

West Virginia Domestic Violence Fatality Review Team

West Virginia code recognizes that “every person has a right to be safe and secure in his or her home and family” and that “domestic violence is a major health and law enforcement problem in the state, with enormous costs exacted in terms of both dollars and human lives.” In addressing the domestic violence problem, state code broadly defines such violence to include that directed against family and household members as well as intimate partners.

As a part of the state’s efforts to address the problem of domestic violence, legislation mandating the formation of the West Virginia Domestic Violence Fatality Review Team (DVFRT) was enacted in 2003 (see Appendix A). The DVFRT is a multidisciplinary and multiagency body charged with reviewing domestic violence deaths of state residents that occur within the state, with the goal of reducing domestic violence incidence and mortality as defined above. While not an investigative body, the Team reviews the results of investigations conducted by member organizations as well as other information provided to it in order to fulfill its mission. The DVFRT is tasked with:

- (1) Reviewing all deaths of victims or suspected victims of domestic violence, including suicides, who are state residents, in order to identify trends, patterns, and risk factors;
- (2) Providing statistical analysis regarding the causes of domestic violence fatalities in West Virginia;
- (3) Promoting public awareness of the incidence and causes of domestic violence fatalities, including recommendations for their reduction; and
- (4) Providing training for state agencies.

The DVFRT classifies the domestic violence deaths it reviews into one of three groupings:

Intimate partner violence – homicide or suicide occurring within the context of an intimate/romantic relationship between victim and suspect;

Intimate partner associated – homicide occurring within the context of an intimate partner situation, e.g., a current boyfriend murdered by an estranged husband; or

Family violence – homicide occurring within the context of a family relationship not including an intimate/romantic partner, e.g., a brother killing a brother.

DVFRT Membership. According to statute, the DVFRT operates under the auspices of the West Virginia Office of the Chief Medical Examiner (OCME), with the Chief Medical Examiner acting as chair of the Team and the part-time coordinator housed within that office. The Team is to consist of, but is not limited to, the following members appointed by the governor to serve three-year terms:

the Chief Medical Examiner;

four prosecuting attorneys or their designees;

the state superintendent of the West Virginia State Police or his or her designee;

one county law enforcement official;

one municipality police officer;

one physician, resident, or nurse practitioner specializing in the practice of obstetrics and gynecology;
one adult protective service worker currently employed in investigating reports of adult abuse or neglect;
one social worker who may be employed in medical social work;
the commissioner of the Office of Behavioral Health Services of the Department of Health and Human Resources (DHHR) or his or her designee;
the director of the Office of Social Services of DHHR or his or her designee;
one domestic violence advocate from a licensed domestic violence program;
a representative of the West Virginia Coalition Against Domestic Violence (WVCADV);
one physician, resident, or nurse practitioner specializing in the practice of family medicine or emergency medicine;
the director of the state Division of Corrections or his or her designee; and
the director of the Office of Epidemiology and Health Promotion of DHHR or his or her designee.

DVFRT Review Process. The initial screening of fatalities to determine if they meet the definition for domestic violence is done by the OCME. The OCME investigators, pathologists, and the DVFRT coordinator review all potential cases, making a determination of domestic violence status based on information available when cases are first presented to the OCME. Because vital information is sometimes missing at initial review, some domestic violence cases may be overlooked at that time. For this reason, regional on-line newspapers are reviewed weekly for articles related to domestic violence incidents. Additional information relating to incidents, as well as case disposition, is also tracked in this manner.

A listing of all identified domestic violence fatalities is maintained for future review by the DVFRT. The actual review of a case may occur only after the incident has had an initial court determination, i.e., a suspect has been tried and convicted or there is a determination of no further legal action, as in the case of a homicide followed by the suicide of the perpetrator. Due to this, most cases are reviewed about two years following the actual event.

Prior to the review of a case by the Team, a request for records is sent to all agencies that were identified as having relevant information. These records might include the investigating police agency report, the county prosecution records, OCME records, medical records, criminal justice incarceration records, and local domestic violence shelter information. When the records are received by the DVFRT coordinator, they are forwarded to the appropriate team members for review, e.g., prosecution records to the prosecutors on the Team, etc.

At the DVFRT meetings, which are held bimonthly, the members present a summary of the records of each case they reviewed. A team discussion then addresses the following issues for each event:

- Was this fatality the result of a domestic violence incident as identified by the state statute?

- What were the critical elements that led to the fatality?
- Were there opportunities to prevent the fatality?
- Does the incident suggest training or education related to specific areas or occupations?
- How does this incident relate to other reviewed incidents?
- Are there policies relevant to this incident that need to be reviewed or changed?
- Are there lessons or educational messages to be derived from this incident?

Recommendations for public education and system changes are formed on the basis of cumulative fatality reviews and presented to the Governor, the legislature, appropriate agencies, and the general public.