

Confidential Solano County Domestic Violence Death Review Case Review Form (Penal Code 11163 et seq)

IDENTIFYING INFORMATION

I. Decedent Identification

1. Decedent's name: (First, M. Last) / /		2. Date of Birth (mm/dd/yyyy)		3. Date of Death (mm/dd/yyyy)	
4. County of Death	5. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	7. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single		8. Place of residence <input type="checkbox"/> House/Apt. <input type="checkbox"/> Shelter <input type="checkbox"/> Friend's house <input type="checkbox"/> Family's house <input type="checkbox"/> Other:	
	6. Age, years:				
9. Residence County	10. Zip code	11. Race/Ethnicity (check all that apply) <input type="checkbox"/> African Am <input type="checkbox"/> Asian: <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other:			

II. Assigned Identification Number: DVDRT - -

DVDRT-Number sequence of cases reviewed (e.g., 1, 2, etc) –Year

III. Reasons Why Case Was Assigned to Death Review Team

Why was this case referred to DVDRT? Was this death a result of domestic violence or was there a history of domestic violence?

CAUSE AND CIRCUMSTANCES OF DEATH

IV. General Information

1. Cause of death from death certificate or autopsy report		2. Autopsy Performed? Autopsy Number: <input type="checkbox"/> Yes full <input type="checkbox"/> Yes partial: <input type="checkbox"/> No <input type="checkbox"/> Pictures Reviewed	
3a. Other significant contributing conditions to death: 3b. Were weapons (gun, knife, blunt object, rope, etc) used? 3c. Place where DV incident occurred?			
4. Place of Death: <input type="checkbox"/> Decedent's home <input type="checkbox"/> Relative's home (which relative?) <input type="checkbox"/> Friend's home <input type="checkbox"/> Shelter: _____ <input type="checkbox"/> Workplace: _____ <input type="checkbox"/> Suspect's home: _____ <input type="checkbox"/> Hospital: _____ <input type="checkbox"/> Other:			
5. Did decedent have children? <input type="checkbox"/> Yes, names and ages: <input type="checkbox"/> No		6. Were children present at time of death? <input type="checkbox"/> Yes, describe circumstances: Children were <input type="checkbox"/> Decedent's <input type="checkbox"/> Suspects <input type="checkbox"/> Relatives <input type="checkbox"/> Friends <input type="checkbox"/> Strangers <input type="checkbox"/> No children were present	
7. Were services offered to the children post death? <input type="checkbox"/> Yes, explain: <input type="checkbox"/> No		8. Where are children currently residing? <input type="checkbox"/> Father <input type="checkbox"/> Foster care <input type="checkbox"/> Kinship care (which relative) <input type="checkbox"/> Unknown <input type="checkbox"/> Other:	
9. Custody of children <input type="checkbox"/> Decedent had full custody <input type="checkbox"/> Shared custody, define: <input type="checkbox"/> No custody order in place		10. Visitation <input type="checkbox"/> Supervised, describe frequency and location of supervision: <input type="checkbox"/> Unsupervised, describe frequency:	
11. Where were children residing at the time of the lethal incident?			

V. Narrative summary of cause and circumstances of death

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DEATH INVESTIGATION INFORMATION

VI. Decedent's Medical/Mental Health Information

<p>1. Was decedent pregnant at time of death? <input type="checkbox"/> Yes, number of weeks of gestation <input type="checkbox"/> No</p>	<p>2. Decedent's pregnancy history: <input type="checkbox"/> None <input type="checkbox"/> Yes, decedent had _____ pregnancies <input type="checkbox"/> Decedent had _____ number of live births <input type="checkbox"/> The following children were fathered by the suspect: Name: _____ <input type="checkbox"/> Complications during pregnancy <input type="checkbox"/> Low birth weight <input type="checkbox"/> Premature birth <input type="checkbox"/> Other:</p> <p>Name: _____ <input type="checkbox"/> Complications during pregnancy <input type="checkbox"/> Low birth weight <input type="checkbox"/> Premature birth <input type="checkbox"/> Other:</p> <p>Name: _____ <input type="checkbox"/> Complications during pregnancy <input type="checkbox"/> Low birth weight <input type="checkbox"/> Premature birth <input type="checkbox"/> Other:</p> <p>Name: _____ <input type="checkbox"/> Complications during pregnancy <input type="checkbox"/> Low birth weight <input type="checkbox"/> Premature birth <input type="checkbox"/> Other:</p>										
<p>3. Was the decedent battered during pregnancy? <input type="checkbox"/> Yes, explain: <input type="checkbox"/> No</p>											
<p>4. Were there other injuries sustained by the decedent other than those that caused the death? <input type="checkbox"/> Yes, explain: <input type="checkbox"/> No</p>											
<p>5. Was decedent sexually assaulted during fatal assault? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>6. Other life problems for Decedent</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Hx of Alcohol Abuse</td> <td><input type="checkbox"/> Hx of Mental Illness</td> </tr> <tr> <td><input type="checkbox"/> Hx of Drug Abuse:</td> <td><input type="checkbox"/> Hx of Depression</td> </tr> <tr> <td><input type="checkbox"/> Hx of Suicidal ideation/actions</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Hx of DV in previous relationships</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other:</td> <td></td> </tr> </table>	<input type="checkbox"/> Hx of Alcohol Abuse	<input type="checkbox"/> Hx of Mental Illness	<input type="checkbox"/> Hx of Drug Abuse:	<input type="checkbox"/> Hx of Depression	<input type="checkbox"/> Hx of Suicidal ideation/actions		<input type="checkbox"/> Hx of DV in previous relationships		<input type="checkbox"/> Other:	
<input type="checkbox"/> Hx of Alcohol Abuse	<input type="checkbox"/> Hx of Mental Illness										
<input type="checkbox"/> Hx of Drug Abuse:	<input type="checkbox"/> Hx of Depression										
<input type="checkbox"/> Hx of Suicidal ideation/actions											
<input type="checkbox"/> Hx of DV in previous relationships											
<input type="checkbox"/> Other:											
<p>7. Describe Decedent's contact with health professionals during the 6 months prior to death: <input type="checkbox"/> Physician: <input type="checkbox"/> ER: <input type="checkbox"/> Case Manager: <input type="checkbox"/> Other: What was the nature of the contact?</p>											

VII. Decedent's Relationship to Suspect

<p>1. Decedent's relationship to suspect? <input type="checkbox"/> Spouse <input type="checkbox"/> Former spouse <input type="checkbox"/> Boyfriend/girlfriend <input type="checkbox"/> Former boyfriend/girlfriend <input type="checkbox"/> Co-habitants <input type="checkbox"/> Former co-habitants <input type="checkbox"/> Share children in common <input type="checkbox"/> Child <input type="checkbox"/> Parent</p>	<p>2. Was Decedent leaving or attempting to leave relationship? <input type="checkbox"/> Yes, describe: <input type="checkbox"/> No</p>
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VIII. Alleged Perpetrator Information (if applicable)

1. Name of Alleged Perpetrator: (First, M. Last) / / AKA's:		2. Age	3. Additional Suspects:
4. Gender of Alleged Abuser <input type="checkbox"/> Male <input type="checkbox"/> Female		5. Race/Ethnicity (check all that apply) <input type="checkbox"/> African Am <input type="checkbox"/> Asian: <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other:	
6. Relationship of alleged abuser with Decedent: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Boyfriend <input type="checkbox"/> Girlfriend <input type="checkbox"/> Wife <input type="checkbox"/> Sibling <input type="checkbox"/> Husband <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend/Acquaintance <input type="checkbox"/> Same sex partner <input type="checkbox"/> Other:		7. Describe circumstances and length of relationship:	
Additional Details:			
8. Did Alleged Abuser Display Risk Behaviors? <input type="checkbox"/> Hx of DV/Intimate Partner Violence against decedent <input type="checkbox"/> Hx of DV/Intimate Partner Violence in prior relationships <input type="checkbox"/> Hx of CPS reports against decedent <input type="checkbox"/> Hx of CPS reports against suspect <input type="checkbox"/> Hx of APS reports against suspect <input type="checkbox"/> Cruelty to animals <input type="checkbox"/> Criminal history <input type="checkbox"/> Alcohol problem/abuse <input type="checkbox"/> Drug problem/abuse <input type="checkbox"/> Mental health problems <input type="checkbox"/> Financial problems <input type="checkbox"/> Unemployment <input type="checkbox"/> Other:		9. Did alleged abuser gain financially from Decedent's death? <input type="checkbox"/> Yes, describe: <input type="checkbox"/> No	
		10. Was there a protective order in place between Decedent and alleged perpetrator? If so what type? <input type="checkbox"/> No, explain: <input type="checkbox"/> Emergency Protective Order, Jurisdiction <input type="checkbox"/> Temporary Restraining Order, Jurisdiction <input type="checkbox"/> Criminal Restraining Order, Jurisdiction <input type="checkbox"/> No contact order, Jurisdiction <input type="checkbox"/> Military Protection Order, Jurisdiction Who was covered under the protective/restraining order?	
11. Type of abuse suspected: <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Stalking <input type="checkbox"/> Isolation <input type="checkbox"/> Threats, explain: <input type="checkbox"/> Other:			
12. Narrative summary of type of abuse suspected:			

IX. Decedent's Contact with Domestic Violence Advocates/Shelter

Name of Shelter/Agency:	
1. Number of referrals regarding Decedent:	2. Date of first referral/contact (mm/yy):
3. Describe what led to referral(s):	
4. Describe actions taken by Advocate/Shelter:	

X. Decedent's Contact with Other Support Services

Name of Agency/Department:	
1. Number of referrals regarding Decedent:	2. Date of first referral (mm/yy): Additional referral dates:
3. Describe what led to the referral(s):	
4. Describe actions taken by service provider:	

XI. Decedent’s Contact with Emergency Medical Services (EMS)

Name of Agency/Department:	
1. Number of EMS contacts regarding Decedent:	2. Date of first EMS contact (mm/yy): Additional contact dates:
3. Describe what led to EMS contact(s):	
4. Describe actions taken by EMS:	

XII. Decedent’s Contact with Law Enforcement

Name of Agency/Department:	
1. Number of police contacts regarding Perpetrator: Or Decedent:	2. Date of first police contact (mm/yy): Report #:
3. Additional Police contacts/report #:	
3. Describe what led to police contact(s):	
4. Describe actions taken by police:	

XIII. Decedent’s Contact with Other Agency (DA, Victim Witness, etc)

Name of Agency/Department:	
1. Number of contacts regarding Decedent:	2. Date of first contact (mm/yy): Additional contact dates:
3. Describe what precipitated the contact(s):	
4. Describe actions taken:	

XIV. Brief Summary of Case

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CONCLUSIONS AND RECOMMENDATIONS FROM TEAM REVIEW

XV. Conclusions

1. Team members present for case: <input type="checkbox"/> DA <input type="checkbox"/> City Attorney <input type="checkbox"/> Victim Witness <input type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner <input type="checkbox"/> EMS <input type="checkbox"/> APS <input type="checkbox"/> Police <input type="checkbox"/> Social Worker <input type="checkbox"/> CPS <input type="checkbox"/> Probation <input type="checkbox"/> Courts <input type="checkbox"/> Others:	
2. Was death a result of domestic violence? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear Explain:	3. Did abuse directly contribute to Decedent’s death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear Explain:

XVI. Recommendations and Preventive Actions

1. Did Team Review recommend additional investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	1a. If Yes, explain:
2. Were policy or practice issues raised? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	2a. If Yes, explain:
3. Were system issues raised? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	3a. If Yes, explain:
4. Describe recommendations or prevention activities proposed by the team?	
5. What changes, if any, have been made as a result of this Case Review? ? (Please update later if new information becomes available)	

Case Presented by:

Date:

