Attorney General - Domestic Violence Fatality Review Statewide Team
Year 1 Process Report

The purpose of this report is to provide an update on the progress of Domestic Violence Fatality Review in Nevada. In October of 2011, the Attorney General's Office began work to establish a statewide Fatality Review team as well as ensure consistency among local teams.

I. Overview of Domestic Violence Fatality Review and Need in Nevada

Domestic Violence Fatality Review is considered to be a best practice tool and is becoming increasingly utilized across the country. The process includes a multidisciplinary review team that compiles information to review deaths related to domestic violence. Through these reviews, teams identify red flags that may have indicated escalating levels of violence and enables the team to develop recommendations to improve systems designed to protect victims of domestic violence. In 2011, Nevada had the highest rate of women killed by men with handguns in the United States, and the majority of victims were in an intimate relationship with the perpetrator (Violence Policy Research Center). While these numbers are trending down, domestic violence related fatalities are still a concern in Nevada. This review process will help to identify areas in need of improvement, establish a formal mechanism to further examine those needs and allow agencies and organizations to work together to make improvements, thus reducing deaths related to domestic violence.

II. Team Creation and Coordination in Nevada

The Nevada Legislature created Domestic Violence Fatality Review Teams by enacting NRS 217.475 in 1997. This statute allowed for "a court or agency of local government" to establish a multidisciplinary review team. Since that time, teams were established in Washoe County and Clark County. However, smaller jurisdictions throughout the state were unable to support their own local review teams and work began to enable the Attorney General to establish a special statewide team to review cases in jurisdictions without a local team resource.

AG-DVFRST

Effective October 2011, NRS 228.495 was enacted allowing the Attorney General to create multidisciplinary teams to review fatalities related to domestic violence in areas where no local team existed or where the local court or agency requests the assistance of the Attorney General. As a result of this statute, the Ombudsman for Domestic Violence in the Attorney General's Office began work to coordinate a Domestic Violence Fatality Review Statewide Team. In addition, the Attorney General's Office contracted with the Nevada Institute for Children's Research and Policy (NICRP) at the University of Nevada Las Vegas and the Nevada Network Against Domestic Violence. The NICRP was contracted to assist in establishing the statewide review team, creating protocols and data collection procedures, and facilitating the team's review meetings. NICRP has worked within the state system for child death review, as well as coordinating the Clark County Child Death Review Team since 2005. The Nevada Network provided subject matter expertise and assisted with coordination of the first review meeting.

Members of the statewide team were selected by the Attorney General to represent multiple disciplines and various parts of the state. Members were sent letters inviting their participation and were all officially appointed to the team at the team's first meeting in January of 2012. At this meeting, the team heard from the coordinator for the Montana Domestic Violence Fatality Review Team about their process and then discussed a draft of protocols for the Nevada statewide team. The team met via teleconference again in March to finalize team protocols and select its first case for review. The review meeting was held in June of 2012, and a follow up meeting to complete that review was completed in September of 2012.

Clark County – DVFRT

In addition to the duties associated with the statewide team, NICRP was also asked to help establish a team in Clark County as none existed in that area prior to 2011. NICRP worked with the Ombudsman to identify individuals and agencies that would be appropriate to participate on a review team. Potential members were contacted and initial meetings were held in December 2011 and May 2012. At the meeting in May, the group reviewed and adopted protocols that were adapted from those created by the statewide team, and decided to meet monthly to conduct case reviews and discuss recommendations for prevention. Also in this meeting, team members from Henderson volunteered to select a case from their jurisdiction for the first review. That small group gathered together information and created a timeline for presentation to the full team. The full team met in July and conducted its first review. From that review, the team refined its process for collecting information for reviews and planned to select the next case at the review meeting in August of 2012. In August the team finalized the team protocols and selected its next case to be reviewed at the September of 2012 meeting. To-date, the Clark County team has reviewed a total of three cases and information regarding those cases is listed below, and recommendations developed from these case reviews are listed in Appendix A.

	Case 1	Case 2	Case 3
Date of First Review Meeting	7/26/2012	9/26/2012	11/28/2012
Type of Fatality	Murder (Firearm)	Murder (Stabbing)	Murder/Suicide (Firearm)
Gender of Perpetrator	Male	Male	Male
Law Enforcement Jurisdiction	Henderson Police Department	Las Vegas Metropolitan Police Department	North Las Vegas Police Department
Year of Fatality	2004	2008	2009
Green = Review Complete Red = Review Ongoing			

Washoe County DVFRT

The Washoe County Domestic Violent Fatality Review Team (WCDVFRT) was established over fifteen years ago. Over the years the team has continually reviewed various domestic violence cases within Washoe County in an attempt to identify indicators or recommendations that could reduce the occurrences of domestic violence fatalities within the Washoe County region. The WCDVFRT conducts quarterly meetings with a small group of representatives from various governmental entities as well as citizens working within the mental health and community support services. Several years ago the team developed a data collection sheet to assist the team in identifying trends within domestic violence cases and developing recommendations from those trends to assist the community in reducing domestic violence. At the meeting in December 2012, the group reviewed and adopted protocols that were adapted from those created by the AG-DVFRST. The new protocols will assist in creating a consistent process throughout the state for all domestic violence fatality teams in reviewing, identifying and developing recommendations to reduce domestic violence throughout our state. Information on WCDVFRT case reviews are listed below and recommendations for prevention are listed in Appendix A.

	Case 1	Case 2
Date of First Review Meeting	1/6/12	12/7/12
Type of Fatality	Near Fatality (Razor Blade)	Murder (Asphyxiation)
Gender of Perpetrator	Male	Male
Law Enforcement Jurisdiction	Reno Police Department	Reno Police Department
Year of Fatality	2009	2011

III. Domestic Violence Fatality Review Process and Protocols

Domestic Violence Fatality Review in Nevada has been modeled after best practices established by the National Center on Domestic Violence Fatality Review and in consultation with experts in fatality review including Dr. Neil Websdale from the National Center on Domestic Violence Fatality Review as well as Matthew Dale, fatality review team coordinator for the state of Montana. Matthew Dale and the Montana review team has been cited as implementing national best practices and has been featured in an informational video discussing how they conduct their team's case reviews from the Office of Violence Against Women. Reviews are conducted using an "inch wide, mile deep" approach. Although only a few cases are reviewed each year, these are examined in depth to understand the circumstances that led to the fatality and identify red flags and potential recommendations for changes to prevent future fatalities. Cases are selected by each individual team and all members work to collect related records and information to construct a timeline of the lives of the victim and the perpetrator. This same approach is used in all three teams throughout our state.

In March of 2012, the statewide team created protocols for the review process including a procedure to ensure confidentiality of information shared during review meetings. These protocols were adopted by both the Washoe County and Clark County teams to ensure consistency statewide. Confidentiality procedures include all members signing a confidentiality agreement at all review meetings to remind participants of the confidential nature and create a record of participants for each case review meeting. Each team has a separate jurisdiction from which to select cases for review, but recommendations made as a result of team reviews will be shared with the Ombudsman for Domestic Violence in an effort to coordinate efforts and focus statewide initiatives related to the prevention of domestic violence and fatalities related to domestic violence.

IV. The Future of Domestic Violence Fatality Review in Nevada

In 2012, the AG-DVFRST reviewed one case and developed a set of recommendations for system improvement. These recommendations are listed under Appendix A. The team has also selected the next case for review and is in the process of setting the next review meeting. In addition, the team is working on creating a process to share these recommendations with other coalitions and task forces statewide to work to further examine or implement the recommendations for prevention.

V. Team Membership

The tables below contain the membership list for the statewide team, Clark County team, and Washoe County team.

Attorney General Domestic Violence Fatality Review Statewide Team

NAME	ORGANIZATION/AGENCY
Catherine Cortez Masto	Nevada Attorney General
Darin Balaam	Reno Police Department
Kathleen Ja Sook Bergquist, LCSW, JD, PhD	UNLV School of Social Work
Julie Butler	Nevada Department of Public Safety
Karen Carey	Tahoe SAFE Alliance
Sandra Dieterich-Hughes	S.A.F.E. House
Dr. Robert Fowler, Sr.	Victory Missionary Baptist Church
April Green	Legal Aid Center of Southern Nevada
Mark Jackson	Douglas County District Attorney
Brett Kandt	Council for Prosecuting Attorneys
Maria Kies	Nevada Network Against Domestic Violence
Katherine Loudon	Washoe County Risk Free Schools
Leslie Mieras Preston	Newmont Mining Corporation
Marla Morris, LSW	Nevada Division of Child and Family Services
Susan Meuschke	Nevada Network Against Domestic Violence
Team Facilitator	
Tara Phebus	Nevada Institute for Children's Research and Policy, UNLV
Attorney General Staff	
Kareen Prentice	Domestic Violence Ombudsman
Lorraine Webber	Assistant to the AG-DVFRST
Lisa South	Assistant to the AG-DVFRST

Clark County Domestic Violence Fatality Review Team (Updated January 9, 2013)

NAME	ORGANIZATION/AGENCY
Lyn Amie	Nevada Coalition Against Sexual Violence
Maricar Andrade	Bamboo Bridges, NCPDV, and Andrade Law
Barbara Aupperle	Clark Co. DA's Victim/Witness Assistance Ctr.
Mayra Castro	Henderson City Attorney's Office - Criminal Division
Kimberly Del Rossi	Henderson Police Department
Christopher Delacanal	Henderson Police Department
Brigid Duffy	Clark County District Attorney's Office
Carol Ferranti	Las Vegas Metropolitan Police Department
Debora Flowers	Nevada Division of Child and Family Services
April Green	Legal Aid of Southern Nevada
Elynne Greene	Las Vegas Metro Police Department
Caroline Greene	Henderson City Attorney's Office - Criminal Division
Vicky Hardaway	United HealthCare, NV
Karen Heriford	Clark County Coroner's Office
Benjamin Hughes	Nellis Air Force Base, Family Advocacy and Treatment
Margaret King	District Court - Family Mediation Center
Suzette Landholm	Las Vegas City Attorney's Office
Susie Lewis	Henderson Police Department
Renee Lightford	Community Member
Jan Lucherini	North Las Vegas Police Department
Rob Lundquist	LVMPD- Crimes Against Youth and Family- Family Crimes
John Martin	North Las Vegas City Attorney's office
Adriana Martinez	Las Vegas City Attorney's Office
Kimberly Phillips	North Las Vegas City Attorney's office
Julie Proctor	S.A.F.E. House
Athena Raney	Henderson Police Department
Sharon Savage	Clark County Dept. Family Services.
Janette Speer	Henderson City Attorney's Office
Jake Merback	Clark County District Attorney's Office
Tami Utzig	SafeNest
Adriana Van Buskirk	North Las Vegas City Attorney's office
Wendy Wilkinson	District Court - Family Division
Lourdes Yapjoco	Southern Nevada Health District
Robert Zentz	Henderson City Attorney's Office
Team Coordinator/Facilitator	
Tara Phebus, Team Coordinator	Nevada Institute for Children's Research and Policy, UNLV

NAME	ORGANIZATION/AGENCY
Darin Balaam	Washoe County Sheriff's Office
Roni Branson	Committee to Aid Abused Women
Tom Green	Washoe County Sheriff's Office
Dr. Michael Freda	Ridgeview Counseling Group
Rebecca Lebeau	Child Assault Prevention Project (CAP)
Jennifer Olsen	Sparks Police Department
Stephanie O'Rourke	Department of Public Safety Parole and Probation
Carol Patton	Washoe County Social Services Office
Dr. Melissa Piasecki	University of Nevada, Reno
Kareen Prentice	Nevada Office of the Attorney General
Suzanne Ramos	Reno City Attorney's Office
Dina Salvucci	Washoe County District Attorney's Office
Kimberly Schweickert	Washoe County Social Services
Robert Smith	Washoe County Regional Animal Services
Judy Buckman	Director of the Protection Order Project
Dorene Whitworth	Consultant
Greta Woyciehowsky	Sparks Police Department

APPENDIX A: Recommendations from Statewide and Local Teams

AG-DVFRST Recommendations

Case Review #1 – June 26-27, 2012

RECOMMENDATION #1:

Create policy, protocol, or other method to ensure that agencies are submitting complete and accurate information to the Nevada Criminal Justice Information System or NCJIS.

RATIONALE: **:** NCJIS – Nevada Criminal Justice Information System is a database for information sharing that contains all information on criminal activity, but is only as good as the agencies and individuals submitting the information. DA's, city attorney's, courts, law enforcement should all have processes in place to ensure that full, accurate, and complete information is input into this system – including arrests, convictions, and TPOs

RECOMMENDATION #2

Ensure that once a danger/lethality assessment is complete that the victim is referred for services and also follow up with the perpetrator. This could come in the form of the creation of high risk teams that place the focus on the prevention of crime and strengthen police response to high risk perpetrators.

RATIONALE: Many agencies (law enforcement and other service providers) have implemented lethality assessments, but need more resources and guidance on how to use that information once the assessment is complete. The implementation of high risk teams would allow for specialized treatment of these cases to strengthen the ability for police to respond and prevent violent crimes.

RECOMMENDATION #3

Provide support to agencies to allow them to achieve a level of capacity that will allow them to implement best practices in their field.

RATIONALE: Best practices in many areas related to domestic violence treatment and prevention have been developed but local agencies struggle to implement these processes because of high case loads and/or insufficient staffing levels.

RECOMMENDATION #4

Explore the possibility of the creation and implementation of a process/procedure for instant Temporary Protection Orders (TPOs) at the time of arrest.

RATIONALE: The Temporary Protection Order (TPO) at the time of the incident is often most valuable at the time of the incident and an instant system would prevent delays in protecting victims from additional abuse. This system may require on-call judges, and advocates that could be available immediately at the time of arrest.

NRS 33.017 Definitions. As used in NRS 33.017 to 33.100, inclusive, unless the context otherwise requires:

1. "Extended order" means an extended order for protection against domestic violence.
2. "Temporary order" means a temporary order for protection against domestic violence.

(Added to NRS by 1985, 2283; A 1997, 1808; 1999, 1372; 2001, 2128; 2003, 1754; 2007, 1275)

RECOMMENDATION #5

Work with judges and attorneys statewide to discontinue the practice of pleading down domestic violence cases.

RATIONALE: When these cases are pleaded down to lower level offenses, sentencing is ineffective or even dangerous. For example, impulse control classes are not effective in domestic violence cases. In addition, this creates a system where future domestic violence incidents are treated as a first offense, and therefore the cumulative nature of domestic violence sentencing is ineffective.

RECOMMENDATION # 6

Implement a regular review for the processes used when perpetrators are "Gone on Arrival."

RATIONALE: In these circumstances, law enforcement may or may not follow up on locating these individuals. If 24 hours pass, then law enforcement can seek a warrant for their arrest but this is not consistently done across jurisdictions.

RECOMMENDATION #7

Ensure that a language line or other reliable and certified interpretation services are available for 911 operators as well as law enforcement and ensure staff are trained on when and how to use these services in the course of their job.

RATIONALE: Interpretation services may not be available 24 hours a day in all jurisdictions and staff may not be aware of when and how to access these services. In DV cases, reporting abuse is a very important step and if victims are not understood at the time of the call or law enforcement response, victims may become frustrated by the system and not use the systems that are there for their protection.

RECOMMENDATION #8

Review standard procedures for 911 operators in Public Safety Answering Point (PSAP) locations statewide to ensure that operators are trained using national best practices in how to respond to calls related to domestic violence.

RATIONALE: When victims of domestic violence call 911 for help operators should be trained to conduct a safety assessment of the caller to ensure their safety is secured before demographic information is collected. In some instances, valuable time is lost and victims remain at risk while the operator gets basic demographic information like name, address, etc.

Clark County-DVFRT Recommendations

Case Review #1-3 June – March 2012

NOTE: *These recommendations come from the first three case reviews of the Clark County Team and recommendations from the third case review are still in development as the team finalizes that case review.*

RECOMMENDATION #1:

Work with the Nevada Council for the Prevention of Domestic Violence's Education Committee to identify existing programs and best practices for increasing age appropriate education and awareness about domestic violence for children and youth in Nevada schools.

RATIONALE: In one of the cases reviewed by the team, the couple had children in the home that witnessed the abuse and in one case even made multiple calls to law enforcement when domestic violence occurred. The team identified a need to educate students about domestic violence so that they have tools and resources available if they recognize the signs in their own homes or dating relationships.

RECOMMENDATION #2

Work with the Nevada Council for the Prevention of Domestic Violence's Public Information Committee to implement a broad public education campaign to recognize that even seemingly minor incidents in a relationship can be red flags that often escalate to more severe violence, power and control issues in a relationship.

RATIONALE: In all of these cases in hindsight someone in the victim or perpetrator's family, their friend, neighbors or coworkers identified incidents of controlling behavior or violence and if these earlier incidents (although perceived as minor or isolated) would have been taken more seriously the death may have been prevented.

RECOMMENDATION #3

Create a subcommittee at the state level to review laws/policies related to the minimum age when a protection order may be requested without a parent or guardian to see if these restrictions can be changed to accommodate younger victims.

RATIONALE: In some cases the domestic violence or dating violence starts very young and victims may be too embarrassed to talk to their parents about their concerns so requiring a parent or guardian for victims under age 18 may be a barrier to them seeking out these protections even when they have very serious concerns.

RECOMMENDATION #4

Amend NRS 202.360 so that persons convicted of a misdemeanor offense of battery constituting domestic violence are included in the list of persons prohibited from owning or possessing a firearm.

RATIONALE: In two of the cases reviewed the perpetrator used a firearm to commit the murder and in both of those cases the firearm was owned by the perpetrator. In one of the cases reviewed the perpetrator had been previously convicted of domestic violence but still remained in possession of his firearms. This suggested change would bring Nevada state law more in line with federal law.

RECOMMENDATION #5

Work with the Nevada Council for the Prevention of Domestic Violence to identify existing or develop educational messaging or training about mental illness/substance abuse and the impact on victims of domestic violence to help professionals to be more sensitive to these issues

RATIONALE: In one of the cases reviewed mental health issues of the victim may have led to chronic alcohol abuse which may have hindered her ability to advocate for herself, and may have impacted her credibility with law enforcement when reporting incidents of domestic violence. We know that victims may use substances as a coping mechanism to deal with the abuse and their abusers may withhold treatment for mental illness to maintain control. Training for sensitivity to these issues may allow for better services to victims with these special needs.

RECOMMENDATION # 6

Request that the Nevada Council for the Prevention of Domestic Violence and their Underserved Populations Committee could work with inpatient/outpatient mental health service providers as well as domestic violence shelters statewide to help address specific concerns for domestic violence victims with mental health diagnoses.

RATIONALE: Historically it has been difficult for victims of domestic violence with mental health or substance abuse issues to access domestic violence shelters. For the safety of all the women in the shelters there are strict rules of conduct that must be followed and these can be difficult for victims with mental illness or those addicted to drugs or alcohol, but they could still benefit from the safety a shelter can offer. Currently there has been some work done to address these concerns, but it would be more beneficial if the issues were addressed on a statewide level.

RECOMMENDATION #7

Identify existing training or develop training based on best practices, for medical providers on what to do after a lethality assessment or how to provide information discreetly if medical staff suspect that a patient is the victim of domestic violence.

RATIONALE: In two of the cases reviewed, the team identified that the victim had been to the hospital for medical treatment after a violent incident and although a lethality assessment was completed, it was unclear what steps were taken after the assessment to help ensure the victim's safety. In addition, in these incidents even if the assessment wasn't done medical staff likely had a suspicion and could have provided resources or information even if the victim indicated that the injury was not a result of domestic violence.

Washoe County-DVFRT Recommendations
January 1, 2012-December 2012

RECOMMENDATION #1:

Create policy, protocol, and training to ensure that all Temporary Protection Order Office within the courts have access and/or staff are bilingual to ensure that the victims applying for TPO's are afforded the opportunity to have all their questions, concerns and education explained to them in a language they understand.

RATIONALE: Several of our previous cases over the past two years have involved immigrants from other countries who did not speak or understand English very well. There are international language services which provide bilingual speakers to assist in the interpretation and explanation of a TPO and would assist in ensuring the victim understands the TPO process and any fears or concerns they may have could be addressed at the time of application.

RECOMMENDATION #2

Provide statewide training to law enforcement personnel on domestic violence, signs of domestic violence and TPO process.

RATIONALE: Many agencies throughout the state have experienced a increase in the number of new officers on the street. This influx is can partially be attributed to the early retirement age for law enforcement personnel (25 years of service). The basic law enforcement academy provides a very limited amount of domestic violence and TPO training to new officers. Nevada continues to lead the nation in domestic batteries and we need to educate our first responders on identifying and addressing this issue. This training should also involve the best practices in the prevention and outreach resources available for victims.

APPENDIX B: Statewide Team Protocols

ATTORNEY GENERAL-DOMESTIC VIOLENCE STATEWIDE FATALITY REVIEW TEAM (AG-DVFRST)

TEAM PROTOCOLS

DRAFT: Updated March 21, 2012, Approved March 22, 2012

These protocols are designed to help guide process and provide structure for the Attorney General – Domestic Violence Statewide Fatality Review Team. The team can choose to change or update these protocols at any time.

Purpose
The purpose of the Attorney General-Domestic Violence Fatality Review Statewide Team (AG-DVFRST) is to review selected cases of domestic violence related deaths in communities where a domestic violence fatality review (DVFR) team does not exist, or if a local team, established pursuant to NRS 217.475, has requested a review by the AG-DVFRST.

Mission
The AG-DVFRST will carefully select and review deaths of victims of crimes that constitute domestic violence pursuant to NRS 33.018, in order to improve the coordination and delivery of service outcomes and prevent incidents and deaths related to domestic violence.

Goals and Objectives
The AG-DVFRST will achieve its mission by:

- Identifying adjudicated domestic violence fatalities for review;
- Reviewing circumstances of domestic violence related deaths;
- Identifying patterns that lead to fatal outcomes;
- Determining whether reviewed deaths may have been preventable;
- Identifying strategies for prevention of domestic violence related deaths, including but not limited to, delivery of agency services and intervention methods;
- Developing intervention strategies to reduce fatalities and eliminate ongoing abuse;
- Identifying ways to improve and enhance interagency reporting and communication;
- Identifying methods, services, and strategies that were used effectively and efficiently; and
- Following any and all statutory requirements, including those set forth in NRS 228.495.

Team Structure
Members are appointed for a minimum of one year by the Attorney General. The initial team members were sworn in on January 12, 1012. New members may be appointed by the Attorney General at any time, and the Attorney General may revoke an appointment at any time. All new members will be provided with an informational packet to familiarize themselves with the process and team structure. The AG-DVFRST may include members from a number of agencies and organizations pursuant to NRS 228.495(2)

Note: *The structure of these protocols was adapted from the Solano County, California Domestic Violence Fatality Review Team Protocols.*

Meeting Schedule
The AG-DVFRST will meet at least two times per year to review cases. Meeting dates and times will be decided by the team in advance of meetings. The team may decide to increase the number of review meetings held each year if the team decides to review more cases. In addition, the team may meet once a year to review overall findings and recommendations for inclusion in an annual report or to handle other non-review specific business. AG-DVFRST meetings are not subject to Nevada Open Meeting Law; however, meetings may be open to the public at the discretion of the Attorney General.

Case Selection and Review Process
The AG-DVFRST will only select adjudicated cases where the death was found to be related to domestic violence. Cases for the next review will be selected by the team after each review meeting. In addition, the team may choose to review a case at the written request of a victim's family member. Written requests must be made to the Attorney General.

The review process will take a timeline approach whereby the team members share case specific information to create a timeline of the relationship between the victim and perpetrator. The team's discussion will be led by a facilitator who will help to guide discussion of case details. The timeline approach has been recognized as a best practice by the National Domestic Violence Fatality Review Initiative. Case reviews may also involve non-team members ("case review participants") with pertinent information to assist in a more comprehensive review of each case. Case review participants may be invited to participate in the review by the Attorney General.

Confidentiality
All information shared during these review meetings is confidential and cannot be used for any purpose other than the review itself. All team members, staff and case review participants will sign a confidentiality agreement at the beginning of each review meeting, and all materials collected for the review will be destroyed with the exception of the data collection tool and the recommendations drafted by the team. Any requests from media outlets for information about the AG-DVFRST will be referred to the Attorney General for comment. The confidentiality agreement is attached in Appendix A of this document.

Data Collection
For each case reviewed, the Nevada Ombudsman for Domestic Violence will complete a data collection tool to capture basic statistics for tracking and reporting information on cases reviewed. This tool will also track recommendations for improvement. The data collection tool is attached in Appendix B of this document.

Reporting
Annually the AG-DVFRST will create a report of its activities including the number of cases reviewed, team membership, and any findings or recommendations generated from the team's reviews. This report will be compiled by the Nevada Ombudsman for Domestic Violence in the Attorney General's Office.

Note: *The structure of these protocols was adapted from the Solano County, California Domestic Violence Fatality Review Team Protocols.*

Statutory Authority

NRS 228.495 Organizing or sponsorship; powers and duties; membership; participation by organizations concerned with domestic violence; authority and duties of Attorney General; immunity and liability of members; inadmissibility of review; report.

1. 1.The Attorney General may organize or sponsor one or more multidisciplinary teams to review the death of the victim of a crime that constitutes domestic violence pursuant to NRS 33.018 if a court or an agency of a local government does not organize or sponsor a multidisciplinary team pursuant to NRS 217.475 or if the court or agency requests the assistance of the Attorney General. In addition to the review of a particular case, a multidisciplinary team organized or sponsored by the Attorney General pursuant to this section shall:

    a) Examine the trends and patterns of deaths of victims of crimes that constitute domestic violence in this State;
    b) Determine the number and type of incidents the team wishes to review;
    c) Make policy and other recommendations for the prevention of deaths from crimes that constitute domestic violence;
    d) Engage in activities to educate the public, providers of services to victims of domestic violence and policymakers concerning deaths from crimes that constitute domestic violence and strategies for intervention and prevention of such crimes; and
    e) Recommend policies, practices and services to encourage collaboration and reduce the number of deaths from crimes that constitute domestic violence.

2. A multidisciplinary team organized or sponsored pursuant to this section may include, without limitation, the following members:

    a) A representative of the Attorney General;
    b) A representative of any law enforcement agency that is involved with a case under review;
    c) A representative of the district attorney's office in the county where a case is under review;
    d) A representative of the coroner's office in the county where a case is under review;
    e) A representative of any agency which provides social services that is involved in a case under review;
    f) A person appointed pursuant to subsection 3; and
    g) Any other person that the Attorney General determines is appropriate.

3. An organization that is concerned with domestic violence may apply to the Attorney General or his or her designee for authorization to appoint a member to a multidisciplinary team organized or sponsored pursuant to this section. Such an application must be made in the form and manner prescribed by the Attorney General and is subject to the approval of the Attorney General or his or her designee.
4. Each organization represented on a multidisciplinary team organized or sponsored pursuant to this section may share with other members of the team information in its possession concerning a victim who is the subject of a 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.
5. The organizing or sponsoring of a multidisciplinary team pursuant to this section does not grant the Attorney General supervisory authority over, or restrict or impair the statutory authority of, any state or local governmental agency responsible for the investigation or prosecution of the death of a victim of a crime that constitutes domestic violence pursuant to NRS 33.018.

6. Before organizing or sponsoring a multidisciplinary team pursuant to this section, the Attorney General shall adopt a written protocol describing the objectives and structure of the team.
7. A multidisciplinary team organized or sponsored pursuant to this section may request any person, agency or organization that is in possession of information or records concerning a victim who is the subject of a review or any person who was in contact with the victim to provide the team with any information or records that are relevant to the review. Any information or records provided to a team pursuant to this subsection are confidential.
8. A multidisciplinary team organized or sponsored pursuant to this section may, if appropriate, meet with any person, agency or organization that the team believes may have information relevant to a review conducted by the team, including, without limitation, a multidisciplinary team:

    a) To review the death of the victim of a crime that constitutes domestic violence organized or sponsored pursuant to NRS 217.475;
    b) To review any allegations of abuse, neglect, exploitation or isolation of an older person or the death of an older person that is alleged to be from abuse, neglect or isolation organized pursuant to NRS 228.270;
    c) To review the death of a child organized pursuant to NRS 432B.405; or
    d) To oversee the review of the death of a child organized pursuant to NRS 432B.4075.

9. Except as otherwise provided in subsection 10, each member of a multidisciplinary team organized or sponsored pursuant to this section is immune from civil or criminal liability for an activity related to the review of the death of a victim.
10. Each member of a multidisciplinary team organized or sponsored pursuant to this section who discloses any confidential information concerning the death of a child is personally liable for a civil penalty of not more than $500.
11. The Attorney General:

    a) May bring an action to recover a civil penalty imposed pursuant to subsection 10 against a member of a multidisciplinary team organized or sponsored pursuant to this section; and
    b) Shall deposit any money received from the civil penalty with the State Treasurer for credit to the State General Fund.

12. The results of a review of the death of a victim conducted pursuant to this section are not admissible in any civil action or proceeding.
13. A multidisciplinary team organized or sponsored pursuant to this section shall submit a report of its activities to the Attorney General. The report must include, without limitation, the findings and recommendations of the team. The report must not include information that identifies any person involved in a particular case under review. The Attorney General shall make the report available to the public.

(Added to NRS by 2011, 734)

Protocol Appendix A: Confidentiality Agreement

Attorney General- Domestic Violence Fatality Review Statewide Team Confidentiality Agreement

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The purpose of the Attorney General-Domestic Violence Fatality Review Statewide Team (AG-DVFRST) is to review selected cases of domestic violence related deaths pursuant to the provisions of NRS 228.495. All information shared during case review is confidential and cannot be used for any purpose other than the review itself. As a condition of participation, the undersigned agrees to the following:

1. SCOPE OF PARTICIPATION. Pursuant to the provisions of **NRS 228.495,** the undersigned may share with the AG-DVFRST information concerning the victim who is the subject of a review or any person who was in contact with the victim and any other information pertinent to the review.

2. TREATMENT OF INFORMATION SHARED; CONFIDENTIALITY.

a. Pursuant to the provisions of **NRS 228.495**, any information shared by and between the AG-DVFRST and the undersigned is confidential.

b. The undersigned shall keep confidential all information, in whatever form, produced, prepared, observed or received through participation in the AG-DVFRST to the extent necessary to comply with the provisions of **NRS 228.495.**

c. The undersigned shall return any materials received through participation in the AG-DVFRST to the extent necessary to comply with the provisions of **NRS 228.495.**

d. To the extent applicable, the undersigned acknowledges that pursuant to **NRS 228.495(10)**, each member of the AG-DVFRST who discloses any confidential information concerning the death of a child is personally liable for a civil penalty of not more than $500.

3. EARLY TERMINATION. Participation by the undersigned may be terminated by the Attorney General with or without cause prior to the conclusion of a case review. In the event of early termination the provisions of paragraph (2) survive termination

IN WITNESS WHEREOF, the parties hereto have caused this Confidentiality Agreement to be signed and intend to be legally bound thereby.

Participant [NAME] _____:

BY:_____ _____ _____

Signature Title/Agency Date