District of Columbia
Domestic Violence Fatality Review Board

2014 Annual Report

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

DISTRICT OF COLUMBIA
DOMESTIC VIOLENCE FATALITY REVIEW BOARD
2014 ANNUAL REPORT

PRESENTED TO:

THE HONORABLE MURIEL BOWSER, MAYOR, DISTRICT OF COLUMBIA

THE COUNCIL OF THE DISTRICT OF COLUMBIA
AND
THE RESIDENTS OF THE DISTRICT OF COLUMBIA

APRIL 2018

Table of Contents

A Word from the Domestic Violence Fatality Review Board Co-Chairs

Erin S. Larkin and Rafael Sa'adah

The District of Columbia's Domestic Violence Fatality Review Board (DVFRB) is honored to present this Annual Report for reporting year 2014. Over the past few years, the DVFRB has been working to improve our review process, general board functioning, and annual report publication. Here are some highlights of our recent work.

In 2015, the District of Columbia's Office of Victim Services and Justice Grants (OVSJG) provided funding to support the administration of the DVFRB. With this critical funding, OVSJG hired a Board coordinator to gather the necessary data for our case reviews, organize and convene our regular meetings, and draft reports. The coordinator has strengthened the Board by recruiting new members and developing policies and procedures to govern the Board's work. The coordinator has also improved our review process by standardizing data collection and case review tools as well as launching an online file sharing tool for reviewing reports and record keeping.

In the last year, we revised our policies and procedures and selected a co-chair. We are continuing to secure our partnerships with independent agencies such as the federal Court Services and Offender Supervision Agency (CSOSA), which provides supervision and support services to adult offenders on probation, parole, and supervised release in the District. The new online file sharing system has allowed us to share information in a more timely and efficient manner while maintaining strict confidentiality.

Looking forward, the DVFRB is exploring opportunities to better collaborate with our neighboring jurisdictions' fatality review teams and benefit from the expertise of national technical assistance providers in the field.

Because the DVFRB conducts in-depth reviews, we are able to examine only a portion of the District's yearly homicides that qualify as domestic violence-related. The DVFRB's enabling statute recognizes this reality and allows the Board to decide which types of domestic violence-related deaths it will review. As our main goal is to prevent future domestic violence deaths by identifying gaps in services in the past and issuing recommendations for improvement, the DVFRB decided to focus the in-depth reviews on intimate partner homicides and monitor those committed by family members, relatives, roommates, and "common partners" (defined in the statute as people whose only connection to each other is a current or former intimate partner in common).[1] With intimate partner homicides, there is a well-developed body of scientific

[1] Intimate partner homicides include those committed by current or former romantic and/or sexual partners.

research surrounding risk factors and prevention strategies to guide our review and recommendations. This is not to say that one type of homicide is more important than another. Each life cut short is of equal value. Rather, we hope our recommendations will be a catalyst for systems change that will have the greatest impact on people's lives as we continue to search for the ways and means to prevent all homicides.

The DVFRB is committed to developing systemic recommendations that can be used to improve the response to domestic violence victims throughout the District and prevent further homicides. We are honored to serve in this role and humbled by the responsibility of it. With the hope that we can prevent a future death by shining a light on what too often is a hidden tragedy, we dedicate this report to the women and men whose lives and untimely deaths are represented here.

Executive Summary

Purpose of the Domestic Violence Fatality Review Board

The purpose of the Domestic Violence Fatality Review Board (DVFRB or the Board) is to prevent domestic violence fatalities by improving the response of individuals, the community, and government agencies to domestic violence (D.C. Code §16-1052). The Board is a formally established mechanism for tracking domestic violence-related fatalities, assessing the circumstances surrounding the deaths and associated risk indicators, as well as making recommendations for improvement of systemic response to victims of domestic violence.

Findings and recommendations in this report are based on an analysis of police, court, and medical records received by the DVFRB for deaths that occurred in calendar year 2014. This report highlights the summary data of the 2014 domestic homicides but also puts forth a more in-depth synopsis of the data, trends, and recommendations from the six intimate-partner violence homicide cases reviewed by the Board for this reporting period.

When considering all domestic homicides (including non-intimate partner homicides), findings show that the majority of the victims were from Wards 7 and 8, almost half of victims were female, and a majority of perpetrators of domestic violence homicides are male.

When considering intimate-partner homicides reviewed by the Board, the reviews suggest that only some had contact with domestic violence advocates and/or victim services. Two victims, before they were killed, were identified through DC SAFE's Lethality Assessment Project (LAP), which uses an evidence-based screening tool to identify domestic violence victims at risk of serious injury or homicide. Demographic and relationship characteristics of this year's reviews mirror themes found in many intimate partner homicide incidents nationwide. Most of the individuals killed were black women under 35 years old (the median age of victims killed was 31). All of the victims were mothers, some with young children. The perpetrators were mostly men and all had a known history of criminality – often prior domestic violence – and histories of substance abuse and mental health concerns.

The reviews highlight the critical need for all agencies responding to domestic violence to coordinate their efforts. These efforts need to include the federal agencies that serve the District of Columbia but also "non-traditional" agencies that are not commonly associated with working on domestic violence. All agencies have a role to play in improving the response to domestic violence victims in the District of Columbia.

DVFRB Structure, Membership, and Review Process

The DVFRB is a city-wide collaborative effort that was originally established by the Uniformed Interstate Enforcement of Domestic Violence Protection Orders Act of 2002, DC Law 14-296. The work of this Board is achieved through a multi-disciplinary analysis of the victims' experiences and the circumstances surrounding their deaths. Through the case review process, the Board identifies lethality factors and trends related to the decedents, perpetrators, and systems responsible for supporting, assisting, and protecting victims from family and/or intimate partner violence. The review process provides an opportunity for professionals and/or concerned citizens, through a cooperative effort, to enhance and increase services and improve the District's response to address the needs of residents.

The DVFRB enabling legislation provides for **twenty-three (23)** appointed members pursuant to D.C. Code §16-1053, including:

Nine (9) governmental entities appointed by the Mayor:

1. Metropolitan Police Department;
2. Office of the Chief Medical Examiner;
3. Office of the Attorney General (formerly Office of the Corporation Counsel);
4. Department of Corrections;
5. Fire and Emergency Medical Services Department;
6. Department of Behavioral Health (formerly Addiction Prevention and Recovery Administration);
7. Department of Health;
8. Child and Family Services Agency; and
9. Mayor's Office on Women's Policy and Initiatives (formerly Mayor's Commission on Violence Against Women).

Six (6) federal, judicial, and private agencies or entities with domestic violence expertise either appointed by the Mayor or at the Mayor's request:

1. Superior Court of the District of Columbia;
2. Office of the Unites States Attorney for the District of Columbia;
3. District of Columbia hospitals;
4. University legal clinics;
5. Domestic violence shelters; and
6. Domestic violence advocacy organizations.

Eight (8) community representatives (non-DC government employees), appointed by the Mayor, with the advice and consent of the Council.

For a list of DVFRB members at the time of this publication, please see Appendix A.
The DVFRB meets every other month and maintains contact via email and phone calls throughout the year. Cases are selected for review based on referrals from membership agencies if they meet agreed-upon criteria. Based upon protocols established by the Board,

homicides are reviewed after closure of the criminal case. The Board obtains records from a variety of public and private agencies and programs that had contact with or provided services to the victim or the perpetrator. The Board coordinator (with support when possible from students with the District's law school legal clinics) prepares a summary of case material. The Board then discusses the facts and circumstances leading up to the homicide and identifies potential gaps in service delivery and systemic breakdowns. The Board then considers recommendations and system improvements to prevent future homicides. The fatality review process is not investigative and the Board decisions are made collectively. All DVFRB meetings are confidential, and participants are required to sign confidentiality statements.

A major strength of the DVFRB is the purposeful inclusion of a diverse set of system and agency representatives, as well as community stakeholders. The Board convenes to identify gaps in the District's response to domestic violence. Our hope is that the "no blame" philosophy of our work will inspire improved agency and system collaboration and a sense of urgency to work together to create a safer community for victims of domestic violence.

This ***Annual Report for 2014*** summarizes data, key findings, and recommendations regarding domestic violence homicides that occurred in 2014 and were reviewed by the board in 2014-2017.

Domestic Violence Fatalities Defined

According to DC law that created the DVFRB, D.C. Code § 16–1051, a "domestic violence fatality" includes a homicide under any of the following circumstances:

- **The alleged perpetrator and victim resided together at any time;**
- **The alleged perpetrator and victim have a child in common;**
- **The alleged perpetrator and victim were married, divorced, separated, or had a romantic relationship, not necessarily including a sexual relationship;**
- **The alleged perpetrator is or was married to, divorced, or separated from, or in a romantic relationship, not necessarily including a sexual relationship, with a person who is or was married to, divorced, or separated from, or in a romantic relationship, not necessarily including a sexual relationship, with the victim;**
- **The alleged perpetrator had been stalking the victim;**
- **The victim filed a petition for a protective order against the alleged perpetrator at any time;**
- **The victim resided in the same household, was present at the workplace of, was in proximity of, or was related by blood or affinity to a person who experienced or was threatened with domestic violence by the alleged perpetrator; or**
- **The victim or the perpetrator was or is a child, parent, sibling, grandparent, aunt, uncle, or cousin of a person in a relationship that is described within this subsection.**

2014 Cases Reviewed by the DVFRB

The DVFRB reviewed a total of seven cases that occurred in 2014. In six of the cases, the victim was killed by an intimate partner; in one, the victim was killed by a family member. At the time of publication for this report, the Board reviewed 100 percent of the Intimate Partner Violence (IPV) cases eligible for review.

The Board deems a case eligible for review when the case is closed, meaning the perpetrator has been criminally convicted of the homicide, and most or all of the criminal appeals have expired (which may take years), or the perpetrator is deceased. When a reasonable amount of time has passed since a domestic violence homicide (usually three years), the Board may also review those cases that are classified as unsolved by law enforcement or when an alleged perpetrator was never criminally charged for the death. Therefore, this report focuses only on cases from 2014.

Lethality Risk Factors

The work of the DVFRB includes examining cases for recognized indicators of lethality. There are several nationally-recognized indicators of the potential for lethal violence in an intimate partner violence relationship.[2,3,4] The perpetrators in the six IPV cases reviewed by the Board exhibited many of these. These factors include prior history of domestic violence, prior criminal history, jealousy, stalking, threats, and strangulation. The more risk indicators present in a case, the greater the risk of escalating violence and death. The table below shows the lethality risk factors and the percentage of reviewed cases in which the factor was present.

Lethality Risk Factors			
Prior criminal history	**100%**	**Victim had child that was not perpetrator's**	**67%**
Threats of violence	**100%**	**Actual or pending separation**	**50%**
Prior domestic violence history	**83%**	**Perpetrator unemployed**	**33%**
Excessive substance use (alcohol and/or drugs)	**83%**	**Stalking**	**33%**
Perpetrator on probation or parole at time of homicide	**83%**	**Perpetrator witnessing /experiencing abuse as a child**	**33%**
Escalation of violence	**67%**	**Jealousy, possessiveness, and obsessiveness**	**33%**

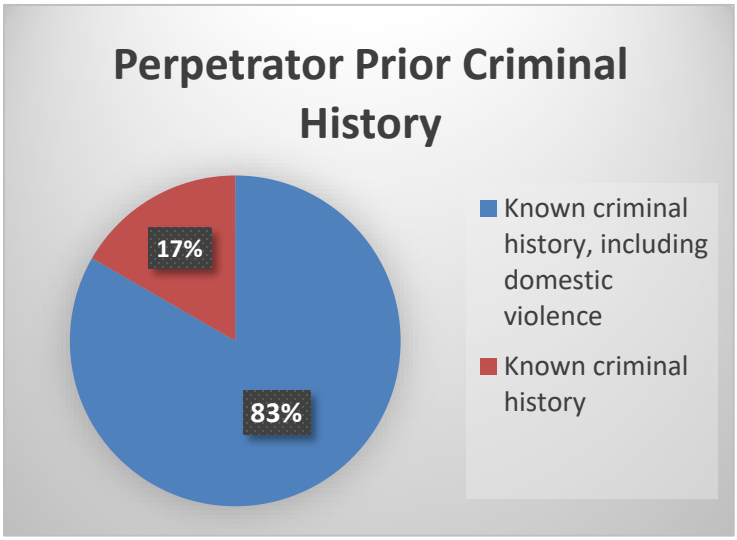
[2]Campbell, Jacquelyn C. et al. “Risk Factors for Femicide in Abusive Relationships: Results from a Multisite Case Control Study.” *American Journal of Public Health* 93.7 (2003): 1089–1097.

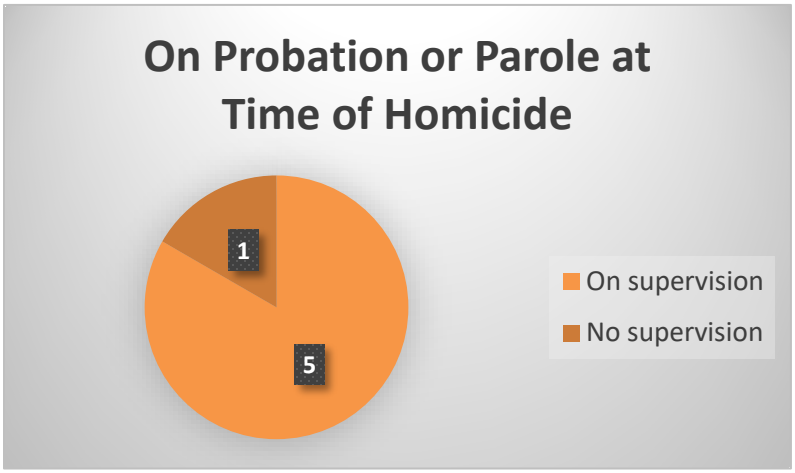
[3] Campbell, Jacquelyn C., D. Webster, and P. Mahoney. "Intimate Partner Violence Risk Assessment Validation Study. Final Report." (2005).

[4] Sabri, Bushra et al. “Factors Associated with Increased Risk for Lethal Violence in Intimate Partner Relationships among Ethnically Diverse Black Women.” *Violence and Victims* 29.5 (2014): 719–741. *PMC*. Web. 8 Aug. 2017.

Lethality Risk Factors			
Access to, or possession of, firearms	**67%**	**Child custody dispute**	**33%**
Depression or other mental health/psychiatric problems	**67%**	**Public display of violence toward victim**	**17%**
Strangulation	**67%**	**Destruction of property**	**17%**
Suicide (attempts or threats)	**67%**	**New partner (in victim or perpetrator's life)**	**17%**

One of the most significant lethality risk factors is previous violence. In the reviewed intimate partner homicide cases for 2014, all perpetrators had a criminal history and criminal convictions; the majority had a criminal history of domestic violence perpetration. One perpetrator had previously killed another intimate partner prior to killing his partner in 2014. All perpetrators used threats of violence against their victims.





The majority of perpetrators had reported extensive substance use, including both alcohol and illegal drugs. The majority of the perpetrators were also under some form of court supervision (e.g. probation, parole, other supervision) at the time they committed homicide.

Recommendations

The ultimate purpose for reviewing domestic violence fatalities is to reduce the incidence of such homicides. At each case review, Board members discuss possible recommendations for improving the system's response to domestic violence. The following recommendations from the review of 2014 cases are presented here. These recommendations are suggestions for improvement, not indication of blame or fault.

These recommendations have been sent to relevant agencies and organizations; responses already received can be found in Appendix B. The responses to the other recommendations will be published in next year's report. The Board is extremely grateful to participating agencies for their commitment towards improving the District of Columbia's response to domestic violence.

Recommendation #1: Increase opportunities for prevention and intervention among offenders who are on probation or supervised release.

In the intimate partner homicide cases the Board reviewed, all but one offender was currently under supervision for a criminal offense (either domestic violence or another offense) when they murdered their victims. In the District of Columbia, probation is handled by a federal agency, Court Services and Offender Supervision Agency Community Supervision Officers (CSOSA). CSOSA has a domestic violence unit that supervises offenders convicted of domestic violence-related crimes. This specialized unit screens for current domestic violence relationships and creates a plan to reduce the risk that the offender will commit a new domestic violence crime. Offenders not under the supervision of this unit may not get any screening regarding domestic violence. The Board recommends that, in addition to the Domestic Violence Unit, CSOSA routinely inquire about the offender's relationships and screen for domestic violence. In the event the client is involved in an intimate relationship; the Community Supervision Officer may determine if any domestic violence intervention is needed.

Recommendation #2: Enhance the interagency response to domestic violence victims who are identified as at increased risk for severe injury or death.

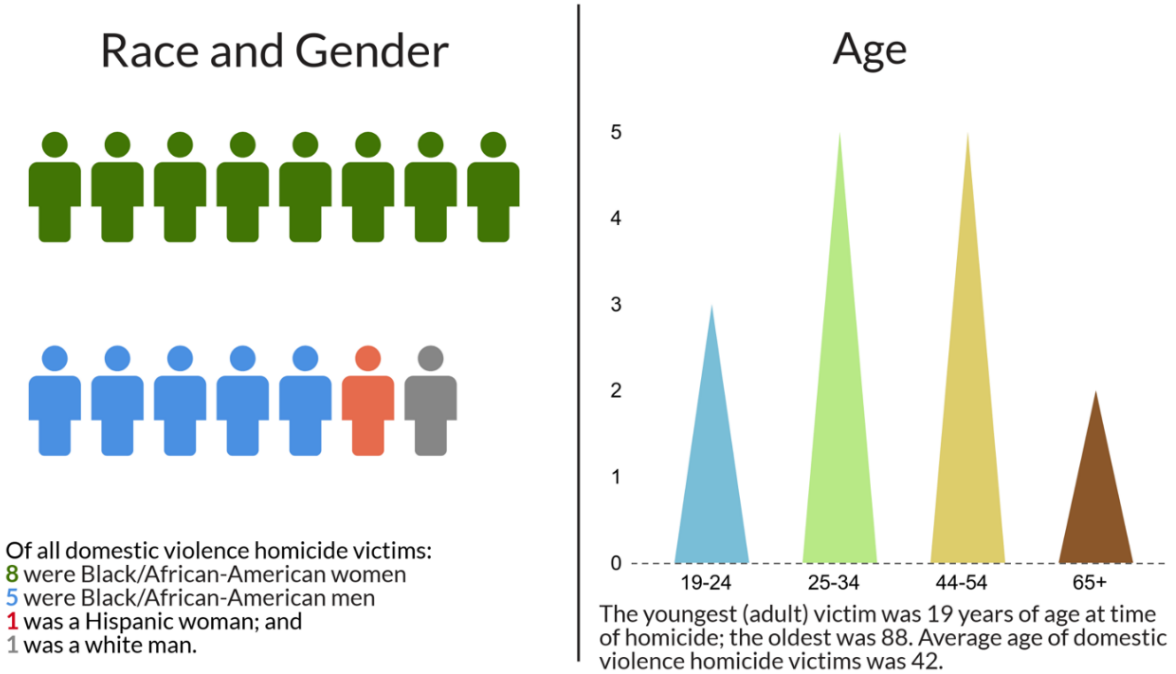
In 2009, DC SAFE and several agency partners created the Lethality Assessment Program (LAP) to identify and coordinate services for victims who, according to an assessment tool, are at increased risk of severe injury or death from their intimate partner. The LAP is a specifically tailored model of the national Danger Assessment work of Dr. Jacqueline Campbell for the District of Columbia. As of today, the LAP operates in all seven MPD districts. During its review of 2014 cases, the Board found that two victims of intimate partner homicide had been identified as high lethality through the LAP. The Board recommends that the LAP partner agencies enhance their response and coordination of efforts once a victim at increased risk for homicide has been identified through the LAP assessment. A more robust, timely, and collaborative response by the LAP partners and system may prevent future homicides. As clients identified at high risk through the LAP receive enhanced responses, communication about what those victims need from the system agencies and the coordination therein should be strengthened.

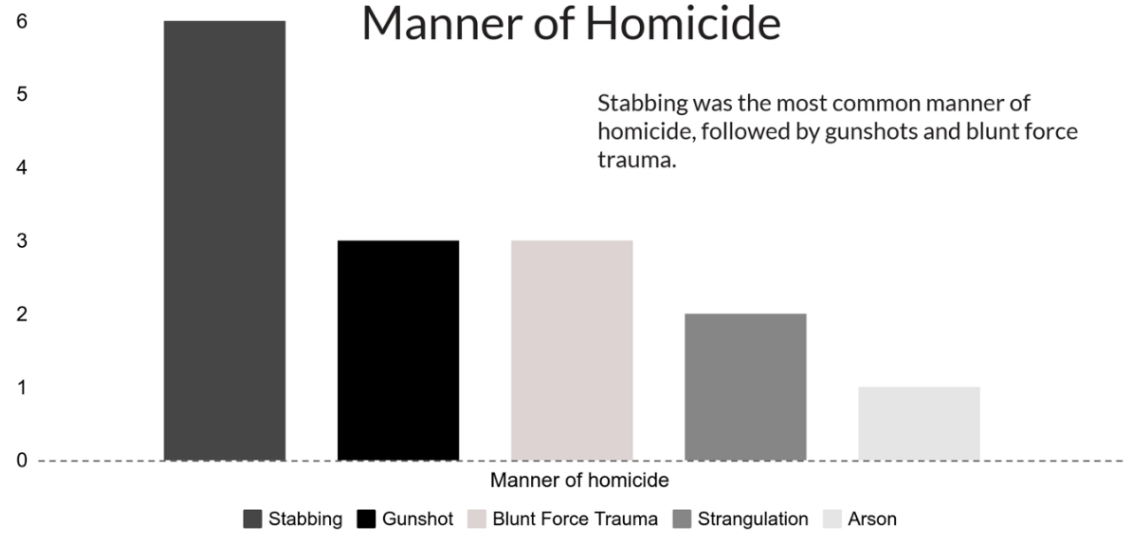
Key Findings

There are three sections of findings. The first details findings from all 2014 domestic violence homicides, the second details findings specifically from intimate partner violence (IPV) homicides, and the third details findings from non-IPV homicides.

All Domestic Violence Homicides

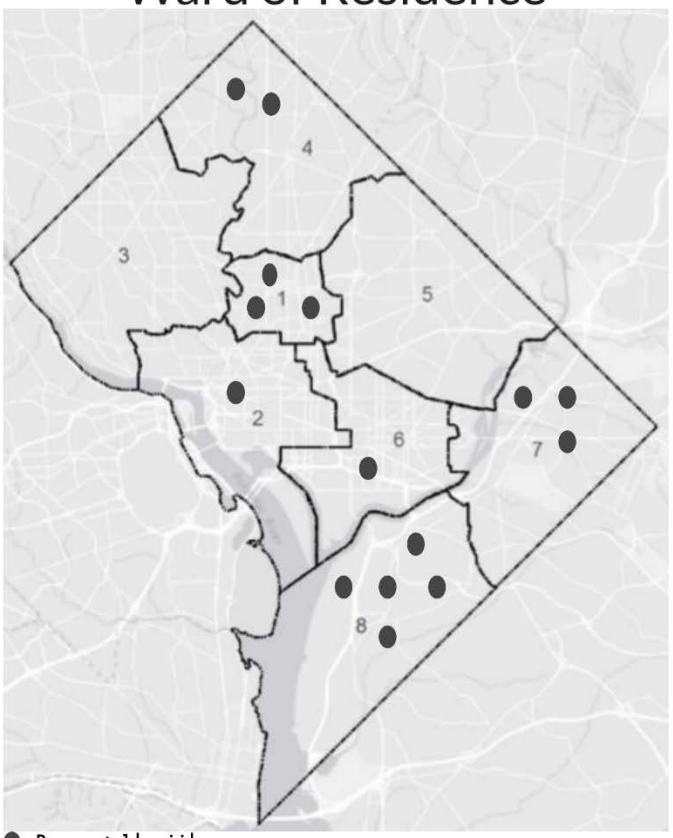
In 2014, according to available Metropolitan Police Department records, 15 adults and two children were killed in domestic violence fatalities in the District of Columbia.[5]





[5] The statistical summaries here reflect data only for adult domestic violence fatalities. The District's Child Fatality Review Committee leads reviews of victims under the age of 19 years. Please see: https://ocme.dc.gov/page/ocme-annual-reports.

Ward of Residence

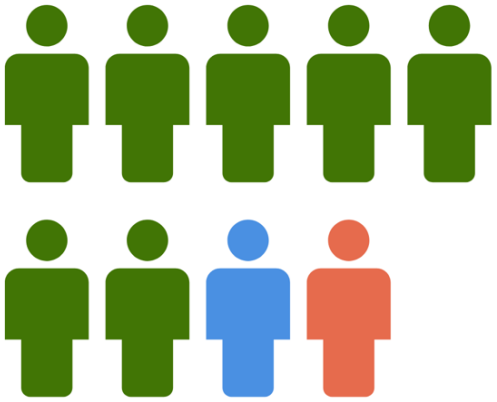


Represents 1 homicide

Ward 8 had the largest number of domestic violence homicides, followed by Wards 1 and 7.

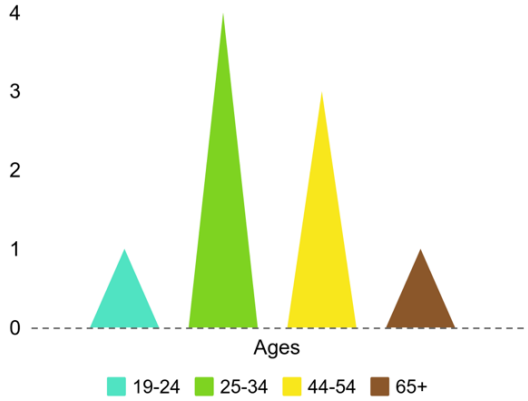
Intimate Partner Violence (IPV) Homicides

Race and Gender



Of the victims of intimate partner violence (IPV) homicide:
7 were Black/African-American women,
1 was a Hispanic woman, and
1 was a Black/African-American man.

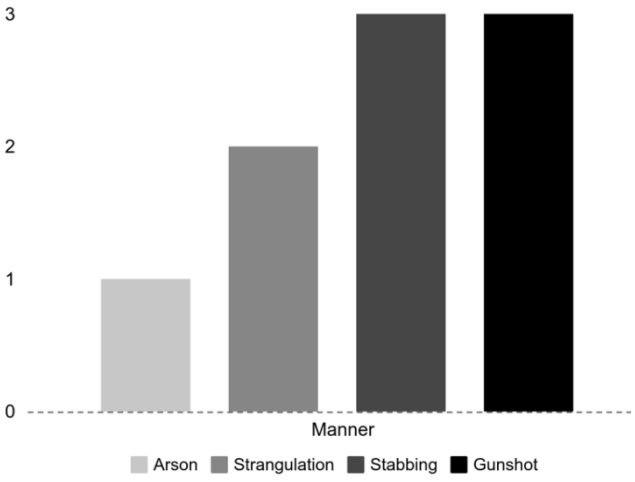
Age



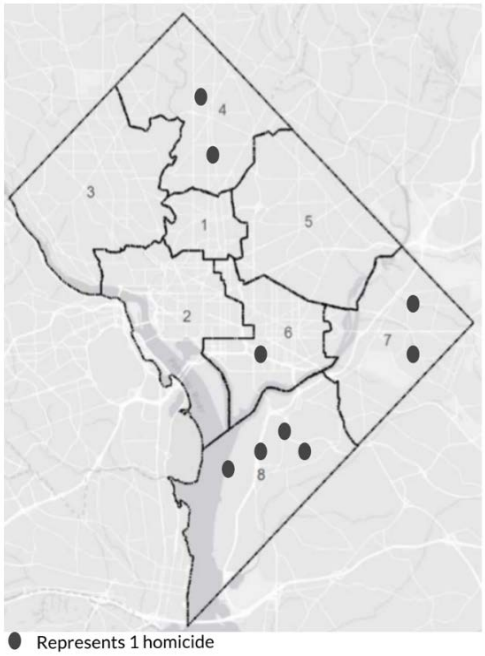
Five victims of IPV homicide were less than 34 years old. The oldest IPV victim was 80 years old at the time of her murder.

Manner of Homicide

Intimate partner homicide victims were equally likely to be killed by gunshot or stabbing. In two of the cases, the victims were strangled by hand; one case was homicide by arson.



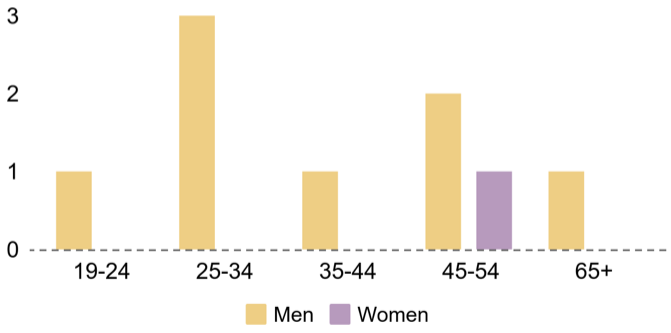
Ward of Residence

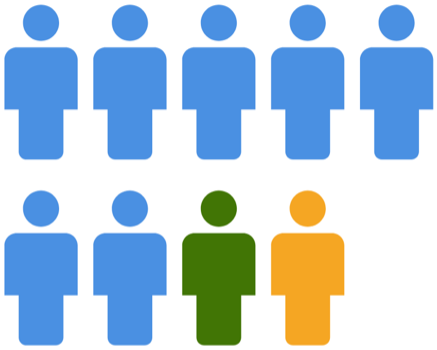


Ward 8 had the highest number of IPV homicides.

Perpetrators of IPV Homicide

The majority of intimate partner homicide perpetrators were men and the average age was 42.

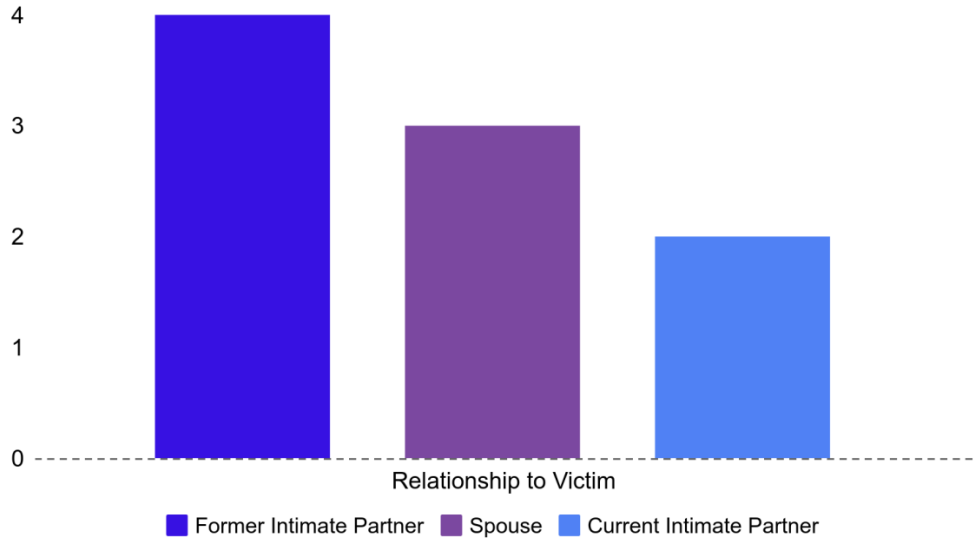




Of the perpetrators of IPV homicide:
7 are Black/African-American men;
1 is a Black/African American woman;
1 is a Hispanic man.

Relationship of Perpetrator to Victim

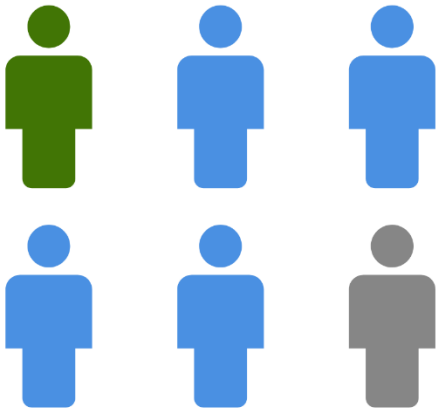
Four intimate partner violence homicide perpetrators were former intimate partners to the victims. Three were current spouses and two were current intimate partners when they killed their victims.



Non-Intimate Partner Domestic Violence Homicides

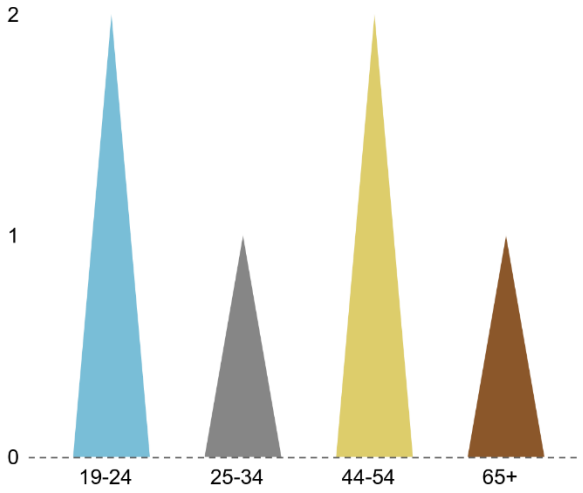
In 2016, the DVFRB made the decision to prioritize reviewing and examining intimate partner violence (IPV) homicides, while continuing to collect and monitor data on non-intimate partner homicides. Below is summary data regarding the non-intimate partner homicides that occurred in 2014.

Race and Gender



Of non-IPV domestic violence homicide victims:
4 were Black/African-American men;
1 was a Black/African-American woman;
1 was a white man.

Age

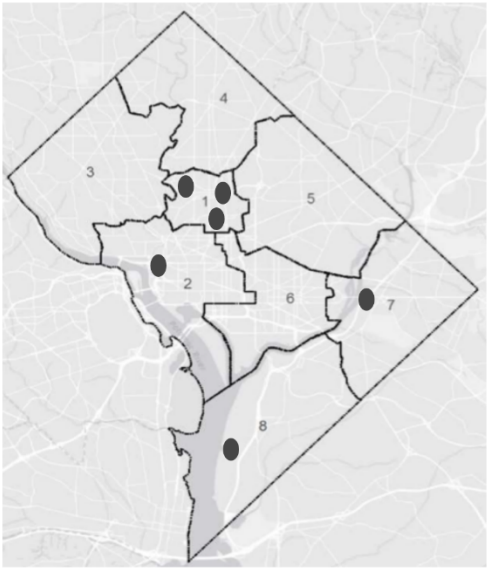


Three (50%) of the non-intimate partner domestic violence homicide victims were less than 30-years old when they were killed. The oldest victim was 88 years of age when he was killed.

Manner of Homicide

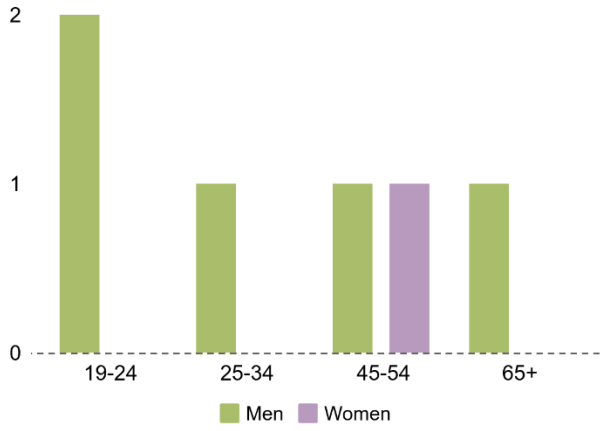
The manner of homicide for non-intimate partner domestic violence homicide victims was equally likely to be stabbing or death by blunt force trauma.

Ward of Residence

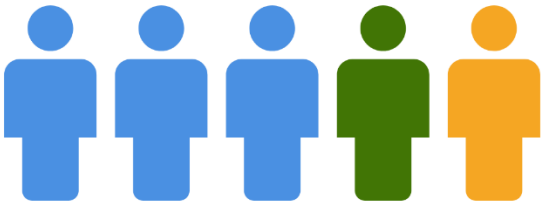


Ward 1 had the highest number of non-intimate partner domestic violence homicides in 2014.

Perpetrators of Non-IPV DV Homicide



In 2014, five perpetrators committed 6 non-intimate partner domestic violence homicides. The youngest perpetrator was 21 years old and oldest was 57. Median age was 26 years old.



Of the perpetrators of non-IPV DV homicide:
3 are Black/African-American men,
1 is a Black/African American woman,
1 is a Hispanic man.

Relationship of Perpetrator to Victim

Two victims of non-intimate partner homicide were killed by a prior roommate. 1 victim was killed by an adult daughter, 1 by an adult son, 1 by a nephew and 1 by a person in a former relationship with the victim's partner.

* Other relationship indicates the category of the domestic violence statute (D.C. Code § 16–1051) which reads: The alleged perpetrator is or was married to, divorced, or separated from, or in a romantic relationship, not necessarily including a sexual relationship, with a person who is or was married to, divorced, or separated from, or in a romantic relationship, not necessarily including a sexual relationship, with the victim.

Appendix A – DVFRB Members & Invited Guests

Local Governmental Entities (9)	
DVFRB Member	***Agency***
Lt. Angela Cousins	Metropolitan Police Department
Dr. Sasha Breland	Office of the Chief Medical Examiner
Janese Bechtol	Office of the Attorney General
Maria Amato	Department of Corrections
Rafael Sa'adah (Board co-chair)	Fire and Emergency Medical Services Department
Shermain Bowden	Department of Behavioral Health
VACANT	Department of Health
Sarita Spinks	Child and Family Services Agency
Shana Armstrong	Mayor's Office of Women's Policy Initiatives
Federal Government Entities and Nongovernmental Organizations with Domestic Violence Expertise (6)	
DVFRB Member	***Agency***
Nelly Montenegro	Superior Court of the District of Columbia
Marcia Rinker	Office of the United States Attorney District of Columbia
Erin Pollitt	District of Columbia Hospitals
VACANT	University legal clinics
Shakeita Boyd	Domestic violence shelters
Jennifer Wesberry	Domestic violence advocacy organizations
Community Representatives (8)	
DVFRB Member	***3-Year Term***
Erin S. Larkin (Board Co-chair)	Community Representative 1
Sharlene Kranz	Community Representative 2
Varina Winder	Community Representative 3
Dianne Hampton	Community Representative 4
Heather Powers	Community Representative 5
Laila Leigh	Community Representative 6
Ian Harris	Community Representative 7
Laurie Kohn	Community Representative 8
Invited Guests	
Valerie Collins	Court Services and Offender Supervision Agency
Toni Zollicoffer	Office for Victim Services and Justice Grants (OVSJG)
Rebecca Dreke	DVFRB Coordinator, OVSJG

The members and guests listed above are current as of publication of this report. Previous members who contributed to the review and recommendations of the 2014 cases include Rita Blandino and Blanche Watson, Court of the District of Columbia; Lt. Michelle Robinson, Metropolitan Police Department; Tara Humphrey, Department of Health; Dr. Roger Mitchell, Chief Medical Examiner; Carolyn Hollinger, Department of Behavioral Health; and Lisa Martin. The Board would like to extend a special thank you to Lisa Martin, formerly the Associate Professor at Columbus School of Law and Co-Director of the Families and the Law Clinic at Catholic University of America. Ms. Martin served on the Board as the University Legal Clinics representative from 2009 – 2017.

Appendix B – Recommendations to CSOSA

The following pages detail the July 2, 2014 recommendation from the Domestic Violence Fatality Review Board to the Court Services and Offender Supervision Agency and the agency response.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
FATALITY REVIEW UNIT
DOMESTIC VIOLENCE FATALITY REVIEW BOARD
401 E Street SW
6th Floor
Washington, D.C. 20024

TO: **Nancy M. Ware**
Director, Court Services and Offender Supervision Agency

Mr. Paul A. Quander, Jr.
Deputy Mayor for Public Safety and Justice

FROM: **Janese Bechtol,**
Co-Chair, Domestic Violence Fatality Review Board
Chief, Domestic Violence Section, OAG

Dr. Roger A. Mitchell, Jr. MD FASCP
Co-Chair, Domestic Violence Fatality Review Board
Chief Medical Examiner, OCME

DATE: **July 2, 2014**

SUBJECT: **Recommendation from the District of Columbia Domestic Violence Fatality Review Board**

The District of Columbia's Domestic Violence Fatality Review Board (DV FRB) is charged with preventing domestic violence fatalities by improving the response of individuals, communities and government agencies to domestic violence. On behalf of the DV FRB, we are forwarding the following recommendation that addresses the needs of victims of domestic violence who may come into contact with the Court Services and Offender Supervision Agency (CSOSA):

All Court Services and Offender Supervision Agency Community Supervision Officers, in addition to the Domestic Violence Unit, should routinely inquire about offenders' relationships and screen for domestic violence. In the event the client is involved in an intimate relationship, the Community Supervision Officer should determine if any intervention is needed.

As this recommendation will benefit victims of domestic violence in the community, CSOSA's General Community Supervision Officers may need training on the risks associated with domestic violence. General Community Supervision Officers may also need to become knowledgeable about community and government based resources for both victims and perpetrators of domestic violence.

The DV FRB recognizes that CSOSA is an independent agency; however the recommendation was developed in consultation with CSOSA Branch Chief, Valerie Collins, to maximize its benefit. The DV FRB is confident that its recommendation can have the most impact on improving outcomes for the residents of the District of Columbia. Attached with this correspondence is the DV FRB recommendation form, which also provides CSOSA with an opportunity to respond. We ask that you please submit your agency's response to the adopted recommendation– Section II of the attached form, within 30 days. If you have any questions or need additional information related to the recommendation or the process, please contact the DV FRB's point of contact, Tracie Martin at 202-698-9024, or Tracie.Martin@dc.gov.

Thank you for your continued support and participation in the work of the Domestic Violence Fatality Review Board.

DOMESTIC VIOLENCE
FATALITY REVIEW BOARD
ADOPTED RECOMMENDATION
FOR THE
COURT SERVICES AND OFFENDERS SUPERVISION AGENCY

DISTRICT OF COLUMBIA FATALITY REVIEW COMMITTEES

RECOMMENDATION

Fatality Review Comm	[ ] CFRC [X] DVFRB [ ] MRDD FRC		
Statement of Need	Through its discussion of a domestic violence fatality, the DV FRB observed the need for additional dv screening of clients involved with the Court Services and Offender Supervision Agency (CSOSA). This recommendation speaks to the need for CSOSA Community Supervision Officers to conduct this screening.		
Beneficiary Population	[ ] Infants [ ] Children 1 - 13 [ ] Youth 13 – 24 [ ] Families/Caretakers [X] Victims of Violence [ ] MRDD Population [X] Other, specify __Services for Perpetrators of Domestic Violence___		
Recommendation	All Court Services and Offender Supervision Agency Community Supervision Officers in addition to the Domestic Violence Unit should routinely inquire about offenders' relationships and screen for domestic violence. In the event the client is involved in an intimate relationship, the Community Supervision Officer should determine if any is needed.		
Implication of Recommendation	[X] Policy [X] Practice [ ] Legal [ ] Budget [ ] Other, explain _____		
Agencies Involved	[ ] Single Agency: **Court Services and Offender Supervision Agency** [ ] Multiple Agencies: [ ] If Multiple, Lead Agency: _____		
1st Recommendation Date		***Number of times issue/ recommendation repeated (include case #'s)*** 1	

AGENCY RESPONSE

Does Agency Accept Recommendation?	Please Respond: [X] Yes [ ] Yes, with modification [ ] No, with explanation and alternative recommendation		
	Provide Modification or Alternative Recommendation:		
Describe Best Practices	The best practices used for supervision of Domestic Violence Cases is a coordinated community response. This involves intra and inter agency partnerships and collaborations. CSOSA partners with MPD, the DV Court, the US Attorney's Office and SAFE. The collaborations involve training, information sharing, and case consultations/staffings. DV cases are assigned to various branches within CSOSA to include DV, Mental Health, Sex Offender and Interstate. The branches collaborate on the services provided for the DV population. The collaboration will be expanded for staff in the General Supervision and Young Adult Units for a protocol to inquire about offender's intimate relationships and to provide intervention and services when there are issues of domestic violence.		
Describe specific actions planned towards implementation (include steps and timetable)	An Operational Instruction (OI) will be developed for staff as guidance on the inquiry about intimate relationships for offenders and the instructions for follow-up interventions and referrals for services.		
Describe specific actions taken to date towards implementation	The CSOSA Community Supervision Services Associate Director Thomas Williams, Deputy Associate Director Yolanda Bethea and Branch Chief Valerie Collins are assigned to develop the OI.		
Describe expected outcomes	Offenders who are experiencing domestic violence issues will be assessed for interventions and services to assist them with addressing abusive behavior and or receive victim services if needed. Outreach will be provided to identified victims for safety planning and information about available domestic violence resources. The OI will serve as the protocol of guidance to the Community Supervision Officers and Supervisors. They will also receive training from SAFE on domestic violence.	Time Period to Achieve Outcome: 4-10-15	
Describe measurable indicators/milestones related to implementation that can be reported on regular basis	Indicator/milestones: OI developed	Date:1-31-15	
	Indicator/milestones: OI Implemented with Community Supervision Officers and Supervisors	Date:2-16-15	
	Indicator/milestones: Lethality Assessment Training for General Supervision and Young Adult Community Supervision Officers and Supervisors	Date: All units by 4-10-15	
Date Response Due:		***Date Submitted December 10, 2014***	
Name of Agency Contact for Follow-Up Questions Valerie Collins, Branch Chief		***Telephone: (202) 442-1822***	***Email Address: Valerie.collins@csosa.gov***