Panel Meets Most Requirements for Domestic Violence Fatality Review

Audit Team
Ed Pound, Audit Supervisor
Masooma Hussain, Auditor-In-Charge
Lawrence Perry, Deputy Auditor and Audit Supervisor
Candace McCrae, Program Analyst

Kathleen Patterson, District of Columbia Auditor
www.dcauditor.org
Executive Summary

What ODCA Found

The Domestic Violence Fatality Review Board (Board) examines the circumstance surrounding domestic violence fatalities in order to improve the District’s response and prevent future fatalities. When the Board became fully operational in 2006, the Office of the Chief Medical Examiner (OCME) provided administrative support. While under OCME, the Board failed to consistently produce annual reports required by law. At the end of 2015, administration of the Board was transferred to the Office of Victim Services and Justice Grants (OVSJG) and since the transfer, Board operations have improved.

The law requires the Board to document the scope and nature of domestic violence fatalities, record trends surrounding domestic violence, recommend system improvements, education programs and training improvements, and prepare an annual report.

Among ODCA’s findings are that:

- The Board’s scope and trends analysis has been limited to an annual report.
- The Board examined past events and circumstances surrounding domestic violence fatalities.
- The Board developed and revised procedures for the review of domestic violence fatalities.
- The Board made recommendations in compliance with legal requirements.
- The Board has not consistently prepared annual reports on its findings and recommendations.
- Nine out of 11 recommendations issued by the Board have been implemented.
- The Board’s structure and procedures to perform case reviews and produce quality and actionable recommendations largely align with best practices.

Why ODCA Did This Audit

1. To meet the requirements of D.C. Code § 1-614.14(c) and determine whether the Board, with administrative support from OVSJG, complied with D.C. Code § 16-1052.
2. To determine whether the Board has adopted best practices to perform case reviews and produce quality and actionable recommendations.

What ODCA Recommends

- The Board Coordinator should develop a standardized information request system to formally request information based on what is needed for case reviews as listed in the Board’s Operating Rules and Procedures. The information request should be completed on Board letterhead and received by Board representatives as well as agency and organization directors.
- The Board Coordinator should incorporate in the current case summary form a method to detail dates of requests and compliance with these requests and a system to track this information.
- To ensure that the Board continues to review domestic violence fatalities and produce annual reports as required, OVSJG should perform an annual staffing assessment and ensure that there is adequate funding for a dedicated Coordinator.
- The Board should work to eliminate the four-year-lag in reporting by reviewing and reporting on more than one year of data in their upcoming reports.
# Table of Contents

Background .................................................................................................................................................. 1  
Objectives, Scope, and Methodology ........................................................................................................ 4  
Audit Results ............................................................................................................................................ 6  
Conclusion ................................................................................................................................................ 13  
Agency Comments ..................................................................................................................................... 14  
ODCA Response to Agency Comments .................................................................................................... 20  
Summary of Report Recommendations ..................................................................................................... 21  
Appendices .................................................................................................................................................. 23

**Appendix A:** *Publication of Domestic Violence Fatality Review Board Reports by Year  
Including Administrative Agency and Fatality Data Covered* ............................................................. 24

**Appendix B:** *Domestic Violence Fatality Review Board Practices per the National Domestic  
Violence Fatality Review Initiative (NDVFRI), in the District of Columbia, and  
Other Jurisdictions* ................................................................................................................................. 26

**Appendix C:** *Status of Recommendations* .......................................................................................... 40

**Appendix D:** *Full EOM Response and CSOSA* .................................................................................... 44
Background

Domestic violence exacts a tremendous price in the District:

- An estimated 104,000 female District residents have been hit, slapped, punched, threatened, beaten, stalked, or raped by an intimate partner in their lifetime.\(^1\)
- There were 17 domestic violence fatalities in 2016, 15 in 2017, and 12 in 2018.\(^2\)
- Twelve children died as a result of domestic violence between 2012 and 2018.
- There were 19,527 domestic violence assault calls for service received in 2016 and 2017.

The District government plays a critical role in protecting families who are affected by domestic violence, as described by the DC Coalition Against Domestic Violence: “Residents who are desperately trying to navigate the perils of abusive relationships often turn to District government agencies for life-saving assistance such as housing, protection, medical care, and more.” Further, domestic violence is at the intersection of some of the District’s biggest policy challenges, including homelessness. Roughly one-third of homeless women surveyed by the Interagency Council on Homelessness stated that domestic violence was the cause of their homelessness or housing instability.\(^4\)

The District, like other jurisdictions, established a Domestic Violence Fatality Review Board (Board), which was authorized in 2002 to “bring government, public health, advocacy and community stakeholders together to examine the circumstance surrounding domestic violence fatalities in order to improve the District’s response to domestic violence and prevent future fatalities.” The Board became a fully operating entity in 2006, many years after the enactment of the Domestic Violence Protection Orders Act of 2002.\(^5\)

About the Board

The Board is composed of nine governmental entities appointed by the Mayor; six federal, judicial, and private agencies or entities with domestic violence expertise either appointed by the Mayor or at the Mayor’s request; and eight community representatives (non-D.C. government employees), appointed by the Mayor, with the advice and consent of the Council of the District of Columbia (D.C. Council).\(^6\)

The Board is required to:

- Identify and characterize the scope and nature of domestic violence fatalities in the District of Columbia.
- Describe and record any trends, data, or patterns that are observed surrounding domestic violence fatalities.
- Examine past events and circumstances surrounding domestic violence fatalities by reviewing records and

---

1 The Board defines intimate partner as current or former romantic and/or sexual partners.
3 This is based on information the Metropolitan Police Department provided for this audit.
6 See D.C. Code § 16-1053.
other pertinent documents of public and private agencies responsible for investigating deaths or treating victims.

- Develop and revise, as necessary, operating rules and procedures for review of domestic violence fatalities, including identification of cases to be reviewed, coordination among the agencies and professionals involved, and improvement of the identification, data collection, and record keeping of the causes of domestic violence fatalities.
- Recommend systemic improvements to promote improved and integrated public and private systems serving victims of domestic violence.
- Recommend components for prevention and education programs.
- Recommend training to improve the identification and investigation of domestic violence fatalities.
- Prepare an annual report of findings, recommendations, and steps taken to implement recommendations. The annual report shall be submitted to the public, the Mayor, and the Council on July 1 of each year, and shall be presented to the Council at a public hearing. 7

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 D.C. Code states that facilities and other administrative support may be provided in a specific department or through the Board, as determined by the Mayor. 8

From 2006 through 2015, the Office of the Chief Medical Examiner (OCME) provided administrative support to the Board. The Mayor transferred authority of the Board from OCME to the Office of Victim Services and Justice Grants (OVSJG) on December 31, 2015. 9 OVSJG explained that the transfer was due in part to the fact that OVSJG provided similar support to multidisciplinary review processes, their expertise regarding domestic violence, and their ability to allocate resources to the project. For example, they hired a Coordinator to support the Board.

While under OCME, the Board issued three annual reports which provided a high-level statistical summary of 85 domestic violence fatalities that met the criteria for review. 10 Of the 85 fatalities reviewed, the annual reports include a more in-depth review of the data from 42 fatalities, as seen in Figure 1.

---

7 See D.C. Code § 16-1052.
8 See D.C. Code § 16-1052(a).
9 Pursuant to Mayoral Order 2015-270.
10 The 2007 annual report stated that the Board was “responsible for conducting reviews of all domestic violence-related homicides and suicides. This includes victims of all ages and involved in all types of intimate/familiar relationships, who are determined to be residents of the District of Columbia and non-residents where the death occurred in the District. Based on policy, the case review process was initiated with deaths that occurred during the 2004 calendar year.” The report cited D.C. Law § 14-296 which provides the definition of a domestic violence fatality as the basis of case selection, Page 4, see https://ocme.dc.gov/sites/default/files/dc/sites/ocme/page_content/attachments/OPT%202006%20First%20Annual%20Report%20DV.pdf
### Figure 1: Summary of Reports Issued by Domestic Violence Fatality Review Board While Under OCME

<table>
<thead>
<tr>
<th>Year of Annual Report Publication</th>
<th>Year of Fatalities Covered in the Report</th>
<th>Number of In-Depth Fatality Reviews</th>
<th>Date of Board Review</th>
</tr>
</thead>
</table>

Source: ODCA analysis of data found in the 2007, 2008, and 2009 Annual Reports.

While these three reports were publicly released, the Board did not publish reports between 2010 and 2015, which means the Board was not in full compliance with the law while under OCME. This also resulted in 71 cases that occurred between 2010 and 2013 not being reviewed. Because these in-depth reviews were not conducted, the District missed opportunities for valuable recommendations on ways to reduce the number of deaths resulting from domestic violence. Appendix A provides a summary of the publication of annual reports by year and the years the domestic violence fatalities were reported.

---

11 The 2014 cases were reviewed by the Board in its annual report released in April 2018. The 2015 cases are to be reviewed in the report that is due to be published in 2019.
Objectives, Scope, and Methodology

Objectives
The Office of the D.C. Auditor (ODCA) completed a discretionary evaluation of the Domestic Violence Fatality Review Board (Board) to determine if it complied with D.C. law.

Specifically, the objectives of the evaluation were to determine:

- Whether the Board, with administrative support from OVSJG, complied with D.C. Code § 16-1052.
- Whether the Board has adopted best practices to perform case reviews and produce quality and actionable recommendations.

This review fulfills ODCA’s mandate to conduct an audit of selected performance measures per D.C. Code § 1-614.14(c).12 OVSJG’s FY 2017 Performance Accountability Report (PAR) reported that OVSJG completed its Strategic Initiative to “establish, staff, and coordinate the District’s High Risk Domestic Violence Review Team.” OVSJG’s FY 2018 PAR lists the publication of the Domestic Violence Fatality Review Annual Report as one of its FY 2018 Top Accomplishments.

Scope
Our scope was originally fiscal years 2003 through 2017. Due to the fact that the Board administration changed from OCME to OVSJG beginning in January 2016, and that Board reporting focuses on calendar years, we focused our review on calendar years 2016 through 2018.

Thus, this report’s findings are only related to the Board under OVSJG and will not focus on the Board’s compliance with legal requirements when it was administered by OCME from 2003 through 2015. Information about the Board’s performance under OCME will be limited to the report’s background section with the exception of our review of the implementation of all of the Board’s recommendations made since its inception.

Methodology
To determine whether the Board complied with D.C. Code § 16-1052, we:

- Reviewed relevant D.C. Code standards.
- Reviewed the Board’s Operating Rules and Procedures.
- Interviewed the Board Coordinator and Board members, and staff from various District and federal agencies.
- Attended Board meetings.
- Reviewed Board case summaries, meeting minutes, and annual reports.
- Analyzed domestic violence fatality data provided by MPD and the Office of Unified Communications (OUC).
- Reviewed the Board’s case files.

---

12 D.C. Code § 1-614.14(c) requires that “The Office of the District of Columbia Auditor shall conduct an audit of selected performance measures presented in performance reports of certain agencies each fiscal year.”
Created an inventory of all available domestic violence homicide related documents.\textsuperscript{13}

Additionally, we reviewed responses from the Executive Office of the Mayor (EOM) and the Court Services and Offender Supervision Agency (CSOSA) to determine the implementation status of recommendations made throughout four annual reports issued by the Board.

To determine whether the Board adopted best practices to perform case reviews and produce quality and actionable recommendations, we:

- Reviewed best practice established by the National Domestic Violence Fatality Review Initiative (NDVFRI)\textsuperscript{14}.
- Reviewed the operations of Domestic Violence Fatality Review Boards or “Teams”, as they are sometimes referred to, in the states of Florida, Georgia, Maryland, Virginia, New York, Montana, and the District. We selected these jurisdictions per the recommendation of the NDVFRI.
- Interviewed staff from Domestic Violence Fatality Review Teams within other jurisdictions and reviewed background information on Board operations.
- Interviewed domestic violence prevention experts.

To fulfill ODCA’s mandate to conduct an audit of selected performance measures per D.C. Code § 1-614.14(c), we:

- Reviewed OVSJG’s Performance Accountability Reports (PARs) for FY 2016 through FY 2018;
- Verified that OVSJG successfully accomplished its Strategic Initiative to “Establish, staff, and coordinate the District’s High Risk Domestic Violence Review Team”.
- Verified OSVJG’s top accomplishment of publishing the Domestic Violence Fatality Review Annual Report.
- Compared the Board and its Operating Rules and Procedures to national best practices and Boards in other jurisdictions.

This report was drafted, reviewed, and approved in accordance with the standards outlined in ODCA’s Policy and Procedure Manual.

\textsuperscript{13} In conducting the review, and criteria for testing, the ODCA team compared the National Domestic Violence Fatality Review Initiative’s (NDVFRI) guidance on the types of documents/information fatality review initiatives may/should have for case reviews against the policy outlined in the Board’s current standard operating procedures (SOPs). ODCA staff determined that the two lists were identical. See Appendix B - Jurisdictional Analysis section on “Data Collection Methodology for Case Reviews” in the Board’s Operating Rules and Procedures.

\textsuperscript{14} The NDVFRI is funded by a grant through the Office on Violence Against Women, U.S. Department of Justice.
Audit Results

The Board’s compliance with scope and trends analysis has been limited to annual report publication.

D.C. Code requires the Board to “identify and characterize the scope and nature of domestic violence fatalities in the District of Columbia” and to “describe and record any trends, data, or patterns that are observed surrounding domestic violence fatalities.”

The 2014 annual report, released in April 2018, includes data on race, gender, age, and other factors for all domestic violence homicides reviewed. It also listed the lethality—the capacity to cause death or serious harm or damage—risk factors and prior criminal history of the perpetrators in the cases reviewed. The annual report, however, was the only public document through which the Board communicated information on the scope, nature, trends and/or patterns surrounding domestic violence fatalities in the District of Columbia.

The D.C. Code requirement is included in the Board’s Operating Rules and Procedures with the additional statement that the Board will do a statistical review for all non-intimate partner violence related cases to expand the Board and the community’s knowledge about the way victims are dying and share demographic information about the families and the perpetrators.

The report released in 2018 covered four-year-old data which means that the scope and trend information included in the report was based on old data. If the Board were to release trends and data on domestic violence related homicides more frequently than just in the annual report, or provided annual reports without the time lag, District residents and decision makers would have more current information. The Board could periodically release a domestic violence trend analysis in addition to producing annual reports.

The Board examined past events and circumstances surrounding domestic violence fatalities.

D.C. Code requires the Board to “examine past events and circumstances surrounding domestic violence fatalities by reviewing records and other pertinent documents of public and private agencies responsible for investigating deaths or treating victims.”

For the report released in 2018 the Board examined past events and circumstances surrounding domestic violence fatalities by focusing on an in-depth review of intimate partner homicides. For example, between 2014 and 2017, the Board conducted in-depth reviews of six intimate partner violence homicides. The Board focuses on these homicides because there is a well-developed body of scientific research on this topic.

The Board met seven times in 2016 and six times in 2017. For each meeting the Coordinator created a case summary that included documentation about victim interactions with District agencies and details about the homicide. ODCA reviewed 12 case summaries which documented domestic violence homicides that occurred in 2014 and 2015, and reviewed source documentation for eight of those cases, as four case summaries happened under OCME’s

15 See D.C. Code § 16-1052(c)(1) and (2).
16 See D.C. Code § 16-1052(c)(3)
administration and documentation was not in the current Board’s case files. ODCA also attended two board meetings to observe the Board reviewing cases and discussing potential recommendations.

Of the eight case files we reviewed, all of the files included the cause of death. Most files also included medical reports, an autopsy report, criminal history details for the offender and the victim and summaries of psychological evaluations. Of the eight case files, three included details on prior protective orders and one victim had multiple interactions with the Child and Family Services Agency, Survivors and Advocates for Empowerment (DC SAFE), and the Court Services and Offender Supervision Agency (CSOSA).

The reviews undertaken for the Board’s report released in 2018 differ from reviews in other jurisdictions. Most of the teams in other jurisdictions reviewed original case records rather than a staff-prepared summary. Many teams build timelines of events as a team. Both are considered best practices supported by the NDVFRI and Neil Websdale, NDVFRI’s director, indicated the D.C. Board may consider following these practices.

All of the review teams from other jurisdictions we surveyed conduct reviews of fewer cases than the District’s Board and devote more time to each case review. For example, both Montana and New York State spend two days per review. Many of the teams included interviews of family members, friends, first responders, and co-workers, as part of their case review. D.C.’s Board has not been conducting such interviews though it is allowed under the Board’s Operating Rules and Procedures. According to the Coordinator, conducting such interviews is something that the Board is interested in and foresees doing soon.

**The Board developed and revised procedures for the review of domestic violence fatalities.**

D.C. Code requires the Board to “develop and revise, as necessary, operating rules and procedures for review of domestic violence fatalities, including identification of cases to be reviewed, coordination among the agencies and professionals involved, and improvement of the identification, data collection, and record keeping of the causes of domestic violence fatalities.”

The Board adopted Operating Rules and Procedures in January 2017 that pertain to the review of domestic violence fatalities, including the identification of cases to be reviewed, and coordination among the agencies and professionals involved. The rules and procedures addressed how the Board addresses confidentiality, conflicts of interest, meeting requirements and the request of case documents among other procedures detailed below.

**Confidentiality**

The Board’s policy requires the Board’s Coordinator and Chairperson to ensure the confidentiality of records and proceedings. Therefore, all Board meetings are closed and confidential and all members, including alternates and other persons presenting information and records on specific fatalities, must execute a sworn statement at each meeting honoring the confidentiality of the information, records, discussions and opinions disclosed during case reviews. This is done prior to the review of any case.

The Coordinator distributes binders with case information at the start of every meeting and collects and houses the

---

17 See D.C. Code § 16-1052(c)(4).
binders until she redistributes them at subsequent meetings. ODCA observed the binders being distributed and confidentiality agreements being signed at the start of the Board meetings we attended.

Conflict of Interest
According to the Board’s policy, “Any member of the Board who has a substantial interest in the outcome of any matter brought before the Board shall make known that interest and the minutes of the meeting shall reflect that the member made such fact known. The member shall refrain from voting or in any way participating in the matter.”

Meeting Requirements
The Board’s policy requires at least six meetings each year. The Board met seven times in 2016 and six times in 2017 prior to approval of the Operating Rules and Procedures.

Requesting Case Documents
The Board’s Operating Rules and Procedures detailed the following process for requesting and collecting case documentation:

- Once cases are identified, the Coordinator works with Board members to determine which agencies or systems the victim had contact with prior to the death and which friends or family had contact with prior to or following the death.
- Those agencies will obtain and share all pertinent records and case information with the Board Coordinator. No more than one week after a case is identified, the Coordinator shall require records.
- Agency representatives have ten (10) business days to respond as to whether records exist and if they exist, the agency representative has 30 business days to provide those records to the Coordinator.

The Coordinator, on behalf of the Board, asks for records and other information in a general email to Board members. The email does not list documents that could or should be provided according to the Operating Rules and Procedures. Because there is no formal tracking system, ODCA was unable to determine whether agencies provided information requested of them. Emails typically went to agency representatives serving on the Board but not to agency or community organization leadership.

The Coordinator disputed that a more formal process is needed and said agencies have never refused to provide requested information. The coordinator creates a case summary based on what is provided by agencies.

The Coordinator further indicated that during the Board’s review meetings, the members could determine whether they need additional information for the review of the case, and if the victim had services provided by an agency that is not represented on the Board, the Board would determine if there was a need to contact the agency. Jurisdictions such as Montana and Georgia take a more formal approach to requesting records from government entities. Their documentation process includes letters requesting information that cite the legal authority upon which the request relies and the time frame within which the recipient entities must provide records/information. In addition, recipients are directed to cite the legal authority in the event a records/information request is not satisfied.
The lack of a formal system to collect and document record requests may result in a lack of transparency. Without an established methodology there may be records available regarding the victim that have not been pursued because an agency representative was not responsive to the email request method currently used. Additionally, agency directors may not know that a specific request has been made for information from their agency. We found that two of the eight case files reviewed did not include an autopsy report. Not having available documents could compromise the quality of case reviews. A documented process is also necessary in case there is a change in personnel or the Coordinator is out for a period of time. Developing a methodology could be an opportunity for training for Board members, the Executive Director, and District government agencies and entities and raise awareness of the Board’s work. This could also help to make the Board aware of the operations of an agency/entity that may be relevant to the collection and provision of information necessary for the Board’s ability to perform quality case reviews.

Types of Documentation That Could Be Requested

The Board’s policy includes a list of the types of information that could be collected during a case review which was extensive and resembles the list recommended by the NDVFRI as record types that may be included in a domestic violence homicide case file. For example, such documents included:

- Law enforcement report (including crime scene investigation, detective investigative report).
- Media reports.
- Details on prior protective orders (temporary and permanent).
- Details on the criminal history of the offender and the victim.
- Civil court data (divorce, termination of parental rights, child custody, or child visitation).

For a full list of the types of information collected by the Coordinator for use in case investigation and compilation, see Appendix B - Domestic Violence Fatality Review Board Practices per the National Domestic Violence Fatality Review Initiative (NDVFRI), in the District of Columbia, and Other Jurisdictions.

We saw examples of these types of documents in our review of eight case files from deaths that occurred in 2014 and 2015, including:

- Six that contained medical reports and hospital emergency room information.
- One that contained relevant social services reports (e.g. shelter, services given by advocacy organizations).
- Three that contained statements from friends, neighbors and witnesses.

Recommendations

1. The Board Coordinator should develop a standardized information request system, based upon the types of information to be used in case reviews as listed in the Board’s Operating Rules and Procedures to formally request information. The information request should be completed on Board letterhead and received by Board representatives as well as agency and organization directors.

2. The Board Coordinator should incorporate in the current case summary form a method to detail dates of requests and compliance with these requests and a system to track this information.
The Board made recommendations in compliance with legal requirements.

D.C. Code requires the Board to recommend:

- Systemic improvements to promote improved and integrated public and private systems serving victims of domestic violence.
- Components for prevention and education programs; and
- Training to improve the identification and investigation of domestic violence fatalities.\(^\text{18}\)

In the 2007, 2008, 2009, and 2014 (published in 2018) annual reports, the Board made a total of 11 distinct recommendations. Appendix C provides a full list of recommendations, one of which was repeated in subsequent reports. Some of the recommendations are highlighted below. Appendix D includes the implementation status responses received from the EOM and CSOSA.

- Recommendations to improve services included a 2007 recommendation that the Department of Human Services and its contractor, The Community Partnership for the Prevention of Homelessness, increase the number of shelters available to domestic violence victims.
- The Board also in 2007 recommended that District programs partner with the religious community.
- In 2007, the Board recommended service provider training specific to serving individuals within the District’s immigrant community.
- The Board recommended in 2008 incorporation of gun safety into health programs in D.C. Public Schools and recommended a Mayor’s Order on the District’s commitment to the prevention and elimination of domestic violence.
- In 2009 the Board recommended improved standards and training for call-takers at the Office of Unified Communications, and that the Department of Health and Department of Health Care Finance work with the D.C. Hospital Association to improve discharge planning to better ensure recovering victims receive appropriate referrals.
- Both recommendations in the 2014 report were for service improvements: (1) that supervision officers working with ex-offenders routinely inquire about relationships and screen for domestic violence; and (2) improve inter-agency response and coordination of services for victims identified through the Lethality Assessment Program (LAP), which coordinates services for victims who are at an increased risk of serious re-assault or homicide at the hands of an intimate partner.

Out of 11 recommendations made by the Board, ODCA found that nine had been implemented.

The Code also requires the Board to report on its recommendations and to document steps taken to implement the recommendations in its annual report.\(^\text{19}\)

The EOM and CSOSA provided ODCA with the implementation status of all 11 recommendations made and supporting documentation in some cases. For example, in 2007 and again in 2008, the Board recommended a city-wide public education campaign and in 2008, the Office of Victim Services awarded a $750,000 grant to the DC. Coalition Against Domestic Violence for a 3-year public education effort.

---

\(^{18}\) See D.C. Code § 16-1052(c).

\(^{19}\) See D.C. Code § 16-1052(d).
Additionally, the Board recommended that District-based domestic violence programs partner with the religious community on methods of identification and prevention of domestic abuse. According to the EOM, grants were awarded for funding for education and training activities to a broad spectrum of community service providers, including those involved with immigrant and religious communities.

Figure 2 shows the number of recommendations made and the number of recommendations implemented as of June 2018.20

<table>
<thead>
<tr>
<th>Annual Report Year</th>
<th>Number of Recommendations Made</th>
<th>Number of Recommendations Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>2008</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2009</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2014</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: ODCA analysis of the status of recommendation implementation.

The Board has not consistently prepared annual reports of findings and recommendations in accordance with D.C. Code.

D.C Code requires the Board to prepare an annual report of its findings, recommendations, and steps taken to implement previous recommendations. This report shall be submitted to the public, the Mayor and the Council on July 1 of each year and shall be presented to the D.C. Council at a Council hearing.21 The Board did not comply with the requirement to produce annual reports in 2016 and 2017. The Board transferred to OVSJG effective December 31, 2015, and an annual report was not issued until April 2018. According to OVSJG, there was a significant amount of time and effort put into rebuilding the Board when administrative oversight was transferred to them. They hired a Coordinator, reviewed policies and procedures, and worked with Boards in neighboring jurisdictions to determine best practices. The Coordinator, who was hired in May 2016, explained that a large part of the Board’s time was spent filling vacancies. She went on to explain that the Board has better processes in place now but rebuilding the Board took considerable time in 2016. The Board spent time during 2017 and 2018 reviewing domestic violence fatalities that occurred in 2014 and compiling their first annual report.

20 There were twelve recommendations made within the four reports; however, one recommendation was issued twice, which drops the total to eleven individual recommendations: (Recommendation #1 in the 2007 report was also issued as Recommendation #1 in the 2008 report).

21 See D.C. Code § 16-1052(d).
Additionally, the Board has a four-year lag in the data that it is reporting on. This 2018 report reviewed domestic violence fatalities that occurred in 2014. The Board is currently working on the 2019 report which will cover domestic violence deaths that occurred in 2015.

OVSJG explained that there will always be a three-year lag in case reviews due to the fact the case has to go through the court adjudication process prior to their review. However, this does not explain the current four-year lag.

Recommendations made using older data may not accurately capture current trends or address immediate problems.

**Recommendations**

3. To ensure that the Board continues to review domestic violence fatalities and produce annual reports as required, OVSJG should perform an annual staffing assessment and ensure that there is adequate funding for a dedicated Coordinator. If not, the lack of review of domestic violence fatalities that occurred while the Board was under OCME could reoccur.

4. The Board should work to eliminate the four-year-lag in reporting by reviewing and reporting on more than one year of data in their upcoming reports.

**The Board’s structure and procedures to perform case reviews and produce quality and actionable recommendations largely align with best practices.**

The mission of the Board 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 parties.

We found that the Board’s operations were generally in alignment with guidance provided by NDVFRI and with many other jurisdictions. Appendix B summarizes our research comparing NDVFRI guidance, practices in the District, and practices in other jurisdictions. For example, we found that:

- The District has a strong enabling statute for Board operations and is currently supported by a dedicated Coordinator, which is not the case in many jurisdictions.
- The enabling legislation also provides great latitude and authority of the Board to gather information for effective case reviews.
- The Board has established Operating Rules and Procedures and is working towards consistently producing annual reports.

As stated above in our findings and recommendations, we would encourage a review of other jurisdictions, regarding their practices of collecting and tracking vital information and incorporate these into their current practices.
Conclusion

The Domestic Violence Fatality Review Board significantly improved its operations after the transfer from OCME to OVSJG in 2015. A Coordinator was hired to provide support such as reconstructing the Board, orchestrating Board meetings, and building case summaries. The first annual report under OVSJG's administration was released in July 2018 covering domestic violence fatalities that occurred in 2014. To continue improving its operations, the Board should develop a standardized information request system, perform an annual staffing assessment and ensure that there is adequate funding for a dedicated Coordinator, and work to eliminate the four-year-lag in reporting so that the Council and the public are receiving the most recent information as possible.

This audit also focused on best practices of fatality review boards in other jurisdictions. The practices of the District's Board are aligned with guidance provided by the National Domestic Violence Fatality Review Initiative and practices of boards in many other jurisdictions.
Agency Comments

On May 14, 2019, we sent a draft copy of the report to OVSJG and the OCME for review and written comment. Both OVSJG and OCME responded on June 11, 2019. Agency comments are included here in their entirety, followed by ODCA’s response.
June 11, 2019

The Honorable Kathleen Patterson
D.C. Auditor
Office of the District of Columbia Auditor
717 14th Street, N.W., Suite 900
Washington, DC 20005

Dear Ms. Patterson,

This letter serves as a response of the Office of the Chief Medical Examiner (OCME) to the draft report entitled, “Panel Meets Most Requirements for Domestic Violence Fatality Review,” provided on May 14, 2019 for review and comment.

The OMCE understands that, while the agency administered the Domestic Violence Fatality Review (DVFR) during fiscal years 2003-2015, the report’s scope and findings focus on calendar years 2016-2018 when administered by Office of Victim Service and Justice Grants (OVSJG). As such, while the OCME has reviewed the report, we respectfully defer to OVSJG’s response on this matter.

Given our historical role administering the DVFR, should there be any questions or concerns that the OCME can respond to during this audit, we are certainly available to provide assistance. Thank you for your commitment to transparency and efficient operations of the District government.

Sincerely,

Roger A. Mitchell, Jr., MD FASCP
Chief Medical Examiner
June 11, 2019

Ms. Kathleen Patterson
District of Columbia Auditor
Office of the District of Columbia Auditor
717 14th Street NW, Suite 900
Washington, DC 20005

Subject: Panel Meets Most Requirements for Domestic Violence Fatality Review draft report response

Dear Ms. Patterson:

Thank you for providing us with the opportunity to review the draft report entitled Panel Meets Most Requirements for Domestic Violence Fatality Review (Report). We are pleased that the Report recognizes the efforts of the Domestic Violence Fatality Review Board (DVFRB or Board) and the Office of Victim Services and Justice Grants (OVSJG). Since assuming responsibility for the Board in 2016, OVSJG and the DVFRB have worked diligently to enhance the activities of the Board and ensure it is meeting its statutory requirements. We are committed to preventing domestic violence fatalities by improving the response of individuals, the community, and government agencies to domestic violence. The Report highlights many aspects of the work of the Board and we welcome the opportunity to provide a response to the Report and its recommendations. The following reflect the responses of OVSJG and the Domestic Violence Fatality Review Board Coordinator.

As the Report notes, Mayor Bowser transferred authority of the Board from the Office of the Chief Medical Examiner (OCME) to the Office of Victim Services and Justice Grants (OVSJG) on December 31, 2015. Since that time, OVSJG has taken numerous steps to build the capacity of the Board, including hiring a Board Coordinator, working with the Mayor’s Office of Talent and Appointments to address vacancies on the Board, reviewing and updating Board procedures, and working with national experts to incorporate best practices. We appreciate that the Report reflects the work that has gone into reviving the Board and ensuring it meets its legislative mandate.

The audit of the Board commenced in October 2017, at which time the Board was still in the process of reviewing existing processes and enacting changes. During the many meetings, calls,
interviews, and emails with the auditors, OVSJG staff, the DVFRB Coordinator, and Board members emphasized that while some statutorily required activities had not been occurring prior to 2016, many steps had been taken to improve the Board functioning since the transfer to OVSJG. Not all changes could be implemented at once, but the Coordinator and the Board were taking intentional, careful steps to bring the Board in line with practices that enable the Board to best carry out its statutory mission. All of the recommendations presented in the report reflect actions or processes the Board had already started or that were in the planning stages. More detailed responses to each of the five recommendations in the Report follow.

**Recommendation 1: The Board Coordinator should develop a standardized information request system, based upon the types of information to be used in case reviews as listed in the Board’s Operating Rules and Procedures to formally request information. The information request should be completed on Board letterhead and received by Board representatives as well as agency and organization directors.**

OVSJG agrees in part with the recommendation and has already taken action. Prior to the commencement of the audit, the Board Coordinator had begun developing a system to request and receive information. The system currently in place is effective and efficient, with all records requested to date having been provided by the target agencies. The Board takes seriously the statutory provisions related to confidentiality of any information and records obtained or created by the Board, and therefore, works to limit the number of individuals to whom it discloses the name of a victim whose case is being reviewed. If needed information or records could be obtained via an agency representative that serves on the Board, the Board would be reluctant to create additional correspondence identifying the victim. What could be more beneficial is a better understanding by agency directors of the role and responsibilities of the DVFRB, and their required compliance/response to Board requests. The Board Coordinator is working with OVSJG staff to develop information sheets and a briefing for agency directors.

**Recommendation 2: The Board Coordinator should incorporate in the current case summary form a method to detail dates of requests and compliance with these requests and a system to track this information.**

OVSJG agrees with this recommendation and has already implemented action. The Coordinator already employs a formal system to track records received using an Excel spreadsheet, which was shown to the auditors during their review. Additionally, the Coordinator titles and uploads all received records upon receipt to the confidential file sharing system for Board members to access.

Additionally, this recommendation references the case summaries that had been prepared by the Board Coordinator, and the draft report notes, “The reviews undertaken for the Board’s report released in 2018 differ from reviews in other jurisdictions. Most of the other jurisdiction teams reviewed original case records rather than a staff-prepared summary. Many teams build timelines of events as a team. Both are considered best practices supported by the NDVFRI and Neil Websdale, NDVFRI’s director, indicated the D.C. Board may consider following these practices.”
Before the audit began, the Board Coordinator, OVSJG staff, and Board members were already considering how to enhance the case review process and had been designing a process to increase the involvement of Board members in the reviews. Further, since hire, the Board Coordinator has ensured the work of the Board included practices put forth by the National Domestic Violence Fatality Review Initiative (NDVFRI). This has included numerous consultations and discussion with Dr. Neil Websdale, Director of the NDVFRI; attending a day-long fatality review training provided by Dr. Websdale and other national experts; and an in-person training for the full Board by Dr. Websdale in 2018.

Effective January 2019, the full Board is reviewing all available confidential records; discussing and establishing a timeline of events leading to the homicide; identifying risk factors; and, when appropriate, interviewing surviving family members and friends.

**Recommendation 3: The Board should follow its Operating Rules and Procedures and meet six times per year.**

OVSJG agrees with the recommendation and has already implemented action. However, the finding stating that the Board only met five times in 2017 is incorrect. The Board met in-person on January 24, March 15, May 17, July 19, September 20, and November 15 of 2017. Additionally, the Board held one conference call in December 2017.

In 2018, the DVFRB met in-person on January 17, May 16, July 18, September 19, and November 28. Due to weather and the District and Federal government closing, the Board needed to cancel one in-person meeting scheduled for March 21, 2018. Given scheduling conflicts and lack of meeting space availability, the Board held a web-based conference call meeting on April 23, 2018. This call was recorded and made available to all Board members via the confidential file sharing service. The Board held one additional conference call on December 19, 2018.

**Recommendation 4: To ensure that the Board continues to review domestic violence fatalities and produce annual reports as required, OVSJG should perform an annual staffing assessment and ensure that there is adequate funding for a dedicated Coordinator. If not, the lack of review of domestic violence fatalities that occurred while the Board was under OCME could reoccur.**

OVSJG agrees and is committed to supporting the DVFRB and the Coordinator position.

**Recommendation 5: The Board should work to eliminate the four-year-lag in reporting by reviewing and reporting on more than one year of data in their upcoming reports.**

OVSJG disagrees with this recommendation because the four-year-lag may be appropriate in some cases. As the Board notes in the 2018 report:

“"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.”

After a reasonable amount of time has passed, i.e., three years, the Board still needs time to conduct the review of the case and then compile any findings and recommendations to include in the next annual report. Depending on the timing of the review and the publication date of the annual report, this will routinely result in up to four years passing from the time of homicide to inclusion in the annual report for in-depth case reviews.

Additionally, we are already planning to publish current trend data on a more regular basis. We anticipate releasing a report that details demographic data and key findings for domestic violence homicides for the past four years in October to coincide with Domestic Violence Awareness Month.

Thank you again for providing the opportunity to review and comment on the draft report. If you have any questions, please do not hesitate to contact me or Rebecca Dreke, the DVFRB Coordinator.

Sincerely,

Michelle M. Garcia
Director
ODCA Response to Agency Comments

We thank the OSVJG and the OCME for their cooperation during our audit. ODCA is pleased that OVSJG agreed with most of our recommendations. OVSJG disagreed with a recommendation that was in the draft report, which stated, “The Board should follow its Operating Rules and Procedures and meet six times per year.” Upon request, OVSJG provided ODCA with proof that the Board conducted six meetings in 2017 and for that reason the recommendation was removed from the final version of the report.
Summary of Report Recommendations

Most of the recommendations in this report can be implemented without any additional costs to the agency/entity, and/or help to advance the goals of the Office of Victim Services and Justice Grants (OVSJG), as seen below.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Is There a Cost to the Agency/Entity to Implement?</th>
<th>Potential to Generate Revenue or Savings to the District?</th>
<th>Specific Agency/Entity or District-Wide Goal Advanced by Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Board Coordinator should develop a standardized information request system, based upon the types of information to be used in case reviews as listed in the Board’s Operating Rules and Procedures to formally request information. The information request should be completed on Board letterhead and received by Board representatives as well as agency and organization directors.</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>2. The Board Coordinator should incorporate in the current case summary form a method to detail dates of requests and compliance with these requests and a system to track this information.</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Is There a Cost to the Agency/Entity to Implement?</td>
<td>Potential to Generate Revenue or Savings to the District?</td>
<td>Specific Agency/Entity or District-Wide Goal Advanced by Recommendation</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>3. To ensure that the Board continues to review domestic violence fatalities and produce annual reports as required, OVSJG should perform an annual staffing assessment and ensure that there is adequate funding for a dedicated Coordinator. If not, the lack of review of domestic violence fatalities that occurred while the Board was under the Office of the Chief Medical Examiner (OCME) could reoccur.</td>
<td>Yes</td>
<td>No</td>
<td>OVSJG Strategic Initiative: Establish, staff, and coordinate the District’s High Risk Domestic Violence Review Team to ensure law enforcement and social services systems visibility, and coordination of services to victims, on the domestic violence cases with highest risk of lethality. The High Risk Domestic Violence Review Team will begin meeting on a monthly basis no later than January 1, 2017.¹</td>
</tr>
<tr>
<td>4. The Board should work to eliminate the four-year-lag in reporting by reviewing and reporting on more than one year of data in their upcoming reports.</td>
<td>No</td>
<td>No</td>
<td>OVSJG Strategic Objective: Create and maintain a highly efficient, transparent and responsive District government.²</td>
</tr>
</tbody>
</table>

Appendices
Appendix A
## Appendix A

**Publication of Domestic Violence Fatality Review Board Reports by Year**
Including Administrative Agency and Fatality Data Covered

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency with Administrative Responsibility for DVFRB</td>
<td>N/A</td>
<td>N/A</td>
<td>OCME; DVFRB Began Full Operation</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td></td>
</tr>
</tbody>
</table>

**Publication of Domestic Violence Fatality Review Board Reports by Year**
Including Administrative Agency and Fatality Data Covered

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency with Administrative Responsibility for DVFRB</td>
<td>N/A</td>
<td>N/A</td>
<td>OCME; DVFRB Began Full Operation</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td>OCME</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B
Appendix B

Domestic Violence Fatality Review Board Practices per the National Domestic Violence Fatality Review Initiative (NDVFRI), in the District of Columbia, and Other Jurisdictions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>The NDVFRI did not provide specific guidance on where a review team or board should be located, indicating on their website: “Teams are also located in a variety of ways, all of which impact their mode of operation. Some are domestic violence coalition or advocate based (Washington state, Denver, CO, Berks County, PA). Some are located as a subcommittee of an existing domestic violence coordinating effort (Palm Beach County, FL, Santa Clara County, CA, New Hampshire). Still others are system-based and are an adjunct to a governmental office (Philadelphia, PA).”</td>
<td>D.C. Code §16-1052</td>
<td>Of the states reviewed, only Georgia did not have an enabling statute.</td>
</tr>
<tr>
<td></td>
<td>The DVFRB is currently provided with administrative support and facilities within the Office of Victim Services and Justice Grants (OVSJG).</td>
<td></td>
<td>New York: The Office for the Prevention of Domestic Violence, created in 1992, is the country’s only executive level state agency dedicated to the issue of domestic violence. It replaced the former Governor’s Commission on Domestic Violence established in 1983.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Florida: Review teams are established at local state level. Per statute, the teams are assigned to the Florida Coalition Against Domestic Violence for administrative purposes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Georgia: The Commission on Family Violence, a state agency that carries out various statutory duties, including domestic violence fatality reviews. The Commission is administratively attached to Georgia’s Department of Community Supervision.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Virginia: The Office of the Medical Examiner is mandated to provide technical assistance to local fatality review teams and is also mandated to issue reports.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maryland: County level teams are mandated to organize under the State Attorney, primary law enforcement agency, or the director of the domestic violence program; however, the MD local teams are also provided technical assistance from the MD Network Against Domestic Violence, another coalition group.</td>
</tr>
</tbody>
</table>

1 https://ndvfri.org/about/faqs/
### National Domestic Violence Fatality Review Initiative (NDVFRI) Guidance

The NDVFRI does not provide specific guidance on staffing and funding, but does indicate this on their website regarding funding direct services vs fatality reviews:

“Some skeptics have suggested it is better to channel scarce resources into direct services for victims of domestic violence than to scrutinize the relatively small proportion of cases where victims die. We have a lot of sympathy with this perspective. It is indeed the case that fatality review is not a process that every community will want to embark on. Some communities will want to use their funds for direct service for battered women. Others will conduct safety and accountability audits. Neither is it possible to prove in any scientific manner that fatality reviews reduce the amount of domestic violence or the number of domestic violence related homicides. In defense of fatality reviews, it does appear that domestic homicide attracts widespread attention and can serve as a vehicle for improving service delivery. It is also a highly focused mechanism for bringing diverse agencies to the table to discuss major social problems.”

“To date, most teams are resourced by volunteer efforts and many have done exemplary work without funding. Team members incorporate death review work into their regular and very busy work schedules. Some teams have sought and received funding. For example, one team in Florida receives funding from the county for a line item

### District of Columbia’s Domestic Violence Fatality Review Board

The District’s Board has a single Coordinator. The Board is also provided administrative support and facility space by the Office of Victim Services and Justice Grants.

### Review Boards in Other Jurisdictions

- **Montana:** A consultant and a Coordinator within the government agency - Montana Department of Justice, support the state review team.
- **Georgia:** Does not have a state team, but two Coordinators support local teams: one from the Georgia Commission on Family Violence and another from the Georgia Coalition Against Domestic Violence.
- **Florida:** Has a state team and several staff from Florida’s Coalition Against Domestic Violence along with a co-chair from the Florida Attorney General’s Office supports the work of the state team and several local teams in Georgia.
- **New York State (NYS):** Has two staff within the NYS Office for the Prevention of Domestic Violence supports the state team.

---

2. [https://ndvfri.org/about/faqs/](https://ndvfri.org/about/faqs/)
in the municipal budget to fund two persons to engage in death review work and at least one team has received funding from the state’s STOP grant program. Similarly, the Washington State death review team also received state STOP Grant funding.

There are also a variety of funding opportunities through the various federal agencies that offer assistance to multi-agency teams working to prevent domestic violence. These agencies include the Violence Against Women Office (including the STOP Grant Program and the Grants to Encourage Arrest Grant Program). The State Justice Institute has also funded state fatality review development in New Hampshire.

When teams are formed as subcommittees to existing state or local domestic violence task forces, funding and resource support (such as administrative staff to set meetings, take minutes, prepare reports and monitor recommendations) can come from those umbrella efforts to support fatality reviews. It is also wise for teams to solicit the presence of local business people on their teams. Not only is domestic violence and domestic homicide an important workplace issue; these individuals may be able to offer support or sponsorship to assist with supplies, telephone costs, and other administrative expenses.”

The District’s Board has a single Coordinator. The Board is also provided administrative support and facility space by the Office of Victim Services and Justice Grants.

Membership on the fatality review boards is generally voluntary. Montana, Georgia, Florida, and even New York State all have dedicated staff support.

**Montana:** A consultant and a Coordinator within the government agency - Montana Department of Justice, support the state review team.

**Georgia:** Does not have a state team, but two Coordinators support local teams: one from the Georgia Commission on Family Violence and another from the Georgia Coalition Against Domestic Violence.

**Florida:** Has a state team and several staff from Florida’s Coalition Against Domestic Violence along with a co-chair from the Florida Attorney General’s Office supports the work of the state team and several local teams in Georgia.

**New York State (NYS):** Has two staff within the NYS Office for the Prevention of Domestic Violence supports the state team.

---

3 https://ndvfri.org/about/faqs/
### Composition of Board Membership

NDVFRI indicates on its website:

“Usually adult fatality review teams are inclusive rather than exclusive, often being open to incorporating new members and agencies. Anyone remotely involved with or affected by a domestic violence fatality might serve on a team. Two observations are helpful: teams ought to be inclusive rather than exclusive, creatively constituted with an eye on learning more about how the deaths might have been prevented. Also, teams might consider having a core group or executive committee work on administrative and process issues, as well as a larger group.

Finally, membership can be local or statewide, depending on the jurisdiction where the team is being established. Here are some membership suggestions: Attorney general, Prosecution, Law enforcement, Public Health, Medical examiner/coroner, Emergency medical department representative, Nurse, Mental health service provider (psychiatrist, psychologist, counselor), Social worker Victim advocate, Judiciary/court personnel, Animal control, Public defender/defense, Legal aid, A surviving family member, Representative from employers/business community, Education/Schools/Universities, Child protective services, Probation and parole, Batterer intervention program, Public at large, Housing authorities, Substance abuse treatment specialist, Faith community representative, Researcher/evaluator.”

As mandated by D.C. Code, the current board membership includes representation from various agencies:

- Metropolitan Police Department, Office of the Chief Medical Examiner, Office of the Attorney General, Department of Corrections, Department of Behavioral Health, Child and Family Services Agency, Mayor’s Office on Women’s Policy Initiatives, D.C. Superior Court, Office of the U.S. Attorney of the District of Columbia, District of Columbia Hospitals, domestic violence shelters, domestic violence advocacy organizations, and eight community representatives.

This is in line with the guidance provided by NDVFRI.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NDVFRI indicates on its website: “Usually adult fatality review teams are inclusive rather than exclusive, often being open to incorporating new members and agencies. Anyone remotely involved with or affected by a domestic violence fatality might serve on a team. Two observations are helpful: teams ought to be inclusive rather than exclusive, creatively constituted with an eye on learning more about how the deaths might have been prevented. Also, teams might consider having a core group or executive committee work on administrative and process issues, as well as a larger group. Finally, membership can be local or statewide, depending on the jurisdiction where the team is being established. Here are some membership suggestions: Attorney general, Prosecution, Law enforcement, Public Health, Medical examiner/coroner, Emergency medical department representative, Nurse, Mental health service provider (psychiatrist, psychologist, counselor), Social worker Victim advocate, Judiciary/court personnel, Animal control, Public defender/defense, Legal aid, A surviving family member, Representative from employers/business community, Education/Schools/Universities, Child protective services, Probation and parole, Batterer intervention program, Public at large, Housing authorities, Substance abuse treatment specialist, Faith community representative, Researcher/evaluator.”</td>
<td>As mandated by D.C. Code, the current board membership includes representation from various agencies: Metropolitan Police Department, Office of the Chief Medical Examiner, Office of the Attorney General, Department of Corrections, Department of Behavioral Health, Child and Family Services Agency, Mayor’s Office on Women’s Policy Initiatives, D.C. Superior Court, Office of the U.S. Attorney of the District of Columbia, District of Columbia Hospitals, domestic violence shelters, domestic violence advocacy organizations, and eight community representatives.</td>
<td>Montana, Georgia, Florida, New York State, Virginia and Maryland, all have a multidisciplinary board, one that includes representation from a variety of disciplines, such as the medical field, the criminal justice and law enforcement field, and social service. Some states legislate membership. For example, NDVFRI’s website states that according to the Florida fatality review legislation (Section 741.316, Florida Statutes), “local domestic violence fatality review team” should include representatives the following offices, agencies and organizations: Local law enforcement, State attorney, Medical examiner, Certified domestic violence center, Child protection, Office of court administration, Clerk’s office, Victim services programs, Citizens at large, Other representatives as determined by the local community”</td>
</tr>
</tbody>
</table>

---

4 https://ndvfri.org/about/faqs/
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Legal Abilities to Access Information</strong>&lt;br&gt; The NDVFRI does not provide specific guidance on legal abilities to access information on their website.</td>
<td>Statute gives the Board subpoena authority. The statute gives the Board access to a wide range of records. Of the jurisdictions reviewed by ODCA, we found that the District’s statute is the most robust including subpoena authority.</td>
<td>Of the jurisdictions reviewed by ODCA, many did not have subpoena authority. In fact, Georgia and Florida rely on their Open Records/Sunshine laws to obtain records from various entities.</td>
</tr>
<tr>
<td><strong>Data Collection Methodology for Case Reviews</strong>&lt;br&gt; The NDVFRI does not provide specific guidance on data collection methodology on their website but does indicate the types of records to review:&lt;br&gt; • Police department homicide logs. Examine for overall estimate of domestic violence homicides in a jurisdiction. Check classification/coding of cases. This is a good important starting point.&lt;br&gt; • Newspaper reports.&lt;br&gt; • Crime scene investigations.&lt;br&gt; • Detective’s follow-up investigative reports.</td>
<td>The Board’s SOPs states that these are types of information collected by the Coordinator for use in case investigation and compilation:&lt;br&gt; • Law enforcement reports, including crime scene investigations and detective’s investigative reports</td>
<td>Some of the jurisdictions interviewed (Georgia, Florida, and New York State) explained that their process of compiling data on domestic violence homicides requires reviewing multiple sources, including monitoring the media for reports on deaths resulting from domestic violence. Some jurisdictions indicated that a single homicide list provided by an entity informs the selection of cases to review.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>• Details of any prior protective orders, temporary, and permanent.</td>
<td>• Media reports</td>
<td></td>
</tr>
<tr>
<td>• Notice of service of protective orders.</td>
<td>• Details of any prior protective orders (temporary and permanent)</td>
<td></td>
</tr>
<tr>
<td>• Affidavits requesting issuance of protection orders.</td>
<td>• Civil court data regarding divorce, termination of parental rights, child custody, or child visitation</td>
<td></td>
</tr>
<tr>
<td>• Civil court data regarding divorce, termination of parental rights, child custody battles, or child visitation.</td>
<td>• Criminal histories of the offender and the victim</td>
<td></td>
</tr>
<tr>
<td>• Any criminal histories of the perpetrators and victim.</td>
<td>• CFSA child protective services data (regarding alleged child abuse or neglect involving either the victim or the offender) and juvenile justice data (prior delinquency history of the offender or the victim)</td>
<td></td>
</tr>
<tr>
<td>• Child protective agency summary data and prior abuse histories.</td>
<td>• Adult protective services summary data and prior abuse history</td>
<td></td>
</tr>
<tr>
<td>• Summaries of psychological evaluations/reports appearing in public record documents such as police files.</td>
<td>• Summaries of psychological evaluations or reports appearing in public record documents, such as police files</td>
<td></td>
</tr>
<tr>
<td>• Medical examiners report.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Autopsy report.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Workplace information, perhaps regarding harassment, abuse, alerts among Medical data, hospital emergency room data.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Shelter/outreach data from advocates for battered women, if appropriate and legally permissible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• School data regarding children reporting abuse in the home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Statements from neighbors, friends, witnesses, and so on. May be contained in police files as transcribed material, or in court documents/transcripts from trials.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-sentence investigation report (probation).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
</tbody>
</table>
| • Parole information including notification of victims.  
• State statutes on domestic violence.  
• Information regarding weapons confiscation, purchase, background checks.  
• Drug and alcohol treatment data.⁵ | • OCME autopsy report  
• Workplace information (stalking/harassment, alerts among co-workers)  
• Medical reports and hospital emergency room information  
• Shelter or program services information from domestic violence or sexual assault advocates (if appropriate and legally permissible)  
• School reports regarding children reporting abuse  
• Statements from neighbors, friends or witnesses (often found in police files as transcripted material or in court documents or trial transcripts)  
• Pre-sentence investigation report | |

⁵ [https://ndvfri.org/about/faqs/](https://ndvfri.org/about/faqs/)
The NDVFRI advises that teams must develop procedures and protocols for what the team will review, including the scope of review and types of cases that will be reviewed. For instance, only closed cases, murder-suicides, or all cases within one year. The NDVFRI acknowledges that most domestic violence fatality review teams in the country focus on intimate partner homicides. NVDRI provides the following guidance on their website:

“The simple answer to this question is, resources permitting, as many cases as the team feels it is able to review in order to better understand, intervene in, and prevent domestic violence and domestic homicide. Cases for review can include:

- Closed cases (perpetrator has been convicted, most or all appeals have expired)
- Open cases (case is pending)
- Child deaths
- Familicide (where entire family is murdered)
- Near deaths

The statute does not limit the types of domestic violence cases to be reviewed by the Board. According to the Board Coordinator, the Board reviews closed cases and does not have access to records of open cases. See D.C. Code 16-1054(c). The Board conducts statistical reviews of all domestic violence fatalities, but their SOPs dictates that in-depth reviews will be done of intimate partner violence cases only.

For the jurisdictions we reviewed, restrictions placed by statute call for teams to limit their review to closed cases, i.e. cases that are well-past potential for litigation. Some jurisdictions only perform in-depth case reviews of intimate partner violence cases.
### National Domestic Violence Fatality Review Initiative (NDVFRI) Guidance

- Murder-suicide (a type of closed case, where the perpetrator is dead)
- Suicide
- All deaths of women between certain ages
- High-profile or cases deemed significant by community

The Philadelphia Death Review Team reviews hundreds of women’s deaths per year, taking perhaps 30 minutes per review. The idea in Philadelphia is to identify as many cases as possible where women died as a direct or indirect result of domestic violence. Conversely, reviews like the Charan Investigation (a homicide-suicide case in San Francisco in 1990) seek to identify system failures through an extremely detailed analysis of one case. Some jurisdictions review a large number of cases in summary fashion, others delve into individual cases in great depth. Both approaches have the potential to improve the delivery of multiple services to victims of domestic violence.\(^6\)

### District of Columbia’s Domestic Violence Fatality Review Board

The Board Coordinator makes a general request via email. This is a much less

### Review Boards in Other Jurisdictions

**Montana** and **Georgia** issue letters which call for the provision of records from the recipient entities; the letters also include the legal authority upon which the request relies, the time frame within which the recipient entities must provide records/information; and recipients are directed to cite the

---

\(^6\) [https://ndvfri.org/about/faqs/](https://ndvfri.org/about/faqs/)
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The NDVFRI supports teams building timelines together as a full team group, and that case documents are reviewed by all team members.</td>
<td>Once the Coordinator obtains records, the Coordinator will primarily review the case records and uses these records to construct a case summary, using a case summary template. The Coordinator will also work with law students to compile a case summary. Once a case summary is completed, the summary is shared with the co-chairs of the Board for input. About 48 hours before the review board meeting where cases are to be reviewed, the case summary is shared with the rest of the Board members using an online portal.</td>
<td>legal authority in the event a records/information request is not satisfied.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>How Case Review is Conducted</strong></td>
<td>The Board's current policy is to meet every other month. The Board's policy is to perform case reviews of all intimate partner violence cases that occur in a given year. AT THE TIME OF OUR REVIEW, The District's Board DID NOT include interviews with family members, friends, first responders, coworkers, etc. as part of their review, BUT STATED THEY MAY ADD IT TO THEIR PROCESS IN THE FUTURE.</td>
<td>We found that in addition to document review, many teams included interviews of family members, friends, first responders, coworkers, etc. All members of the review teams reviewed by ODCA participate in building timelines together.</td>
</tr>
<tr>
<td><strong>Are there Standard Operating Procedures</strong></td>
<td>Identifies setting up procedures and protocols for what the team will review, including the scope of review and types of cases that will be reviewed.</td>
<td>The Board has written Operating Rules and Procedures.</td>
</tr>
<tr>
<td><strong>How Reports are Produced and What they Contain</strong></td>
<td>The NDVFRI recommends that annual or regular reports that include formal findings and recommendations for action be prepared as formal products of domestic violence fatality review teams. The NDVFRI also includes this on their website: “There are formal and informal products of fatality review. Among the informal products are:</td>
<td>D.C.’s Board is required by law to prepare and submit annual reports to the Council, the Mayor, and the public.</td>
</tr>
</tbody>
</table>
### National Domestic Violence Fatality Review Initiative (NDVFRI) Guidance

- Better educated and trained team members as the team review is an intensive and in-depth learning process. Very often, team members incorporate what they have learned into improving their daily jobs as well as improving training programs.
- Team member awareness about others’ jobs expands; team members begin to appreciate the duties and responsibilities of other system and agency players and this can help improve communication between them outside of the review.
- Greater collaboration on other projects like grant applications, policy initiatives or advocacy for resources.

Among the formal products are:

- Annual reports. An annual or regularly produced report gives coherence to the work of a fatality review team. Team reports often make formal findings and offer recommendations for action such as public awareness and prevention campaigns and can focus attention on needed system reforms or on particular topics such as suicide, teens, marginalized women, or firearms. (See Washington State)

### District of Columbia’s Domestic Violence Fatality Review Board

Sections of the reports include:

- Executive Summary
- Board Structure, Membership and Review Process
- Cases Reviewed by the Board (data/information on the presence of lethality risk factors)
- Recommendations
- Key Findings

### Review Boards in Other Jurisdictions

Not all Boards or review teams from the various jurisdictions reviewed by ODCA are required to prepare annual reports. For example, while the Montana team is required to prepare/publish a report every two-years, other states like New York are statutorily required to prepare/publish reports "periodically." Still other teams, Georgia for example, does not have an enabling statute but publish reports on an annual basis.
|---|---|---|
| • Data and other aggregate information. The team can also produce aggregate data based on information gathered from a number of reviews or teams. Such information can be valuable for supporting policy changes, raising awareness and helping policy makers to allocate resources more responsibly. (See Florida)  
• Legislation and other reform. Team reviews can highlight the need for legislative reforms in a particular area.  
Press events and public awareness campaigns. The release of an annual report that contains aggregate information or policy recommendations can rivet public attention and motivate reforms.” | | |

7 https://ndvfri.org/about/faq/
Appendix C
Appendix C

Status of Recommendations

<table>
<thead>
<tr>
<th>#</th>
<th>Annual Report Year</th>
<th>Recommendation(s)</th>
<th>Recommendation Implemented?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2007 and 2008</td>
<td>Office of Victim Services (OVS) in collaboration with the Departments of Health (DOH) and Mental Health (DMH) should work with domestic violence programs to develop and implement a city-wide public education campaign to broaden the community's knowledge of the cycle of domestic violence; symptoms of abuse, including emotional and verbal; lethality risk indicators; reporting methods; and services/resources available in the community.</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>2007</td>
<td>OVS in collaboration with DOH and DMH should advocate for professional training for service providers and others involved with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services and resources available in the community. The training should minimally focus on the cycle of domestic violence; lethality risk factors; protection orders; legal, social, mental health and other community-based resources that are available to this population; significance of risk assessments, early intervention strategies and safety plans for victims and their families.</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>2007</td>
<td>Department of Human Services, Family Services Administration in collaboration with the Community Partnership for the Prevention of Homelessness should increase the number of domestic violence shelters available for victims in the District of Columbia.</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>2007</td>
<td>District-based domestic violence programs should partner with the religious community on methods of identification and prevention of domestic abuse.</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>2008</td>
<td>In light of the recent Court decision striking down a portion of the District law that banned guns and the problem of easy access to guns, the District should incorporate education on gun safety into health programs in the DC Public School system. The education should emphasize the dangers of possessing guns as well as the need to utilize safety devices and practices when handling or exposed to firearms.</td>
<td>Yes</td>
</tr>
<tr>
<td>#</td>
<td>Annual Report Year</td>
<td>Recommendation(s)</td>
<td>Recommendation Implemented?</td>
</tr>
<tr>
<td>---</td>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>6</td>
<td>2009</td>
<td>Office of Unified Communications (OUC) which handles the District’s 9-1-1 calls should reevaluate the quality measures that it currently has in place regarding call-taker performance. If there are no quality measures for call-takers, OUC should develop and implement standards to address who, what, when, and how questions, with respect to obtaining accurate information from 911 callers are posed, and to ensure that 911 calls receive appropriate instructions during an emergency call. OUC supervisors should randomly listen to the performance of call-takers to determine the quality of service that is being provided, the need for individual training, as well as the need for overall staff training. OUC should reinforce protocols to ensure DV first responder safety by immediately publishing an “Alert-Bulletin” and re-train dispatchers against sending a civilian (911 callers) into a domestic violence situation.</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>2009</td>
<td>The Mayor, [sic] should issue an Order declaring that the District is dedicated to the prevention and elimination of domestic violence, sexual assault and stalking. The District has a zero tolerance policy for domestic violence, sexual assault and stalking at the workplace and will take appropriate disciplinary action and/or criminal prosecution against any employee or non-employee who commits such act in District government office, facility, work-site, and vehicle or while conducting District business. All District agencies should be directed to establish such policies in writing and the policy elements should include: 1) definitions; 2) statement that using work time or workplace facilities to commit or threaten to commit these acts are cause for discipline up to and including dismissal; 3) a statement that all acts, regardless of whether they occur in or near the workplace, may be caused [sic] for discipline and may be considered as part of the employee’s work history; 4) information indicating where victims and abusers can go for assistance; 5) guidance regarding training for managers and employees are responsible for making reasonable efforts to promote the safety of all employees. This information must be disseminated and accessible to all employees.</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>2009</td>
<td>Department of Health (DOH) and Department of Health Care Finance (DHCF) should work in collaboration with the District Hospital Association to improve city-wide standards for discharge planning to ensure that when a patient is ready for release</td>
<td>Yes</td>
</tr>
<tr>
<td>#</td>
<td>Annual Report Year</td>
<td>Recommendation(s)</td>
<td>Recommendation Implemented?</td>
</tr>
<tr>
<td>----</td>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>9</td>
<td>2009</td>
<td>The Office of Aging (OOA) should provide ongoing information to educate the community about the broad range of services that are available to the elderly and methods of accessing services.</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>2014 (Published in 2018)</td>
<td>Increase opportunities for prevention and intervention among offenders who are on probation or supervised release.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specific recommendation to Court Services and Offender Supervision Agency: 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.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>2014 (Published in 2018)</td>
<td>Enhance the interagency response to domestic violence victims who are identified as at increased risk for severe injury or death. Specific recommendation to Lethality Assessment Program (LAP) partner agencies – 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.</td>
<td>No</td>
</tr>
</tbody>
</table>
Appendix D
June 29, 2018

Ms. Kathleen Patterson
District of Columbia Auditor
Office of the District of Columbia Auditor
717 14th Street NW, Suite 900
Washington, DC 20005

Subject: Requests for Information on ODCA Evaluation on the Domestic Fatality Review Board

Dear Auditor Patterson,

This letter is a response to additional requests for information sent by your audit team, led by Masooma Hussain, on June 7, 2018.

On October 4, 2017, the Office of the District of Columbia Auditor sent engagement letters to the Office of the Chief Medical Examiner (OCME) and the Office of Victim Services and Justice Grants (OVSJG) informing them of a discretionary audit of the Domestic Violence Fatality Review Board (Board). The Board was under the supervision of OCME until 2015. Specifically, the Board reviews cases of domestic violence fatalities in the District and makes recommendations to District and Federal agencies, along with community organizations, to reduce such incidents. This administration is committed to making the District safer and stronger for all of its residents. One of our priorities is to reduce domestic and sexual violence, and improve outcomes for survivors.

Initially, the audit team requested information on recommendations made by the Board in Fiscal Years 2014-2017, as described in D.C. Official Code § 16-1052(c), meeting minutes of the Board from Fiscal Years 2014-2017, and information collected by the Board related to instances of domestic violence fatalities, organized by Fiscal Years 2014-2017. While the audit team initially requested reports from Fiscal Years 2003-2017 and indicated a scope that covered 15 fiscal years, its document requests primarily covered Fiscal Years 2014-2017. The Board’s request to OVSJG only covered Fiscal Years 2016 and 2017.

The audit team revised its objectives in February 2018 and indicated that its new objectives were to determine “(1) Whether the Domestic Violence Fatality Review Board, with administrative support from the Office of the Chief Medical Examiner and the Office of Victim Services and Justice Grants, complied with the D.C. Code § 16-1052; (2) Whether the Domestic Violence Fatality Review Board has adopted best practices to perform case reviews and produce quality and actionable recommendations.”

While the audit team reserved its right to adjust the scope and/or timeline of this audit as it gathered information, the additional letters and requests for information sent to numerous...
agencies focused on recommendations from the Board in its July 2007, July 2008, and July 2009 report. The additional agencies that were sent correspondence include: District of Columbia Public Schools (DCPS), DC Health, Office of Aging (DCOA), Department of Behavioral Health (DBH), Department of Health Care Finance (DHCF), Office of Unified Communications (OUC), and the Executive Office of the Mayor (EOM). The audit team’s requests spanned over a decade of information and documentation. Over the past decade, we have seen three Mayoral administrations and many leadership changes and transitions at every agency involved.

While attempting to respond to these supplementary requests in a matter of weeks, agencies focused on obtaining records from this administration and current policies and practices. Most agencies do not maintain records beyond the required retention period. Moreover, if records from almost a decade ago did exist, many would be in the Archives. Similarly, while agencies may have responded to recommendations from the Board in Fiscal Years 2007, 2008, and 2009, leadership and staff have experienced transitions and current leadership is either unaware of those responses or may have different views on the issues.

Broadly, in response to your request, Mayor Bowser’s administration has invested significant resources for domestic violence programs in the District. As further explained below, in fiscal years 2015 - 2018, OVSJG has awarded over $32 million in grant funding to community-based programs with a focus on domestic violence services. This includes funding for emergency and transitional housing, counseling and mental health services, legal advocacy and assistance, education and training, and culturally specific services for victims/survivors of domestic violence.

OVSJG supports organizations that host Spread Love DC, a unique way to engage young people, community leaders, and advocates around raising awareness on domestic violence issues. Spread Love DC helps change the conversation by sparking discussions about healthy relationships encouraging everyone – in their homes, neighborhoods, schools, faith communities and workplaces – to proactively engage in dialogue that promotes safety, respect and accountability.

In your questions, you asked several agencies about the recommendation made to educate and train providers that work with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services and resources available in the community. Grants awarded by the District include funding for education and training activities to a broad spectrum of community service providers, including those involved with immigrant and religious communities. Beyond training, OVSJG has committed funding to community-based organizations that have a specific focus on providing victim services to immigrant victims, including the Asian Pacific American Legal Resource Center, Ayuda, CARECEN, La Clinica del Pueblo, the Latin American Youth Center, Mary’s Center, and The Person Center.

Mayor Bowser has also launched the first of its kind, national model, Immigrant Justice Legal Services Fund, which has supported the work of a dozen community-based organizations
directly, and more indirectly through partnerships. These organizations have held numerous
Know Your Rights events, provided brief legal consults, referrals to pro bono counsel, and
provided full direct legal services to immigrants seeking to file Violence Against Women Act
(VAWA) petitions or asylum claims based on domestic violence. Moreover, MPD, working
with various offices within the Mayor’s Office of Community Affairs, and the Executive Office
of the Mayor, has also hosted or participated in a number of community events aimed at
immigrant audiences where the point is reiterated time and again that people should call MPD to
report crimes against them; that as a sanctuary city, MPD will not ask about immigration status;
and that if someone’s legal status is contingent on a relationship with an abuser, they should
know that the Violence Against Women Act protects their ability to stay here and leave a
situation where they are endangered by domestic violence. The Mayor herself speaks often to
immigrant communities urging them to take advantage of city services and to report crimes and
be active in solving crimes – including domestic violence without fear.

In this administration, agencies have employed new tactics to further increase resources for
victims of domestic violence. One of OUC’s newest initiatives includes a partnership with
OVSJG to reach out directly to domestic violence victims. In FY2017, OUC implemented text to
911, a feature that allows persons who cannot make a voice call, such as someone who is the
victim of a crime and the perpetrator is still in the area, as in the case of a domestic violence
incident, to connect with public safety resources.

Lastly, in line with expressing Mayor Bowser’s commitment to DC Values, we would be remiss
not to expand upon the specificity of the audit team’s question to DCPS about “health curriculum
pacing guides indicating a focus on priority health topics including a focus on gun safety.”
Health curriculum pacing guides exist, but they do not comprehensively represent the current
community discussion on gun safety and violence in schools. Almost a decade has passed since
the Board issued that recommendation and the reality of gun violence in schools has changed
drastically in the intervening years. As Mayor Bowser told a group of students from Thurgood
Marshall and Stoneman Douglas this year before the March for Our Lives, “we are finally having
a real conversation about guns” and how people need to step up and keep our students and our
communities safe. It is a top priority of this administration to ensure the safety of all DC
residents, especially our student community. Not only will that include keeping the conversation
going about gun violence and safety in our schools, but also encouraging federal action on
common sense gun control regulations.

Your requests drew attention to the recommendations of a Board from almost a decade ago, but
we more relevantly direct your attention to the current actions and priorities of this
administration, as described above and in the responses below. While documentation may not
exist or be recoverable without a visit to the Archives, the current actions of agencies exemplify
similar priorities and commitment to the Board’s mission of reducing instances of domestic
violence fatalities.
Enclosed you will find an addendum of responses to your specific questions from agencies. Should you have any questions, please do not hesitate to contact me.

Sincerely,

Betsy Cavendish
General Counsel, Executive Office of the Mayor

Michelle M. Garcia
Director, Office of Victim Services and Justice Grants

Amanda Alexander
Interim Chancellor, District of Columbia Public Schools

Karima Holmes
Director, Office of Unified Communications

Dr. LaQuandra Nesbitt
Director, Department of Health

Laura Newland
Executive Director, Office of Aging

Dr. Tanya Royster
Director, Department of Behavioral Health

Wayne Turnage
Director, Department of Health Care Finance
Office of Victim Services and Justice Grants:

Board Recommendations:

July 2007 Recommendation: 1. “Office of Victim Services (OVS) in collaboration with the Departments of Health (DOH) and Mental Health (DMH) should work with domestic violence programs to develop and implement a city-wide public education campaign to broaden the community’s knowledge of the cycle of domestic violence; symptoms of abuse, including emotional and verbal; lethality risk indicators; reporting methods; and services/resources available in the community.”

Recommendation 1 was reissued in the July 2008 annual report, and OVS provided the following response: “This issue has been and continues to be addressed by OVS and to a lesser extent by DHS. OVS dedicated substantial resources ($750,000) over a three-year period that was managed by DC Coalition Against Domestic Violence and distributed to other domestic violence service providers. We continue to dedicate funds in this area. The more the better, but additional funding sources must be identified.”

July 2007 Recommendation 2. “OVS in collaboration with DOH and DMH should advocate for professional training for service providers and others involved with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services and resources available in the community. The training should minimally focus on the cycle of domestic violence; lethality risk indicators; protection orders; legal, social, mental health and other community-based resources that are available to this population; significance of risk assessments, early intervention strategies and safety plans for victims and their families.”

Information Requested:

1. Documentation to validate the disbursement of $750,000 to DC Coalition and other domestic violence service providers for developing and implementing a city-wide public education campaign, as stipulated in OVSJG’s response to recommendation 1.

OVSJG does not have the records requested for activities that occurred a decade ago. The agency retains all financial records, supporting documents, statistical records, and all other records pertinent to an award for a period of three years after final action is taken on the award, per federal guidance. We can speak to efforts over the past several years related to awareness, education and resources for victims/survivors of domestic violence.
In alignment of Mayor Muriel Bowser’s priorities to reduce domestic and sexual violence, and improve outcomes for survivors, OVSJG has provided significant resources for domestic violence programs in the District. In fiscal years 2015 - 2018, OVSJG has awarded over $32 million in grant funding to community-based programs with a focus on domestic violence services. This includes funding for emergency and transitional housing, counseling and mental health services, legal advocacy and assistance, education and training, and culturally specific services for victims/survivors of domestic violence.

It also includes funding for the DC Coalition Against Domestic Violence (DCCADV) to coordinate and participate in annual local outreach campaigns for national awareness activities for Domestic Violence Awareness Month (DVAM), Teen Dating Violence Awareness Month, and other related awareness months. DCCADV hosts community events, engages social media to connect community members and members programs to local events, promotes activism, and increases awareness through its Spread Love DC campaign.

Spread Love DC is a unique way to engage young people, community leaders and advocates around raising awareness throughout Domestic Violence Awareness Month (DVAM). Spread Love DC “helps change the conversation by sparking discussions about healthy relationships encouraging everyone – in their homes, neighborhoods, schools, faith communities and workplaces – to proactively engage in dialogue that promotes safety, respect and accountability. Together, we can spread love and prevent domestic violence.” [https://www.dccadv.org/index.php?pid=169](https://www.dccadv.org/index.php?pid=169)

2. Documentation of funding dedicated and disbursed by OVSJG, as described in your response to recommendation 1, for fiscal years 2007 to 2018, along with information on potentially new funding sources.

As noted in the previous response, OVSJG has awarded over $32 million to community-based organizations with a primary focus on domestic violence, as detailed below. This does not take into account the dozens of other victim services programs funded that provide services to domestic violence victims under a broader crime victim services program.
### FISCAL YEAR 2018

<table>
<thead>
<tr>
<th>Grantee</th>
<th>Description</th>
<th>Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Pacific Islander Domestic Violence Resource Project</td>
<td>Enhancing Outreach and Services to D.C.’s Asian/Pacific Islander Communities</td>
<td>$10,000.00</td>
</tr>
<tr>
<td>Ayuda</td>
<td>Domestic Violence, Sexual Assault, and Stalking Program</td>
<td>$300,000.00</td>
</tr>
<tr>
<td>Break the Cycle</td>
<td>Youth Legal Services</td>
<td>$10,000.00</td>
</tr>
<tr>
<td>Community Family Life Services</td>
<td>Transitional Housing and support services for women who are returning citizens and victims/survivors of DV/SA</td>
<td>$475,000.00</td>
</tr>
<tr>
<td>DC Courts</td>
<td>Domestic Violence Intake Center</td>
<td>$38,908.00</td>
</tr>
<tr>
<td>DC Forensic Nurse Examiners</td>
<td>IPV Access Outreach</td>
<td>$9,950.00</td>
</tr>
<tr>
<td>DC SAFE</td>
<td>Domestic Violence Crisis Intervention Services Project</td>
<td>$1,354,128.00</td>
</tr>
<tr>
<td>DC SAFE</td>
<td>Intimate Partner Violence ACCESS Project Outreach</td>
<td>$11,623.00</td>
</tr>
<tr>
<td>DC Volunteer Lawyers Project</td>
<td>Legal and Case Management Services</td>
<td>$442,804.00</td>
</tr>
<tr>
<td>Deaf Abused Women’s Network (DAWN)</td>
<td>Survivor Support Services and Community Education</td>
<td>$250,000.00</td>
</tr>
<tr>
<td>District Alliance for Safe Housing</td>
<td>Cornerstone Safe Housing Program and Housing Resource Center Program</td>
<td>$1,760,000.00</td>
</tr>
<tr>
<td>District of Columbia Coalition Against Domestic Violence</td>
<td>Enhancing the Response to Survivors of Domestic and Sexual Violence in Washington, DC</td>
<td>$678,951.00</td>
</tr>
<tr>
<td>Dynamic Strategies</td>
<td>Intimate Partner Violence ACCESS Project</td>
<td>$8,000.00</td>
</tr>
<tr>
<td>House of Ruth</td>
<td>Service Enriched Housing &amp; Counseling</td>
<td>$1,000,000.00</td>
</tr>
<tr>
<td>Legal Aid Society of the District of Columbia</td>
<td>Domestic Violence Victims Representation Project</td>
<td>$249,605.00</td>
</tr>
<tr>
<td>Mary’s Center</td>
<td>Domestic violence advocacy program</td>
<td>$100,000.00</td>
</tr>
<tr>
<td>My Sister’s Place</td>
<td>Comprehensive Opportunities for Recovery &amp; Empowerment</td>
<td>$572,000.00</td>
</tr>
<tr>
<td>The Person Center</td>
<td>African Immigrant Domestic Violence Outreach and Education Project</td>
<td>$50,000.00</td>
</tr>
<tr>
<td>The Women’s Center</td>
<td>Coordinated Counseling Services for Sexual Assault, Domestic Violence, and Stalking Victims</td>
<td>$255,804.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$7,576,773.00</td>
</tr>
</tbody>
</table>

### FISCAL YEAR 2017

<table>
<thead>
<tr>
<th>Grantee</th>
<th>Description</th>
<th>Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Pacific Islander Domestic Violence Resource Project</td>
<td>Enhancing Outreach and Services to D.C.’s Asian/Pacific Islander Communities</td>
<td>$100,000.00</td>
</tr>
<tr>
<td>Ayuda</td>
<td>Domestic Violence, Sexual Assault, and Stalking Program</td>
<td>$500,000.00</td>
</tr>
<tr>
<td>Break the Cycle</td>
<td>Youth Legal Services</td>
<td>$99,996.00</td>
</tr>
<tr>
<td>DC Courts</td>
<td>Domestic Violence Intake Center</td>
<td>$38,908.00</td>
</tr>
<tr>
<td>DC Forensic Nurse Examiners</td>
<td>IPV Access Outreach</td>
<td>$9,999.00</td>
</tr>
<tr>
<td>DC SAFE</td>
<td>Intimate Partner Violence ACCESS Project</td>
<td>$1,315,247.00</td>
</tr>
<tr>
<td>DC SAFE</td>
<td>Domestic Violence Crisis Intervention Services Project</td>
<td>$176,804.00</td>
</tr>
<tr>
<td>DC SAFE</td>
<td>Emergency DV Housing</td>
<td>$2,500,000.00</td>
</tr>
<tr>
<td>DC Volunteer Lawyers Project</td>
<td>Legal and Case Management Services</td>
<td>$336,000.00</td>
</tr>
<tr>
<td>Deaf Abused Women’s Network (DAWN)</td>
<td>Survivor Support Services and Community Education</td>
<td>$200,000.00</td>
</tr>
<tr>
<td>District Alliance for Safe Housing</td>
<td>Cornerstone Safe Housing Program and Housing Resource Center Program</td>
<td>$1,600,000.00</td>
</tr>
<tr>
<td>District Alliance for Safe Housing</td>
<td>Survivor Resilience Fund</td>
<td>$100,000.00</td>
</tr>
<tr>
<td>District Alliance for Safe Housing</td>
<td>Transitional Housing</td>
<td>$125,000.00</td>
</tr>
<tr>
<td>District of Columbia Coalition Against Domestic Violence</td>
<td>Enhancing the Response to Survivors of Domestic and Sexual Violence in Washington, DC</td>
<td>$607,951.00</td>
</tr>
<tr>
<td>Dynamic Strategies</td>
<td>Intimate Partner Violence ACCESS Project</td>
<td>$24,772.00</td>
</tr>
<tr>
<td>House of Ruth</td>
<td>Service Enriched Housing &amp; Counseling</td>
<td>$1,000,000.00</td>
</tr>
<tr>
<td>Legal Aid Society of the District of Columbia</td>
<td>Domestic Violence Victims Representation Project</td>
<td>$239,126.00</td>
</tr>
<tr>
<td>Legal Aid Society of the District of Columbia</td>
<td>Victim Legal Network (VLN)</td>
<td>$12,500.00</td>
</tr>
<tr>
<td>My Sister’s Place</td>
<td>Comprehensive Opportunities for Recovery &amp; Empowerment</td>
<td>$500,034.00</td>
</tr>
<tr>
<td>The Person Center</td>
<td>A Victim Services Outreach Project</td>
<td>$100,000.00</td>
</tr>
<tr>
<td>The Women’s Center</td>
<td>RESTORE: Coordinated Counseling Services for Sexual Assault, Domestic Violence, and Stalking Victims</td>
<td>$265,935.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10,042,122.00</td>
</tr>
</tbody>
</table>
Additionally, OVSJG routinely explores opportunities to enhance funding for victim services in the District. For example, specific to domestic violence, in FY15, OVSJG received an award from the U.S. Department of Justice Office on Violence Against Women for nearly $650,000 to expand crisis services, on-call medical forensic care, and advocacy services for victims of intimate partner violence.

3. Documentation of professional training for service providers and others involved with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services, as stipulated in recommendation 2. If the
The recommendation was that OVS in collaboration with DOH and DMH should advocate for professional training for service providers and others involved with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services and resources available in the community.

Funding provided to domestic violence programs, and other victim service providers, includes funding for education and training activities to a broad spectrum of community service providers, including those involved with immigrant and religious communities. In FY17, OVSJG grantees held 204 training or professional development events for 5,117 individuals. In FY16, OVSJG grantees held 251 training or professional development events for 4,678 individuals.

Additionally, beyond training, OVSJG has committed funding to community-based organizations that have a specific focus on providing victim services to immigrant victims, including the Asian Pacific American Legal Resource Center, Ayuda, CARECEN, La Clinica del Pueblo, the Latin American Youth Center, Mary’s Center, and The Person Center.

**District of Columbia Public Schools:**

**Board Recommendation:**

July 2008 Recommendation: “In light of the recent Court decision striking down a portion of the District law that banned guns and the problem of easy access to guns, the District should incorporate education on gun safety into health programs in the DC Public School system. The education should emphasize the dangers of possessing guns as well as the need to utilize safety devices and practices when handling or exposed to firearms.”

DCPS’ response, which can be found on page 14 of the attached July 2009 report, stated: “The health standards, adopted by the DC Board of Education in 2007, included gun safety. DCPS is currently updating its health curriculum pacing guides, with a focus on priority health topics including safety.”

**Information Requested:**

1. A copy of the updated health curriculum pacing guides indicating a focus on priority health topics including a focus on gun safety.

DCPS notes that its standards and curricular resources generally do not point to specific topics such as gun safety, but instead focus on themes or skills – such as “safety,” “self-management,” “decision making,” and “conflict resolution” – that apply across all content areas of health education. The concepts taught also include bullying, how to respond in threatening situations; and, in standards 4.5.3 and 5.3.3, what to do in the event a student encounters a “weapon.”

The recommendation’s specific language that the “education should emphasize the dangers of possessing guns as well as the need to utilize safety devices and practices when handling or exposed to firearms” is misapplied to its audience. DCPS personnel are neither trained nor certified to instruct students in handling or utilizing firearms, nor are those things a requirement of the standard.

2. Copies of the health curriculum pacing guides in place prior to July 2008.

DCPS does address gun safety in our current curricular scope and sequence documents. It is addressed in our DC health standards, which are attached and identify health skills related to gun safety. DCPS had not been able to develop safety units until the last few years. Currently, DCPS conducts revisions to the curriculum each summer.

DCPS has a website informing the public and its community about student safety, available here: https://dcps.dc.gov/page/school-safe. MPD has a webpage devoted to informative and helpful resources on the topic of school violence and safety available here: https://mpdc.dc.gov/page/school-safety-resources.

3. If the health curriculum pacing guides have not been updated, an explanation as to why.

Not applicable.

Department of Health Care Finance

Board Recommendation:

July 2009 Recommendation: “Department of Health (DOH) and Department of Health Care Finance (DHCF) should work in collaboration with the District Hospital Association to improve city-wide standards for discharge planning to ensure that when a patient is ready for release and needs supportive care, the hospital discharge plan includes an assessment of a caretaker’s ability to provide the patient with appropriate care in a safe environment and linkage with appropriate referrals as needed.”

DHCF’s response stated that: “Department of Health Care Finance agrees with the recommendation for the development of improved standards and assessment tools for
hospital discharge planning throughout the District that includes not only an assessment of the patient’s continued medical, function, and social support needs after hospital discharge, but also an assessment of the entire family unit, caretaker challenges, and home environment to ensure continuity of care for the patient as well as social well-being and safety in the home environment. Care coordination of a family member can be a very challenging process for spouses or any family member(s). Hospital discharge planning must focus on the entire spectrum of the patient’s environment.”

Information Requested:

1. Written documentation to support implementation of the improved or revised standards and assessment hospital discharge planning throughout the District.

DHCF instituted a new assessment process for individuals needing community-based supports and services including those being discharged from a hospital in 2013. The rules supporting the assessment process are posted here.

In addition, to promote timely and effective community transitions, DHCF established protocols for hospital discharge planners. The protocol, known as a “Pathway,” is reproduced below.

Pathway for Hospital discharges into the community

- The discharge planner seeks a discharge on behalf of the beneficiary, and submits a Prescription Order Form (POF) to the Long-Term Care Services and Supports (LTCSS) Contractor. The POF will indicate the request for Personal Care Aides (PCA) services in section iii under (d) – Reason for request.
- Please Note- New beneficiaries seeking PCA services will not have an existing Level of Care (LOC) determination sheet and assessment. The LTCSS Contractor will only need to conduct a new assessment if the current assessment is older than ten months.
- If the nurse contractor cannot make contact with the beneficiary after three attempts, then they must send them an Administrative Denial Notice 1 and Admin. Denial Notice 2, if applicable. If the nurse makes contact with the beneficiary, they will conduct the assessment.
- The nurse contractor: (1) conducts the assessment with the beneficiary; (2) administers the beneficiary freedom of choice form to select the Home Care Agencies (HCA), and (3) populates the LOC determination sheet with new information within 48 hours of receipt of the complete request.
- Once a HCA provider accepts a case, the LTCSS Contractor must submit the LOC determination sheet to Qualis to issue a PA#, and Qualis will subsequently create the PA#, and notify the contractor of the PA#.
- The LTCSS Contractors will complete their assigned case by: (1) mailing the beneficiary, the POF prescribing clinician and hospital discharge planner an approval or denial legal notice (Approval of State Plan PCA hours which includes the PA#).
DHCF also is working to improve discharge planning by promoting Health Information Exchange (HIE). In 2014, via a grant funded by DHCF, the District’s six participating hospitals connected to the Chesapeake Regional Information System for our Patients (CRISP) and began exchanging discharge information with other providers and care managers in the region via the Encounter Notification Service (ENS). CRISP uses the ENS to deliver notifications regarding inpatient, emergency, outpatient, and long-term care visits to its network of providers in the District. This information is matched at the centralized CRISP repository, and alerts are delivered to providers based on matching the ENS messages against subscriber lists developed by providers and health plans. A practice can also customize the ENS alerts for specific groups of providers or care management programs. While the HIE services do not explicitly create a standard for data on discharge planning, there is potential to use these tools to collaborate with District providers and develop new HIE services that can support discharge and follow-up among primary and specialty care in the community, as well as alerts for social service providers with whom an individual has an established relationship (e.g. supportive housing provider; social worker). Today, eight acute care hospitals in the District are connected to CRISP. These data include standardized information on admissions, discharges, transfers, lab results, radiology reports, and other clinical documents, such as discharge summaries.

Finally, DHCF has incorporated a standardized, national performance measure on follow-up after hospitalization for mental illness as part of our pay-for-performance programs with the Federally-Qualified Health Centers, and the My Health GPS Health Home program. This measure creates an incentive for partners across the District’s health system to respond to alerts provided in by the HIE tools, and to follow-up with patients with whom the provider has an established relationship.

2. A copy of the standards and assessment tools in place prior to DVFRB’s recommendation in 2009.

Current DHCF personnel do not have knowledge of the standards or tools in place prior to DVFRB’s 2009 recommendation and have not been able to locate copies.

3. If the DHCF has not developed written improved or revised standards and assessment tools for hospital discharge planning, an explanation as to why.

Not applicable. The discharge planning protocol was revised in 2013.
July 2009 Board Recommendation: “Office of Unified Communications (OUC) which handles the District’s 9-1-1 calls should reevaluate the quality measures that it currently has in place regarding call-taker performance. If there are no quality measures for call-takers, OUC should develop and implement standards to address who, what, when, and how questions, with respect to obtaining accurate information from 911 callers are posed, and to ensure that 911 callers receive appropriate instructions during an emergency call. OUC supervisors should randomly listen to the performance of call-takers to determine the quality of service that is being provided, the need for individual training, as well as the need for overall staff training. OUC should reinforce protocols to ensure DV first responder safety by immediately publishing an “Alert-Bulletin” and re-train dispatchers against sending a civilian (911 callers) into a domestic violence situation.”

OUC’s response, found on page 13 of the attached report, stated: “The OUC has an internal quality assurance program in which all supervisors are required to monitor calls daily. Supervisors complete a daily monitoring report. The results are evaluated to determine if additional training and coaching is needed, and if so if it is individual training or group training. Monitoring results are also used for employee recognition. The OUC Transcriptions Department which maintains all 911 radio and call recordings also serves as a quality assurance program. As the calls are requested they are also monitored for training and coaching purposes. Training is provided for employee groups either during scheduled training sessions or daily roll calls. Individual sessions are scheduled based on the need. The OUC works cooperatively with the organization Women Empowered Against Violence, Inc. (WEAVE) in providing annual domestic violence training. The last training dates were September 25th and 26th, 2008.”

Information Requested:

Over the past several years, OUC leadership has gone through several transitions. Specifically, there have been five directors and interim directors since 2009. Along with these transitions, there have been changes in the leadership team and agency practices. There have also been developments in the 911 and emergency response field, which have necessitated changes in the way OUC functions.

In January 2016, Karima Holmes was appointed as the fifth director. At that time, she spearheaded a comprehensive assessment of OUC’s operations and set into motion several initiatives to cultivate the agency into a leading Public Safety Answering Point and customer service contact center.

Additionally, one of OUC’s newest initiatives includes a partnership with OVSJG to reach out directly to domestic violence victims. In FY2017, OUC implemented text to 911, a feature that allows persons who cannot make a voice call, such as someone who is the victim of a crime and the perpetrator is still in the area, as in the case of a domestic violence incident, to connect with
public safety resources. OUC continues to work with OVSJG and other public safety partners to monitor and develop ways to increase collaboration and improve public safety outcomes.

1. Written policies and procedures detailing the quality assurance program cited in your response above.

One of the major findings during the operations assessment, spearheaded by Director Holmes, was the need for a quality assurance and quality control program, along with formalized and intensive training for new and tenured employees. In 2016, OUC created the Office of Professional Standards and Development (OPSD), which was established by the Fiscal Year 2017 Budget Support Emergency Act of 2016. OPSD helped transition agency operations from substandard performance to improved strength in call processing and dispatch through uniform training and quality assurance.

Prior to the implementation of OUC’s new call taking protocol (discussed in more detail as a response to Inquiry No. 3), the agency used the Priority Dispatch system. Attached please find a Police Dispatch Case Evaluation Record template that was used with the former system. The quality assurance program for the newly implemented call taking software is currently in the development stages, as managers and OPSD staff work on proficiency and determining the most effective measures for assuring quality. The new quality assurance measures will be completed and implemented next month, in July 2018.

2. Copies of daily monitoring reports for the last quarter.

As part of OUC’s ongoing operations assessment, Director Holmes and her team solicited input from supervisors on the daily call monitoring process. OUC’s watch commanders and assistant watch commanders serve an important function on the operations floor, providing real time direction and feedback to call takers and dispatchers who may be experiencing challenges on the call floor. This has been of particular importance since the agency implemented new call taking protocols this year, which are detailed in response to Inquiry No. 3 below. OUC operations managers determined that while monitoring calls is still mandatory, providing real time feedback would be the highest priority during this transition period to ensure proficiency with the new system. If an employee is experiencing a challenge that requires a more robust intervention than onsite coaching, the watch commander or assistant watch commander will contact OPSD, which will design an appropriate training and document the employee’s progress. This may include class instruction, field exercises, and/or chair-side training with a Certified Training Officer (CTO), which is a colleague who has been selected to serve as a mentor/coach for other employees.

The completion of all training and coaching for the new call taking protocol is projected to be completed by the end of this quarter. At that time, supervisors will begin a more formalized call monitoring process, which will include a revised daily monitoring report. In the meantime,
attached please find the 2018 SMART goals for all watch commanders and assistant watch commanders on the operations floor, which details the call monitoring and performance feedback requirements.

3. Copies of current training materials, and any retained documentation of trainings held since FY 2009 to present.

Since the establishment of OPSD, OUC has instituted a full cross-training/unified curriculum for all new 911 dispatchers, reinforcing their ability to adeptly deploy response plans and manage units for police, fire and emergency medical service events. The curriculum and training are coordinated with industry associations and partner agencies to ensure OUC employees receive knowledge and develop expertise in the latest developments in the field. Provision and possible publication of third party training materials could violate those providers’ intellectual property rights.

In FY16, OUC staff participated in over 30,000 hours of specialized training. This past year, OUC overhauled the 911 infrastructure, including executing Criteria-Based Dispatch (CBD), a new call taking protocol that allows our call takers to flow through pertinent questions, while aligning the incident more properly with our partner agencies’ responses. The implementation of this new protocol this past quarter along with other trainings, has increased OUC’s training hours to over 103,000 since April 2016.

In addition to CBD, new call takers and dispatchers complete a comprehensive 16-week training program. One of the responsibilities of OPSD is to document trainings and certifications. To that end, OUC has documentation of training hours and trainings schedules from FY2016 to date for specific individuals. These include lists which contain personal identifiable information for OUC attendees. OUC can provide these specific lists upon request to the audit team, after conducting a privilege and redaction review.

Department of Behavioral Health:

Board Recommendation:

July 2007 Board Recommendation 1. “Office of Victim Services (OVS) in collaboration with the Departments of Health (DOH) and Mental Health (DMH) should work with domestic violence programs to develop and implement a city-wide public education campaign to broaden the community’s knowledge of the cycle of domestic violence; symptoms of abuse, including emotional and verbal; lethality risk indicators; reporting methods; and services/resources available in the community.” Recommendation 1 was reissued in the attached July 2008 report; see page 10.
July 2007 Board Recommendation 2. “OVS in collaboration with DOH and DMH should advocate for professional training for service providers and others involved with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services and resources available in the community. The training should minimally focus on the cycle of domestic violence; lethality risk indicators; protection orders; legal, social, mental health and other community-based resources that are available to this population; significance of risk assessments, early intervention strategies and safety plans for victims and their families.”

Information Requested:

1. Documentation of the implementation of a city-wide public education campaign to broaden the community’s knowledge of the cycle of domestic violence; symptoms of abuse, including emotional and verbal; lethality risk indicators; reporting methods; and services/resources available in the community.

Please refer to our response in question 3.

2. Documentation of professional training for service providers and others involved with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services.

Please refer to our response in question 3.

3. If the education campaign and professional trainings have not occurred, please provide an explanation as to why.

The Department of Mental Health no longer exists, and robust responses to the above questions have been provided by OVSJG, to which the recommendations were primarily directed.

However, DBH notes that in the decade since these recommendations, and in particular in the past few years, DBH has taken shape as a new agency with a transformed organizational structure, staffing, and operations. DBH consulted with units and current and veteran staff in the agency who would likely have any program information or personal knowledge of these recommendations from a decade ago. No DBH unit or staff have any recollection of the recommendations or what may or may not have taken place at that time. The earliest record DBH has of its participation on the DVFRB is from February 2016, when it appointed a representative to the Board. Unfortunately, that representative has since passed away, and her supervisors are no longer with the agency. The current DBH representative, who was appointed May 2017, has no knowledge of the recommendations.
DBH provides behavioral health services to approximately 30,000 adults, youth, children and their families per year. As part of its effort to improve quality of care, it continues to expand current and begin new evidence-based practices. In this fiscal year, DBH introduced Child Parent Psychotherapy for Family Violence (CPP-FV) to the public behavioral health network. While family violence takes many forms, it can include domestic violence. DBH has trained DBH child clinicians and three providers, is building referral pathways, has established a special and higher rate for CPP-FV, and is now actually providing CPP-FV. During the past few months, more than 50 children and their families have begun receiving CPP-FV, and DBH will work to expand over time the benefits of this evidence-based practice to more who need it.

**Office of Aging:**

**Board Recommendation:**

*July 2009 Board Recommendation:* “The Office on Aging (OOA) should provide ongoing information to educate the community about the broad range of services that are available to the elderly and methods of accessing services.*

**Information Requested:**

*We are asking that you provide written documentation demonstrates evidence that OOA has provided ongoing information to educate the community about the broad range of services that are available to the elderly and methods of accessing services. If this information has not been provided to educate the community, an explanation as to why.*

DCOA continues to utilize various media to promote programs and services, including publications such as the Senior Beacon, The Informer, The Current Newspapers and quarterly radio spots on the SeniorZone (1340am). Starting in FY18, all staff at the agency participate in at least four hours of community outreach each quarter, which has increased DCOA’s ability to participate in and host regular Senior Health and Wellness Fairs at places of worship, senior apartments, recreation sites, hospitals, and even the DC Jail.

Further, DCOA is expanding its Ambassador program to include ongoing community training on DCOA programs, as well as quarterly workshops covering a variety of issues that are important to seniors. Through proactive and ongoing engagement with Ambassadors, DCOA seeks to leverage these relationships to bring greater awareness to DCOA services and supports through effective word-of-mouth marketing. DCOA continues to expand its public awareness efforts through information sessions, presentations and outreach events in all eight wards and will continue to partner with sister agencies on community outreach opportunities.
Moreover, OVSJG funds the Network for Victim Recovery of DC’s Training and Response for Older Victims (DC TROV) Project. Launched by NVRDC in January of 2014 to strengthen cross-organizational collaboration and more effectively support victims of elder abuse in the District, the project’s start-up phases were supported by a three-year grant from the U.S. Department of Justice Office Against Violence on Women (OVW). In FY16, OVSJG granted the project funds to continue its outreach and coordinated community response goals past the period in which the federal funds would support these activities. This project encompasses three areas: training, outreach, and service collaboration and includes three related goals: increase the ability of victim service providers to assist older survivors of physical abuse, neglect and financial exploitation in the District through the provision of training and support; continue to increase the number of victims of elder abuse who are able to locate supportive advocacy, case management, assistance with safety planning, counseling, shelter, and legal assistance; and increase the number of older victims served by DC TROV partner agencies. The project will facilitate training events in which providers and other community leaders learn to improve assistance to survivors of elder abuse, utilize local resources, and promote collaboration and communication; provide increased opportunities for senior survivors to access information, assist providers in creating spaces which are welcoming and inclusive of senior survivors, create an Elder Abuse Response Team component dedicated to collaborating on elder abuse cases, continue coordination of DC TROV, and coordinate an Equal Justice Works Fellow that will serve as a legal service provider between Legal Counsel for the Elderly and NVRDC. OVSJG has continued to fund TROV in fiscal years 17 and 18.

Executive Office of the Mayor:

Board Recommendation:

July 2009 Board Recommendation: “The Mayor, should issue an Order declaring that the District is dedicated to the prevention and elimination of domestic violence, sexual assault and stalking. The District has a zero-tolerance policy for domestic violence, sexual assault and stalking at the workplace and will take appropriate disciplinary action and/or criminal prosecution against any employee or non-employee who commits such act in a District government office, facility, work-site, and vehicle or while conducting District business. All District agencies should be directed to establish such policies in writing and the policy elements should include: 1) definitions; 2) statement that using work time or workplace facilities to commit or threaten to commit these acts are cause for discipline up to and including dismissal; 3) a statement that all acts, regardless of whether they occur in or near the workplace, may be caused for discipline and may be considered as part of the employee’s work history; 4) information indicating where victims and abusers can go for assistance; 5) guidance regarding training for managers and employees, and 6) direction that employers are responsible for making reasonable efforts to promote the safety of all employees. This information must be disseminated and accessible to all employees.” The
response from the EOM, provided on page 14 of the attached report, stated that the EOM was “…currently addressing this recommendation.”

Information Requested:

We are asking that you provide a response indicating whether the Mayor’s Order 2017-313 (Sexual Harassment Policy, Guidance and Procedures) meets the goals of the recommendation calling for the Mayor to “…issue an Order declaring that the District is dedicated to the prevention and elimination of domestic violence, sexual assault, and stalking…”

Mayor’s Order 2017-313 provides robust guidance and a statement of values relating to sexual harassment, which can include both sexual assault and stalking. While Mayor’s Order 2017-313 does not explicitly address domestic violence, it does modernize previous guidelines and reaffirm and make clear the District’s zero-tolerance policy for sexual harassment.

Additionally, Mayor Bowser has directed the Department of Human Resources to finalize a District-wide policy on Prevention of Domestic Violence and an Anti-Bullying Policy. DCHR is participating in anti-bullying training in early September along with several agencies and will explore additional options for training District employees in the fall.

Department of Health:

Board Recommendations:

July 2007 Board Recommendation: 1. “Office of Victim Services (OVS) in collaboration with the Departments of Health (DOH) and Mental Health (DMH) should work with domestic violence programs to develop and implement a city-wide public education campaign to broaden the community’s knowledge of the cycle of domestic violence; symptoms of abuse, including emotional and verbal; lethality risk indicators; reporting methods; and services/resources available in the community.” Recommendation 1 was reissued in the attached July 2008 report; see page 10.

2. “OVS in collaboration with DOH and DMH should advocate for professional training for service providers and others involved with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services and resources available in the community. The training should minimally focus on the cycle of domestic violence; lethality risk indicators; protection orders; legal, social, mental health and other community-based resources that are available to this population; significance of risk assessments, early intervention strategies and safety plans for victims and their families.”
July 2009 Board Recommendation: “Department of Health (DOH) and Department of Health Care Finance (DHCF) should work in collaboration with the District Hospital Association to improve city-wide standards for discharge planning to ensure that when a patient is ready for release and needs supportive care, the hospital discharge plan includes an assessment of a caretaker’s ability to provide the patient with appropriate care in a safe environment and linkage with appropriate referrals as needed.”

Information Requested:

1. Documentation of the implementation of a city-wide public education campaign to broaden the community’s knowledge of the cycle of domestic violence; symptoms of abuse, including emotional and verbal; lethality risk indicators; reporting methods; and services/resources available in the community.

The July 2007 Board Recommendation was primarily directed to OVSJG, which has provided robust responses above. DC Health additionally provides the below responses.

Education to raise awareness of different types of violence, including domestic violence, as well as skills-building to prevent and mitigate the effects of violence has been primarily conducted in classroom settings. DC Health staff as well as educational staff have been trained in evidence-based curricula about healthy relationships. These age-appropriate curricula have been delivered to school-age children from K-12 grades since 2011. Education has also been provided to adult residents through partnerships with the Department of Employment Services and the DC Jail.

2. Documentation of professional training for service providers and others involved with the immigrant community (including the religious community) to increase their general awareness of domestic violence and services.

DC Health recognizes the lasting impact domestic violence can have on families, developing fetuses and children. As a result, since 2011, all home visitors have received training on the warning signs of domestic violence. Home visitors serve families living in higher-risk neighborhoods, including immigrant communities. The original scope of the training was to ensure the following:

- Prioritize the safety and well-being of caregiver and their children by addressing barriers that affect safety planning;
- Educate all caregivers about healthy relationships and the concept of consent;
- Ensure that the caregiver has access to services that provide for his/her safety needs;
- Ensure home visitor safety; and,
- Training on the abusive behavior inventory screening tool.
In recent years, home visiting providers have partnered with the District of Columbia Coalition Against Domestic Violence to ensure that home visitors complete the Domestic Violence Advocate Core Competency (DVACC) training course which covers the following modules:

- Dynamics of Domestic Violence
  - Self-Care
  - Civil and Criminal Court Processes
  - Safety Planning
  - Cultural Awareness
  - Trauma
  - Crisis Intervention
  - Risk Assessment and
  - Local Resources

The DVACC training equips home visitors with the knowledge of the cycle of violence and how to successfully intervene to prevent child abuse, neglect and domestic violence.

Additionally, from the Executive Office of the Mayor, Mayor Muriel Bowser, through the Immigrant Justice Legal Services Fund, has supported the work of a dozen community-based organizations directly, and more indirectly through partnerships. These organizations have held numerous Know Your Rights events, provided brief legal consults, referrals to pro bono counsel, and provided full direct legal services to immigrants seeking to file VAWA petitions or asylum claims based on domestic violence. Moreover, MPD, working with various offices within the Mayor’s Office of Community Affairs, and the Executive Office of the Mayor, has also hosted or participated in a number of community events aimed at immigrant audiences where the point is reiterated time and again that people should call MPD to report crimes against them; that as a sanctuary city, MPD will not ask about someone’s immigration status; and that if someone’s legal status is contingent on a relationship with an abuser, they should know that the Violence Against Women Act protects their ability to stay here and leave a situation where they are endangered by domestic violence. The Mayor herself speaks out often to immigrant communities urging them to take advantage of city services and to welcome them to report crimes and be active in solving crimes – including domestic violence without fear.

3. If the education campaign and professional trainings have not occurred, please provide an explanation as to why.

Not applicable.

4. Written documentation to support implementation of the improved or revised standards and assessment hospital discharge planning throughout the District.
The Deputy Mayor for Health and Human Services published a Discharge Planning Manual in 2017, which is available here.

5. A copy of the standards and assessment tools in place prior to DVFRB’s recommendation in 2009.

As mentioned in the above letter, the administration did not focus on obtaining documentation from almost a decade ago in response to the audit team’s request. However, the above information focuses on the actions that DC Health and other agencies have taken since and in the current administration.

6. If the DOH has not developed written improved or revised standards and assessment tools for hospital discharge planning, an explanation as to why.

Not applicable, see response to question 4.
To: Kathleen Patterson  
District of Columbia Auditor, Office of the District of Columbia Auditor  

From: James D. Berry  
Acting Director, CSOSA  

Date: June 20, 2018  

SUBJECT: CSOSA DVFRB Recommendation Implementation Status  

In response to your letter dated June 7, 2018 concerning the subject above-referenced, I have attached the following documents for your information and review: (a) CSS Operational Instruction 4100-01 -- Auto Screener and (b) the training agenda that has been used to educate CSOSA’s supervision staff on domestic violence issues administered by “Survivors and Advocates for Empowerment” (DC SAFE). The Auto Screener is used to elicit data from everyone who is placed under CSOSA’s supervision. Where domestic violence is admitted to or suspected in the life of one of our clients, the recommendation of a referral or multiple referrals for appropriate interventions automatically is included in the Prescriptive Supervision Plan (PSP) that substantially informs the interaction between our probation and parole officers and each of our clients in the supervision process. In addition, we recruited the services of DC SAFE to train our supervision staff (including Branch Chiefs, Supervisory Community Supervision Officers, and Community Supervision Officers).

AUTO SCREENER  

As outlined in CSS OI 4100-01 and indicated above, all offenders beginning supervision with CSOSA require that an initial Auto Screener be completed within 37 calendar days of their supervision start date. Upon completion of the Auto Screener, CSOSA’s Supervision and Automated Record Tracking (SMART) system automatically creates a Prescriptive Supervision Plan (PSP) for the client based on information obtained during the assessment. The PSP is updated every 180 days, based on reassessments.

The Auto Screener assesses offenders across seven domains, one of which is “Victimization.” The following questions are included in the “Victimization” domain:

(1) As an adult, have you been a victim of Sexual Assault, Violent Crime, Property Crime, Physical Abuse, Psychological Abuse? (Check all that apply.)

(2) Do you believe you are currently in danger of being victimized?

(3) Have you ever been a victim of physical domestic violence?
Have you ever been a victim of psychological domestic violence?

Have you ever been a victim of sexual domestic violence?

I certify that all items have been reviewed and are up-to-date.

If the offender answers the “Do you believe you are currently in danger of being victimized?” question in the affirmative, a “Discuss Victimization Concerns” PSP plan item is auto-populated and must be addressed by the Community Supervision Officer (CSO). In order to move beyond this PSP item, the CSO must send a SMART Alert to CSOSA’s Victims Services Program (VSP). Upon receiving the SMART Alert, VSP staff have three business days to make contact with the client, gather initial information, and offer a temporary safety plan. Within two business days of initial contact, VSP staff will schedule a face-to-face appointment with the client to complete program intake, develop a long-term safety plan, and submit external referrals for emergency services.

IN SERVICE TRAINING

Since 2015, CSOSA has used DC SAFE to provide “Domestic Violence Training” to its supervision staff. Notably, all supervision staff were trained by DC SAFE in 2015. This training was then incorporated into the Basic Skills Academy curriculum developed for new Community Supervision Officers (CSO) in 2016. CSOSA has not had a CSO Academy since this time, but we will continue to include domestic violence training as an integral part of our curriculum for future Academies. In short, all of our incumbent supervision officers have received training in domestic violence from DC SAFE.

In direct response to your initial inquiry, CSOSA did not develop an OI that exclusively focused on domestic violence as a “victimization” issue, essentially, because we are of the view that our Auto Screener OI and the in-service training to which we have and will continue to expose our supervision staff, adequately addresses the issues of concern to DVFRB. In this regard, I hope you find this information responsive to the items of interest that you identified in your letter. If you require additional information from us to complete your evaluation, please don’t hesitate to let me know.

Cc: Cedric Hendricks, Acting Deputy Director, CSOSA
    Marcus Hodges, Associate Director, CSOSA
    Masooma Hussain, Analyst-in-Charge, Office of the District of Columbia Auditor

Attached: CSS OI 4100-01 Auto Screener
           DC SAFE Training Outline

JDB/ac
OPERATIONAL INSTRUCTION

Auto Screener

I. COVERAGE

This operational instruction is intended to provide guidance on the appropriate process by which to assess a client’s risks and needs levels in order to develop an effective community supervision strategy. This guidance is applicable to Community Supervision Officers (CSOs), Supervisory Community Supervision Officers (SCSOs) and Branch Chiefs (BCs).

II. BACKGROUND

In accordance with the Agency’s Strategic Objective 1.1 - Risk and Needs Assessments, the Community Supervision Services, (CSS) program assesses risk and needs in a timely and effective manner to determine appropriate levels of supervision and the need for treatment and/or support services. CSOSA has developed a comprehensive assessment-screening instrument, called the Auto Screener, to assist with this effort. Using the Auto Screener, the CSO collects client information in twelve different functional areas. The computerized assessment tool then automatically generates a risk level and a Prescriptive Supervision Plan (PSP) designed to address the client’s needs.

III. GUIDANCE

A. Frequency

1. Initial Auto Screener

   a. Initial Auto Screener assessments shall be conducted by a CSO on all active cases (except for those listed in Section A.3 below) and approved by an SCSO within thirty-seven (37) calendar days of client intake or the client’s supervision period start date, whichever is later. If an initial screener was completed during the Pre Sentence Investigation (PSI) or Transitional Intervention for Parole Supervision (TIPS) processes within the one hundred eighty (180) days leading up to supervision, then an initial Auto screener is not required.

   i. The CSO has 35 calendar days to submit the Auto Screener to the SCSO;
ii. The SCSO (or Branch Chief) has up until the 37th calendar day to approve or deny the Auto Screener.

b. The designated CSO must complete an initial Auto Screener for clients placed in a Re-entry Sanctions Center (RSC) within thirty-five (35) calendar days of assignment to the CSO or prior to discharge.

c. Diagnostic CSOs must complete an initial Auto Screener during the PSI process within seven (7) weeks and two (2) days (51 calendar days) of case assignment to the CSO, or by the expedited due date requested by the Court.

d. No initial and/or reassessments instruments are to be given to the client.

2. Reassessment Auto Screener

a. A reassessment shall be conducted on all active cases (except for minimum risk level cases and those listed in Section A.3 below) and shall be approved by an SCSO at intervals no greater than one hundred eighty (180) calendar days throughout the period of supervision.

b. A reassessment shall be conducted on all active cases and approved by an SCSO within seven (7) calendar days of a significant life event (e.g., death of a family member or close friend, job loss, drug relapse, etc) and/or a rearrest.

c. A reassessment shall not be conducted if the client has 180 days or less remaining on supervision.

d. The employee conducting the reassessment may request an override of the generated risk level.

e. No initial and/or reassessments instruments are to be given to the client.

3. Exceptions for Initial and Reassessment Auto Screeners

If a client falls under the following type of case or case status, a CSO is not required to conduct an Auto Screener assessment for the client:

- Active- Alleged Violation Report (AVR) Submitted Decision Pending (Loss of Contact (LOC));
- Monitored;
- Warrant;
- Active Loss of Contact (LOC); and
- Active Kiosk.
Clients in these statuses are generally not available or are not required to answer questions necessary to complete the Auto Screener assessment. Once they move to or enter an Active status the CSO shall complete an Auto Screener assessment within thirty five (35) calendar days.

a. Clients Assigned to a Young Adult Team
The Initial Auto Screener assessment shall be conducted within fourteen (14) calendar days of intake or the client’s supervision start date, whichever one is later.

IV. AUTHORITIES, SUPERSEDURES, REFERENCES, AND ATTACHMENTS

A. Authorities.


B. Operational Instruction Supersedures.

CSS Operations Manual, Chapter V

C. Procedural and Other References

D. Attachments

Appendix A – General Procedures
Appendix A
General Procedures

A. Gathering Information

CSOs are encouraged to begin planning and establishing internal timelines for completing the initial Auto Screener assessment immediately upon assignment of the client. The Auto Screener provides staff the flexibility to start the screener, save work already entered into the system, collect additional information, and return to the Auto Screener to add new information or modify information that had been entered during a previous session. CSOs can change data up until the time the client’s score is calculated. This method of conducting the Auto Screener allows staff to enter information as it is obtained.

For initial assessments, the responses to some of the questions will pre-populate from Supervision and Management Automated Record Tracking (SMART) system data. For reassessments, the responses will either pre-populate from SMART data or from previous responses. CSOs must make sure all of the data is as accurate as possible.

CSOs should not wait until the Auto Screener assessment is complete to address risks and/or needs that are uncovered during the information gathering and assessment process, especially if the client needs emergency stabilization (e.g., housing, safety, food, mental/emotional, physical health needs) or public safety is at risk. Once a risk or need is identified, the CSO should implement the appropriate intervention or make a referral as soon as possible.

1. Sources of Information
   If needed, the CSO shall obtain a release of information (ROI) from the client to assist with the collection of information from various sources.

   a. The Client
      The CSO must use the client as a primary source of information for the Auto Screener. Information can be gathered from the client through the use of cognitive behavioral interventions (CBI) and motivational interviewing (MI) techniques must be verified by the CSO, to the greatest extent possible, through official documents and databases, collateral contacts, and existing Agency records.

   b. Official Documents
      The information used for the screener should be verified against all official documents and the CSO should judge which information is correct.

   c. Official Databases
      The CSO shall use the following databases/resources to complete the criminal history section of the Auto Screener:
• National Crime Information Center (NCIC)/Washington Area Law Enforcement System (WALES)
• Justice Information System (JUSTIS)
• Interstate Identification Index (III)
• Justice Automated Command Center System (JACCS)
• PSI/TIPS Investigations
• Previously populated SMART information

2. Special Considerations by Auto Screener Section
   While the client will be the primary source of information for the Auto Screener, the CSO shall use the assessment period to attempt to verify the information provided through the use of official sources, documents, and databases.

   a. Education
      The CSO shall obtain from the client his or her education information but not limited to the following:
      • Official school records
      • Transcripts
      • Collateral contacts
      • Diploma
      • School ID (current)

   b. Community
      The CSO shall obtain from the client community contacts information and attempt to confirm the information using but not limited to any of the following:
      • Collateral contacts
      • PSI/TIPS Investigations

   c. Residence
      The CSO shall obtain from the client residence information and attempt to confirm the information using but not limited to the following:
      • Home visit

   d. Employment/Unemployment
      The CSO shall obtain from the client employment information and attempt to confirm the information using but not limited to the following:
      • Year-to-date gross earnings statement from employer
      • Social security statement of earnings or Supplemental security income - SSI
e. Criminal History
The CSO shall run a criminal history record check in order to complete the Criminal History section of the assessment. If information is available regarding the client’s juvenile or out of state criminal history, the CSO may enter this information as well.

i. Types of Arrests or Convictions
The CSO shall categorize every charge/offense/count (for both arrests and convictions) found during the criminal history check into one of the arrest/conviction type categories provided in SMART. If CSOs are unsure of which arrest or conviction category a charge/offense/count falls under, he or she should consult their SCSO for guidance.

ii. Arrest/Conviction Questions
For each charge/offense/count, the CSO shall answer the following questions:
- Age at First Arrest – The client’s age at their first arrest for that specific charge/offense/count category
- Number of Arrests – The number of arrests for that specific charge/offense/count category
- Number of Convictions – The number of convictions for that charge/offense/count category
- Number of Arrests in the Past Six (6) Months – The number of arrests for that charge/offense/count category in the past six (6) months
- Is this arrest/conviction the current (instant) offense – Is this the arrest/conviction the client is currently under supervision for (Yes/No)?

f. Victimization
The CSO shall obtain from the client whether he/she has been a victim of a crime and attempt to confirm the information using but not limited to the following:

- Collateral contacts
- PSI/TIPS Investigations
- Bureau of Prisons (BOP) records
- Treatment records
- Client

**g. Supervision**
The CSO shall obtain from the client his or her supervision information and attempt to confirm the information using, but not limited to, the following:

- SMART (previous supervision periods)
- BOP Records

**h. Substance Use/Abuse**
The CSO shall obtain from the client his or her substance use/abuse information and attempt to confirm the information using, but not limited to, the following:

- Collateral contacts
- PSI/TIPS Investigations
- Treatment records
- SMART (previous supervision periods)

**i. Behavioral Health**
The CSO shall obtain from the client mental/behavioral health information and attempt to confirm the information, using, but not limited to, the following:

- Collateral contacts
- PSI/TIPS Investigations
- Medical/behavioral health records
- Treatment records
- Prescription information
- Health insurance documentation

**j. Physical Health**
The CSO shall obtain from the client physical health information and attempt to confirm this information using, but not limited to, the following:

- Collateral contacts
- PSI/TIPS Investigations
- Medical health records
- Prescription information
k. Leisure
The CSO shall engage the client and attempt to confirm the leisure information using but not limited to the following tools:
- Collateral contacts
- Memberships/Affiliations

l. Attitude
The CSO shall observe the client’s behavior and disposition throughout the 35 calendar days during the assessment period in order to complete this section. This section is not to be conducted as an interview with the client.

m. Comment Boxes
There are comment boxes after each section of the Auto Screener. CSOs shall use the comment boxes to note information relevant to the subject area that cannot be captured through the close-ended questions.

B. Review and Approval Process

1. Once a CSO completes an Auto Screener assessment, an automatic e-mail showing that the assessment is completed will be sent to the SCSO.

2. All completed Auto Screener Assessments must be reviewed and/or acted upon by an SCSO or Branch Chief. Once received, an SCSO can decide to either:

   a. Reset the Auto Screener and request that the CSO make changes (this must be done before approval or dissaproval of the CSOs recommended supervision level). Resets are to be used to fill in missing information and to correct inaccuracies. The SCSO must enter the reason for the reset as well as describe what the CSO must do to correct the issue. Once the SCSO hits the Reset Completed Screener button, the system will remove the current recommended supervision levels and allow the CSO to edit the document. All resets and reasons for a request to reset will be tracked by the Office of Research and Evaluation (ORE).

   b. Approve the supervision level as determined by the Auto screener. If the CSO is requesting an override of the supervision level computed by the Auto Screener, a SCSO must confirm that the rationale for granting an override is
based on risk\(^1\) (client poses a different level of risk) and based on information not already collected by the Auto Screener (e.g., law enforcement intelligence, observed behavior reported by collateral contacts).

c. Disapprove the supervision level as determined by the Auto screener. Disapprovals of the CSOs recommended supervision level when it matches the Auto Screener's recommended level should be extremely rare. The SCSOs rationale must be based on risk\(^2\) (client poses a different level of risk) and based on information not already collected by the Auto Screener (e.g., law enforcement intelligence, observed behavior reported by collateral contacts).

d. The Auto Screener will be considered complete (for CSO staff performance appraisal audit purposes) once the CSO submits it to his or her supervisor for approval. The date of the Auto Screener will be the date the SCSO (or Branch Chief) approves/disapproves the supervision level. The Auto Screener will be considered complete (for SCSO and Agency performance purposes) on the date the SCSO (or Branch Chief) approves the result.

If a CSO is out on scheduled or unscheduled leave during the Auto Screener due date, the SCSO must ensure the Auto Screener is completed and approved by the due date. If leave is scheduled, the CSO must be sure to inform the SCSO of all Auto Screeners due on that date. If leave is unscheduled, the SCSO must access the CSOs upcoming Auto Screeners using the Proactive Dashboard in Microstrategy. If the SCSO is out on scheduled or unscheduled leave, the Branch Chief must ensure the Auto Screener is completed and approved by the due date. If leave is scheduled, the SCSO must be sure to inform the Branch Chief of all Auto screeners due on that date. If leave is unscheduled, the Branch Chief must access the SCSOs upcoming Auto Screeners using the Proactive Dashboard in Microstrategy.

C. The Prescriptive Supervision Plan

Upon completion and approval of an initial or reassessment Auto Screener, SMART will automatically create a Prescriptive Supervision Plan (PSP) for the client, based on information obtained during the assessment.

1. Creating the Prescriptive Supervision Plan (PSP)
   
   a. Upon selecting "Plan" from the Auto Screener Details screen, the CSO will see a list of plan items, origins, needs, status and update information for the client that were

\(^1\) Risk is based on the client's probability of rearrest for a violent, weapons or sex offense within the next twelve (12) months.
\(^2\) Risk is based on the client’s probability of rearrest for a violent, weapons or sex offense within the next twelve (12) months.
identified through the screener assessment. In addition to auto-generating certain items, SMART will pull any incomplete and/or open PSP plan items from the last or latest PSP into the new PSP.

b. The CSO can prioritize, override (with the SCSO’s approval), and/or add items to the PSP. For each plan item that the CSO chooses for a client to complete, a target date, comments, and a status can be added to the plan. The status should be updated on a regular basis as it is intended to capture the life cycle of the plan item (e.g., not started, started, completed, etc). Once the plan items are reviewed, the CSO must save the plan items and then print the PSP.

c. The CSO must give the PSP to the SCSO for approval and signature.

d. The PSP then is reviewed with the client, who is to sign and date the PSP. The PSP then is signed and dated by the CSO.

c. The CSO shall share only the PSP with the client. No initial and/or reassessments instruments are to be given to the client.

2. Maintaining the PSP

   a. The PSP should be periodically updated to add, move, revise and/or reprioritize plan items. PSP should also be updated to reflect the status.
CSOSA/SAFE Training Outline

1. DC SAFE Definition
2. Definitions of Domestic Violence
   a. Intra Family Offense Definition
3. Power and Control
4. Predominate Aggressor Analysis
5. Risk Assessment and Safety Planning
   a. Activity (staying vs leaving)

5 min break

6. Lethality Assessment
   a. Activity (Spectrum of Risk)
7. Lethality Assessment Program
   a. Activity (LAP alert response)

Question and Answer Section
About ODCA

The mission of the Office of the District of Columbia Auditor (ODCA) is to support the Council of the District of Columbia by making sound recommendations that improve the effectiveness, efficiency, and accountability of the District government.

To fulfill our mission, we conduct performance audits, non-audit reviews, and revenue certifications. The residents of the District of Columbia are one of our primary customers and we strive to keep the residents of the District of Columbia informed on how their government is operating and how their tax money is being spent.

Office of the District of Columbia Auditor
717 14th Street N.W.
Suite 900
Washington, DC 20005
Call us: 202-727-3600
Email us: odca.mail@dc.gov
Tweet us: https://twitter.com/ODCA_DC
Visit us: www.dcauditor.org

Information presented here is the intellectual property of the Office of the District of Columbia Auditor and is copyright protected. We invite the sharing of this report, but ask that you credit ODCA with authorship when any information, findings, or recommendations are used. Thank you.