MURIEL BOWSER
MAYOR

October 21, 2025

The Honorable Phil Mendelson
Chairman
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue, NW, Suite 504
Washington, DC 20004

Dear Chairman Mendelson:

I hereby transmit to the Council of the District of Columbia the *District of Columbia Domestic Violence Fatality Review Board 2025 Annual Report*, which was prepared by the Office of Victim Services and Justice Grants ("OVSJG") pursuant to section 2(c) of the Uniform Interstate Enforcement of Domestic Violence Protection Orders Act of 2002, effective April 11, 2003 (D.C. Law 14-296; D.C. Official Code § 16-1052(d)).

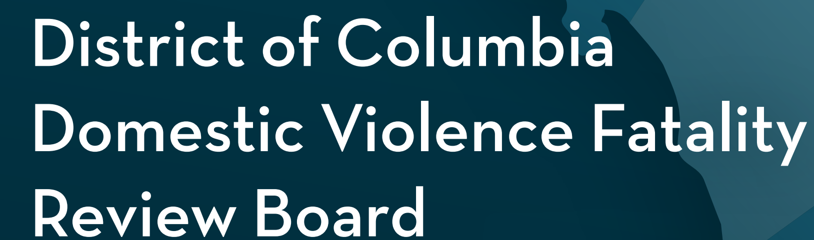
This report summarizes the work of the District of Columbia Violence Fatality Review Board ("DVFRB") from January 2024 through December 2024. It describes homicides that are domestic in nature, changes in legislation, and updates to protections for survivors of domestic violence in the District. This report also provides an update on District agency improvements undertaken in response to previous DVFRB recommendations.

If you have any questions regarding this report, please contact Jennifer Porter, Director, OVSJG, at (202) 724-7216, or by email at jennifer.porter@dc.gov.

Sincerely,

Muriel Bowser

Enclosure



District of Columbia Domestic Violence Fatality Review Board

2025 Annual Report

OVSJG
Office of Victim Services and Justice Grants

WE ARE WASHINGTON DC
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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INTRODUCTION

The District of Columbia Domestic Violence Fatality Review Board ("DVFRB" or "the Board") is honored to present its **2025 Annual Report** highlighting work undertaken from January through December 2024. Operating alongside special task forces, public safety initiatives, public health operations, and targeted legislative tools, the DVFRB represents one portion of the District's multifaceted efforts to address domestic violence and improve the safety and lives of residents.

About the DVFRB

The DVFRB is a 26-member body composed of representatives from District agencies, domestic violence-related bodies, and community members. The DVFRB works to prevent intimate partner and other domestic violence homicides in the District by improving the response of individuals, the community, and government agencies to domestic violence.[1] The Board is the formally established entity for:

- Tracking domestic violence-related deaths;
- Assessing the circumstances surrounding those deaths and any associated risk indicators; and
- Making recommendations to improve the systemic response to victims of domestic violence.

This city-wide, collaborative effort was originally established by the Uniform Interstate Enforcement of Domestic Violence Protection Orders Act of 2002.[2] The Board comprises a cadre of experts from the areas of law enforcement, victim advocacy, social services, health care, child welfare, corrections, and the judicial system, alongside invested community members with relevant subject matter expertise. A major strength of the DVFRB is the purposeful inclusion of this diverse set of system, agency, and community representatives.

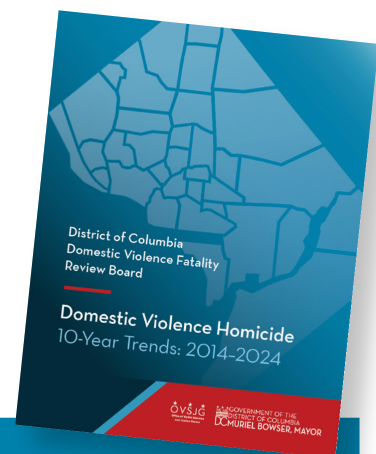
The annual findings and recommendations presented in this report are based on the Board's expert analysis of police, court, medical, and other public media records.[3]

About the 2025 Report

The 2025 Annual Report highlights important activities, policies, recommendations, and data related to domestic violence fatalities in the District from the 2024 calendar year, including:

- A report on notable DVFRB activities;
- New recommendations made to District agencies based on the Board's annual case review and analysis, along with related agency responses;
- A demographic snapshot of last year's domestic violence-related homicides and suicides; and
- Information regarding current District domestic violence protections and programs.

This is also the first year the DVFRB will include information on suicides that were connected to domestic violence, with domestic violence being present up to two years before the suicide occurred. The Board is not implying causation, but domestic violence might have been a stressor and factor contributing to the fatal suicide. Statistical trends and demographic findings specific to the District are covered in our companion report titled "Domestic Violence Homicide: 10-Year Trends." These longer-term data sets provide necessary additional context for analyzing the scope of the problem and the impact of systems change.



DVFRB MEMBERS

Name	Organization
Ashley Archer	Metropolitan Police Department
Nic Rizzi	Metropolitan Police Department
Sherrelle Williams	Metropolitan Police Department
Kunil Raval	Office of the Chief Medical Examiner
Dr. Sasha Breland	Office of the Chief Medical Examiner
Cindy Kim	D.C. Office of the Attorney General
Michelle Wilson	Department of Corrections
Susie Dunn	Fire and Emergency Medical Services
Shermain Bowden	Department of Behavioral Health
Kafui Doe	Department of Health
Gloria Mensah	Department of Health
Jaida Carter	Department of Health
Shayna Marlowe	Child and Family Services Agency
Laquenceyer Johnson	Office of Unified Communications
Kelley Dillon	Office of Victim Services and Justice Grants
Alina Gomez	Office of Victim Services and Justice Grants
Nicole Beck	D.C. Superior Court of the District of Columbia
Dana Joseph	Office of the United States Attorney DC
Kathleen Houck	Office of the United States Attorney DC
Lenore Jarvis	District of Columbia Hospitals
Rachel Camp	University Legal Clinics
Camesha Harris	Domestic Violence Housing Organizations
Dawn Dalton	Coalition Against Domestic Violence
Jennifer Wesberry	Domestic Violence Advocacy Organizations
Ashley Joyner Chavous	Community Representative
Varina Winder	Community Representative
Laila Leigh	Community Representative (Co-Chair)
Lisa Geller	Community Representative
Dana King	Community Representative
Nkiru Nnawulezi	Community Representative
Toshira Monroe	Community Representative (Co-Chair)
Shannarese Sims	Community Representative
Vacant	*Community Representative*

DOMESTIC VIOLENCE: **ITS SCOPE AND EFFECTS**

Domestic violence is a serious public health concern affecting millions of people in the United States every year.[4] It encompasses physical, sexual, emotional, and financial harm and coercion from intimate partners, family members, other household members, and related parties. It can also have lasting, even generational, effects on physical and mental health, financial security, relational health and attachment, and general ability to thrive. Perhaps most tragically, domestic violence can also result in homicide.

To better understand and track the scope of the problem, the Centers for Disease Control and Prevention periodically conducts the National Intimate Partner and Sexual Violence Survey to determine lifetime rates for and prevalence of physical violence, sexual violence, and stalking among women and men. The latest report on intimate partner violence reveals that nearly **one in two women** and more than **two in five men** in the United States have been victims of physical or sexual violence or stalking by a current or former partner at some point in their lifetime—directly affecting more than **17 million** people in the prior year alone.[5] In 2016-2017, more than six million children under the age of 18 have witnessed physical violence toward their parent by a former or current intimate partner during their childhood and over nine million children have witnessed verbal insults, humiliation, and threats of harm.[6] These estimates hold true locally as well: an estimated **47.4% of women in DC** and **43% of men** have been physically or sexually assaulted or stalked by an intimate partner in their lifetime.[7]

Domestic violence has profound effects on victims' wellbeing. It can result in serious injury and correlates with negative mental and physical health outcomes. Victims may experience chronic issues related to heart and gut health, immune response, reproductive and nervous systems, and damage to their muscles and bones.[8] They are also at increased risk of depression, suicidal thoughts, posttraumatic stress disorder, addiction, and may be coerced into risky sexual behaviors or pregnancy.[9] Domestic violence is also the source of huge financial strain. The estimated costs over the course of a lifetime to victims include $2.1 trillion in medical expenses, $1.3 trillion in loss of productivity, $73 billion in criminal justice activities, and $62 billion in property loss, damage, and other costs, with government sources covering 37% of these costs.[10] The individual cost to female victims averages to more than $100,000 each.[11] For a crime that disproportionately affects lower-income and minority women, this burden can limit options for escape, immediate and long-term medical treatment, mental health care, educational and professional opportunities, and overall advancement in quality of life—for both herself and any dependents.[12]

Lethality Risk Factors

Research into intimate partner homicide has revealed a number of factors associated with greater risk of death for women ("femicide"). High-risk indicators include the perpetrator having access to a firearm, making previous threats with a weapon, living with a child not related to the perpetrator, or being recently separated. Separations are at the highest risk of femicide when the victim is leaving the relationship for a new partner.[13] A perpetrator's lack of employment or illicit drug use also increases risk. Living separately, as well as the perpetrator having been arrested previously for domestic violence, are associated with a lower risk of homicide.[14] Risk factors identified from these studies have been used to create danger assessments, which are important screening tools used by service providers to target interventions and services to victims at the most risk of harm. (Read more about the District's Lethality Assessment Program under "Domestic Violence Fatalities in the District.")

Intimate Partner Violence (IPV) and Firearm Access

Over the last decade, intimate partner homicide by firearm increased 58%.[15] Nationally, firearms are used in half of Intimate Partner Homicides (IPH) deaths.[16] IPV victims are five times more likely to die when the abuser has access to a gun and 41 times more likely to die if the abuser has used a gun during a previous severe domestic violence incident.[17] Firearms are also a deterrent to escaping abuse: 4.5 million women have been threatened with a gun by their intimate partner, and nearly one million were nonfatally shot or shot at.[18] These numbers don't account for implied

COMMON LETHALITY RISK FACTORS

- Abuser has access to victim
- Abuser has a history of acute mental health problems (including depression)
- Abuser has a history of physical assault
- Police have received prior calls about abuser
- Abuser threatens homicide or suicide
- Abuser expresses extreme jealousy and possessiveness
- Abuser controls victim's daily activities/ contact with others
- Abuser is unemployed
- Abuser consumes drugs/alcohol
- Abuser demonstrates lack of respect for the law
- Abuser destroys property
- Abuser obsesses over partner
- Abuser feels sense of ownership over victim
- Abuser threatens/intimidates victim's family
- Abuser has a history of sexual violence
- Abuser has strangled victim during previous assaults
- Abuser has access to firearms
- Abuser is publicly violent toward victim
- Abuser and victim are separated/ estranged
- Abuser has a history of stalking
- Victim has children who are not the abuser's
- Abuser witnessed intimate partner violence as a child
- Abuser has abused pets
- Abuser and victim had a short courtship

coercion from knowing an abuser has access to a firearm. The DVFRB does not track near fatal injuries, and the scope of that impact in the District is currently unknown to the board.

IPV and Suicide

Nationally, outside mass shooting events, intimate partner violence contributes to an estimated 6–7% of suicides overall.[19] Data on suicidality and intimate partner violence is difficult to track: the main national fatality dataset, the National Violent Death Reporting System, does not have a mechanism for coding intimate partner violence circumstances with suicide entries as it does for homicide, so information must be gleaned from other coding combinations and narrative text.

Of suicides linked to IPV, the majority (82.8%) are isolated suicide events and not murder suicides.[20] Decedents include both intimate partner violence victims as well as perpetrators. Decedents of IPV-related suicide were more commonly reported to have suicidal intent a month before the suicide and were more likely to use a firearm than suicides unrelated to IPV. There is also a correlation between IPV-related suicide and prior civil or criminal legal problems.[21] Other studies in global populations have reported higher incidence of suicide attempts among women who are victims of intimate partner violence as well as increased incidence of depression in both female and male IPV victims.[22] Findings among women suggest that not only does IPV increase their risk of depression but also, in an insidious loop, that women suffering from depression are more at risk for IPV.[23]

Murder-Suicide

For more than 20 years, the Victim Policy Center has tracked murder-suicides in their periodic publication, *American Roulette*. According to their latest review released in 2023, an estimated 1,176 murder-suicide fatalities occurred in 2021.[24] Of the murder-suicide fatalities reviewed, 69% of the homicide victims were women and 27% men.[25] Of those who died by suicide after committing a homicide, 5% were women and 91% men. In all, 62% of murder-suicides were perpetrated by an intimate partner, and among those incidents, 95% of the victims were women, and 93% involved a firearm. Children under 18 made up 14% of homicide deaths, and another 66 children witnessed some aspects of a murder-suicide over the six-month period studied.[26] On the other end of the spectrum, murder-suicide perpetrators were generally older than the average homicide offender: 21% of offenders who committed murder-suicide were 55 or older, versus 7% of general homicide offenders.[27]

DOMESTIC VIOLENCE **FATALITIES IN THE DISTRICT**

Homicide in the District

In the District, a homicide is considered a “domestic violence fatality” when the perpetrator and victim had been romantically linked, were related, or resided together, or if the perpetrator had previously stalked the victim. Homicide victims are also included if they were killed due to their relation to one of those intended victims.

In the District, homicides experienced a 36% rise between 2019 and 2021, followed by a 10% decline in 2022. However, 2023 saw the highest number of homicides in the last two decades, at 274 fatalities.[28] Over the last decade, domestic violence fatalities have made up on average 8.7% of homicides in the District. As homicides climbed during the pandemic, the percentage began to decline; from 2014–2019, domestic violence fatalities accounted for 9.7% of District homicides, versus 8.2% for 2020–2023.[29] For 2024, DV related homicides accounted for almost 12% of the homicides, which is an outlier for the District so far. This does not include children, which last year was a high child fatality year related to domestic violent homicides of children. In 2024, 28 people in the District were killed in domestic violence-related homicides. Of the 28 victims of domestic violence-related homicides, six were children under the age of five and one victim was 17.

In general, “domestic violence homicide” describes a homicide perpetrated by the victim’s family member, romantic partner, or cohabitant. Homicide by a current or former intimate partner, specifically including spouses, sexual partners, dating partners, or people with a child in common—is termed “intimate partner homicide,” or IPH.

Recognizing the impact of domestic violence homicide on individuals, families, and communities, the District employs a number of measures to identify, prevent, and intervene in high-risk situations. This robust set of protections and responses is designed to reduce the harm of domestic violence. Highlighted below are those programs particularly tailored to decreasing fatalities.

Protections in the District

Extreme Risk Protection Orders

Relatively new to the District is an ERPO, established by legislation and referred to in other jurisdictions as a “red flag law.” ERPOs are civil court orders designed to quickly remove a firearm from someone who poses a danger to themselves or others. Family members, partners, roommates, police officers, mental health professionals, medical professionals, and select others can petition DC Superior Court to issue an ERPO, allowing law enforcement officers

DOMESTIC VIOLENCE FATALITY DISTRICT CODE

According to DC Code § 16-1051, a "domestic violence fatality" is a homicide that occurs under any of the following circumstances:

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

to search for and seize firearms or ammunition from the subject of the order (the respondent). A temporary order can be granted in as little as one business day, while a final order can be granted within two weeks and lasts up to one year at a time. According to DC Superior Court, 63 ERPO cases were disposed in 2024.

Lethality Assessment Program

Lethality assessments are used to determine if a victim is at high risk for re-assault, major injury, or homicide. Lethality assessment programs (LAPs) are used in jurisdictions throughout the country and are often a partnership among victim services, police departments, the courts, and other relevant agencies. The District's LAP is led by DC SAFE. Since its inception in 2009 through December 2024, the LAP has screened 83,087 survivors and identified 38,658 as being at high risk for serious repeat assault or homicide. High-risk survivors can then receive expedited, coordinated, low-barrier access to services. In 2024, 4,571 screenings were conducted, with 2,828 survivors identified as high lethality risk. DC SAFE also sent 403 LAP alerts which made 533 specific requests to different agencies on behalf of the survivor. Over

the life of the program, eight high-risk survivors have been killed. LAP is part of a broader High Risk Domestic Violence Initiative (HRDVI) and is connected to the work of the Domestic Violence Systems Review (DVSR) team, a multi-agency accountability task force for complex, high-risk cases.

Address Confidentiality Program

The District's Address Confidentiality Program (ACP), administered by the Office of Victim Services and Justice Grants (OVSJG), provides a legal substitute address for eligible DC residents to maintain the confidentiality of their actual address. This program helps victims of domestic violence, sexual offenses, stalking, or human trafficking who fear for their safety by shielding their street address from public records, providing one tool in an individual's broader safety plan. The program was established via the Address Confidentiality Act of 2018, effective July 3, 2018 (D.C. Law 22-118; D.C. Official Code § 4-555.01 *et seq.*).

Civil Protective and Anti-Stalking Orders

On April 27, 2021, the Intrafamily Offenses and Anti-Stalking Orders Amendment Act of 2020 went into effect ("the Amendment"). In part, this act amended previous civil protection order (CPO) provisions and created DC's anti-stalking order (ASO).

Civil protection orders are court orders that require the respondent to stay away from and have no contact with the petitioner. CPOs are available for sexual assault and sex or labor trafficking survivors, as well as intimate partners, family members, and household members. With the Amendment, CPOs are now valid for up to two years, although a judge may extend the order for good cause. Additionally, minors ages 13–16 may file for a CPO on their own behalf against a respondent for an intrafamily offense; against a person who sexually assaults them; and under sex trafficking of children if they are the victim. Any minor can have a petition filed on their behalf by a parent, legal guardian, legal custodian, family member who is 18 years old or older, or sexual assault youth victim advocate. The court can also extend a temporary protection order (TPO) for up to 28 days at a time or for a longer time period with the consent of both parties (D.C. Official Code § 16-1004).

In 2024, there were 4,726 new filings under intrafamily cases for TPOs and 4,815 filings for CPOs. Anti-stalking orders are similar to CPOs but apply to petitioners who allege the respondent stalked them within the previous 90 days, regardless of their relationship to one another. (Stalking behaviors are defined in D.C. Official Code § 22-3133.) These orders direct the respondent to have no contact with and stay away from both the petitioner and specified locations, among other requirements. Minors 16 and older may file on their own behalf; minors under 16 must have a parent, legal guardian/custodian, or adult family member file on their behalf. ASOs can remain in effect for up to two years. The court can also grant a temporary order (TASO) without notice to the

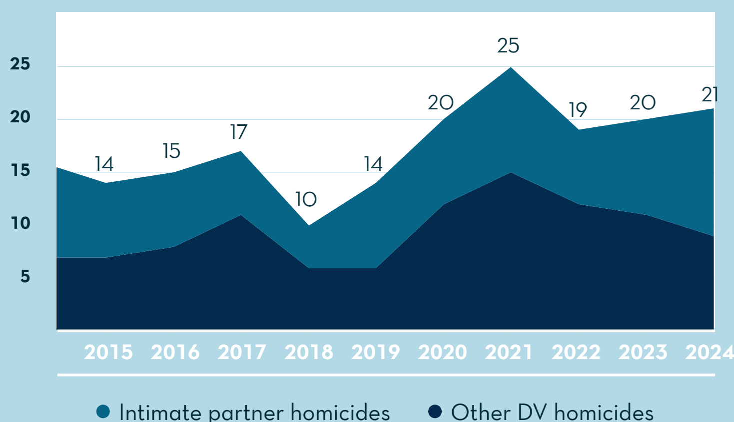
respondent—either in 14-day increments or up to 28 days with good cause (D.C. Official Code § 16-1063). According to the District of Columbia court's upcoming statistical summary, there were 1,204 new filings under the ASO in 2024.

The Amendment also includes offenses against animals owned by the petitioner, a family member, or a household member as an intrafamily offense. It also bars respondents from possessing firearms: after a CPO or ASO is put into effect, respondents are prohibited from purchasing firearms for the duration of the order and must relinquish possession of any existing firearms and ammunition. Additionally, the bill established a unit within the MPD dedicated to serving CPOs and requires them to do so at the petitioner's request.

Employment Protections

Under the Employment Protections for Victims of Domestic Violence, Sexual Offenses, and Stalking Amendment Act of 2018, effective April 11, 2019 (D.C. Law 22-281; D.C. Official Code § 2-1401.01 *et seq.*), employers, employment agencies, and labor organizations ("employers") in the District of Columbia may not discriminate against an employee or an applicant ("employee") based on their status as a victim or family member of a victim of domestic violence, a sexual offense, or stalking ("DVSOS"). The law amended the DC Human Rights Act of 1977. Specifically, employers may not take an adverse employment action against an employee for the following actions if they pertain to DVSOS: participating in a legal proceeding, seeking physical or mental health care, or a third party's disruption of the workplace or threat to their employment. The law also defines family members who are included, reasonable accommodations required of employers, and circumstances under which employers may or may not disclose the employee's status related to DVSOS.

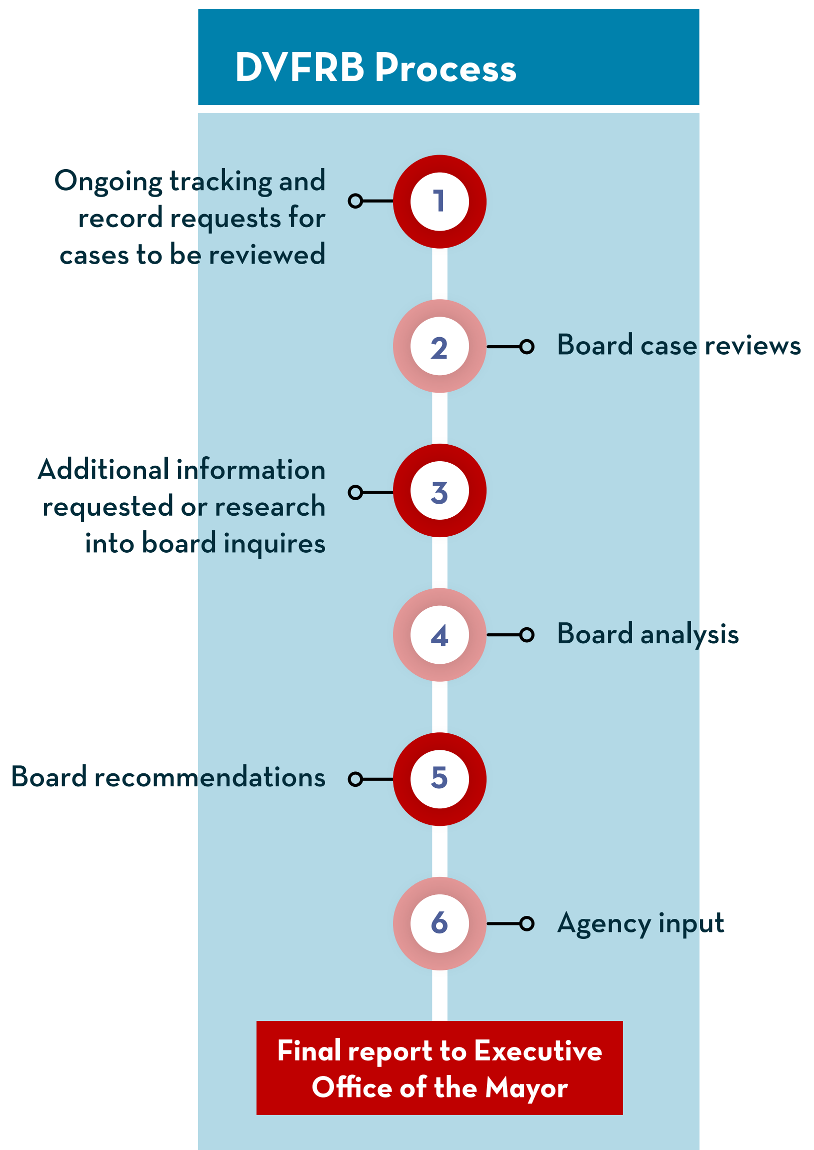
Total Domestic Violence Homicides by Year*



**Please note that current domestic violence homicide figures may differ from those reported previously due to subsequent updates in case information.*

THE ROLE OF THE DVFRB

Despite the District's proactive measures to identify individuals at increased risk for domestic violence-related serious assault and homicide, every year residents are killed by intimate partners and family members. When current protections are unable to prevent domestic violence homicide, the Domestic Violence Fatality Review Board is charged with tracking those deaths and exploring missed opportunities for intervention.



Case Selection and Review

The DVFRB achieves its work through a multidisciplinary analysis of the victims' experiences, perpetrator behaviors, and the general circumstances surrounding the fatalities. Through the case-review process, the Board identifies lethality factors and trends related to the decedents, perpetrators, and systems responsible for supporting, assisting, and protecting victims from family or intimate partner violence. The cooperative efforts of the review process provide an opportunity to enhance and increase services and improve the District's response to address the needs of residents.

The DVFRB meets as a body throughout the year. Domestic violence homicide cases are selected for review based on agreed-upon criteria established by the Board, and cases are only reviewed after the closure of any ongoing criminal case. The DVFRB focuses its in-depth reviews and recommendation process on intimate partner homicides, which tend to follow similar patterns and could, therefore, benefit from systemic prevention efforts. A well-developed body of scientific research surrounding intimate partner fatality risk factors and prevention strategies guides the Board's review of these cases.

While the Board monitors and provides statistics of homicides committed by family members, relatives, roommates, and "common partners," the Board's annual recommendations stem from intimate partner homicide cases. The Board seeks to honor these victims by attempting to understand their experience and use that knowledge to shape recommendations related to policy, practice, training, and public awareness. DVFRB meetings are confidential and, thus, are not subject to open meeting rules. Board members must sign confidentiality agreements. The Board obtains records from a variety of public and private agencies and programs that had contact with or provided services to the victim or the perpetrator. The Board coordinator prepares an initial summary of case material and provides the relevant records to Board members. During review meetings, Board members discuss the facts and circumstances leading up to the homicide and identify potential gaps in service delivery and systemic breakdowns.

The Board then proposes recommendations and suggests system improvements to prevent future homicides. The fatality review process is not investigative, and Board decisions are made collectively. A retrospective analysis of fully adjudicated fatalities allows the Board to objectively observe gaps in the service system without assigning fault. With its "no blame" philosophy, the DVFRB hopes to inspire improved agency and system collaboration and a sense of urgency to work together to create a safer community for victims of domestic violence.

Types of Domestic Violence Homicide

Intimate Partner Homicide	*Non-Intimate Partner Homicide*
• Current spouse • Former spouse • Current intimate partner (unmarried) • Former intimate partner (unmarried)	• Parent, child, sibling, other family • 3rd-party to current/former intimate partner • Roommate • Landlord/renter

2024 DVFRB SUMMARY FINDINGS

While much of the DVFRB's work is confidential in nature, the following section details the Board's publicly reportable activities, data collection findings, and agency recommendations for the 2024 calendar year.

2024 DVFRB Activities

The Domestic Violence Fatality Review Board is composed of public service professionals across a range of disciplines. From January through December 2024, the Board engaged in the following critical work:

- **Met via Webex and in person**: The Board met 10 times during the calendar year for 20 hours of discussion, training, and case review. Two meetings were hosted by Board members at their workplaces.
- **Held the Annual Board retreat**: The DVFRB coordinator planned the Annual Board retreat for the Board members. The retreat kicked off with a welcome by OVSJG Director Jennifer Porter, followed by a presentation by the Department of Behavioral Health on services and youth programming, a workshop on mindfulness and meditation for the members, a presentation on the Crime bill in the District and legislative updates, and then a panel of DV fatality boards in the DMV.
- **Appointed new Board members**: During 2024, new Board representatives were appointed for the MPD, OCME, DBH, OVSJG, and the USAO. The Board also welcomed community member Nkiru Nnawulezi.
- **Published an internal Board directory**: The DVFRB coordinator compiled a directory of all current Board members to facilitate communication and provide background information on relevant areas of expertise.
- **Conducted in-depth case reviews**: The Board examined four complex intimate partner-related homicide cases.
- **Facilitated related District systems briefings**: To foster a deeper understanding among Board members of District programs and agencies tasked with responding to domestic violence and homicide victims, the DVFRB coordinator facilitated a briefing to help the board understand the process needed to serve the community.

To that end:

- Office of Unified Communications presented on 911 calls, screening, training, and text to 911 operations.

- **Continually assessed status of the field**: The Board stayed abreast of ever-changing procedures, policies, and ways of providing services across the city, and regularly incorporated those changes into a flexible workflow.

- **Responded to inquiries**: The Board responded to public and agency inquiries related to its work.

- **Published "DVFRB 2024 Annual Report"**: This annual report included a recap of the DVFRB's work over the 2023 calendar year, information regarding related District protections, and new recommendations based on a review of recently closed domestic violence-related homicides.

2024 BY THE NUMBERS

According to MPD records, 21 people age 18 and older were killed by 25 perpetrators in domestic violence fatalities in the District of Columbia in 2024. The breakdown between intimate partner homicide (IPH) and non-IPH is as follows:

IPH Victims

- **Gender**: 7 women; 5 men.
- **Race**: 11 were Black; 1 was Hispanic.
- **Age range**: 21 to 58; average age was 39.
- **Wards**: Four homicides occurred in Ward 7; Three homicides occurred in Ward 8; Two homicides occurred in Wards 1 and 4 and One homicide occurred in Ward 5.
- **Manner of homicide**: Four victims were shot; Four were stabbed; Three died of blunt force trauma with either stabbing or strangulation playing a role in the demise of the victim, and one of arson.

IPH Perpetrators

- **Gender**: 3 women; 7 men.
- **Race**: 8 were Black; 1 was White; 1 was Hispanic.
- **Age range**: 21 to 69; average age was 44.
- **Relationship to victim**: Six were current intimate partners, Two were a former intimate partner, Two had a sexual relationship. There are two cases believed to be IPH, but are not solved cases, therefore the demographics of the perpetrators is missing. Additionally, there is a case with three individuals involved with the homicide, but the relationship with the victim and perpetrator is not considered IPH for all three. Only one perpetrator will be included in the summary.

Non-IPH Victims

- **Gender**: 2 women; 7 men.
- **Race**: 9 were Black; 1 was Hispanic.
- **Age range**: 23 to 85; average age was 45.
- **Wards**: Seven homicides occurred in Ward 8; One occurred in Wards 1 and 5.
- **Manner of homicide**: Six victims were shot, One was stabbed, and Two died of thermal injuries associated with arson.

Non-IPH Perpetrators

- **Gender**: 1 woman; 8 men.
- **Race**: 9 were Black.
- **Age range**: 19 to 62; average age was 37.
- **Relationship to victim**: One perpetrator was a child of the victim; One was a sibling; Two were considered a love triangle; Four were related in another way; and Two were victims due to proximity. One unsolved case, demographic information is missing for one perpetrator believed to be domestic in nature.
- **Multiple perpetrators**: Two perpetrators were charged with one victim's death.

2024 Fatal Suicides

- Total individuals who **died by suicide** in the District: 64
- Total DC residents who died by suicide and have **recent DV**: 9/45 (20%)

Of those, the total number of fatal suicides of DC residents that took place in the District was 45 for 2024. Overall, the District has the lowest suicide rate in the United States at 6.1 compared to the national rate is 12.6 per 100,000.[30] One might assume the percentage of suicides where domestic violence is present would be consistent with the 6-7% estimated for IPV related suicides,[31] although we did not narrow down to only IPV suicides but by domestic violence as a whole (see "Types of Domestic Violence Homicide" for relationship types). Through preliminary searches, it appears that in 2024, 20% of the suicides of District residents that took place in the District had recent domestic violence as a stressor leading up to the fatal suicide.

2024 DVFRB Recommendations and Responses

The ultimate purpose for reviewing domestic violence fatalities is to reduce the incidence of such homicides. To that end, the Board uses its findings to craft recommendations for system improvements to strengthen the community response to domestic violence. In 2024, the DVFRB issued eleven recommendations to seven District agencies. The agencies involved have since reviewed the Board's recommendations, and available responses are included below.

Recommendation One

Mitigate Risk for Harm through Early Identification of Domestic Violence and Access to Mental Health Services

Victims and perpetrators of domestic violence homicide may have several contacts with the health system prior to the homicide. Each interaction with the health system is an opportunity for both the victim and perpetrator to access services and obtain referrals that could address underlying mental health concerns and potentially prevent the homicide from occurring. As a result, it is imperative that health providers are trained not only to identify concerning behaviors in patients but also to provide appropriate referrals for District residents. However, health providers may not regularly screen current patients' records for indicators of declining mental health or may fail to understand what risk factors to look for or where to direct patients for help when such declines are observed.

Therefore, the DVFRB recommends that:

A. **All DC hospital and community health center providers** and patient-facing staff use their institution's electronic health record or CRISP (Chesapeake Regional Information System for our Patients) to identify a possible decline in a patient's mental health or other patterns that may indicate self-harm and/or threats of harm to or from others. When such declines or patterns are observed, providers should make appropriate referrals to attend to that patient's mental health and safety needs. Providers are also encouraged to include observations about a patient's mental health in their records for future reference.

Providers also should conduct an electronic health records search for patients brought into hospital with an injury suspected or known to be the result of domestic violence. For such patients, providers and staff should be provided with a clear referral process to resources for survivors of domestic violence. If there is not an existing, clear referral protocol, the DVFRB recommends that such a protocol be created and implemented.

B. **DC Health**, in collaboration with the **District of Columbia Hospital Association** (DCHA) and the **Department of Behavioral Health** (DBH), implement training for providers on available DBH referrals and resources for DC residents experiencing or perpetrating domestic violence.

C. **DC Health**, in collaboration with **DCHA** and **DBH**, provide training to health care providers, including DC hospital and community health center providers, patient-facing staff, and social workers, on "red flags" or behavioral risk factors regarding domestic violence perpetration or victimization. The training should include how to set up and use a standardized referral process for patients at high risk for harm (against self or others or from victimization) to obtain ongoing support, treatment, and care. Additionally, providers should be trained to engage in "warm hand-off" referrals to support agencies and/or community care if the client or patient expresses interest in such care.

Agency Responses

Department of Behavioral Health

The DC Department of Behavioral Health (DBH) accepts the recommendations of the Domestic Violence Fatality Review Board with minor changes.

DBH representatives met with DCHA and DC Health and concur with the recommendations that they have submitted to the DVFRB. DBH regulates and certifies 74 community based behavioral health providers with 128 locations throughout the District. As part of our regulations, DBH currently requires bi-directional access to CRISP as a condition of certification.

DBH provides information for the referral process and resources on our website, www.dbh.dc.gov. We also have outreach teams that provide information on referrals and resources throughout the community. We agree with the DVFRB's recommendation to provide additional training on the referral process for providers and community partners. DBH will provide this training through our Training Institute and make any necessary updates to our website.

District of Columbia Hospital Association

The District of Columbia Hospital Association, though not a District Agency, supports the DVFRB prevention and improvement aims. In response to the above referenced recommendations, DCHA conferred with the District Agencies noted as collaborators for this request.

The standardized Health Related Social Needs (HRSN/SDOH) screening tools that are being implemented as part of the work with DHCF, CRISP, and providers include domestic violence screening. These efforts focus on proactively identifying, treating, coding, and referring including capture of this critical information in standard locations in hospital EHRs and information exchange via CRISP. Through these efforts, DCHA member providers also develop protocols and share best practices in implementation. DCHA is currently collaborating with the relevant District agencies, CRISP and our hospital members on these efforts and encourages alignment to proactively identify domestic violence concerns, facilitate referrals, and ensure providers can readily find this information in standardized locations in EHRs and CRISP.

DCHA is prepared to collaborate with DC Health and other relevant District agencies through our standing committees, summits/symposia and others chanels to training for our member providers. DCHA has historically collaborated with DC Health and the DC Forensic Nurse Examiners (DCFNE) program, through our Chief Nursing Officers quality collaborative committee, to facilitate implementation of model policies and training. DCHA is prepared to support DC Health, DBH and others such as DCFNE on training programs for providers focused on meeting the needs of patients at high risk of harm.

DC Health provided additional insights in support of this response to the recommedendations as follows:

In alignment with public health priorities, DC Health already requires all healthcare licensees to complete continuing education on domestic violence and mental health. This ongoing requirement strenghtens the knowledge and capacity of healthcare proviers to address these critical issues.

DC Health, through the DC Rape Prevention Program (DC RPE), provides grant funding to the DC Coalition Against Domestic Violence (DCCADV) to assist with addressing youth violence specifically sexual violence. During the current grant cycle, DCCADV is developing a violence prevention curriculum for elementary-aged students (K-3). The curriculum will focus on identity, personal safety, and relationships to assist students with exploring who they are, behaviors and language for safety and how to develop healthy relationships. The material is focused on age-appropriate discussion topics that can be incorporated into lesson plans for elementary school-aged children. DCCADV's intention with the curriculum is to instill youth with the skills and values they need to make safe and healthy relationship choices, to respect the boundaries and needs

of their peers, and to know how to support their own needs in social situations. It also helps to address the harmful habits and behaviors that contribute to all forms of community violence- including domestic and gun violence- through a community-centered and supportive manner. The prevention education materials developed and provided also help eductional institutions to come into compliance with the School Safety Ombnibus Amendment Act of 2018.

With this curriculum, DCCADV will provide training and technical assistance to teachers, school administrators, and approved community organizations that provide in-school support and services. DC Health will work with the DCCADV, in collaboration with DCHA and DBH in supporting the development of age appropriate violence prevention training and education for mental and behavioral health providers.

DC Health has supported the work of the DC Forensic Nurse Examiners to institutionalize data-driven best practices in acute care local hospital settings to ensure that pediatric and adult victims of sexual violence received timely referral to and treatment from qualified DC Sexual Assault Nurse Examiner (SANE) Progam health care providers through adoption of a citywide protocol among health systems. DCNE developed and provided a toolkit to standardize protocols within and among four hospital emergency departments. Included in the toolkit were agreement templates for hospitals to review and approve, thus ensuring standard practicies across the District in referring victims of sexual for services.

The current model for adult victims of sexual assault victims includes transportation to Medstar Washington Hospital Center where the DC SANE program has trained personnel and facilities to conduct forensic exams, collect data and prepare evidence for submission if requested. Similarly, Children's National Medical Center provides trained personnel to conduct exams and collect data and evidence for pediatric victims of sexual assault.

Based on previous work with partners suchs as DCHA and the DC Forensic Nurse Examiners, recommended changes include the following:

- Ensure awareness of locations of Sexual Assault Nurse Exams
- Assess current data on victims of domestic violence
- Ensure hospital staff have received awareness training(s)
- Ensure development and dissemination of a model protocol and/or policy for domestic violence for health care providers and community-based organizations to train staff and raise awareness of available resources and referral mechanisms (expansion of sexual assault toolkit).

Recommendation Two

Increase Access to Services by Collaborating on Training and Awareness

Victims and perpetrators of domestic violence homicide may have several contacts with the health system prior to the homicide. Each interaction with the health system is an opportunity for both the victim and perpetrator to access services and/or obtain referrals that could address underlying mental health concerns and potentially prevent the homicide from occurring. As a result, it is imperative that, when providers notice concerning behaviors in patients and/or their companions, they provide appropriate education and referrals. However, health care providers may not be aware of the most current and relevant resources available for District residents or have the referral information on hand to present to patients in a timely manner.

Therefore, the DVFRB recommends that:

A. The **Department of Behavioral Health** (DBH), in collaboration with the **Department of Health Care Finance** (DHCF), **DC Health**, and the **District of Columbia Hospital Association** (DCHA), provide an annual (at a minimum) training to hospital and community health center providers, or anyone else who acts as a liaison for patients in need of ongoing mental health care, on current mental health programs available in the District. This training should also include appropriate/required referral processes and information. These trainings should be accompanied by written resources.

   With regards to the written resources, the DVFRB recommends that:

   - DBH include a list of current mental health programs and services, the corresponding program coordinator or main contact information for those programs, any eligibility requirements, and an outline of the relevant referral process.
   - DBH make the list of current mental health programs and services immediately and directly available to providers so that patient-facing staff can make appropriate client referrals expeditiously to avoid any delays that may flow from having to research programs. DBH should publicize the availability of the list through training for medical staff.

B. **DBH**, in collaboration with **DHCF**, **DC Health**, and **DCHA**, schedule trainings for hospital and community health center providers on current programs and referral processes for ongoing mental health or wraparound services in the District. An example of one such program is the Assertive Community Treatment for adult consumers in mental health rehabilitation services program within DBH.

C. **DBH** take steps to raise general awareness among District residents on available and current mental health and wraparound services, so they can better advocate for themselves and any loved ones struggling with domestic violence and/or their mental health.

Agency Responses

Department of Behavioral Health

The DC Department of Behavioral Health (DBH) accepts the recommendations of the Domestic Violence Fatality Review Board with minor changes. DBH representatives met with DCHA and DC Health and concur with the recommendations that they have submitted to the DVFRB.

DBH regulates and certifies 74 community based behavioral health providers with 128 locations throughout the District. DBH also operates a Training Institute that provided over 4,000 training certificates in FY 24. In partnership with our sister agencies, we agree with the recommendation to produce an annual training on behavioral health resources and referrals in support of domestic violence prevention and awareness.

Currently, DBH provides information for the referral process and resources, including a list of providers, on our website, www.dbh.dc.gov. We also have outreach teams that provide information on referrals and resources throughout the community. We agree with the DVFRB's recommendation to ensure that the annual training provides a list of current providers, behavioral health resources and the referral process to receive services. DBH will provide this training through our Training Institute and make any necessary updates to our website.

DBH also agrees with the recommendation to expand collaborative training with DHCF, DCHA, and DC Health to provide current information on resources and the referral process for behavioral health services.

DBH currently provides outreach and awareness on behavioral health resources through our outreach teams and media campaigns. We will review opportunities to expand our reach and increase the general awareness about the variety of services and supports offered through our network of certified providers.

Department of Health Care Finance

DHCF is engaged with the other cited DC agencies and DCHA on the recommendation. DHCF will continue to collaborate with the agencies as described in the additional response provided by DC Health through DCHA.

District of Columbia Hospital Association

The District of Columbia Hospital Association, though not a District Agency, supports the DVFRB prevention and improvement aims. In response to the above referenced recommendations, DCHA conferred with the District Agencies noted as collaborators for this request.

DCHA is prepared to work with DBH and other relevant parties to promote and facilitate training activities targeted at providers and those in patient liaison roles through our standing provider committees and other relevant avenues. DCHA cautions that education regarding

behavioral health with respect to perpetrators avoid implications that individuals with behavioral health diagnoses are as a group potentail perpetrators of domestic violence. DCHA also encourages connecting efforts to ensure information on current services are aligned with District wide efforts to leverage the Link U platform as a unified resource for providers and the community.

DCHA has collaborated with District agencies in the past on education and information sharing with respect to a number of critical health related concerns through our relevant standing committees, summits/symposia as well as other channels and stands ready to support collaborative education efforts regarding programs and referral processes.

DC Health provided additional insights in support of this responses as follows:

DC Health currently funds the DC Coalition Against Domestic Violence (DCADDV). DCCADV has developed training requirements for youth serving organizations that are interested in providing violence prevention, specifically sexual violence, activities to youth.

DC Health's partnership with DCCADV will be leveraged to assist with the development of additional training and curriculum for trainings of healthcare providers and community-based providers and staff. DC Health, DBH, DHCF and DCHA, will cross-promote current and existing resources and education. This includes promotion of resources such as LinkU and Help Me Grow (1-800-MOM-BABY) for pregnant and postpartum individuals who may be experiencing domestic violence.

DC Health, in collaboration with DBH, DHCF and DCHA, will promote awareness and utilization of the LinkU platform to providers to aid in improving connectiong to existing services and resources in the District. In addition, DC Health will support the development and implementation of an annual summit on Domestic Violence, including an annual training which coincides with Domestic Violence Prevention Month.

The DC Rape Prevention Education Program (DC RPE), has conducted trainings with the DCPS Mental Health Team, which include mental health professionals and school social workers. Online training modules for school nurses have also been developed. Trainings were centered on mandated reporting, teen dating violence, the Sexual Assault Victims' Rights Amendment Act of 2019, warning signs of violence and how to support students and their families. In addition, DC RPE has provided technical assistance to the DCPS Mental Health Team to support implementation of the Stop Abuse for Everyone (SAFE) Expect Respect Curriculum. The goal of the curriculum is to help adolescents reach their full potential by reducting and preventing the harmful and long-term impacts of violence and abuse. The sessions have been used to educate and empower vulnerable youth who have already been exposed to violence, mobilize youth leaders, and promote safe schools and communities.

Recommendation Three

Foster Healthy Relationships to Prevent Domestic Violence among Youth Involved with the Criminal Justice System

Although numerous agencies and resources exist to assist victims of domestic violence, the DVFRB's review of IPH cases suggests that many District residents are still unaware of domestic violence risk factors, behaviors, and potential outcomes; markers of healthy relationships and communication techniques that contribute to successful interactions; and availability of supports and where to go for help. While practical information and training is needed among all sectors of the public, youth in particular stand to gain from timely outreach and education on the topic.

The DVFRB has observed that some intimate partner homicide perpetrators first enter the criminal justice system at a young age. When they do so, these youth engage with the Department of Youth Rehabilitation Services (DYRS). DYRS works with youth who have been committed into their care for supervision, custody, and care when charged with a delinquent act in the District—and also with non-committed youth and their families—through programs at New Beginnings, the Youth Service Center, and Achievement Centers. For youth under their care, the department is responsible, in part, for seeing to their physical, social, and behavioral needs; the department emphasizes physical activity, diet and nutrition, mental and behavioral health, and a healthy lifestyle as critical for youth to successfully transition to adulthood. The agency has medical personnel on staff and also links youth to outside services, as appropriate.

The youth DYRS serves are at particular risk of harm to self and others and are also at risk of victimization. Some of the youth have already been victims of domestic violence, and some have engaged in violence in their own relationships. Due to its investment both in youths' current wellbeing as well as in future violence prevention, DYRS is uniquely poised to provide education on healthy relationships, the impact of domestic violence, and risk factors for domestic violence. It can also work with targeted youth to develop coping mechanisms, teach de-escalation techniques, and improve other communication skills to prevent future violence.

Therefore, the DVFRB recommends that:

A. **DYRS** should coordinate the development of an ongoing training and education series on healthy relationships that includes information on domestic violence and stalking behaviors, related risk factors, and communication and de-escalation skills. The series should be led by domestic violence providers and experts with special training in youth and domestic violence. The training should be incorporated into the regular programming that all youth involved with DYRS receive.

B. **DYRS** staff also be trained on healthy relationships and risk factors for domestic violence and stalking. The training should include information on available community resources so that staff can provide appropriate support and referrals for the youth they serve.

Agency Response

Department of Youth Rehabilitation Services

DYRS accepts the recommendation and plans to partner with CFSA's domestic violence training coordinator to develop a train-the-trainer curriculum for the DYRS training unit. This curriculum will be developed into two modules: the first module will be focused on staff and incorporated into orientation training for all new staff as well as in-service training for existing staff. The curriculum will identify risk factors for domestic violence and stalking and include coaching on healthy relationships as well as appropriate boundaries between staff and youth.

The second module will be focused on youth in the care of DYRS and will be co-facilitated by DYRS behavioral health professionals and members of the training unit. The curriculum will include components on healthy peer relationships, risk factors for domestic violence and stalking, healthy communication, and de-escalation skills.

Both modules will include community resources for victims of domestic violence.

Recommendation Four

Strengthen Workplace Communication Skills and Healthy Relationship Formation in Emerging Adults to Counter Effects of Early Exposure to Violence

Although numerous agencies and resources exist to assist victims of domestic violence, the DVFRB's review of IPH cases suggests that many District residents are still unaware of domestic violence risk factors, behaviors, and potential outcomes; markers of healthy relationships and communication techniques that contribute to successful interactions; and availability of supports and where to go for help. While practical information and training is needed among all sectors of the public, youth in particular stand to gain from timely outreach and education on the topic.

The DVFRB has found that violence often is present at a young age in the lives of District domestic violence homicide victims and perpetrators—whether at the hands of guardians, witnessed in the home, or experienced (or perpetrated) in early relationships. This early experience of violence can disrupt healthy growth and development, impeding appropriate engagement and constructive communication across a range of personal and professional relationships. An inability to align with

relational workplace expectations also undermines a youth's sense of hope for future opportunities and success. Part of decreasing violence and preventing future fatalities means reaching out to current youth and helping them successfully and peacefully transition into a stable adulthood.

The Office of Youth Programs (OYP) develops and administers workforce development programs for District youth ages 14-24. OYP provides occupational skills training, work experience, academic enrichment, and life-skills training to help youth develop essential work habits and skills for the workplace. These skills include how to engage in healthy communication, de-escalate heated interactions, and resolve conflict—necessary skills for youth both in and out of the workplace—and they align with themes and goals outlined in the Department of Employment Services (DOES) Strategic Priorities to Create Workforce Opportunities for Young People in Washington, DC report regarding emotional factors and supporting emotional growth. To reach their ultimate potential, these workforce development programs should take into consideration how violence affects youth participants and incorporate ways to mitigate those harms in the workplace.

Therefore, the DVFRB recommends that:

- **OYP** and **DOES** incorporate information about healthy relationships and communication into the onboarding process for all youth in mentoring and employment programs and that healthy communication and relationships be a stated expectation of the program. This education should extend beyond the Youth and Parent Informational Packets to include: more in-depth information; modeling from trusted adults on healthy relationships and dynamics; and practice in resolving conflicts, perspective-taking, and expressing empathy.

Agency Response

Office of Youth Programs, Department of Employment Services

While the recommendations presented are consistent with recognized best practices, the absence of supporting empirical evidence limits the basis for immediate adoption. At this time, the agency is not able to modify its current program implementation beyond established practices. In subsequent program years, the agency may evaluate the feasibility of incorporating additional workplace communication skill development that complements occupational competencies and job readiness outcome.

Recommendation Five

Raise Public Awareness Regarding Healthy Relationships and Domestic Violence among Parks and Recreation Visitors, Especially Youth

Although numerous agencies and resources exist to assist victims of domestic violence, the DVFRB's review of IPH cases suggests that many District residents are still unaware of domestic violence risk factors, behaviors, and potential outcomes; markers of healthy relationships and communication techniques that contribute to successful interactions; and availability of supports and where to go for help. While practical information and training is needed among all sectors of the public, youth in particular stand to gain from timely outreach and education on the topic.

Raising general awareness about the dynamics of domestic violence and available community resources is paramount to preventing future violence and fatalities among all ages of District residents. Related, the DVFRB has found that violence often is present at a young age in the lives of District domestic violence homicide victims and perpetrators—whether at the hands of guardians, witnessed in the home, or experienced (or perpetrated) in early relationships. This early experience of violence can disrupt healthy growth and development, impeding appropriate engagement and constructive communication across a range of current and future relationships. Part of decreasing violence and preventing future fatalities means raising awareness among current youth about domestic violence dynamics and risk factors as well as healthy relationships and communication.

The DC Department of Parks and Recreation (DPR) provides quality urban recreation and leisure services for residents and visitors to the District of Columbia. DPR supervises many of the District's recreation spaces, including community centers, parks, athletic fields, playgrounds, spray parks, tennis courts, community gardens, dog parks, and aquatic facilities. The agency also coordinates a wide variety of recreation programs for all ages, including sports leagues, youth development programs, therapeutic recreation, aquatic programming, outdoor adventure activities, camping, and senior citizen activities. In addition, adaptive programs and facilities are available for persons with disabilities. With its breadth of facilities, extensive use by residents, and targeted youth and adult programming, DPR is well-positioned as a community conduit for sharing vital information to both general and age-specific audiences. However, the agency has not yet been leveraged to help raise awareness regarding domestic violence.

Therefore, the DVFRB recommends that:

A. **DPR**, in conjunction with subject matter experts, create a session, training, or webinar on healthy relationships and teen dating violence to be used in teen programming at all facilities, either as part of the program or as a prerequisite for participation. Among the programs where this training could be required are: Supreme Teen Club, Roving Leaders, Young Men Future Leaders, and Young Ladies on the Rise. The training should also be required for youth-

programming staff, alongside their required mandated-reporting training. Between the two trainings, staff content should include a component on how to respond to teens when they disclose abuse—whether the abuse occurred within the home, in a dating relationship, or in another setting—along with what reporting actions are required.

B. **DPR** employ signage or other tools designed to raise awareness about healthy relationships and domestic violence for all facility visitors. These tools could include bathroom signs, stickers, or related materials that contain information and resources for teens and adults on dating violence and stalking, potentially accessed via QR code links. Publicly posted resources can also aid staff in providing referrals and help employees understand what resources are available for their own needs.

Agency Response

Department of Parks and Recreation

The Department of Parks and Recreation (DPR) appreciates the opportunity to respond to the Domestic Violence Fatality Review Board (DVFRB) recommendations. We are committed to supporting DVFRB's mission to prevent domestic violence-related tragedies and ensure the well-being of DC residents. DPR accepts DVFRB's recommendations with changes.

Through our ongoing youth development programs, DPR will continue promoting education about healthy relationships and teen dating/domestic violence awareness. Our Roving Leaders Program covers these topics in weekly sessions like "Chicken and Waffles" and "Get It Off Your Chest." Additionally, our Supreme Teens program partners annually with the Office of the Attorney General (OAG) to co-host a teen dating and domestic violence summit, educating approximately 200 young people each year on prevention strategies, warning signs, and available resources.

In accordance with DPR Policy, all new seasonal and year-round employees receive training on mandatory reporting requirements, including reporting suspicion of abuse or neglect of a minor and any incident involving DPR employees or program participants during DPR-sponsored activities. This training is also incorporated into ethics training for all DPR employees. While all staff receive comprehensive training, we welcome the DVFRB to advise on any additional training opportunities.

Finally, DPR will coordinate internally to identify and implement appropriate facility signage. We invite the DVFRB to provide guidance on the proper signage or tools to safely connect community members and staff to critical educational and support services.

Recommendation Six

Raise Public Awareness about Domestic Violence and Related Resources

Although numerous agencies and resources exist to assist victims of domestic violence, the DVFRB's review of IPH cases suggests that many District residents are still unaware of domestic violence risk factors, behaviors, and potential outcomes; markers of healthy relationships and communication techniques that contribute to successful interactions; and availability of supports and where to go for help. While practical information and training is needed among all sectors of the public, youth in particular stand to gain from timely outreach and education on the topic.

Raising general awareness about the dynamics of domestic violence and available community resources is a shared responsibility among all public-facing agencies. However, agencies with a direct role in public health and safety have a special charge to reduce domestic violence incidence and impact. Doing so protects the physical, mental, and emotional health of current residents, their children, and future generations.

DC Health promotes health, wellness, and equity, and protects the safety of all District residents. The agency's responsibilities include identifying risks, providing health and safety education, and preventing injuries for all residents. For instance, under its Community Health Administration, the Rape Prevention Education program provides education on sexual assault and dating violence in select schools. DC Health is well-positioned, and in fact beholden, to broaden its outreach efforts to all age groups and, in one sustained effort, to address maternal health, reproductive healthcare and sexual coercion, serious assault and lethality, adverse childhood experiences, and overall wellbeing.

Therefore, the DVFRB recommends that:

- **DC Health** work with domestic violence programs to develop and implement a city-wide online public education campaign to broaden the community's knowledge of: the cycle of domestic violence; symptoms of abuse, including emotional, sexual, and financial abuse; lethality risk indicators; reporting methods; and services and resources available in the community. The campaign should be publicized via social media and through select hard-copy marketing pieces with strategic distribution. It should also:
  - Address stalking and unhealthy versus healthy behaviors in relationships.
  - Specifically address male survivors of domestic violence, as they are less likely to disclose abuse, engage in services, or adequately assess risk of escalating harm.
  - Include an assessment to help determine if someone may be experiencing domestic violence. In addition to general information on domestic violence, the assessment should also include information on how to access services and how to talk to a loved one about your observations and concerns.

- The assessment should be available via QR code posted throughout the community and in all District-owned buildings.

Agency Response

DC Health

Beginning in FY25, DC Health, in partnership with the DC Coalition Against Domestic Violence (DCCADV), Department of Behavioral Health (DBH), Department of Healthcare Finance (DHCF), and District of Columbia Hospital Association (DCHA) plans to develop an annual summit and annual training during Domestic Violence Prevention Month. Educational materials, survey and assessment tools, and tailored-messaging, which will include age-appropriate violence prevention messaging and assessments, will be developed and distributed across the District. Focus groups and experience-based co-design sessions will be implemented with District residents, community-based providers and organizations to inform development of the campaign.

DC Health currently funds DCCADV thorugh its DC Rape Prevention and Education Program (DC RPE). DCCADV has implemented several activities, including development and training for youth and youth serving organizations around violence prevention, specifically, sexual violence. DCCADV also provides training and technical assistance to providers, educators, administrators, as well as community-based organizations.

DC Health will utilize current campaigns and initiatives, such as its Well Woman Campaign, Help Me Grow program (1-800-MOM-BABY), LinkU, and its fatherhood initiatives to disseminate campaign materials, as well as provision of resources in an effort to reach the target populations, including survivors of violence.

DC Health will work with the Office of Communications and Community Relations (OCCR) to disseminate and distribute awareness of the assessment throughout the District. DC Health will also work with the DC Office of Human Rights Language Access Progam to ensure the assessment developed is made available in English, Spanish, Amharic, Korean, Chinese and French in accordance with the Language Access Act of 2004. DC Health will also collaborate with key partners including the Office of Victim Services and Justice Grants (OVSJG), DC Department of Buildings, Department of Behavioral Health (DBH), and Office of the State Superintendent of Education (OSSE), as well as community-based providers, hospitals and health centers, service-based organizations and university-based partners, to ensure distribution of the assessment within the District.

CONCLUSION

Domestic violence victims have often been isolated from their support system by their abuser, restricted from basic needs and comforts, and controlled financially, emotionally, and physically—commonly with their children or other loved ones under threat as well. They frequently have limited means for escape, compounded mental and physical health declines, and a well-founded fear for their safety after leaving. Prevention and response efforts that are aligned with victims' needs, that coordinate across agency lines, and that offer robust, effective interventions with adequate enforcement and follow-up—for victims and offenders alike—can quite literally help save lives.

The DVFRB is grateful to the agencies listed in this report, as well as to the Executive Office of the Mayor, for their commitment to improving the District of Columbia's response to domestic violence. The work of the DVFRB to note, track, and analyze the related fatalities—and then to collaborate across the community on effective homicide prevention efforts—is critical to breaking the cycle of violence, keeping communities intact, and creating a city where residents feel safe and valued. The DVFRB is honored to serve the District and its residents in this capacity.

CITATIONS

1 D.C. Official Code § 16-1052. Establishment and purpose.

2 Uniform Interstate Enforcement of Domestic Violence Protection Orders Act of 2002, effective April 11, 2003 (D.C. Law 14-296; D.C. Official Code § 16-1051 et seq.).

3 Media records include data from DC Witness, which tracks all homicides in the District of Columbia. Only those homicides of victims 15 years and older that were attributed to domestic violence are eligible for DVFRB review and included in this report. For information regarding child and infant fatalities, see reports from the Office of the Chief Medical Examiner.

4 Ruth W. Leemis et al., *The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence*, (Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2022), 1, https://stacks.cdc.gov/view/cdc/124646.

5 Ibid., 4, 5.

6 Ibid., 15.

7 Sharon G. Smith et al., *The National Intimate Partner and Sexual Violence Survey: 2016/2017 State Report*, (Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2023,) Table 5.3.a, Table 5.4.a, available at https://www.cdc.gov/nisvs/documentation.

8 Jacquelyn C. Campbell, "Health Consequences of Intimate Partner Violence," Lancet 359 (2002): 1331-36, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)08336-8/fulltext?cc=y%3D%3D; Centers for Disease Control and Prevention, "About Intimate Partner Violence," February 8, 2024, (Atlanta, GA), https://www.cdc.gov/intimate-partner-violence/about.

9 Ibid.; Julie M. Kafka et al., "Intimate Partner Violence and Suicide Mortality: A Cross-Sectional Study Using Machine Learning and Natural Language Processing of Suicide Data from 43 States," *Injury Prevention* 30, no. 2 (2023): 125-31, https://injuryprevention.bmj.com/content/30/2/125; Elizabeth Miller et al., "Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy," Contraception 81, no. 4 (2010): 316-22.

10 Cora Peterson et al., "Lifetime Economic Burden of Intimate Partner Violence among U.S. Adults," *American Journal of Preventive Medicine* 55, no. 4 (2018): 433-44, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6161830.

11 Ibid.

12 Jamila Stockman, Hitomi Hayashi, and Jacquelyn C. Campbell, "Intimate Partner Violence and Its Health Impact on Disproportionately Affected Populations, Including Minorities and Impoverished Groups," *Journal of Women's Health* 24, no. 1 (2015): 62-79, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302952.

13 Jacquelyn C. Campbell et al., "Risk Factors for Femicide in Abusive Relationships: Results from a Multisite Case Control Study," *American Journal of Public Health* 93, no. 7 (2003): 1089–97, https://ajph.aphapublications.org/doi/10.2105/ajph.93.7.1089?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed.

14 Ibid.

15 Elizabeth Tobin-Tyler, "Intimate Partner Violence, Firearm Injuries and Homicides: A Health Justice Approach to Two Intersecting Public Health Crises," Journal of Law, Medicine, and Ethics 51 (2023): 65, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10209983.

16 April Zeoli, Rebecca Malinski, and Brandon Turchan, "Risks and Targeted Interventions: Firearms in Intimate Partner Violence," Epidemiologic Review 38, no. 1 (2016): 125–139, https://academic.oup.com/epirev/article/38/1/125/2754863.

17 Jacquelyn C. Campbell et al., "Risk Factors for Femicide in Abusive Relationships: Results from a Multisite Case Control Study," American Journal of Public Health 93, no.7 (2003): 1089–97, https://ajph.aphapublications.org/doi/10.2105/ajph.93.7.1089?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed.

18 Susan Sorenson and Rebecca Schut, "Nonfatal Gun Use in Intimate Partner Violence: A Systematic Review of the Literature," Trauma, Violence and Abuse 19, no. 4 (2016): 431–442, https://journals.sagepub.com/doi/abs/10.1177/1524838016668589.

19 Millan AbiNader, "Examining Intimate Partner Violence-Related Fatalities: Past Lessons and Future Directions Using U.S. National Data," Journal of Family Violence 38 (2023): 1-12, https://link.springer.com/article/10.1007/s10896-022-00487-2; Kafka, "Intimate Partner Violence and Suicide Mortality," https://injuryprevention.bmj.com/content/30/2/125.

20 Kafka, "Intimate Partner Violence and Suicide Mortality," https://injuryprevention.bmj.com/content/30/2/125.

21 Ibid.

22 Karen Devries et al., "Intimate Partner Violence and Incident Depressive Symptoms and Suicide Attempts: A Systematic Review of Longitudinal Studies," PLOS Medicine (2013), https://journals.plos.org/plosmedicine/article?id=10.1371/journal.

23 Ibid.

24 American Roulette: Murder-Suicide in the United States, (Victim Policy Center, 2023), 2 http://vpc.org/studies/amroul2023.pdf.

25 Ibid.

26 Ibid.

27 Ibid.

28 Calculations based on Metropolitan Police Department, "District Crime Data at a Glance," June 2, 2025, https://mpdc.dc.gov/page/district-crime-data-glance.

29 "Domestic Violence Homicide 10-Year Trends: 2014-2023," (DC: Office for Victim Services and Justice Grants, 2024), 3, https://ovsjg.dc.gov/sites/default/files/dc/sites/ovsjg/service_content/attachments/2024DVFRB_Trends.pdf.

30 Provisional Mortality statistics, 2018-2023, and from provisional data for years 2024 and later. Centers for Disease Control and Prevention. Accessed June 2, 2025, http://wonder.cD.C..gov/mcd-icd10-provisional.html.

31 Kafka, "Intimate Partner Violence and Suicide Mortality," https://injuryprevention.bmj.com/content/30/2/125.

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