Suggested Guidelines for Advocates Participating in Domestic Violence Fatality Reviews

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Against Domestic Violence

March 2005

ACKNOWLEDGEMENTS

Thanks to Barbara Hart, Sue Julian and Jacquelyn Hauser, who all provided comments on earlier drafts. Their incisive comments improved the paper immeasurably. Thanks to Kelly Starr for help with refining the ideas presented here, as well as to Christine Olah for her careful proofreading.

This project was supported by Grant No. 2003-WT-BX-K015 awarded by the Violence Against Women Office, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

The Washington State Coalition Against Domestic Violence

is a statewide non-profit organization committed to ending domestic violence through advocacy and action for social change.

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By Margaret Hobart, Washington State Coalition Against Domestic Violence

Introduction

Advocates contemplating participation in fatality review teams should carefully consider both the contributions they can make to the process of discovery and system change and the constraints on participation based in fundamental advocacy guidelines and practice. Because of the diversity in how domestic violence fatality reviews are structured, the laws and rules that govern them, the states and regions where they take place, and the roles advocates take within them, it is not possible to propose a single protocol for the role of advocates in fatality reviews across the nation. Wherever a fatality review exists, though, and however it is structured, advocates must decide whether and how to participate. This protocol, therefore, is intended as a tool for thinking through that participation, given local purpose, composition, processes and structures.

We hope this paper will be useful to advocates as they consider participation in local reviews, and to other team members on fatality review teams as well, as they work with the advocates in their community.

This paper offers six basic guidelines for advocate participation in fatality reviews. It may serve as a starting point for the domestic violence program in devising a role and negotiating an agreement with the fatality review team for participation in individual reviews and (ideally) as an ongoing partner on a team.

In discussion of the six basic guidelines for advocates, this paper addresses enabling legislation, guidelines for disclosure and protection of confidential information, the focus and goals of reviews, with particular emphasis on the potential contributions and roles of domestic violence advocates in review panels.

Six Guidelines for Advocates on Domestic Violence Fatality Reviews

1. Domestic violence advocates should offer the review panel education on the complexities of battered women's experiences.
2. Advocates should follow ethical, contractual, regulatory, common law and statutory state or federal confidentiality requirements when participating in review panels.
3. Advocates may choose to implement an "In the Event of my Death" release policy in domestic violence programs in order to facilitate information sharing in reviews.
4. Advocates should participate fully in a systems analysis of their program.
5. Even if state law, a governor's executive order or a legally binding release enables sharing of otherwise confidential information, advocates should share information only as the program determines that it is reliable, relevant to the fatality review investigation and does not compromise the interests of the domestic violence victim or innocent family survivors.
6. Advocates should fully participate in formulating the findings and recommendations of the fatality review team.

1. Domestic violence advocates should offer the review panel education on the complexities of battered women's experiences.

Of all the people likely to sit on a review panel, the people who have consistently had the most wide-ranging, candid conversations with battered women are battered women's advocates. Generally, police, prosecutors, medical professionals, TANF workers and others who encounter battered women do not have time to hear all the details of battered women's stories; they need to focus on the current incident or the information necessary to take action at the moment. Advocates, in the course of safety planning, answering the hotline, sharing meals, facilitating groups, seeking resources

for and providing support to women, are likely to hear women's stories in greater length and detail, and thus have a fuller sense of the struggles women in their community face with police, courts, housing, healthcare and other systems.

Advocates can often offer important insights into the complexities and nuances of how batterers function to control their partners; batterers' sense of entitlement to their partners' bodies, minds and time; and how batterers make "rules" for their partners which influence how battered women perceive their choices.

Advocates can inform the team about attempts to seek help by battered women, about the deficits in community resources typically identified as essential for safety and security, about the cost/benefit analyses that battered women undertake in deciding to comply with or resist the demands of batterers, return to batterers or permanently separate from them.

Even when advocates have not had contact with the specific victim or cannot reveal those contacts, their specialized knowledge can help place the specific facts of the homicide or suicide being examined in the context of typical community response to domestic violence. When relevant, advocates should provide the panel with information on common problems women like the domestic violence victim in the particular case encounter, or their understanding of how domestic violence victims typically perceive particular interventions. For example, if the review panel is looking at a case in which the battered woman was arrested for "assaulting" her abuser, the advocate can discuss, in her experience, what battered women say after they have found themselves arrested for assault when they called the police for help, and how being arrested for domestic violence might affect victims' perceptions of the criminal legal system. Advocates may also be able to speak to how intimidating or welcoming a protection order court is, or the consistency with which other organizations follow their policies for intervening in domestic violence, based on reports from domestic violence victims and their own observations while advocating for battered women in those systems.

Because advocates play such a critically important role in the success of fatality reviews, domestic violence programs should staff fatality reviews with advocates who are

comfortable speaking in groups, have the capacity to maintain a calm and non-judgmental stance even when they disagree or are providing information someone lacks, and can make connections between their work with individual battered women and larger policy questions.

2. Advocates should follow ethical, contractual, regulatory, common law and statutory state or federal confidentiality requirements when participating in review panels.

Legal backdrop for decision-making about advocate participation

Advocates participating in fatality reviews must make decisions about revealing information about domestic violence victims who have used their programs against the backdrop of ethical, contractual, regulatory, common law or statutory protections for advocate/victim communications.

Battered women's advocates are subject to federal and state provisions with regard to confidentiality. (For a summary of federal provisions, please see Appendix A.) These frequently do not specify whether the obligation to protect victim confidentiality continues after the death of the victim. Moreover, advocates often resist requests to open their records or break confidentiality because they are acutely aware of:

- Battered women's desire to keep their experience of domestic violence confidential.
- The risk that any disclosure will encourage prosecutors, defense counsel or civil attorneys to seek to compel discovery of the contents of the program's records and testimony of domestic violence advocates.
- The ethical commitment that their records will not be used against battered women in court, the media, or other contexts.

Legal considerations and legal cultures

Legal "cultures" vary from state to state with regard to confidentiality practices. Some domestic violence fatality reviews have been built on a shared assumption that

professionals will reveal information to each other that would otherwise be confidential, even if legislation does not exist that protects the discussion of fatality review teams from disclosure. In other states, professionals are much more cautious about using their discretion to share confidential information, even if the meeting in which sharing takes place is itself confidential.

Fatality review teams have several options for facilitating communication and information sharing:

1. Pursue legislation or a governor's decree that allows sharing of confidential information governed by the state (this would not affect confidential information made so by federal law – substance abuse treatment records, for example).
2. Seek releases of information from relatives or victims themselves for the purposes of fatality reviews (see section on "In the Event of My Death" releases below).
3. Conduct reviews that do not require breaches of confidential information, by advocates or anyone else. (For help with this, see the discussion of system analysis in our June 2004 paper, *Advocates and Fatality Reviews,* available at www.wscadv.org.)
4. Identify the circumstances when otherwise confidential information can be shared. Some laws allow sharing of information for research purposes, as long as individual identifiers are purged in reporting on the data.

Advocates who have privileged communication vs. advocates who do not

Advocates who fight to keep records from disclosure in civil and criminal cases cannot be expected to freely share records in domestic violence fatality reviews and are understandably reluctant to support legislation that would open their records to fatality review.

In Washington State, the lack of an advocate/client privilege has led domestic violence agencies to adopt protective policies and minimal record keeping. Advocates in Washington were concerned that if they came into fatality reviews with detailed

information on individual cases, prosecutors might wonder why that type of information is not available for criminal trials and begin to seek it more aggressively. They also did not want to set a precedent for breaching confidentiality protections many believe are too weak.

Advocates in states in which advocate/client communications are privileged may feel less concerned about the consequences of revealing the level of depth or detail contained in their program records. Thus, they may be more open to legislation allowing sharing confidential information, as the stakes are different. Still, these advocates should not breach confidentiality requirements in the absence of a release, legislation or governor's decree.

3. Advocates may choose to implement an "In the Event of My Death" release policy in domestic violence programs.

In Washington, some programs ask women using in-person services to sign an "In the Event of My Death" release. This simple release has a few checkboxes on it listing entities and people to whom the program may release information about their stay (e.g., the police, a family member, the fatality review panel). See a sample "In the Event of My Death" release and model policy for implementation in Appendix B.

Implementing such a release must be weighed against the possible arguments against them:

1. If not discussed sensitively, battered women may feel cajoled or coerced into signing the release.
2. The release is potentially one of many pieces of paper given to women when they are highly stressed, in a hurry or in crisis; they may not have the time, inclination or ability to consider it carefully.
3. Women may be discouraged by the release, or feel it represents a routinized response to the danger they face and fear they experience.

4. The release process asks a woman to entertain the possibility of her death, but does not offer any other resources she may need in such a circumstance, such as creating a will or stating her wishes regarding her children's placement.

On the other hand, women may feel validated by the acknowledgment of the possibility of their murder, which for many is their worst fear.[1]

Ask victims/survivors what they think

We encourage advocates struggling with this issue to go directly to survivors utilizing domestic violence programs and ask them how they might feel about "In the Event of My Death" releases. In Washington, we conferred with support groups in several domestic violence programs before encouraging programs to consider implementation of these releases. It takes just a small portion of group time to explain the concept, show women the form and get their thoughts on it. We also received feedback from survivors serving on our board of directors and in our survivors' caucus.

What became clear in these conversations was that women using program services did not realize that domestic violence programs' commitment to confidentiality would carry on past their deaths, and they were surprised to know that domestic violence programs would not notify the police that they had been abused if they were murdered, or (for example) call their mother to arrange to transfer their property if they were killed while staying in shelter. Advocates who have worked with the releases have reported that when they are discussed thoughtfully, victims find them validating of the danger they are in, and make a variety of choices about who may be made aware of their contact with the domestic violence program after their death.

Our model policy for use of "In the Event of my Death" releases suggests that the information saved should be limited, and that discretion be used to ensure that

[1] Homicide threats are frequently part of abusers' tactics to control their partners. When the Washington State Coalition Against Domestic Violence examined over 600 protection orders to identify the incidence of homicide threats, we found that about a third of the petitioners mentioned homicide threats, suggesting that many victims fear being killed.

information provided by the domestic violence program does not contribute to victim blaming.

4. Whether or not they are able to share confidential information, advocates should participate fully in a *systems analysis* of their program.

Do advocates "play by the same rules" as other panel members?

When representatives of various agencies are revealing information about their agency's contacts with the victim or perpetrator in a review, and advocates clearly refuse to reveal such information, tensions can arise on a fatality review panel. Other panel members may expect that advocates be held to the same standard with regard to revealing information in the review process. Panel members may feel that a refusal to reveal service delivery (or lack of) to a victim allows the domestic violence program to avoid the examination and critique their agency is undergoing.

This is a legitimate concern. Like the police, social service agencies and medical providers, domestic violence programs have rules, policies, employee training and protocols, even professional norms. Like other institutions, domestic violence programs' standards and protocols may not be followed consistently, or always enhance safety for battered women. It is exactly these aspects of institutions, including domestic violence programs, which should be subject to critical analysis within fatality reviews.

System analysis

The goal of a Domestic Violence Fatality Review (DVFR) project is to engage in a multidisciplinary in-depth review of the domestic violence victim's and perpetrator's lives prior to the domestic violence fatality, and to think through how they were affected by institutional and community responses. This generally entails a close examination of prior contacts with legal and social service systems in order to identify gaps, problems, barriers to service and accountability.

In examining institutional contacts, panel members should ask, "Is this institution structured such that it could meaningfully provide assistance to the domestic violence victim or hold the domestic violence perpetrator accountable? What affected the ability of this institution to respond appropriately, or even to be perceived as a resource by this victim and perpetrator – and other people in similar circumstances?"

All review panel members should ask each other hard (but not accusatory) questions in order to deepen analysis of why institutions functioned as they did. Asking these questions through the detailed examination of individual lives gives the opportunity to examine how the resources in a community respond to people in particular situations, (e.g., limited English proficiency, women with criminal histories, drug-involved abusers).

While fatality reviews look through the lens of a particular victim's and perpetrator's lives, the focus of the examination should be on the institution, and its ability to serve people similarly situated to the victim or perpetrator. (See the section "Beyond Counting Cases: Examining the Context of Domestic Violence Fatalities" in the author's June 2004 paper *Advocates and Fatality Reviews* for a more general discussion of this topic area.)

Participating without revealing confidential information

Even without revealing confidential information, domestic violence programs *can* engage in examination of their agency's structure and practices, particularly with regard to people similar to the victim and abuser in the case before the review panel. Without confirming or denying that a woman accessed services, domestic violence program representatives can provide information about the degree to which their services could have met the victim's needs.

For example, if the victim in the examined case was drug-involved and had a warrant history of her own for drug- and prostitution-related crimes, the panel can ask the domestic violence program:

- How would they serve a hypothetical woman with similar issues?
- Does the program routinely ask women about unresolved warrants?

- Do advocates in the program have an understanding of how warrants can be a barrier to accessing helping resources?
- Does the program staff know how to advocate for women to get their warrants resolved (without going to jail)?
- Does the program have contacts with attorneys or court staff who can help assess options and problem solve when women have warrants?
- Does the program serve drug-involved women?
- Do policies result in most drug-involved women being asked to leave the program?

All of these policy and procedure questions can be asked in the context of the review without compromising confidentiality. If the program was not equipped to serve drug-involved women, it is not necessary to know if the victim actually contacted the program to understand how her choices were limited and the barriers she faced to getting help. System analysis can reveal a great deal in terms of the challenges particular groups of domestic violence victims face in accessing help.

If the victim did not have contact with the domestic violence program

No potential helping resource should be "off the hook" at a fatality review when records reveal a lack of contact with the organization. The review provides the opportunity to examine why the person in such need did not have the information to obtain services that might have helped them. Lack of contact may signal institutional shortcomings and the need for further examination.

The DVFR should begin from the premise that the battered woman did the best she could (to end the abuse, protect herself, protect her children, function within society). Lack of contact or intervention must be understood as failures of society and various systems to reach out, inform, engage, provide resources and otherwise assist and protect her, not a failure of the battered woman to locate and access community

services and protection. Identifying those system/society failings is the work of the panel.

5. **Even if state law, a governor's executive order or a legally binding release enables sharing of otherwise confidential information, advocates should share information only as the program determines that it is reliable, relevant to the fatality review investigation and does not compromise the interests of the domestic violence victim or innocent family survivors.**

Do no harm

Even with a release or legislative permission to reveal information to the DVFR, advocates should exercise discretion on release of information consistent with the purposes of the Fatality Review project. The DVFR should not focus on the victim's perceived flaws and failings, or degenerate into victim blaming. (See the author's *Advocates and Fatality Reviews* paper for more discussion on how over-emphasis on the victim's choices and victim blaming can impair review panels and make them less effective at achieving their goals.) The domestic violence program's records should not fuel victim blaming in a review.

Depending on program practices, domestic violence program records, especially shelter records, may differ significantly from other agencies' records. The records associated with a 30-day stay in a program with 24-hour staffing may exceed in both volume and intimacy those of doctor's visits or police interactions. However, shelter records do not predictably include commentary and notes that are relevant to fatality reviews. While domestic violence programs vary in their record-keeping norms, records generally should not contain judgments, venting, observations or opinions of advocates, diagnoses, verbatim statements of victims or any subjective comments of program staff. However, this standard is not always achieved. For this reason, advocates should exercise discretion regarding what information is released from records,

ensuring that information that is released is reliable, relevant and does not compromise the interests of the domestic violence victim or innocent family survivors.[2]

In most cases, the following must *not* be shared with a review panel, as it is not critical to accomplishing the goals of Domestic Violence Fatality Review:

- "Venting" by advocates, expressions of frustration or judgments regarding the battered woman.
- "Diagnoses" of mental health conditions (e.g., depression, manic, borderline).
- Domestic violence program staff critiques of parenting or histories of parenting problems.

Advocates may decide to reveal limited information when releases or legislation allows

As a general rule, the information shared by advocates should be detailed enough to illuminate the challenges or barriers faced by the victim, but not so detailed that the panel becomes focused on the psychology of the battered woman instead of shortfalls in agency or community response.

Some useful information may be:

- Dates of contact and services provided.
- Needs the victim identified (e.g., safe housing, legal representation, high-quality and affordable childcare).
- Challenges, barriers and problems identified by the victim as she sought to end the abuser's control of her life and choices (e.g., untimely and inadequate response from police, lack of subsidized housing, lack of family support).

Battered women's shelters should reveal if a woman was asked to leave for rule infractions, *for the purpose of re-examining the rule structure,* not condemning the

[2] Good record-keeping practices can alleviate some of the concerns associated with sharing records. WSCADV has developed a model protocol for record-keeping, which can be downloaded for free at www.wscadv.org/Resources/index.htm.

victim or affirming the impossibility of helping her. For advocates, as well as others, difficulty in serving a particular person may cause providers to deliver inferior service to the "difficult" victim. Inferior service delivery can place victims at heightened risk of homicide and should be seen as *institutional* failures, not failures of the victim.[3] Domestic violence programs should be willing to examine:

- Rationale for and application of program rules
- Quality and relevance of educational tools and support groups
- Safety planning
- Strategies for supporting battered women as they engage with other agencies in efforts to obtain safety and security for themselves and their children

6. Advocates should be closely involved in formulating findings and recommendations.

Ideally, advocates should participate fully or even lead all aspects of a Domestic Violence Fatality Review project: formation of the review panel, creation of the data collection instrument, recruitment of the panels, identifying cases for review, conducting the reviews themselves, analysis and synthesis of findings, creation of recommendations and publicizing results.

In considering proposed recommendations, advocates should bring their broad knowledge of numerous battered women's experiences to the table to think through potential unintended consequences of proposed "solutions" for domestic violence victims.

[3] *Any* time a domestic violence program becomes aware that someone who has used their services has been murdered or committed suicide, engaging in a process of self-examination is good practice, whether or not a fatality review project exists in their area.

Appendix A:

Federal Confidentiality Requirements Affecting Domestic Violence Programs

Federal Confidentiality Requirements Affecting Domestic Violence Programs[4]

Federal Funding Statutes Require Domestic Violence Program Confidentiality

Funding programs from the U.S. Department of Health and Human Services (HHS), the U.S. Department of Justice (DOJ) and the U.S. Department of Housing and Urban Development (HUD) attach statutory and regulatory requirements to recipients of funding which compel domestic violence programs to maintain confidentiality of program participants.

For example, some grant programs authorized by federal law—the Family Violence Prevention and Services Act (FVPSA), the Victim Compensation and Assistance Program (part of the Victims of Crime Act of 1984) (VOCA) and the Emergency Shelter Grants Program (ESP)—include statutory or regulatory language which require a domestic violence program, as a condition of funding, to have policies and procedures which will assure that confidentiality of served individuals will be maintained.

1. *Family Violence Prevention and Services Act (FVPSA) (42 U.S.C. 10402(a)(2)(E)):*

   (E) [Grant recipients must] provide documentation that procedures have **been developed and implemented, including copies of the policies and procedure, to assure the confidentiality of records pertaining to any individual provided family violence prevention or treatment services by any program assisted under this chapter** and provide assurances that the address or location of any shelter-facility assisted under this chapter will, except with written authorization of the person or persons responsible for the operation of such shelter, not be made public. [emphasis added]

2. *Victim of Crime Act (VOCA) (42 U.S.C. 10601-10604)*

   Domestic violence programs which are granted funds under VOCA are required to follow 42 U.S.C. 10604(d) and (e), which specifically prohibit recipients of money under VOCA from revealing any information about a program participant that could be identified as any specific private person. Also, this information is immune from legal process in all proceedings. Violations of these provisions can result in suspension of funding.

3. *Homeless Assistance, Emergency Shelter Grants (42 U.S.C. 11375(c)(5)):*

   (c) Certifications on use of assistance. Each [grant] recipient shall certify to the Secretary that—

[4] From *Model Protocol on Confidentiality when Working with Battered Women,* Washington State Coalition Against Domestic Violence, May 2003 (available at www.wscadv.org/resources/index.htm).

(5) it will develop and implement procedures ***to ensure the confidentiality of records pertaining to any individual provided family violence prevention or treatment services*** under any project assisted under this subtitle and that the address or location of any family violence shelter project assisted under this subtitle will, except with written authorization of the person or persons responsible for the operation of such shelter, not be made public. [emphasis added]

Congress has made clear that it has expectations of confidentiality and privacy for battered women.

In the Violence Against Women Act, Congress ordered the Attorney General to evaluate the necessary nature and extent of confidentiality provisions and develop model legislation to protect confidentiality [42 U.S.C. 13942 (2000)].

The Department of Justice report, which resulted from 42 U.S.C. 13942, analyzes the justification for keeping confidential the communications between domestic violence counselors and battered women. The report concludes that "there are persuasive policy arguments supporting the protection of victim counselor/victim communications."[5]

Congress ordered the Department of Justice to investigate confidentiality laws and to make recommendations "which will provide the maximum protection possible for the confidentiality of [battered woman/counselor] communications." This order indicates Congress' expectation that confidentiality will be preserved.

[5] *Report to Congress: The Confidentiality of Communications Between Sexual Assault or Domestic Violence Victims and Their Counselors, Findings and Model Legislation*, U.S. Department of Justice, December 1995, at 16.

Appendix B:

Sample "In the Event of My Death" Release and Model Policy

Washington State Domestic Violence Fatality Review

Permission for Release of Information in the Event of My Death

Battering can result in death. Over a third of women who are murdered in Washington State are killed by their current or former intimate partners. Abusers sometimes kill family members and children as part of their efforts to gain power and control over their intimate partners.

I understand that signing this release is completely voluntary and will not affect my ability to receive services from [program].
In the event of my death, I authorize [program] to release information in their files about me and my children to (please check):

- ❑ The police and prosecutor

  Please be aware that information released to the police or prosecutor may become public information and be accessible to the media.

- ❑ A family member:

  name:_____phone:_____

- ❑ A friend:

  name:_____phone:_____

- ❑ The Domestic Violence Fatality Review

  The Washington State Domestic Violence Fatality Review Project reviews cases in which domestic violence results in death. The purpose of the Domestic Violence Fatality Review Project is to help other battered women by increasing safety for victims and accountability for perpetrators of domestic violence by identifying gaps in services and accountability structures, and formulating recommendations for policies, services and resources to fill those gaps. The Project also seeks to identify patterns in domestic violence-related fatalities and make recommendations to improve domestic violence interventions.

I do not intend the limited waiver of my rights described above to operate as a general waiver of confidentiality. I understand I can revoke this release with a written request.

_____ _____
Signature Date

_____
Printed Name

_____ _____
Witness Signature Date

_____
Printed Name

Model Policy Regarding Confidentiality in the Event of a Client's Death and the Domestic Violence Fatality Review Project

Each woman receiving services from the agency will be informed of her rights with regard to confidentiality and the limits of confidentiality, and that the agency's confidentiality policy remains in effect in the event of her death.

1. In the Event of My Death Release

A. Advocates will discuss the possible lethal nature of domestic violence with each woman and her wishes regarding confidentiality and sharing of records in the event of her death.

1) This discussion should include clarification that the program will not reveal that she had used the program's services to anyone (e.g., family, police, prosecutor) if she is murdered, unless required to do so by law or directed to do so by the client.

2) Each client will be informed that she can specify whether or not she would like information about her contact with the program released to the Domestic Violence Fatality Review, her family, or criminal justice authorities by signing the "Permission for Release of Information in the Event of My Death" release. No woman should be pressured to agree to release her records to the Fatality Review or any other person or entity.

3) While releases of information for the purposes of advocacy and coordinated service delivery should "expire" in a set period of time, the "In the Event of My Death" releases should <u>not</u> include an "expiration date." However, women should be informed of their right to revoke this release by a written request to the agency.

4) Agency will keep the "In the Event of My Death" release with the client's file.

2. When a Client Dies

A. An agency may find out about the death of a client several ways:

1) Staff and volunteers may hear about the death from the client's children, friends or family.

2) Staff and volunteers may read/hear about it in the news media.

3) The Domestic Violence Fatality Review may periodically send out lists of women involved in domestic violence fatalities and ask programs to search records to see if any of these women were served by the program.

4) Program staff may participate in a domestic violence fatality review panel and find out about the death through this participation.

B. When the program realizes that a client the program has served has died, a designated member of the staff will search out that client's file in order to find out if she had signed an "In the Event of My Death" release. If the client had signed a release, the program will follow the requests set forth in that release.

C. If the client requested that records be made available to the Domestic Violence Fatality Review, the program will keep a copy of the release information and send the original release to the Domestic Violence Fatality Review. (Do <u>not</u> send the client file.)

D. Caution should be exercised in releasing information to criminal justice authorities, since that information can become public information. Programs should refrain from turning over all

records and use discretion in deciding what to share. Some considerations are: Is the information recorded here consistently respectful and non-judgmental in language choice? Is there information here about surviving family members (such as the victim's children) which should remain confidential? Could this information be used to support defense arguments or blame the victim?

E. Programs may wish to define parameters on what they will share with police, prosecutors, family members and fatality review panels. Some suggestions are: dates of contacts, types of services used, victim's reports of prior violence and threats to kill, victim's identification of needs and barriers to ending violence.

3. Participation in the Washington State Domestic Violence Fatality Review

A. Programs will be asked to send representatives to a Domestic Violence Fatality Review panel.

1) Pursuant to Washington Administrative Code, representatives from the program will not disclose specific information about a client (including that she sought services) without release of information.

2) Like all members of the Domestic Violence Fatality Review panel, the domestic violence program representative will search program records for any history of service for the battered woman involved in the domestic violence fatality.

3) In the event that the program has provided services to someone discussed in the course of a fatality review, the program staff will review program records.

a) If no release of information exists for the Domestic Violence Fatality Review:

(i) The program representative to the Domestic Violence Fatality Review panel will not reveal to the review panel that the program provided services to the battered woman.

(ii) Program staff sitting on the review panel will participate as an advocate for battered women and expert on battering and community resources. This would include offering general information about common struggles and difficulties battered women face, without compromising the confidentiality of a particular client.

b) If a release exists:
The program representative will reveal relevant information from the woman's file during the course of the review. This information may be limited to dates of service, service requested and provided, goals, needs and barriers identified by the victim. Information revealed should be determined by program staff to be reliable and relevant to the review process, and should not compromise the domestic violence victim or surviving family members.

4. A Note About Records Destruction

A. Most programs are required by contract or statute to keep records for a specified length of time. Some programs then destroy rather than archive records. Programs with a <u>destruction</u> policy may want to consider the following proposal:

1) [Agency] will keep the client's records for no less than [the contract/statute specified number] years have passed since the last time the client sought services from the program.

a) <u>If</u> the woman had specified that she wished to have information released to the Domestic Violence Fatality Review, the program will preserve only the name of the client and the time period she used services (e.g., Mary Smith, in shelter 12/1/95 - 2/1/96 or Jane Doe, support groups 7/12/98 - 12/30/98) and the "In the Event of My Death" release of information.