your community here.

Arizona Child and Adolescent Survivor Initiative*

socialwork.asu.edu/family-violence-center/acasi

300 East University, 6th Floor | Temple, AZ 85281 | (602) 496-1327 | acasi@nau.edu | @acasi_fvc

The Arizona Child and Adolescent Survivor Initiative (ACASI) mission is to foster the healing of intimate partner violence survivors. ACASI provides free, statewide services to the caregivers and parents of children and adolescents who have been impacted by intimate partner violence (IPV).

Battered Women's Justice Project

www.bwjp.org

540 Fairview Avenue N, Suite 208 | St. Paul, MN 55104 | (800) 903-0111

The Battered Women's Justice Project is the national legal resource for gender-based violence. Their projects provide some of the nation's leading specialized policy and practice initiatives on improving survivor safety.

Blue Shield of California Foundation* Report

breaking the cycle: a life course framework for preventing domestic violence

This report applies relevant research in behavioral science to an urgent social question – how to stop domestic violence at its root. Childhood and adolescent risk factors linked to domestic violence perpetration were identified using a life course approach. The key themes of the report include prevalence and consequences of domestic violence, drivers of domestic violence, pathways to perpetration, the limitations of punitive approaches, and insights and actions to strengthen prevention.

City of Oakland Report

Department of Violence Prevention Strategic Spending Plan

This report is an example of how communities can prioritize investments and strategies to reduce domestic violence through the application of a public health approach. The Department of Violence Prevention (DVP) was established in 2017 to tackle the problem of violence in Oakland. Where previous city programs focused primarily on those at the center of violence, the DVP has an expanded prevention and intervention mission of advocating for and supporting families impacted by unsolved cold cases and addressing broader community trauma. The ultimate goal is a safer and thriving Oakland for all.

Commonly Used Terms When Discussing Domestic Violence (National Domestic Violence Hotline*)

If you are unfamiliar with the domestic violence field, it can be difficult to understand terms like intimate partner violence or vicarious trauma. This page explains various and frequently used terms in an understandable way. As you raise awareness and become more familiar with domestic violence issues, we hope you will use these terms in your conversations.

Confidentiality Institute

www.confidentialityinstitute.org

(312) 278-1136

Implementing confidentiality can be challenging, especially in the modern world of routine oversharing. Confidentiality Institute helps non-profit organizations, government agencies, and educational institutions to solve confidentiality challenges. They can help with on-call technical assistance, policy research, in-person training, webinars, and protocol developments.

Crime in California 2022 Report

This report by the California Department of Justice Criminal Justice Statistics Center presents an overview of the criminal justice system in California. Current year statistics, provided by California law enforcement agencies, are presented for reported crimes, arrests, dispositions of adult felony arrests, adult probation, criminal justice personnel, civilians' complaints against peace officers, domestic violence-related calls for assistance, anti-reproductive-rights crimes, law enforcement officers killed or assaulted, and violent crimes against senior citizens.

Illinois Coalition to Address Intimate Partner Violence-Induced Brain Injury

tbi-dv-il.org

This coalition was founded in 2018 by Dr. Dorothy Kozlowski, Professor of Neuroscience and Biological Sciences at DePaul University, Dr. Sonya Crabtree-Nelson, Associate Professor of Social Work at DePaul University, and Kate Lawler, Director of Swedish Hospital's Pathways Program (formerly the Violence Prevention Program). The Coalition has collaborated with groups and individuals across the country to provide education, research, services, and advocacy on brain injury symptoms as well as services to assist survivors of intimate partner violence and bring attention to the intersection of domestic violence and brain injury.

Illinois Statewide Domestic Violence Fatality Review Committee

dvfr.illinois.gov

The Statewide Domestic Violence Fatality Review Committee is responsible for overseeing the formation of regional domestic violence review teams across Illinois and providing technical assistance and support to those teams. The Statewide Committee developed several resources, including a guidebook to help its regional teams, which includes model guidelines and practices to assist stakeholders in forming and maintaining domestic violence review teams. The Statewide Committee is dedicated to a culture of continuous learning and improvement.

International Critical Incident Stress Foundation, Inc.

icisf.org

The International Critical Incident Stress Foundation (ICISF) is an organization that provides education, training, consultation, and support services in comprehensive crisis intervention and disaster behavioral health services to emergency responders, and other professions, organizations, and communities. They offer virtual training, online courses, and onsite training on trauma informed practices with a focus on critical incident stress management (CISM).

LGBTQIA Resource Center Glossary

lgbtqia.ucdavis.edu/educated/glossary

This Glossary has been collectively built and created by the staff members of the LGBTQIA Resource Center since the early 2000s. The terms and definitions included are not universal, but should be seen as a starting point for discussion and understanding. This glossary is provided to help give others a more thorough but not entirely comprehensive understanding of the significance of these terms. You may even consider asking someone what they mean when they use a term, especially when they use it to describe their identity. Ultimately it is most important that each individual define themselves for themselves and therefore also define a term for themselves.

Marcus Bruning Training and Consulting, LLC

www.marcusbruning.com

3769 Estate Court NE | Bemidji, MN 56601 | (218) 232-3762 | marcusbruning@gmail.com

Marcus Bruning Training and Consulting, LLC provides educational programs in special investigations and coordination training in domestic violence, sexual assault, and crimes against persons from the very young to the elderly.

Montana Domestic Violence Fatality Review Commission

dojmt.gov/victims/domestic-violence-fatality-review-commission

Joan Eliel, Executive Director | Office of Victim Services | Department of Justice
P.O. Box 201410 | Helena, MT 59620-1410 | (406) 444-1907 | Fax: (406) 442-2174 | jeliel@mt.gov

The Fatality Review Commission, authorized by MCA 2-15-2017, seeks to reduce homicides caused by family violence. The Commission meets twice yearly to review closed domestic homicide cases. The review seeks to identify gaps in Montana's system for protecting domestic violence victims and better coordinate multi-agency efforts to protect those most at risk of domestic homicide.

National Center on Domestic Violence, Trauma, and Mental Health

ncdvtmh.org

(312) 726-7020 | TTY: (312) 957-0449

The National Center on Domestic Violence, Trauma, and Mental Health promotes survivor-defined healing, liberation, and equity by transforming the systems that impact survivors of domestic sexual violence and their families. The team offers subject matter expertise, training, and technical assistance on topics including domestic and sexual violence, culturally responsive and trauma-informed (ACRTI) approach as a framework for healing centered engagement, and supporting families and youth.

National Domestic Violence Fatality Review Initiative

www.ndvfri.org

Dr. Neil Websdale, Director | Family Violence Center | Arizona State University
400 E Van Buren St, Suite 935 | Phoenix, AZ 85004 | (602) 543-6650 | FVC@asu.edu

The mission of the National Domestic Violence Fatality Review Initiative (NDVFRI) is to provide technical assistance for the reviewing of domestic violence related deaths with the underlying objectives of preventing them in the future, preserving the safety of battered women, and holding accountable both the perpetrators of domestic violence and the multiple agencies and organizations that come into contact with the parties.

Websdale, *The State of the Art* (September 8, 2020) Handbook of Interpersonal Violence and Abuse Across the Lifespan

S.T.O.P IN ACTION: Montana Domestic Violence Fatality Review Commission video.

National Domestic Violence Hotline*

www.thehotline.org

PO Box 90249 | Austin, Texas 78709 | 1-800-799-SAFE (7233)

24 hours a day, seven days a week, 365 days a year, the National Domestic Violence Hotline provides essential tools and support to help survivors of domestic violence so they can live their lives free of abuse. The Hotline's mission is to answer the call to support and shift power back to those affected by relationship abuse. The Hotline has answered over 7 million contacts, with services operated by expert advocates and other staff members dedicated to spreading education and awareness about domestic violence.

Dynamics of Abuse | People with Disabilities and Domestic Violence

National Sexual Violence Resource Center

www.nsvrc.org

The National Sexual Violence Resource Center (NSVRC) is the leading nonprofit in providing information and tools to prevent and respond to sexual violence. NSVRC translates research and trends into best practices that help individuals, communities and service providers achieve real and lasting change. The center also works with the media to promote informed reporting.

Plain Language for Sexual Assault, Abuse, and Harassment, a 30 minute webinar

National Sexual Assault Coalition Resource Sharing Project

resourcesharingproject.org

At the Resource Sharing Project (RSP), we are always learning from sexual assault survivors, advocates, coalition staff, and administrators across the US. Together, we find new questions and perspectives. And as we explore, we reshape what is possible for healing from sexual assault. RSP is a project born out of sexual assault coalitions' desire to collaborate across state and territory lines. Staying true to those roots, RSP today is a partnership between the Iowa Coalition Against Sexual Assault and the North Carolina Coalition Against Sexual Assault. As the lead partner, IowaCASA runs the grant management logistics and staff from both coalitions contribute to planning and implementing RSP's work at various levels.

Vicarious Trauma and the Coalition (March 2016) report.

Praxis International

www.praxisinternational.org

179 Robie St. E., Suite 275 | St. Paul, Minnesota 55107 | (651) 699-8000 | Fax: (651) 699-8001
info@praxisinternational.org

Praxis International has developed and pioneered the use of the Safety Audit process as a problem-solving tool for communities that are interested in more effective intervention in violence against women. The Safety Audit is a tool used by interdisciplinary groups and community-based advocacy organizations to

further their common goals of enhancing safety and ensuring accountability when intervening in cases involving violence against women. Its premise is that workers are institutionally organized to do their jobs in particular ways—they are guided to do jobs by the forms, policies, philosophy, and routine work practices of the institution in which they work. When these work practices routinely fail to adequately address the needs of people it is rarely because of the failure of individual practitioners. It is a problem with how their work is organized and coordinated. The Audit is designed to allow an inter-agency team to discover how problems are produced in the structure of case processing and management.

Prevent, Assess, and Respond: A Domestic Violence Toolkit for Health Centers & Domestic Violence Programs (Futures Without Violence*)

Health centers and domestic violence/sexual assault (DV/SA) advocacy programs are natural partners given their shared mission to improve the health, wellness, and safety of their clients. Health centers can use this toolkit to build a comprehensive and sustainable response to DV/SA and human trafficking in partnership with DV/SA advocacy programs (social service organizations) to improve how they identify and respond to DV/SA and promote prevention and develop proactive partnerships with local DV/SA advocacy programs to address the health needs of patients and connect them to health centers for care.

Quattrone Center for the Fair Administration of Justice

www.law.upenn.edu/institutes/quattronecenter

John F. Hollway, Executive Director
3501 Sansom Street | Philadelphia, Pennsylvania 19104 | (215) 573-9420 | Fax: (215) 573-2025
jhollway@law.upenn.edu

The Quattrone Center is a first-of-its-kind organization focused explicitly on inter-disciplinary, data-driven policy level research and recommendations designed to address the system factors that lead to criminal justice error. Rather than focusing primarily on individual cases or on remedying past errors, the Center works to identify institutional and policy-level barriers to fairness and accuracy and then to implement solutions that prevent future mistakes. The Center focuses primarily on two types of error: (1) wrongful arrests, incarcerations or convictions; and (2) policies or procedures that result in disparate outcomes among similarly situated individuals. The Center analyzes these situations using a broad range of techniques with proven success in reducing errors in such diverse industries as healthcare, aviation, and manufacturing, among others.

Racial Equity Tools Glossary

www.racialequitytools.org/glossary

Words and their multiple uses reflect the tremendous diversity that characterizes our society. Even the most frequently used words in any discussion on race can easily cause confusion, which leads to controversy and hostility. It is essential to achieve some degree of shared understanding, particularly when using the most common terms. In this way, the quality of dialogue and discourse on race can be enhanced. It is important for groups to decide the extent to which they must have consensus and where it is okay for people to disagree. It is also helpful to keep in mind that the words people use to discuss power, privilege, racism and oppression hold different meanings for different people. When people are talking about privilege or racism, the words they use often come with emotions and assumptions that are not spoken.

The Safety Net Project*

nnedv.org/content/technology-safety

1325 Massachusetts Ave NW, 7th Floor | Washington, DC 20005-4188 | (202) 543-5566
Fax: (202) 543-5626

The National Network to End Domestic Violence's Safety Net project focuses on the intersection of technology and domestic and sexual violence and works to address how it impacts the safety, privacy, accessibility, and civil rights of victims by: working with communities, agencies, and technology companies to address how current and emerging technology impacts the safety, privacy, and accessibility rights of victims, educating victim advocates and the general public on ways to use technology strategically to increase and maintain safety and privacy, training law enforcement and justice systems, social services, coordinated community response teams and others on tactics of technology misuse and offender accountability, and advocating for strong local, state, national and international policies that ensure the safety, privacy and civil rights of all victims and survivors.

The Training Institute on Strangulation Prevention (Alliance for Hope International*)

www.strangulationtraininginstitute.com

501 W. Broadway, Suite A #625 | San Diego, CA 92101 | (888) 511-3522

The Training Institute on Strangulation Prevention (Institute) is a program of Alliance for HOPE International. The Institute was developed in response to the increasing demand for Intimate Partner Violence Strangulation Crimes training and technical assistance (consulting, planning and support services) from communities across the world and was launched with support from the United States Department of Justice, Office on Violence Against Women. The Institute provides consulting, training, resources, and support services to professionals working in the fields of domestic violence and sexual assault, as well as technical assistance, web-based education programs, a directory of national trainers and experts, and a clearinghouse of all research related to domestic violence and sexual assault strangulation crimes.

Vermont Domestic Violence Fatality Review Commission

Carolyn Hanson, Chair | Assistant Attorney General | Office of the Attorney General
(802) 828 5512 | Fax: (802) 828-2154 | carolyn.hanson@state.vt.us

The Vermont Domestic Violence Fatality Review Commission was created by statute in 2002. The purpose of the Commission is to collect data and conduct in-depth reviews of domestic violence-related fatalities to better understand how the fatalities occurred and what can be done to prevent them. Under 15 V.S.A. § 1140, the Commission was established with the following purposes: (1) to examine the trends and patterns of domestic violence-related fatalities in Vermont; (2) to identify barriers to safety, the strengths and weaknesses in communities, and systemic responses to domestic violence; (3) to educate the public, service providers, and policymakers about domestic violence fatalities and strategies for intervention and prevention; and (4) to recommend policies, practices, and services that will encourage collaboration and reduce fatalities due to domestic violence. All reports are publicly available on the Attorney General's Office's website.

ENDNOTES

[1] Sen. Comm. on Crim. Procedure Analysis of Sen. Bill No. 1230 (1995-1996 Reg, Sess.); Pen. Code § 11163.3(a).

[2] *Id.*

[3] Pen. Code § 11163.4. The Office of the Attorney General last published a protocol in 2001. (Cal. Dept. of Justice, California's Domestic Violence Death Review Team Protocol (2001)).

[4] Cal. Dept. of Justice, Office of Gun Violence Prevention, Data Report: Domestic Violence Involving Firearms in California (Nov. 2023) p. 11.

[5] *Id.* at pp. 15-16.

[6] Little Hoover Comm'n, *Beyond the Crisis: A Long-Term Approach to Reduce, Prevent, and Recover from Intimate Partner Violence* (Jan. 2021) p. 3.

[7] *Id.* at p. 9.

[8] See Messing et al., *Femicide in the United States* (2023) p. 293 (in Dawson & Vega, *The Routledge International Handbook on Femicide and Feminicide* (2023)) (highlighting the importance of community-driven interventions).

[9] See Albright et al., Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation (2013) 17 Homicide Stud. 436, 447; Jones et al., Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review (2022) 28 Homicide Stud. 78, 89.

[10] Pen. Code § 11163.4.

[11] No organizations serving the following counties responded to the survey: Alpine, Calaveras, Fresno, Kern, Lassen, Marin, Merced, Modoc, San Francisco, Santa Cruz, Sierra, Tuolumne.

[12] Websdale, *Domestic Violence Fatality Review: The State of the Art* (2022) p. 3094 (in Geffner et al., Handbook *of Interpersonal Violence and* Abuse Across the Lifespan (2022)).

[13] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 7:10-8:36.

[14] Substance Abuse and Mental Health Servs. Admin., *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, *supra*, at p. 2.

[15] See *ibid.*

[16] Becker-Blease, *As the world becomes trauma—informed, work to do*, *supra*, at pp. 134-35.

[17] Substance Abuse and Mental Health Servs. Admin, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, *supra*, at p. 10-11.

[18] Websdale, *Domestic Violence Fatality Review: The State of the Art, supra*, at p. 3105.

[19] *Ibid.*

[20] Websdale, *Child Survivors of Intimate Partner Homicide: Wraparound Intervention* (2022) p. 1395 (in Geffner et al., Handbook *of Interpersonal Violence and* Abuse Across the Lifespan (2021)).

[21] Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews*, *supra*, at p. 242.

[22] Roguski et al., Te Pou: *An Indigenous Framework to Evaluate the Inclusion of Family Voice in Fatality Review Homicide Review* (2024) 39 J. Fam. Violence 325, 328.

[23] *Id*. at pp. 328-337 (describing, in depth, each guidepost or "pou" and its application in the fatality review process).

[24] See S.F. Domestic Violence Death Review Team, *Pilot Report* (May 2023) p. 15, fn. 3.

[25] *Id.* at p. 17.

[26] Office of Justice Programs, *Advancing Hospital-Based Technology to Support Victims of Interpersonal Violence: The Development and Implementation Assessment of MRG Suite*, (Sept. 2023).

[27] Ethical guidelines vary by state. In California, active judges may individually decide their ethical obligations as it relates serving on Review Teams.

[28] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review, supra* at 39:00 — 39:50.

[29] N.J. Domestic Violence Fatality & Near Fatality Review Bd., *Intimate Partner Homicide in Immigrant Communities* (2018) p. 14.

[31] Websdale, *Domestic Violence Fatality Review: The State of the Art, supra,* at p. 3101.

[32] *Ibid.*; Ga. Domestic Violence Fatality Review Project, *Advanced Topics in Fatality Review* (Mar. 19, 2019) at 25:00 — 26:34.

[33] Websdale, *Domestic Violence Fatality Review: The State of the Art, supra,* at p. 3101. [citation to SF report needed]

[34] S.F. Domestic Violence Death Review Team, *Pilot Report*, *supra*, at p. 20.

[35] See Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission* (2011) at 2:10.

[36] *Id.* at 3:01.

[37] Albright et al., Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation), *supra*, at p. 452.

[38] Websdale, *Domestic Violence Fatality Review: The State of the Art, supra,* at pp. 3102-3103; Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra,* at 2:10.

[39] In California, active judges may individually decide their ethical obligations as they relate to serving on Review Teams. Compare Cal. Judges Assn., Jud. Ethics Comm., Opn. No. 80 (June 2022) p. 6 ("A family law commissioner may participate in a Domestic Violence Task Force created by the court which includes the District Attorney's Office, the Public Defender's Office, County Counsel, probation, and a variety of local law enforcement agencies to address issues related to domestic violence cases and how best to address them.") with Cal. Supreme Ct., Comm. on Jud. Ethics Opns., Expedited Opn. No. 2021-041 (Mar. 3, 2021) p. 5 ("The broad scope of the task force's activities would make it difficult or impossible for a judge to participate as a member for all purposes while attempting to adhere to the ethical boundary between matters directly related to the law and social, moral, or policy imperatives. It is not reasonable to expect a judge acting as a task force member to bifurcate issues or limit involvement to permissible topics and discussions, particularly when many of the task force's activities concern matters beyond law.") However, "retired judges are exempted from the limitations of Canon 4C(2) and are allowed to accept appointment to a governmental committee or commission or other governmental position that is concerned with issues of fact or policy on matters other than the improvement of the law, the legal system, or the administration of justice." Cal. Judges Assn., Jud. Ethics Comm., Opn. No. 80, *supra,* at p. 5.

[40] Ga. Comm'n on Fam. Violence & Ga. Coalition Against Domestic Violence, Ga. Domestic Violence Fatality Review Project, *Policies and Operating Procedures Manual* (Dec. 2011) p. 11.

[41] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review, supra,* at 1:11:40-1:12:00.

[42] Ga. Comm'n on Fam. Violence & Ga. Coalition Against Domestic Violence, Ga. Domestic Violence Fatality Review Project, *2018 Annual Report* (2018) p. 24.; Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review, supra,* at 1:14:09.

[43] *Id.* at 1:11:40-1:12:00.

[44] Evans et. al., Male Perpetrators' Accounts of Intimate Femicide: A Global Systematic Review (2023) p. 542 (in Dawson & Vega, The Routledge International Handbook on Femicide and Feminicide (2023)).

[45] Websdale, *Domestic Violence Fatality Review: The State of the Art, supra*, at p. 3111; Albright et al., Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the L*ens of Evaluation*, *supra*, at p. 446; Little Hoover Comm'n, *Beyond the Crisis: A Long-Term Approach to Reduce, Prevent, and Recover from Intimate Partner Violence, supra,* at p. 9; Jones et al., Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review, *supra*, at p. 12; Bent-Goodley, Domestic Violence Fatality Reviews and the African American Commun*ity* (2013) 17 Homicide Stud. 375, 382; Albright et al., Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, supra,* at p. 446.

[46] Ga. Comm'n on Fam. Violence & Ga. Coalition Against Domestic Violence, Ga. Domestic Violence Fatality Review Project, *Policies and Operating Procedures Manual, supra,* at p. 12.

[47] See also United Kingdom Home Office, Multi-agency Statutory Guidance for the Conduct of Domestic *Homicide Reviews* (Dec. 2016) p. 12; Health Quality and Safety Comm'n, N.Z. Family Violence Death Rev. Comm., *A Duty to Care, Me manaaki te tangata* (June 2022) p. 23.

[48] *National Domestic Violence Fatality Review Initiative*.

[49] Substance Abuse and Mental Health Servs. Admin., *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (July 2014) p. 9.

[50] See, e.g., Becker-Blease, *As the world becomes trauma—informed, work to do* (2017) 18 J. Trauma & Dissociation 131, 135.

[51] Ill. Domestic Violence Fatality Review: *A Comprehensive Guide for Regional Teams*, pp. 16-17; see also Motta, Secondary Trauma: Silent Suffering and Its Treatment (2023) pp. 46-48, 151-153; see Kulkarni et al., *Exploring Individual and Organizational Factors Contributing to Compassion Satisfaction, Secondary Traumatic Stress, and Burnout in Domestic Violence Service Providers* (2013) 4 J. Soc'y Soc. Work & Rsch. 114, 115-118; Wood et al., *Turnover Intention and Job Satisfaction Among the Intimate Partner Violence and Sexual Assault Workforce* (2019) 34 Violence & Victims 678, 679-680.

[52] Ill. Crim. J. Info. Auth., *Annual Report: Domestic Violence Fatality Review* (2023) pp. 11-12.

[53] Little Hoover Comm'n, Beyond the Crisis: A Long-Term Approach to Reduce, Prevent, and Recover from Intimate Partner Violence, *supra,* at pp. 5-8.

[54] Members of a review team may include domestic violence services attorneys, domestic violence counselors, and human Trafficking caseworkers, each of whom owe a duty of confidentiality to the victims they serve, pursuant to Bus. & Prof. Code § 6068, subd. (e) and Evid. Code §§ 954, 1037 and 1038.5.

[55] Pen. Code § 11163.3(g)(1).

[56] Nat. Domestic Violence Fatality Review Initiative, Confidentiality and Fatality Review, Thompson, *Confidentiality: Why is it so Important?* (2016).

[57] Pen. Code §11163.3(e); Aiken, *Striking a Balance: Confidential Information and Fatality Review* (2014) < https://www.youtube.com/watch?v=rfWcp23Ivx4> [as of October 4, 2024], at 1:04:45—1:08:08.

[58] Pen. Code § 11163.3(e); Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews* (in Dawson, *Domestic Homicides and Death Reviews, An International Perspective* (2017)) p. 234.

[59] Albright et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, *supra*, at p. 445; Aiken, *Striking a Balance: Confidential Information and Fatality Review, supra*; Aiken, Confidentiality Inst., *Can We Do That? Fatality Review Teams & Confidential Information* (2020) 1:08:13-1:08:57

[60] Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews, Domestic Homicides and Death Reviews, supra*, at p. 234.

[61] *Ibid.*

[62] Aiken, *Can We Do That? Fatality Review Teams & Confidential Information, supra,* at 1:09:03-1:09:39.

[63] Albright et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, *supra*, at p. 447; Aiken, *Can We Do That? Fatality Review Teams & Confidential Information, supra,* at 1:08:13- 1:08:57.

[64] See Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra*, at 06:48-07:03.

[65] Pen. Code § 11163.3(e); Dale, et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews*, *supra*, at p. 234; *Brady v. Maryland* (1963) 373 U.S. 83, 87.

[66] Websdale et al., *Conducting Remote/Virtual Reviews of Domestic Violence Related Deaths* (2020) 45:40-49:20.

[67] Albright et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, *supra*, at. (2013) Homicide Studies, p. 445; Aiken, *Striking a Balance: Confidential Information and Fatality Review, supra*; Aiken, *Can We Do That? Fatality Review Teams & Confidential Information, supra* at 1:08:13-1:08:57.

[68] Santa Clara County Domestic Violence Death Review Team Annual Report for Jan. 1 — Dec. 31, 2021, p. 28.

[69] See Thompson, *Confidentiality and Fatality Review* (2002) Fatality Review Bulletin pp. 2-5 (providing an overview of laws requiring confidentiality).

[70] Pen. Code § 11163.3, subd., (g)(6); Ga. Domestic Violence Fatality Review Project, *Advanced Topics in Fatality Review*, *supra*, at 30:07-30:45.

[71] Albright, et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, *supra*, at p. 449.

[72] Substance Abuse and Mental Health Services Admin., U.S. Dept. Health & Human Services, *Trauma-Informed Care in Behavioral Health Services* (TIP 57) (2014) pp. 21-22, available at <https://store.samhsa.gov/sites/default/files/sma14-4816.pdf> (as of Oct. 18, 2024).

[73] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (2016) p.18.

[74] Pen. Code § 11163.3, subd. (g)(6)

[75] Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews, Domestic Homicides and Death Reviews, supra*, at pp. 247-248

[76] Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews*, Domestic Homicides and Death Reviews, (Dawson edit 2017) p. 247 *Ibid*.

[77] See, Health Insurance Portability and Accessibility Act, Pub. L. 104 -191 (1996); Civ. Code § 56 et seq.

[78] 34 U.S.C. § 12291 et seq.; 28 C.F.R. Part 94; 42 U.S.C. § 10401 et seq; 28 CFR Part 94;

[79] 34 U.S.C. § 12291(b)(2); 42 U.S.C. § 10406(c)(5); 28 C.F.R. § 94.115; Cal. Const. art. III, § 1; Pen. Code § 11163.3, subds. (g)(2) and (4)

[80] See, .e.g, 34 U.S.C. § 12291(b)(2)(B); 42 U.S.C. § 10406(c)(5); 28 CFR § 94.115(a); 34 C.F.R § 99.30; 45 C.F.R § 164.508; 45 C.F.R § 164.532; 34 C.F.R § 99.30; Pen Code § 11163.3, subd., (g)(4)

[81] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (2016) p. 18; Mullane, *The Impact of Family Members' Involvement in the Domestic Violence Death Review Process* in Domestic Homicides and Death Review (2017) pp. 263-66.

[82] Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews, Domestic Homicides and Death Reviews, supra*, at pp. 246-247.

[83] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews supra,* at p. 17.; Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews, Domestic Homicides and Death Reviews, supra*, at p. 248

[84] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews supra,* at p. 17.

[85] *Id*. at p. 18.

[86] Ga. Domestic Violence Fatality Review Project, *Advanced Topics in Fatality Review - YouTube*, (March 19, 2019) at 27:45 — 28:46.

[87] Mullane, *The Impact of Family Members' Involvement in the Domestic Violence Death Review Process* in Domestic Homicides and Death Review*, supra,* at p. 262.

[88] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews , supra,* at p.18.

[89] *Ibid*.

[90] Mullane, *The Impact of Family Members' Involvement in the Domestic Violence Death Review Process* in *Domestic Homicides and Death* Reviews*, supra,* at p. 262; United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, supra,* at p. 19.

[91] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (2016) *supra,* at p. 18.

[92] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews supra,* at p. 19.

[93] 34 U.S.C. § 12291(b)(2)(A); 42 U.S.C. § 10406(c)(5)(A); 28 CFR § 94.115(a); 45 C.F.R. § 1370.4

[94] 28 C.F.R § 90.4(b)(2)(iii); Civ. Code § 56.10, subd. (a)

[95] Health Insurance Portability and Accountability Act of 1996, Pub. L. 104 - 191 (August 21, 1996);45 C.F.R. §§ 160-164 ; Civ. Code § 56 et seq.

[96] 45 C.F.R. §160; 45 C.F.R. §162; 45 C.F.R. § 164; Civ. Code § 56.10, subd., (a)

[97] Bus. & Prof. Code § 17200 et seq.

[98] 34 C.F.R. § 99.1

[99] Cal. Const. art 1 § 1; See,,*Alch v. Superior Court* (2008) 165 Cal. App.4th, 1412

[100] 5 U.S.C. § 552a

[101] 34 U.S.C. § 12291(b)(2); 42 U.S.C. § 10406(c)(5); 28 CFR § 94.115(a)

[102] 34 U.S.C. § 12291(a)(25); 42 U.S.C. § 10406(c)(5); 28 C.F.R. § 90.2(a); 28 CFR § 94.115; 45 C.F.R. § 1370.2

[103] 34 U.S.C. § 12291(b)(2); 42 U.S.C. § 10406(c)(5)(D); 28 CFR § 94.115(c)

[104] 34 U.S.C. § 12291(b)(2)(C); 42 U.S.C. § 10406(c)(5)(C); 28 C.F.R. § 94.115; Pen. Code § 11163.3, subd., (g)(1)

[105] 28 C.F.R. § 90.4(b)(4); Pen. Code § 11163.3, subd., (g)(1)

[106] 28 C.F.R. § 90.4(b)(4)(i)

[107] 28 C.F.R. § 90.4(b)(4)(ii)

[108] 28 C.F.R. § 90.4(b)(4)(iii); See, *Mennonite Bd. Of Missions v. Adams*, 462 U.S. 791 (1983)

[109] 28 C.F.R. § 90.4(b)(4)(iv)

[110] 28 C.F.R. § 90.4(b)(4)(iv)

[111] Health Insurance Portability and Accountability Act of 1996, Pub. L. 104 — 191 (August 21, 1996); 45 C.F.R. §§ 160-164; Civ. Code § 56 et seq.

[112] 45 C.F.R. §160.103

[113] 45 C.F.R §164.502(g)(4)

[114] 45 C.F.R. § 164.512(b)

[115] Bus. & Prof. Code § 17200 et seq.

[116] 20 U.S.C. § 1232g; 34 C.F.R. Part 99

[117] 34 C.F.R § 99.30(c)

[118] Cal. Const. art 1 § 1; See, *White v. Davis* (1975) 13 Cal.3d 757, 773-74

[119] *Hill v. National Collegiate Athletic Assn* (1994) 7 Cal.4th 1, 35-36

[120] 45 CFR § 160.103; Cal. Const. Art 1 § 1; Civ. Code § 56 et seq.

[121] Cal. Const. art. 1 § 1

[122] Bus. & Prof. Code, § 17200 et seq.; Civ. Code § 56 et seq.; Health and Saf. Code, §§ 1280.15, 1280.18

[123] Pen. Code §11163.3, subd., (f)

[124] Pen. Code § 11163.3, subd., (g)(6)

[125] Websdale, *Domestic Violence Fatality Review: The State of the Art*, Handbook of Interpersonal Violence and Abuse Across the Lifespan, supra, at p. 3105.

[126] Aiken, *Striking a Balance: Confidential Information and Fatality Review* (2014) at 1:14:24-1:15:32

[127] Aiken, *Striking a Balance: Confidential Information and Fatality Review* (2014) at 1:14:24-1:15:32

[128] Pen. Code § 11163.3, subd., (g)(5)

[129] *Brady v. Maryland* (1963) 373 U.S. 83, 87

[130] Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews*, *Domestic Homicides and Death Reviews, supra,* at p. 24)

[131] Ga. Domestic Violence Fatality Review Project, *Advanced Topics in Fatality Review - YouTube*, (Mar. 19, 2019) at 16:00 — 16:20; Saunders, *Barriers to Leaving an Abusive Relationship*, Handbook of Interpersonal Violence and Abuse Across the Lifespan, *supra*, at pp. 2841-58.

[132] Ga. Domestic Violence Fatality Review Project, *Advanced Topics in Fatality Review - YouTube*, (Mar. 19, 2019) at 16:20 — 16:51

[133] Ga. Domestic Violence Fatality Review Project, *Advanced Topics in Fatality Review - YouTube*, (Mar. 19, 2019) at 14:05 — 14:55

[134] Saunders, *Barriers to Leaving an Abusive Relationship,* Handbook of Interpersonal Violence and Abuse Across the Lifespan (2022) pp. 2841-58.

[135] Ga. Domestic Violence Fatality Review Project, *Advanced Topics in Fatality Review - YouTube*, (Mar. 19, 2019) at 11:15 — 11:45

[136] Ga. Domestic Violence Fatality Review Project, *Advanced Topics in Fatality Review - YouTube*, (Mar. 19, 2019) at 24:20 — 24:55

[137] Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews, Domestic Homicides and Death Reviews, supra*, at pp. 241-242.

[138] Ga. Domestic Violence Fatality Review Project, *Advanced Topics in Fatality Review - YouTube*, (March 19, 2019) at 11:45 — 12:07; Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews, Domestic Homicides and Death Reviews, supra*, at p. 242

[139] Penal Code § 11166, subd., (a)

[140] Little Hoover Comm'n, *Beyond the Crisis: A Long-Term Approach to Reduce, Prevent, and Recover from Intimate Partner Violence, supra,* at p. 2.

[141] *Id*. at pp. 10-11.

[142] *Id*. at pp. 13-14.

[143] Blue Shield of California Foundation, *Perceptions of Domestic Violence in California's African American Communities*, (2017) p. 20, 33; see also Bent-Goodley, *Domestic Violence Fatality Reviews and the African American Community*, *supra*, at, p. 379.

[144] *Id*. at p. 378.

[145] Final Report, Cal. Task Force to Study and Develop Reparation Proposals for African Americans (2023) pp. 314-315.

[146] Rivaux et al., *The Intersection of Race, Poverty, and Risk* (2008) 87 Child Welfare 151, pp. 161-62.

[147] Cal. Legislative Analyst's Office, *Update on Analysis and Key Questions: Racial and Ethnic Disproportionalities and Disparities in California's Child Welfare System* (March 22, 2023) pp. 1, 4.

[148] Summers, *Disproportionality Rates for Children of Color in Foster Care* (FY 2014) (August 2016) The National Council of Juvenile and Family Court Judges at p. 5, available at ,<https://www.ncjfcj.org/wp-content/uploads/2016/11/NCJFCJ-

2014-Disproportionality-TAB-Final.pdf> (as of October 4, 2024); see also National Indian Child Welfare Association, Disproportionality Table (2017) available at <https://www.nicwa.org/ wp-content/uploads/2017/09/Disproportionality-Table.pdf (nicwa.org)> (as of October 4, 2024); Wilson, *Indigenous Populations and the Domestic Violence Death Review Process*, Domestic Homicides and Death Reviews: An International Perspective (2017) p. 288; Rosay, *Violence Against American Indian and Alaska Native Women and Men | National Institute of Justice (ojp.gov)* (2016) 277 NIJ Journal 38 (reporting majority of Native women and men as having experienced physical or psychological aggression from an intimate partner).

[149] Pearce and Sokoloff, *"This Should Not Be Happening in This Country": Private-Life Violence and Immigration Intersections in a U.S. Gateway City* (2013) 28 Sociological Forum 784, pp. 787-88; Medina, *Too Scared to Report Sexual Abuse. The Fear: Deportation.*, New York Times (Apr. 30, 2017) (describing a California nonprofit experiencing an over 90 percent drop in domestic violence reporting by undocumented survivors in response to expectations of increased deportation enforcement by the Trump administration).

[150] New Jersey Domestic Violence Fatality and Near Fatality Review Board, *Intimate Partner Homicide* (2018) at pp. 7, 12; Pearce and Sokoloff, *"This Should Not Be Happening in This Country": Private-Life Violence and Immigration Intersections in a U.S. Gateway City*, *supra* , at p. 803; Thompson, *Disabled Women and Domestic Violence*, The New Social Worker (Spring 2018) p. 29.

[151] Kim, *Disability Often Intersects with Domestic Violence. Here's How to Better Help Survivors*, California Health Report: Solutions for Health Equity (July 7, 2022) at <https://www.calhealthreport.org/2022/07/07/disability-often-intersects-with-domestic-violence-heres-how-to-better-help-survivors/> (as of October 44, 2024).

[152] *Ibid*.

[153] Bent-Goodley, *Domestic Violence Fatality Reviews and the African American Community,* 17 Homicide Studies 375, *supra* , at p. 380; Blue Shield of California Foundation, *Perceptions of Domestic Violence in California's African American Communities*, *supra*, at p. 18; Pearce and Sokoloff, *"This Should Not Be Happening in This Country": Private-Life Violence and Immigration Intersections in a U.S. Gateway City, supra*, at p. 798.

[154] See, e.g., Bent-Goodley, *Domestic Violence Fatality Reviews and the African American Community, supra,* at p. 379.

[155] Brown & Herman, Intimate Partner Violence and Sexual Abuse among LGBT People (2015) The Williams Institute, UCLA, p. 16 at https://williamsinstitute.law.ucla.edu/publications/ipv-sex-abuse-lgbt-people/ (as of October 4, 2024); theNetworklaRed, *Open Minds Open Doors* (2011) p. 8 available at https://safehousingpartnerships.org/sites/default/files/2017-01/Open%20Minds%20Open%20Doors%202013.pdf (as of October 4, 2024).

[156] *Id*. at p. 14

[157] *Id*. at pp. 9, 27.

[158] New Jersey Domestic Violence Fatality and Near Fatality Review Board, *Intimate Partner Homicide* (2018) at pp. 7, 12, available at https://www.nj.gov/dcf/news/reportsnewsletters/taskforce/immigration.report.pdf (as of October 4, 2024); Judicial Council of California and Mosqueda, *Elder Abuse Pocket Reference: A Medical/Legal Resource for California Judicial Officers,* I. Elder Abuse and the Courts, (2012) p. 12.; Drake, *Multidisciplinary Team Works to Reduce Preventable Deaths of Older Adults | National Institute of Justice (ojp.gov)*, Justice (May 9, 2022); Bent-Goodley, *Domestic Violence Fatality Reviews and the African American Community , supra* , at p. 380.

[159] Lee, *Intimate Partner Violence Against Asian American Women: Moving from Theory to Strategy* (2015) 28 Colum. J. Gender & L. 315, p. 333; Pearce and Sokoloff, *'This Should Not Be Happening in This Country': Private-Life Violence and Immigration Intersections in a U.S. Gateway City,* 28 Sociological Forum,, *supra*, at pp. 784—810, 790-91

[160] Blue Shield of Cal. Foundation, *Perceptions of Domestic Violence in California's African American Communities*, (2017) p. 20; Albright & Alcantara-Thompson, *Contextualizing Domestic Violence from a LGBTQ Perspective ,* The Northwest Network of Bi, Trans, Lesbian and Gay Survivors of Abuse (2011)

[161] Wilson, *Indigenous Populations and the Domestic Violence Death Review Process* (2023) p. 289 (in Dawson and Saide Mobayed Vega, The Routledge International Handbook on Femicide and Feminicide (2023)).

[162] Rural Health Information Hub, *Violence and Abuse in Rural America* at <https://www.ruralhealthinfo.org/topics/violence-and-abuse> (as of December 16, 2024); National Advisory Committee on Rural Health and Human Services, *Intimate Partner Violence in Rural America* (March 2015) at <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/2015-partner-violence.pdf> (as of December 16, 2024) (showing lack of urbanicity statistics).

[163] Yurok Tribal Court and Sovereign Bodies Institute, *To' Kee Skuy' Ney-Wo-Chek' I Will See You Again in a Good Way: A Year 1 Project on Missing and Murdered Indigenous Women, Girls, and Two Spirit People of Northern California* (2020), pp. 40-41, available at <https://www.niwrc.org/resources/report/kee-skuy-soo-ney-wo-chek-i-will-see-you-again-good-way-year-1-project-report> (as of Oct. 4, 2024).

[164] *Not One More: Findings & Recommendations of the Not Invisible Act Commission* (2023) available at <https://www.justice.gov/d9/2023-11/34%20NIAC%20Final%20Report_version%2011.1.23_FINAL.pdf> (as of October 4, 2024); Cook, *Unseen: Missing, murdered Indigenous women in California part of nationwide crisis* (April 19, 2023) CBS News, available at < https://www.cbsnews.com/sanfrancisco/news/unseen-indigenous-women-native-american-yurok-missing-murdered-california/> (as of Oct. 4, 2024).

[165] *Ibid*.; (Native communities report heightened levels of missing and murdered women and girls, particularly in rural counties in Northern California, and failures of record keeping and resources mean that there is no accurate count of the number of such cases in California.)

[166] Yurok Tribal Court and Sovereign Bodies Institute, *To' Kee Skuy' Ney-Wo-Chek' I Will See You Again in a Good Way: A Year 1 Project on Missing and Murdered Indigenous Women, Girls, and Two Spirit People of Northern California,* supra, at pp. 33-37; *Not One More: Findings & Recommendations of the Not Invisible Act Commission* (2023) available at <https://www.justice.gov/d9/2023-11/34%20NIAC%20Final%20Report_version%2011.1.23_FINAL.pdf> (as of October 4, 2024)

[167] theNetworklaRed, *Open Minds Open Doors, supra,* at pp. 7-8.

[168] Drake, *Multidisciplinary Team Works to Reduce Preventable Deaths of Older Adults | National Institute of Justice (ojp.gov)*, Justice (May 9, 2022)

[169] See Assembly Member Matt Haney, Press Release*, Bill Lets Survivors of Domestic Violence and Human Trafficking Tell Their Stories in Court* (Apr. 4, 2023) available at <https://a17.asmdc.org/press-releases/20230404-bill-lets-survivors-domestic-violence-and-human-trafficking-tell-their> (as of October 4, 2024); PolicyLink, *Healing Together: Shifting Approaches to End Intimate Partner Violence*, (2019) p. 22.>.

[170] Websdale, et al., *United States* (in Dawson, *Domestic Homicides and Death Reviews: An International Perspective* (2017) p. 49.

[171] Blue Shield of California Foundation (2017) Perceptions of Domestic Violence in California's African American Communities, p. 20.

[172] See, Ruben & Stosic, *Documenting Race and Gender Biases in Pain Assessment and a Novel Intervention Designed to Reduce Biases* (2024) 25 J. Pain 104550; Trawalter & Hoffman, *Got Pain? Racial Bias in Perceptions of Pain* (2015) 9 Social and Personality Psychology Compass, p. 146.

[173] See e.g., National Association of Social Workers, *Standards and Indicators for Cultural Competence in Social Work Practice* (2015) p. 4, at < https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/Standards-and-Indicators-for-Cultural-Competence-in-Social-Work-Practice> (as of Oct. 4, 2024).

[174] See, e.g., Health Quality and Safety Commission New Zealand Family Violence Death Review Committee, *A Duty to Care: Me manaaki te tangata Seventh Report* (June 2022) p. 12-14; Wilson, *Indigenous Populations and the Domestic Violence Death Review Process*, *supra*, at p. 308.

[175] See Bent-Goodley, *Domestic Violence Fatality Reviews and the African American Community*, 17 Homicide Studies*, supra,* at pp. 375, 383; Drake, *Multidisciplinary Team Works to Reduce Preventable Deaths of Older Adults | National Institute of Justice (ojp.gov)*, Justice (May 9, 2022)

[176] Bent-Goodley, *supra*, at p. 379.

[177] *Ibid*.; Blue Shield of Cal. Foundation, *Perceptions of Domestic Violence in California's African American Communities* (2017) pp. 28-29; Wilson, *Indigenous Populations and the Domestic Violence Death Review Process*, *supra*, at p. 3058; Blue Shield of California Foundation (2017) Perceptions of Domestic Violence in California's African American Communities, p. 29.

[178] Bent-Goodley, *supra*, at pp. 383, 385-86.

[179] Little Hoover Comm'n., *Beyond the Crisis: A Long-Term Approach to Reduce, Prevent, and Recover from Intimate Partner Violence*, *supra*, at p. 9.

[180] See, e.g., Websdale, The Montana Native American Domestic Violence Fatality Review Team (2019) 11 Fam. & Intimate Partner Violence Q. 31, 34-35 (discussing the formation of the Montana Native American Domestic Violence Fatality Review Team); Wilson*, Indigenous Populations and the Domestic Violence Death Review Process*, *supra*, at p. 308 ("Ideally the death review process must be inclusive of tribal community representation where change needs to occur.").

[181] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review, supra*, at 18:28-19:03; see also Storer et al., *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?* (2013) 17 Homicide Stud. 418, 420 (The fatality review process is a means of "increasing community-side multidisciplinary collaboration between unlikely partners.").

[182] *See* Albright et al., Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation, *supra*, at pp. 447, 452; Jones et al., *Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review*, *supra*, at pp. 78, 89.

[183] See Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 1:13:19 — 1:14:36.

[184] Albright et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, *supra*, at p. 451.

[185] Websdale, *The Case of Domestic Violence Fatality Review* (Summer 2012) National Civic Review 29, 31; Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 35:30-36:20; see also Albright et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, *supra*, at p. 447; Jones et al., *Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review supra*, at p. 12.

[186] Due to agency reorganization, the San Francisco team disbanded and is being reassembled in a different way from the team that was in operation prior to 2018.

[187] Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra*, at 11:59-12:04.

[188] *Id.* at 11:59-12:31.

[189] Websdale, *The Case of Domestic Violence Fatality Review*, *supra*, at p. 31.

[190] See Albright et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams* Through *the Lens of Evaluation*, *supra*, at p. 449 (explaining that respect for team members requires adversarial agencies to fully understand each other's work and perspectives).

[191] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 35:45- 36:42.

[192] N. Ariz. Univ. & Nat. Domestic Violence Fatality Review Initiative, *Saving the Next Generation: Domestic Violence Fatality Reviews in Indian Country* (Mar. 1, 2019) at 16:29-16:36.

[193] 28 CFR 90.4(b)(4) (describing the limited circumstances under which Violence Against Women Act grantees and subgrantees may release personal information about deceased victims).

[194] United Kingdom Home Office, Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, *supra*, at p. 7.

[195] Blue Shield of Cal. Found., *Breaking the Cycle: A Life Course Framework for Preventing Domestic Violence* (2019) p. 7.

[196] Sherman & Harris, Increased death rates of domestic violence victims from arresting vs. warning suspects in the Milwaukee Domestic Violence Experiment (MilDVE) (2015) 11 J. Experimental Criminology 1, 6.

[197] Id. at p. 9.

[198] Ibid.

[199] *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra*, at 0:25 — 0:55; Montana Department of Justice, Division of Criminal Investigation, Special Services Bureau, Office of Victim Services, *Montana Domestic Violence Fatality Review Commissions* (Mar. 2023) p. 6.

[200] Nat. Domestic Violence Fatality Review Initiative, Introduction *to* Domestic Violence Fatality Review, *supra*, at 20:15-24:20.

[201] See Pen. Code § 11163.4.

[202] Pen. Code § 11163.3(b)(1); Fam. Code § 6211.

[203] Pen. Code § 11163.3(b)(1); Fam. Code §§ 6203, 6320.

[204] Pen. Code § 11163.3(b)(2).

[205] Pen. Code § 11163.6; Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 9:15-10:58.

[206] Pen. Code § 13700(b).

[207] Ga. Domestic Violence Fatality Review Project, *2018 Annual Report* (2018) pp. 3-4.

[208] *Id.* at p. 5.

[209] Jones et al., *Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review*, *supra*, at p. 15; see also Nadia David, *Exploring the Use of Domestic Violence Fatality Review Teams* (2007) Austl. Domestic & Fam. Violence Clearinghouse, at p. 6.

[210] Little Hoover Comm'n, *Beyond the Crisis: A Long-Term Approach to Reduce, Prevent, and Recover from Intimate Partner Violence*, *supra*, p. 9; see also Bent-Goodley, *Domestic Violence Fatality Reviews and the African American Community*, *supra*, at pp. 382-83, 387; David, *Exploring the Use of Domestic Violence Fatality Review Teams*, *supra*, at p. 18.

[211] Albright et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, *supra*, at pp. 440, 445, 452-53.

[212] N.Y. State Office for the Prevention of Domestic Violence, N.Y. State Domestic Violence Fatality Review, *Case Referral*.

[213] Florida Coalition Against Domestic Violence (FCADV), *Domestic Violence Fatality Review: A Guide for Florida's Domestic Violence Fatality Review Teams*, at pp. 16-17.

[214] See Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 41:17-41:38.

[215] Karlsson et al., *Familicide: A Systemic Literature Review* (2021) 22 Trauma, Violence, and Abuse 83, 93-94; see also Buiten, *Familicide, Gender and the Media* (2022) p. 180.

[216] See Karlsson et al., *Familicide: A Systemic Literature Review*, *supra*, at pp. 90, 93, 95-96.

[217] Pen. Code § 11163.3(g)(5).

[218] See, e.g., Orange County Domestic Violence Death Review Team, *Domestic Violence Fatality Review: An Analysis of Over a Decade of Domestic Violence Fatalities in Orange County, CA: 2006-2017* (Feb. 2022) pp. iii, 19-34.

[219] Websdale, *Child Survivors of Intimate Partner Homicide: Wraparound Intervention*, supra, at pp. 1382-83.

[220] Jones et al., *Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review*, *supra*, at p. 3; see also Websdale, *Domestic Violence Fatality Review: The State of the Art, supra*, at p. 3098 (noting that cases of victim suicide may be particularly difficult to identify).

[221] Storer et al., *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?, supra*, at pp. 423-24.

[222] Bugeja et al., *Domestic/Family Violence Death Reviews: An International Comparison* (2015) 16 Trauma, Violence, & Abuse 179, 184.

[223] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 46:15-46:30.

[224] Websdale, *Domestic Violence Fatality Review: The State of the Art*, *supra*, at p. 3100.

[225] Florida Coalition Against Domestic Violence (FCADV), *Domestic Violence Fatality Review: A Guide for Florida's Domestic Violence Fatality Review Teams*, *supra*, at p. 15.

[226] Pen. Code § 11163.3(g)(1).

[227] Websdale, *Domestic Violence Fatality Review: The State of the Art, supra*, at p. 3101.

[228] Pursuant to Family Code sections 7643 and 7643.5, paternity case documents are confidential and only accessible to the parties, counsel, the court, and child support agencies.

[229] All documents in a juvenile dependency case file are confidential under Cal. Rules of Court, rule 5.552 and may only be obtained or inspected in accordance with Welf. & Inst. Code sections 827, 827.12, and 828. With the exception of the parties, their attorneys, and other court and/or government personnel, dependency case files may only be accessed by petitioning the relevant court.

[230] See N. Ariz. Univ. & Nat. Domestic Violence Fatality Review Initiative, *Saving the Next Generation: Domestic Violence Fatality Reviews in Indian Country*, *supra*, at 22:24-22:40, 25:02-24:14 (describing the Montana process, in which team members divide up to conduct interviews and bring the information to the rest of the team).

[231] See Mullane, *The Impact of Family Members' Involvement in the Domestic Violence Death Review Process*, *supra*, at p. 270-73; N. Ariz. Univ. & Nat. Domestic Violence Fatality Review Initiative, *Saving the Next Generation: Domestic Violence Fatality Reviews in Indian Country*, *supra*, at 24:42-26:25; United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*, *supra*, at p. 17.

[232] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 1:12:10-1:12:24.

[233] Ga. Domestic Violence Fatality Review Project, *2018 Annual Report*, *supra*, at p. 39.

[234] *Ibid.*

[235] *Ibid.*

[236] Jones et al., *Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review*, *supra*, at p. 4; Mullane, *The Impact of Family Members' Involvement in the Domestic Violence Death Review Process*, *supra*, at pp. 258, 280-81; United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*, *supra*, at p. 17; Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra*, at 8:00-8:46; N. Ariz. Univ. & Nat. Domestic Violence Fatality Review Initiative, *Saving the Next Generation: Domestic Violence Fatality Reviews in Indian Country*, *supra*, at 24:55-25:15.

[237] Websdale, *Domestic Violence Fatality Review: The State of the Art*, *supra*, at p. 3103.

[238] See Health Quality and Safety Comm'n, N.Z. Family Violence Death Rev. Comm., *A Duty to Care, Me manaaki te tangata*, *supra*, at p. 38.

[239] Ga. Comm'n on Fam. Violence & Ga. Coalition Against Domestic Violence, Ga. Domestic Violence Fatality Review Project, *Policies and Operating Procedures Manual*, *supra*, at p. 17.

[240] *Id.* at p. 19.

[241] *Ibid.*

[242] Pen. Code § 11163.3(g)(6).

[243] Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews*, *supra*, at p. 247.

[244] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 33:40-34:18.

[245] Websdale, *Domestic Violence Fatality Review: The State of the Art*, *supra*, at p. 3103; Office for the Prevention of Domestic Violence, *NYS Domestic Violence Fatality Review* (June 2021) p. 2.

[246] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*, *supra*, at p. 19.

[247] Evans et. al., *Male Perpetrators' Accounts of Intimate Femicide: A Global Systematic Review*, *supra*, at p. 542.

[248] Health Quality and Safety Comm'n, N.Z. Family Violence Death Rev. Comm., *A Duty to Care, Me manaaki te tangata*, *supra*, at p. 46.

[249] See Jones et al., *Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review*, *supra*, at pp. 4, 11.

[250] Parental consent is encouraged when a court wishes to interview a minor regarding a child custody decision. *See, e.g.*, *In re Marriage of Slayton* (2001) 86 Cal.App.4th 653, 659; *Tarling v. Tarling* (1960) 186 Cal.App.2d 8, 11.

[251] N. Ariz. Univ. & Nat. Domestic Violence Fatality Review Initiative, *Saving the Next Generation: Domestic Violence Fatality Reviews in Indian Country*, *supra*, at 23:30-23:50.

[252] Websdale, *Domestic Violence Fatality Review: The State of the Art, supra*, at p. 3101.

[253] See Pen. Code § 11163.3(a).

[254] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 17:48-19:10.

[255] *Id.* at 18:30-18:50.

[256] See Websdale, *The Case of Domestic Violence Fatality Review*, *supra*, at p. 29.

[257] Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra*, at 2:42-2:59.

[258] N. Ariz. Univ. & Nat. Domestic Violence Fatality Review Initiative, *Saving the Next Generation: Domestic Violence Fatality Reviews in Indian Country*, *supra*, at 21:14-21:28.

[259] Blue Shield of Cal. Found., *Breaking the Cycle: A Life Course Framework for Preventing Domestic Violence*, *supra*, at p. 6.

[260] See Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 16:48-17:20.

[261] Blue Shield of Cal. Found., *Breaking the Cycle: A Life Course Framework for Preventing Domestic Violence*, *supra*, at p. 7.

[262] See Armour, *Domestic Fatalities: The Impact on Remaining Family Members* (2010) 5 Internat. Persp. Victimology 22, 29-30.

[263] *Ibid*.

[264] Websdale, *Domestic Violence Fatality Review: The State of the Art, supra*, at pp. 3101, 3104.

[265] *Id.* at p. 3104.

[266] For example, meta-analytic research found that the strongest risk factor for domestic violence deaths is direct access to a gun. Kim & Merlo, *Trauma, Violence, & Abuse, Domestic Homicide: A Synthesis of Systematic Review Evidence, supra,* at pp. 786-787.

[267] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review, supra,* at 21:20; see also Walklate, *Reflections on community safety: the ongoing precarity of women's lives* (2018) 20 Crime Prevention & Cmty. Safety 284, 288-90; Walklate & Hopkins, *Real Lives and Lost Lives: Making Sense of 'Locked in' Responses to Intimate Partner Homicide* (2019) 14 Asian J. Criminology 129, 135.

[268] Websdale, *Domestic Violence Fatality Review: The State of the Art*, *supra,* at p. 3104.

[269] *Ibid.*; Kim & Merlo, *Trauma, Violence, & Abuse, Domestic Homicide: A Synthesis of Systematic Review Evidence*, *supra*, at p. 786.

[270] Cal. Task Force to Study and Develop Reparation Proposals for African Americans, *Final Report*, *supra*, at pp. 415-416; see also Gross, *African American Women, Mass Incarceration, and the Politics of Protection* (2015) 102 J. Am. Hist. 25, 28-33.

[271] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review, supra* at 21:30-21:55.

[272] *Ibid.*

[273] *Id.* at 22:32-23:08.

[274] *Ibid.*

[275] *Ibid.*

[276] *Id.* at 28:08; United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, supra,* at pp. 13-15.

[277] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review, supra*, at 28:08; United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, supra,* at pp. 13-15.

[278] *Id.* at p. 31.

[279] *Ibid.*

[280] *Ibid.*

[281] *Id.* at p. 7.

[282] *Ibid.*

[283] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review, supra*, at 28:40.

[284] *Id.* at 29:20-29:40.

[285] *Id.* at 30:10.

[286] Health Quality and Safety Comm'n, N.Z. Family Violence Death Rev. Comm., *A Duty to Care, Me manaaki te tangata*, *supra*, pp. 12-14.

[287] Little Hoover Comm'n, Beyond the Crisis: A Long-Term Approach to Reduce, Prevent, and Recover from Intimate Partner Violence*, supra,* at pp. 5-9; see also Messing et al., *Femicide in the United States*, *supra*, at p. 293.

[288] See Albright et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, *supra*, at p. 441.

[289] Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra*, at 4:40.

[290] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review, supra*, at 39:00 — 39:50.

[291] *Id.* at 31:43-32:27; Storer, *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?, supra*, at p. 422.

[292] Ga. Comm'n on Fam. Violence & Ga. Coalition Against Domestic Violence, Ga. Domestic Violence Fatality Review Project, *Policies and Operating Procedures Manual, supra,* at p. 21.

[293] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review, supra*, at 31:43-32:27.

[294] See *ibid*.

[295] Little Hoover Comm'n, Beyond the Crisis: A Long-Term Approach to Reduce, Prevent, and Recover from Intimate Partner Violence, *supra*, at pp. 5-8, 30.

[296] See e.g., Blecker-Blease, *As the world becomes trauma-informed, work to do*, *supra*, at pp. 131, 133-136; Blue Shield of Cal. Found., *Breaking the Cycle: A Life Course Framework for Preventing Domestic Violence*, *supra*, at p. 28.

[297] Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra*, at 16:46-18:30; Storer et al., *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?, supra*, at p. 432.

[298] Storer et al., *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?, supra*, at p. 432.

[299] Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra*, at 15:38-16:21.

[300] Storer et al., *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?, supra*, at p. 432.

[301] See United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*, *supra*, at p. 12.

[302] Albright et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, *supra*, at p. 451.

[303] Bugeja et al., *Domestic/Family Violence Death Reviews: An International Comparison*, *supra*, at p. 184.

[304] Albright et al., *Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation*, *supra*, at p. 452.

[305] Bugeja et al., *Domestic/Family Violence Death Reviews: An International Comparison*, *supra*, at p. 184.

[306] See, e.g., Storer et al., *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?, supra*, at p. 424; Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra*, at 4:40-4:48.

[307] See Storer et al., *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?*, *supra*, at p. 424 (Washington state, like Orange County, also presents their findings.).

[308] Bent-Goodley, *Domestic Violence Fatality Reviews and the African American Community*, *supra*, at p. 385.

[309] See United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*, *supra*, at p. 24.

[310] Storer et al., *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?, supra*, at p. 431.

[311] See, e.g., Ga. Comm'n on Fam. Violence & Ga. Coalition Against Domestic Violence, Ga. Domestic Violence Fatality Review Project, *Policies and Operating Procedures Manual*, *supra*, at p. 10.

[312] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*, *supra*, at p. 22.

[313] Austl. Hum. Rts. Comm'n, *A National System for Domestic and Family Violence Death Review* (December 2016) p. 28.

[314] Bugeja et al., Domestic/Family Violence Death Reviews: An International Comparison, *supra*, at p. 184.

[315] Storer et al., *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?, supra*, at pp. 430-31.

[316] See *id.* at p. 422.

[317] See, e.g., Ga. Comm'n on Fam. Violence & Ga. Coalition Against Domestic Violence, Ga. Domestic Violence Fatality Review Project, *Policies and Operating Procedures Manual*, *supra*, at p. 10.

[319] Websdale, *Domestic Violence Fatality Review: The State of the Art, supra,* at pp. 3102-3103; Cline & Cox, *S.T.O.P. in Action: Montana Domestic Violence Fatality Review Commission*, *supra,* at 2:10.

[320] In California, active judges may individually decide their ethical obligations as they relate to serving on Review Teams. Compare Cal. Judges Assn., Jud. Ethics Comm., Opn. No. 80 (June 2022) p. 6 ("A family law commissioner may participate in a Domestic Violence Task Force created by the court which includes the District Attorney's Office, the Public Defender's Office, County Counsel, probation, and a variety of local law enforcement agencies to address issues related to domestic violence cases and how best to address them.") with Cal. Supreme Ct., Comm. on Jud. Ethics Opns., Expedited Opn. No. 2021-041 (Mar. 3, 2021) p. 5 ("The broad scope of the task force's activities would make it difficult or impossible for a judge to participate as a member for all purposes while attempting to adhere to the ethical boundary between matters directly related to the law and social, moral, or policy imperatives. It is not reasonable to expect a judge acting as a task force member to bifurcate issues or limit involvement to permissible topics and discussions, particularly when many of the task force's activities concern matters beyond law.") However, "retired judges are exempted from the limitations of Canon 4C(2) and are allowed to accept appointment to a governmental committee or commission or other governmental position that is concerned with issues of fact or policy on matters other than the improvement of the law, the legal system, or the administration of justice." Cal. Judges Assn., Jud. Ethics Comm., Opn. No. 80, *supra,* at p. 5.

[321] Ga. Comm'n on Fam. Violence & Ga. Coalition Against Domestic Violence, Ga. Domestic Violence Fatality Review Project, *Policies and Operating Procedures Manual* (Dec. 2011) p. 11.

[322] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (2016) p. 18; Mullane, *The Impact of Family Members' Involvement in the Domestic Violence Death Review Process* in Domestic Homicides and Death Review (2017) pp. 263-66.

[323] Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews, Domestic Homicides and Death Reviews, supra*, at pp. 246-247.

[324] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews supra,* at p. 17.; Dale et al., *Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews, Domestic Homicides and Death Reviews, supra*, at p. 248

[325] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews supra,* at p. 17.

[326] *Id*. at p. 18.

[327] Ga. Domestic Violence Fatality Review Project, *Advanced Topics in Fatality Review - YouTube*, (March 19, 2019) at 27:45 — 28:46.

[328] Mullane, *The Impact of Family Members' Involvement in the Domestic Violence Death Review Process* in Domestic Homicides and Death Review, *supra,* at p. 262.

[329] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews , supra,* at p.18.

[330] *Ibid*.

[331] Mullane, *The Impact of Family Members' Involvement in the Domestic Violence Death Review Process* in *Domestic Homicides and Death* Reviews*, supra,* at p. 262; United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, supra,* at p. 19.

[332] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (2016) *supra,* at p. 18.

[333] United Kingdom Home Office, *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews supra,* at p. 19.

[334] See, e.g., Orange County Domestic Violence Death Review Team, *Domestic Violence Fatality Review: An Analysis of Over a Decade of Domestic Violence Fatalities in Orange County, CA: 2006-2017* (Feb. 2022) pp. iii, 19-34.

[335] Websdale, *Child Survivors of Intimate Partner Homicide: Wraparound Intervention*, supra, at pp. 1382-83.

[336] Jones et al., *Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review*, *supra*, at p. 3; see also Websdale, *Domestic Violence Fatality Review: The State of the Art, supra*, at p. 3098 (noting that cases of victim suicide may be particularly difficult to identify).

[337] Storer et al., *The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change?, supra*, at pp. 423-24.

[338] Bugeja et al., *Domestic/Family Violence Death Reviews: An International Comparison* (2015) 16 Trauma, Violence, & Abuse 179, 184.

[339] Nat. Domestic Violence Fatality Review Initiative, *Introduction to Domestic Violence Fatality Review*, *supra*, at 46:15-46:30.

[340] Websdale, *Domestic Violence Fatality Review: The State of the Art*, *supra*, at p. 3100.

[341] Websdale, *Domestic Violence Fatality Review: The State of the Art, supra*, at p. 3101.

[342] Pursuant to Family Code sections 7643 and 7643.5, paternity case documents are confidential and only accessible to the parties, counsel, the court, and child support agencies.

[343] All documents in a juvenile dependency case file are confidential under Cal. Rules of Court, rule 5.552 and may only be obtained or inspected in accordance with Welf. & Inst. Code sections 827, 827.12, and 828. With the exception of the parties, their attorneys, and other court and/or government personnel, dependency case files may only be accessed by petitioning the relevant court.

[344] Health Quality and Safety Comm'n, N.Z. Family Violence Death Rev. Comm., *A Duty to Care, Me manaaki te tangata*, *supra*, pp. 12-14.

[345] Little Hoover Comm'n, Beyond the Crisis: A Long-Term Approach to Reduce, Prevent, and Recover from Intimate Partner Violence*, supra,* at pp. 5-9; see also Messing et al., *Femicide in the United States*, *supra*, at p. 293.