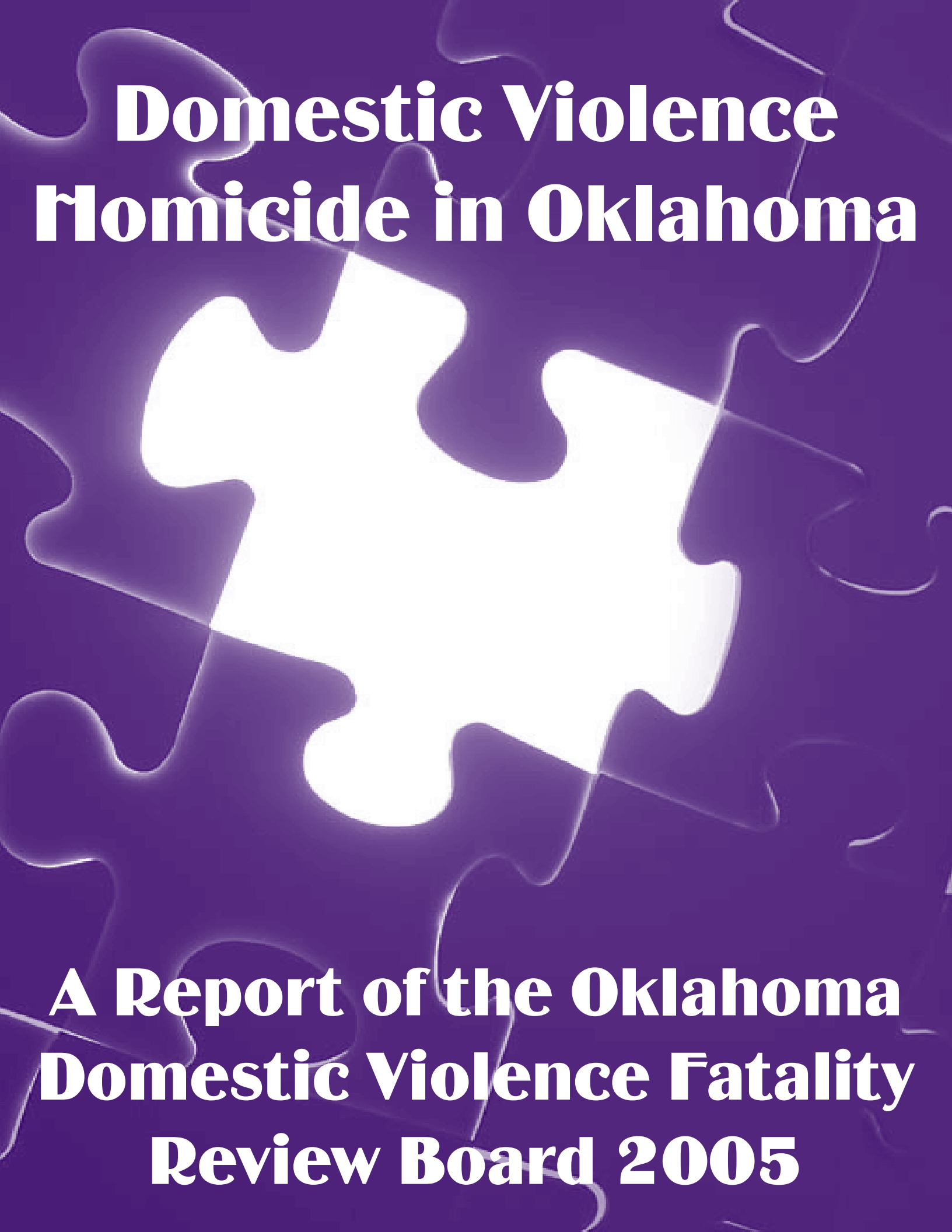

Domestic Violence Homicide in Oklahoma

A Report of the Oklahoma Domestic Violence Fatality Review Board 2005

ANNUAL REPORT

September 2004-December 2005

A MULTI-DISCIPLINARY ANALYSIS BY THE OKLAHOMA DOMESTIC VIOLENCE FATALITY REVIEW BOARD

Inside this report:

Findings in Brief:

- 58% of victims and perpetrators were co-habitating.
- 61% of victims were killed by a current or former intimate partner.
- 37% of the reviewed cases had a child witness.
- 38% of perpetrators made death threats against their victim before the homicide.

The Oklahoma Domestic Violence Fatality Review Board completed ten in-depth reviews of intimate partner domestic violence homicides during 2005. An additional 32 cases were reviewed by staff and added to the database maintained by the Board. The Board has reviewed a total of 170 cases since it began in 2001. This report provides insight into these cases in a summary format and presents Board recommendations for 2005.

The statutes governing the Domestic Violence Fatality Review Board require that review and discussion of individual cases be conducted in a confidential manner in executive session. This report illustrates common themes, best practices, missed opportunities and the danger warning signs or "red flags" recognized in many cases in a compilation narrative derived from fatalities reviewed this past year. Also, this report includes a brief look at a high profile case and the resulting timely system changes. It is the intention of the Board to increase professional and public awareness of the dangers and warning signs of volatile situations so future deaths can be prevented. This year, the Board also took an in-depth look at mental health services for both victims and perpetrators and offers recommendations that practitioners may use to address domestic violence issues.

RED FLAG INDICATORS, BEST PRACTICES & OPPORTUNITIES FOR IMPROVEMENT

The following narrative is a compilation of the lives and deaths reviewed by the Oklahoma Domestic Violence Fatality Review Board in 2005. The reader will notice a two-column approach to the story. The first column symbolically highlights the red flags in the relationship, the best practices and opportunities for improvement among the system responses. The second column is the story detailing the life of an "average" victim. All of the incidents of abuse, red flags and less-than-ideal

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system responses are directly from case reviews. Some of the best practices are also from the files, while others are there to showcase the ideal response to the situation.

Kay*, 36, was married to Tom, 37, for 8 years. They had two children, Trent age 8, and Cathy age 2. They began dating in 1994 when Kay was a junior in college. Kay always told everyone Tom swept her off her feet. They married just six months after meeting. Kay became pregnant right after their marriage and Trent was born in April 1995. During her pregnancy, Tom began telling Kay that she was fat and disgusting looking. He would not go to any of the prenatal appointments with her and did not want to talk about the baby. When they found out it was a boy, Tom said that was good because he did not want another stupid female around.

Because of complications due to her pregnancy Kay did not finish her degree, but she planned to return the following semester to finish. When it came time for Kay to enroll, Tom told her she couldn't because they did not have the money for tuition, and besides what did a stay at home mom need a degree for? Kay was unhappy with this, but thought maybe if she saved some money from what Tom gave her every week to buy groceries and pay bills she would eventually be able to finish.

Kay was able to set aside a small amount of money every week for the next year and finally saved enough to pay the tuition for one class. When she told Tom he accused her of stealing from him and slapped her across the face. Kay was dumbstruck by his reaction. Tom made her show him the money she had saved and took it from her. He told her he would be cutting back on her household allowance since obviously he was giving her too much to pay the bills and buy groceries. He also told her she was too stupid to finish her degree, otherwise she would have already done so.

Tom and Kay were living in the same town where he grew up, so they saw his family regularly. Tom's mother did not like Kay. Every time she saw her she would belittle the way Kay did things from cooking to cleaning to childcare. She would also tell Kay how lucky she was to have a catch like Tom.

Kay's contact with her own family had steadily dwindled since she married Tom. At first she talked to her mother almost weekly and saw her family about once a month since they lived about 70 miles away. After Trent was born, she was able to call her parents only about once a month and was able to see them every couple of months. Calls to Kay's parents were long distance and about a year after Trent was born, Tom said she could not call them anymore and that visiting them was out of the question as it was too expensive. This served to isolate Kay even more. After telling Kay she could not call her parents anymore, Tom opened a phone bill that showed a call to Kay's parents' house. He screamed at Kay that he'd told her she was not supposed to call them. He then shoved her down on the floor and kicked her in the ribs. He told her to never call them again. Tom also instructed Kay not to answer the phone. He informed her that he was the man of the house and anyone who called would want to talk to him; therefore, she was

Red Flag: Isolation
Cutting off contact with family and friends makes it more difficult to get help and easier for batterers to perpetrate the abuse.

*This story is a composite of cases reviewed by the Board and does not represent any one case.

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not to answer the phone. Kay told him she would not answer the phone anymore. Kay's parents tried to call her, but Tom always had some reason she could not come to the phone. Occasionally he would let her talk to them but never without him listening to the conversation. When Tom was at work he would call Kay several times a day to check on her and make sure the phone line was not busy. He would also check the caller-ID and the redial every day when he came home.

In 2000, Kay became pregnant again. She had taken a home pregnancy test. Tom was enraged. He told her she was a horrible mother to Trent and they could not afford another mouth to feed. He beat her that night and left her bleeding on the kitchen floor. A week later Kay miscarried the baby. The emergency room doctor noticed some bruises around Kay's abdomen when he examined her and asked how she received them. Kay told him she wasn't sure, but she was always bumping into a bar countertop at her house and that must be what happened. The doctor asked the nurse to screen Kay for domestic violence. The nurse asked Kay a series of questions to ascertain whether she was a victim of domestic violence. Kay responded negatively to all of the questions because she was afraid of what Tom would do if he found out she had told someone about his abusive behavior. When she arrived home from the doctor Tom told her the miscarriage was God's way of agreeing with him that she was a bad mother.

Best Practice: Screening Medical professionals should screen patients for domestic violence.

In 2001, Kay became pregnant again. She was afraid to tell Tom for fear of his reaction. When she told him this time, he hugged her and told her that it was wonderful news; he wanted another son because all of her coddling had ruined Trent. He wanted another boy so he could "make him a real man." When they found out the baby was a girl he did not say anything. When they came home after the appointment he accused her of leading him to believe it was a boy when she "knew" all along it was a girl. Tom kicked Kay in the stomach and told her he hoped she miscarried again. He refused to go to any more appointments with her and made it extremely difficult for her to go. She missed several doctor appointments because he always needed her to do something else at the same time. Once, when she was finally able to go to her appointment she had a black eye and a large bruise on her belly. The nurse asked her what had happened, and Kay told her that she fell. The nurse looked at her like she did not believe her, but she did not probe further.

Tom would often yell at Trent when they were outside of the house. Even though their closest neighbor was some 500 yards away, one day a neighbor heard Tom yelling at Trent outside. The neighbor then saw Tom kick Trent and Trent fall to the ground. The neighbor called the Oklahoma Department of Human Services (OKDHS) to report the incident and also told them that she often heard Tom yelling at the boy and "knocking him around." The next day after the incident, OKDHS Child Welfare Services made contact with the family to follow-up on the report. When the social worker arrived at the house, Kay had a bruised cheek and wore a long-sleeved turtleneck and jeans even though it was July. The social worker, after introductions, first talked to Trent who stated he did not remember what the social worker was talking about. The social worker inspected Trent for signs of maltreatment by having him raise his t-shirt and looking at his legs (he was in shorts) and found no visible

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marks on his body. When the social worker next spoke with Kay she downplayed the incident that was being investigated. She told the social worker that Trent had misbehaved and that Tom was just disciplining him. The worker never asked Kay about her own bruising and inappropriate attire. The social worker then spoke to Tom. Tom kept asking the social worker who had called OKDHS. When he would not say Tom told the social worker that it was his nosy neighbor. After visiting with everyone, the social worker talked to Tom and Kay about setting an appointment to return for further assessment.

After the caseworker left, Tom went to the neighbor's house, wearing a gun in a holster that could be clearly seen, and told her to mind her own business. The neighbor told Tom to get off of her property. He left, but not before warning her again to mind her own business if she knew what was good for her. After he left, the neighbor went inside and told her husband of the exchange. His response was to tell her that he told her to not get involved with people like that.

In October of 2001 Kay gave birth to Cathy. Tom ignored both her and the baby. Anytime the baby would cry, Tom would tell her to "shut that brat up."

Tom was beating Kay regularly now. He often told her if she ever called the police he would kill her. He told her that if she told anyone they would not believe her and she would regret it. One time while Tom was beating Kay, Trent called 911. When police arrived they arrested Tom. The district attorney charged him with misdemeanor domestic assault and battery. Tom was released on bond according to the bond schedule in the county. Kay went as soon as she could to bail him out. When Tom got home he told Trent to never do that again because if he did the police would take Trent away and he would never see his mother again. He then told Kay that it was a good thing she came and bailed him out otherwise she would have been in big trouble. Kay called the assistant district attorney (ADA) handling the case several times begging for the charges to be dropped, but the ADA told her that while she appreciated Kay's situation, she could not drop the charges just because Kay wanted them dropped. The ADA suggested Kay talk to the victim-witness coordinator in her office and tried to transfer the call, but Kay hung up before the coordinator answered. Tom was eventually convicted—through the use of evidence-based prosecution—of misdemeanor domestic assault and battery and given one year of unsupervised probation.

Missed Opportunity: Those charged with DV offenses should be required to appear before a judge prior to making bond.

Tom lost his job in the winter of 2001 due to his company downsizing. He was having trouble finding another job and told Kay to go get a job so she could start supporting them the way he had always done. Kay got a job as a waitress in town. Tom would call several times a day and get angry when Kay's boss told him she was working and could not come to the phone. Tom would also sit outside of the restaurant and watch Kay working. Often when she got home he would accuse her of flirting with her customers or having affairs with the regulars at the restaurant. After two months of working at the restaurant Kay's boss fired her because Tom was a nuisance to the business. Her boss told her he had to let her go because Tom was interfering with business and scaring off customers by glowering at all the customers who came inside. When Kay

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told Tom she had been fired he told her that she was worthless and couldn't even keep a simple job like waitressing. That night, he beat her and strangled her into unconsciousness.

The next day, Kay left the house to find work and managed to call her parents. She asked them to come get her because she could not stand to live with Tom and the abuse anymore. Her parents were both shocked, but not altogether surprised by what Kay told them. They agreed to come get her and the children.

Red Flag: Strangulation High lethality indicator. Always ask if this is occurring.

When Tom realized Kay had left with the children, he began calling everyone they knew trying to locate her. When he called Kay's parents they told him that Kay was with them and that he was not welcome in their home. Tom responded by saying, "I don't know what that cow told you, but it isn't true. I'll be right over to get them." Tom arrived at Kay's parent's house within two hours. He begged Kay to come home and told her he could not live without her. He told her he would change and that things would be different. When Kay would not leave with him, he screamed at her that this was not over and that she would pay.

Tom constantly called the house to harass Kay and her parents. He would often drive by the house and stopped twice to threaten her father when he saw him outside. Three weeks after they moved in with her parents, Kay went looking for her parent's dog one morning and found him bleeding by the side of the road. The vet told them that the dog had been stabbed. He told them that it was his policy to report such incidents to animal welfare officials and asked them if they knew who might have stabbed the dog. Kay knew Tom had done this, but she was afraid to say so. She was worried about her parents' safety and felt that by staying with them she was putting them in too much danger. She didn't know where else to go so she finally reasoned, if she went back to Tom, he would not hurt her parents. She felt completely helpless and fearful for her parents' safety. The next time Tom called the house she agreed to talk to him about moving back home. He told her again that things would be different and that he would be right over to get her.

Kay and the children moved back home with Tom even though her parents did not want her to. Everything seemed fine for the first few weeks. Tom was as nice as he was before they married, charming almost. Tom had found another job and started going out with friends every weekend. Most of the time he would come home drunk and yell at Kay and beat her. Other times he would just come home and pass out.

One evening, after Kay had forgotten to wash Tom's work clothes, he chased her out of the house with a knife and stabbed her three times. The neighbors heard her screaming and called 911. The police arrived and arrested Tom for assault with a deadly weapon. The police department had recently received a grant to employ a victim advocate who contacted Kay at the hospital after she was transported there. She talked to Kay about the ongoing violence in her life and gave Kay referral contacts to the local domestic violence shelter. She also helped Kay apply for an order of protection. With the support of the advocate, Kay again left the home and went to the local shelter with her children. Kay also followed through and went to court to get the protective order made permanent. Even though Kay was terrified to go to court, she went because the

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advocate supported her. She came to the realization that the protective order could be a useful tool in hopefully ending the violence. The advocate also helped Kay devise a safety plan for she and the children. Meanwhile, Tom was charged with a felony count of Assault with a Deadly Weapon and a misdemeanor count of Domestic Assault and Battery. Through plea-bargaining he was able to plea to only the misdemeanor Domestic Assault and Battery. He was again placed on probation for a year, with six months supervised. He was also supposed to attend anger management classes as part of his probation.

Kay and her children stayed at the shelter for 30 days before moving into a rental house near her parents. In that time she had filed for divorce from Tom. Despite the extreme violence in their relationship, visitation was ordered for Tom in the temporary custody order. He was to have visits every week for one day and every other weekend. Kay's attorney did not request an order for third-party visitation exchanges, and because there was not a visitation center in her small community the visitation exchanges were often done either in front of the police station or in the parking lot of the local restaurant. The advocates working with Kay advised her to have a third party make the exchange even though it was not court ordered. However, that was not always possible so at times she would have to go by herself with the kids. Tom would always verbally harass her every time he saw her. He often threatened her in front of the children. The children appeared afraid of him. Tom would also give the children notes to pass to their mother after his visits. The notes usually contained some sort of degrading and derogatory commentary on her looks or intelligence and often told her she was ruining his life and that she would regret it one day.

During one of Tom's scheduled visits he did not return the children at the scheduled time. Kay reported this to the local police department. Officers escorted her to Tom's residence to determine if the children were there. They were not. Officers told Kay to contact her attorney to file a motion for contempt of court against Tom. After three days of frantically trying to locate Tom and the children, he dropped them off at her parent's house. Kay's attorney asked that Tom's visitation be terminated after he didn't return the children on time. Tom's attorney told the judge Tom had a family emergency that prevented him from returning the children on time and since he was not supposed to contact Kay because of the protection order in place, he did not call. The judge told Tom that in that instance he should have let Kay know of the emergency since it pertained to the return of the children, as communication concerning the children was allowed by the protection order. The judge did not modify the visitation order.

Red Flag: Death Threats Should be taken seriously, particularly if the victim believes they are true.

In February 2003, Kay went to the police and told them that Tom had followed her to her workplace and busted the front windshield of her car with his fist. The day before Tom had called to ask if he could see the kids even though it was not a scheduled visit. Kay relented because she needed to run some errands and he seemed to be acting better lately. The threats had stopped and he had not seemed so angry towards her. She let him come to her apartment and get the children. When he dropped the children off,

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he stayed and talked to Kay until she left for work. Kay dropped the children off at her parent's house and then went to her workplace. She noticed the Tom was following her. When she got to work, Tom came up to her car, smashed her windshield and began yelling at her about cheating on him. He told Kay that if he couldn't have her then no one could. The deputy Kay spoke with asked her if she knew that she was also in violation of the protection order because she allowed Tom to come into her residence. Kay said no she did not think she was, but that she also thought Tom had changed. The officer told her that is not the way a protection order works. He told her not to have any contact with Tom, and if she did want contact with Tom she needed to have the protection order removed by talking with the judge. Kay said she still wanted the protection order because she was really scared now. The officer asked Kay if she wanted to file a violation of a protection order against Tom. Kay stated that she did not because Tom said he would kill some of her friends and the police if the police went after him. The officer asked Kay if Tom had any weapons. She said he did, but that he had probably left town. The officer asked Kay if she had somewhere to stay for a couple of days. Kay said she could stay with a friend. Kay called the officer on the following Monday to inquire about the report. Because of the holiday, the officer explained that he would take the report to the district attorney the next morning. Kay told him that Tom had threatened to harm her as soon as he was released if he was arrested. She informed him Tom had previously assaulted jailers in the adjoining county.

Best Practice: Always ask about the perpetrator's access to weapons.

Four days after Tom was arrested for the protection order violation and released he broke into Kay's house and held her at gunpoint. He told Trent and Cathy to say goodbye to their mother and forced them out of the bedroom and locked the door behind them. He shot Kay twice in the back of the head and then shot himself once. Trent called 911. When officers arrived, the officer who found Kay did not immediately remove Trent and Cathy from the house. The officer's supervisor told him to remove the children from the scene. Trent later told officers the names of relatives who could come and get them. Trent told officers that he and Cathy already had bags packed and hidden under his bed. On the way to the police department, Trent told officers, "Dad should have killed me too."

The children were placed with Kay's parents immediately after the death incident, but no service referrals were given to them. The children were traumatized by the events and could not understand why their father had killed their mother and himself. Kay's parents were grieving as well and very angry with Tom for what he had done. They did not like to talk about what happened and would often get upset when the children wanted to talk about it. They cut off all contact with Tom's family and would not let them see the children. Tom's parents sued for custody of the children and were finally granted monthly visitation with the children. Trent became a discipline problem at school. A school counselor finally suggested that he be taken for counseling. Kay's mother took Trent to a local counselor where he was diagnosed with acute post-traumatic stress disorder (PTSD). Because of Trent's diagnosis Kay's mother took

Best Practice: Opportunities for follow-up care for survivors are essential.

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Cathy to see the counselor too. Cathy was also diagnosed with PTSD. With the help of the local counselor the family found a counselor who was trained to address PTSD in children. Kay's parents also found help in a homicide survivor support group.

The above narrative highlighted several red flags in the relationship between Kay and Tom and the escalating violence in their relationship. Often the relationship onset is short and seemingly perfect. Abusers are often very charming and likable people in their day-to-day lives. It is the drive for power and control over another in their life that many people on the outside—and sometimes the inside—do not recognize. Once Tom romanced Kay into marrying him he slowly began degrading and isolating her. He also began exerting financial control over the family. Once those tactics were in place, he added physical abuse to maintain the power and control he had gained over Kay. Other red flags present in the relationship included child maltreatment, threats to others, and death threats to Kay and others. Job loss and alcohol and drug usage add to the pressures already mounting in the relationship. As the situation escalated toward the final end, elements of harassment, stalking, morbid jealousy, strangulation, and animal cruelty were also added to the mixture of tactics and behaviors employed by Tom to control Kay and the children. Tom also used the children as a tool to control Kay, using them to pass messages to her. He also used the visitation exchanges to intimidate her and purposely delayed returning the children on time to scare her as well. Kay exhibited signs of being battered to others in denying the abuse even when directly questioned, dressing inappropriately for the season to cover bruises, bailing Tom out of jail after he abused her and trying to get the charges dropped against him.

The best practices included in the narrative were:

1. The emergency room doctor had the nurse screen Kay for domestic violence and document her findings;
2. The obstetrics nurse inquired about the bruise on her stomach;
3. The neighbor called the Oklahoma Department of Human Services when she saw Tom kick Trent making him fall to the ground;
4. The police arrested Tom and the District Attorney charged him with domestic assault & battery;
5. The Assistant District Attorney told Kay it was not Kay's decision whether charges were dropped or not;
6. The district attorney's office used evidence-based prosecution to prosecute domestic violence cases rather than relying on victim testimony;
7. The veterinarian treating the dog reported the stabbing to animal welfare officials;
8. The victim advocate recently hired by the police department helped Kay with a protection order, safety plan and referrals;
9. The attorney representing Kay worked to get Tom's visitation terminated;
10. The deputy asked Kay if Tom had weapons at his disposal; and
11. The school counselor suggested to Kay's parents that Trent be taken to counseling to help cope with his parent's deaths.

The missed opportunities included in the narrative were:

1. The obstetric nurse did not screen Kay for domestic violence after observing and questioning the bruise on Kay's stomach;
2. The policy allowing Tom to bond out according to a bond schedule for a domestic violence offense rather than having to appear before a judge;

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3. The employer fired Kay because of Tom's actions;
4. The court ordered Tom to an "anger management" program rather than a batterer's intervention program.
5. The court granting Tom visitation despite the documented violence in their relationship;
6. The judge did not modify the visitation order after Tom did not return the children on time;
7. The deputy told Kay *she* violated the order by allowing Tom in her residence. [*Kay* did not violate the order as there was not a protection order against her, Tom violated the protection order because the judge ruled that *he* could not have contact with Kay];
8. The officers did not remove Trent and Cathy from the homicide scene immediately; and
9. The lack of service referrals given to the family after the homicide.

TIMELY SYSTEM RESPONSE IN A HIGH PROFILE CASE

The statutes governing the Domestic Violence Fatality Review Board, 22 O.S.1601-1603, require that review and discussions of individual cases be conducted in a confidential manner in executive session. However, prior to making any recommendations that may come out of the confidential reviews conducted by the Board, the Board must acknowledge the serious attempt by both members of the Legislature and members of the community to address systemic flaws brought to their attention by the circumstances surrounding the death of 16-year-old Caitlin Wooten in September 2005. Wooten's death caught the attention of the public and the Oklahoma and national media when she was kidnapped and killed by her mother's ex-boyfriend, Jerry Don Savage. Public records indicate that Savage was distraught over the breakup of his relationship with Caitlin's mother, Donna Wooten. He is alleged to have kidnapped Donna Wooten three weeks earlier and while on bail awaiting trial for that crime, Savage appears to have decided that the best way to hurt Donna was by killing her daughter.

One of the "best practices" highlighted in the public record was the notification of Donna Wooten by the Pontotoc County Sheriff's Office that Savage was about to be released from jail on bond after he was arrested for kidnapping. This gave Ms. Wooten an opportunity to prepare for her safety. Additionally, as a result of the circumstances surrounding Caitlin's death, efforts are in progress to improve practices in bail procedures. Legislatively, two bills were introduced to address bail procedures in such cases during the 2006 Legislative session[1]. Locally, judges in Pontotoc County made the decision that all offenders accused of a domestic violence crime are now mandated to have a face-to-face hearing with the judge prior to being released on bail. The Board commends this action. The Board also appreciates those counties that already have this practice in place and encourages this policy be universal in all Oklahoma courtrooms. This case has also spurred legislators to introduce legislation to give law enforcement and the courts more tools to remove weapons from the hands of abusers as well as to automate notification of perpetrator movements within the criminal justice system.

1 SB 1037 and HB 2841 of the 2006 Session.

RECOMMENDATIONS

The following recommendations address issues that have arisen during case reviews.

Oklahoma Domestic Violence Fatality Review Board

1. Investigate and suggest a system for crisis response and develop best practices for assisting children on scene who witness and/or survive homicide.
2. Develop best practice suggestions for journalists reporting on domestic violence.
3. Add a Judicial representative to the Board.
4. Add a Department of Human Services representative to the Board.
5. Support sunset-review legislation in spring 2007 to renew Board authority.

Courts

1. Develop a bench card for judges handling protective orders to assist the court in recognizing red flags and danger potential in cases.
2. Danger assessments should be performed and reviewed by the judge before ordering conditions of a protective order and/or bail.
3. Judges should work to ascertain why a plaintiff is requesting to drop a protection order to make sure that it is in their best interest and safety to do so.
4. Domestic violence information should be available at the time of application for a protective order. Wherever protection order applications are filled out, at the minimum, SAFELINE cards should be available for applicants. [SAFELINE cards are small cards with the state domestic violence hotline number 1-800-522-SAFE (7233) made available to victims of domestic violence, usually by law enforcement and domestic violence advocates.]

Human & Social Service Providers

1. Identify and make referrals to services available for victims of domestic violence and their children.
2. Improve capacity of Oklahoma Department of Human Services workers to assess danger to children and other clients by including domestic violence screening and response in operating procedures. [Note: Screening and assessment of the risk factors for domestic violence requires specialized training. Further, an attempt to provide domestic violence services in the home not only holds potential danger for the home visitation staff, it particularly presents danger for victims and children, especially if conducted by staff who are not specifically trained. In addition to the training, home visitation staff should also complete an internship at a domestic violence shelter or crisis center. As an example, the Children First program operated by the Oklahoma State Department of Health requires at least 4 hours of training for their home visitation nurses that is provided twice a year by the Oklahoma Coalition Against Domestic Violence and Sexual Assault.]

Mental Health & Substance Abuse Providers

1. Standardize assessments in mental health and develop an implementation plan to include screening for violence and appropriate referral/care.
2. Work with mental health practitioners within Oklahoma Department of Mental Health and Substance Abuser Services and with the Health Care Authority-Licensed Behavioral Health Specialists to understand the importance of screening for violence, including domestic violence, in clients and develop implementation protocols for said screening.

RECOMMENDATIONS

Domestic Violence Advocates

1. Public information campaign, i.e., what can communities do when they know "bad activity" is going on? "How can I help my friend/family?"
2. Public Service Announcements on danger.

Education

1. Implement curriculum that educates children and young adults on healthy relationships, starting/ending relationships and recognizing abuse.

Law Enforcement

1. Law enforcement should work with domestic violence advocates to make sure victims of domestic violence receive follow-up contact.
2. First responders and dispatchers should be trained to be aware of the signs of escalation in domestic violence circumstances.
3. Law enforcement investigators need to be aware of custody issues when investigating domestic violence calls.

Health Care

1. Health care providers should routinely screen and assess danger in all patients in order to provide specific interventions (i.e. referral, resources, hotline phone numbers, safety planning) to reduce risk (or vulnerability) and increase safety, especially of women, children, people with disabilities and elders. This should be documented on health care records.
2. All health care professional organizations should become familiar with the current Oklahoma domestic violence reporting law [21 O.S. § 644] and disseminate this information to their members.

All Systems

1. Law enforcement, medical, and social service agencies should always document domestic violence incidences in order to establish a paper trail. These written records should be made even if no follow-up is requested/required.
2. Domestic violence awareness and assessment need to be included in the core education of counselors, attorneys, doctors, nurses, etc.
3. Support interprofessional pilot studies of danger assessment tool in professional settings.

FINDINGS

As of January 2006, the DVFRB reviewed 170 of 359 domestic violence death cases that occurred from 1998 to 2002. The 170 cases represent 190 victims and 190 perpetrators. The findings reported below provide the basis for the Board's annual recommendations. Table 1 provides demographic characteristics of the victims and perpetrators. The average age of victims was 36 years-old and the average age of perpetrators of domestic violence homicides was 38 years old. The youngest victim was less than a day old; the eldest 91. Most of the victims were white (73%), followed by Black (19%) and Native American (8%). Just over 5% of victims were of Hispanic or Latino origin. The youngest perpetrator was 14 years of age; the eldest was 89 years old. The majority of perpetrators were white (72%), followed by Black (22%) and Native American (6%). Some 5% of perpetrators were of Hispanic or Latino origin. Overall, the majority of homicides were homogeneous; only 21 (12%) were interracial homicides.

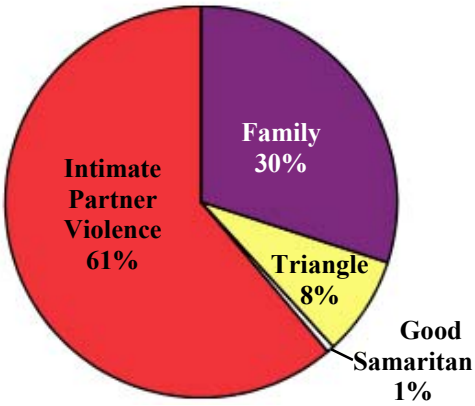
Table 1. Characteristics

	Victims				Perpetrators			
	Female (N=96)		Male (N=74)		Female (N=37)		Male (N=133)	
Age (average, in years)	35.9		35.0		36.4		37.9	
Race								
White	75	78%	49	66%	27	73%	96	72%
Black	14	15%	19	26%	8	22%	29	22%
Native American	7	7%	6	8%	2	5%	8	6%
Of Hispanic or Latino Origin	4	4%	5	7%	1	3%	7	5%

In 58% of the cases, the perpetrator and victim were cohabitating. A current or former intimate partner (IPV) killed 61% of all the victims in the reviewed cases (Figure 1). The average relationship length between the victim and perpetrator was 14.5 years. In 34% of the IPV cases (N=104) the victim was in the process of leaving the perpetrator.

Of the homicides committed by intimate partners, 39% of the victims had children with the perpetrator and 46% had children with a former partner.

Figure 1. Domestic Violence Homicide by Type



There were witnesses in 58% of the cases reviewed. Adults witnessed the homicide in 44% of the cases. The number of adult witnesses ranged from one to 18 in any of the cases. Children witnessed 37% of the slayings. In cases with child witnesses, the number of witnesses ranged from one to 30 children.

Firearms were used in 57% of the reviewed homicides (Table 2). The majority of all of the homicides occurred at the victim's residence (68%), with the majority of those occurring in the bedroom (29%) or the living room (25%).

Table 2. Weapons used (N=170)	# of Cases	% of total cases
No known weapons or bodily force	5	3%
Bodily Force	28	16%
Blunt Object	8	5%
Cutting or Piercing instrument	23	14%
Long Gun (e.g., shotgun, rifle)	22	13%
Handgun	72	42%
Firearm, Type Unknown	2	1%
Another Type of Weapon	9	5%
Unknown	1	1%

Eighty-one percent of victims and 59% of perpetrators did not have a prior conviction record, while 78% of victims and 55% of perpetrators had never been arrested before. Of those with prior conviction records, the average number of convictions was 3.4 for victims; and 4.1 for perpetrators. Five percent of perpetrators had a prior conviction for a domestic violence offense.

FINDINGS

Orders of Protection (PO) had been utilized in 19% of the reviewed cases. The breakdown of who filed the protection order can be seen in Table 3. In over half of the cases where a protective order did exist, the defendant violated the PO prior to the homicide. The average number of violations was 3.44. Victims reported stalking behavior by the perpetrator to law enforcement (7), family (7), friends (5), employer (1), and the court through filing for a protective order (1).

Table 3. Protective Orders & Stalking (N=170)	# of Cases	% of total cases
The Victim had filed a PO against the perpetrator	15	9%
The Perpetrator had filed a PO against the victim	7	4%
A relative of the victim had a PO filed against the Perpetrator	11	7%
The victim had told others the perpetrator was stalking him/her	11	7%

Law enforcement responded to previous domestic disturbances in at least 31% of the cases. For the cases in which law enforcement responded, the average number of responses was 2.57 documented responses. This number could potentially be higher as it only counts documented responses. If an officer responded, but did not fill out a report, it is unaccounted for in this number.

In many homicide cases several people were aware the violence had been occurring. Someone else knew of the ongoing domestic violence in 56% of the reviewed cases. Of those, the majority who were aware of the violence were family members (59%), friends (51%), and law enforcement (37%). In 52 (31%) cases, more than one person or entity was aware of the violence.

As to the outcome of the cases, charges were filed in 69% of the cases. Convictions were attained in 86% of the cases that were filed. Six (4%) were acquitted of the charges (although they admitted to the events causing the death), three (3%) died before the completion of prosecution and two (1%) were found not guilty by reason of insanity. It took an average of one year, four days to complete each case from the date of death to conviction, with a range of 36 days to 3 years and 3 months.

Of those convicted, 79% were sentenced to prison; 12% received a split prison and probation sentence; 2% received probation; 3% were ordered into OJA custody. The average sentence is 22.4 years, not including those sentenced to life or life without parole. Sentences ranged from 4 years to 91 years. Twenty-two were sentenced to life in prison; 25 were sentenced to life without parole; and two were sentenced to death.

BOARD ACTIVITIES 2005

Board members were very active in 2005 presenting information and recommendations from the Board.

Presentations

- Gail Stricklin, presentation to the Oklahoma Nurses Association Intimate Partner Violence Task Force, *Domestic Violence Reporting Requirements*, (January 2005).
- Sue Settles & Brandi Woods-Littlejohn, 13th Oklahoma Conference on Child Abuse and Neglect and Healthy Families Oklahoma 2005 presentation, *The Oklahoma Domestic Violence Fatality Review Board: An Overview* (September 2005).
- Dr. Janet Wilson, Veteran's Affairs Domestic Violence Awareness brown-bag lunch, (October 2005).
- Dr. Janet Wilson, Oklahoma Nurses Association Annual Convention presentation, *'Lest Death Do Us Part: Oklahoma's DVFRB Findings: Implications for Nursing*, (October, 2005).

BOARD ACTIVITIES 2005

Publications

- Oklahoma Nurses Association Continuing Education Unit article, "Identifying and Responding to Intimate Partner Violence in the Health Care Setting," by Dr. Janet Wilson (submitted March 24, 2005).
- Two Board members, Gail Stricklin and Sue Settles collaborated with others at the Oklahoma State Department of Health to update the OSDH Divorce and Visitation for Children Ages 0-5 brochure sponsored by the Oklahoma Lawyers for Children.
- Brown S, Malcoe LH, Carson EA. Intimate Partner Violence Injury - Oklahoma, 2002. MMWR 2005;54:1041-1045.
- Summary of Reportable Injuries - Intimate Partner Violence Injuries in Oklahoma, June 2005. Report of the Injury Prevention Service, Oklahoma State Department of Health, 1000 NE 10th Street, Oklahoma City, Oklahoma, 73112, http://www.health.ok.gov/.

Other Activities

- The board representative from the Oklahoma Nurses Association, Dr. Janet Wilson, worked with her organization to develop the Oklahoma Nurses Association Intimate Partner Task Force in April 2005. Dr. Wilson also chaired the committee.
  - In October 2005, she helped to pass an IPV Resolution at the Oklahoma Nurses Association House of Delegates at the Annual Convention.
  - Further ONA IPV Task force activities resources for RNs have been placed on the ONA web site.
- Four board members and one staff attended the National Domestic Violence Fatality Review Initiative conference in Phoenix, Arizona, in August.
- The Attorney General's Victim Services Unit was added to the Board in July 2005 in response to the Attorney General's Office new responsibilities as the oversight body for domestic violence and sexual assault services in the state.
- In July 2005 staff worked with the Attorney General Victim Services Unit on the appointment of members to the Board. One new member was appointed and 6 others were reappointed to their positions.
- Gail Stricklin prepared and presented the paper, "Representing Clients of Domestic Violence," for the Oklahoma Bar Association and Legal Aid.
- The Department of Mental Health and Substance Abuse Services (DMHSAS) completed initial piloting process for both a standardized integrated screening and a standardized integrated assessment instrument that include mental health, substance abuse, domestic violence, and trauma. The instrument was piloted by agencies in Tulsa, Norman, Oklahoma City, Tahlequah, Vinita, and Grand Lake. One of these agencies was a domestic violence agency.
- As of July 2005, DMHSAS implemented a community based crisis stabilization center for children (ages 10-18) in Oklahoma City. The mission of the center is to quickly assess a child in crisis, stabilize, and then refer to an appropriate level of care. The goal is to minimize the trauma experienced by the child, and connect children to available community resources and/or services.
- DMHSAS continued to provide assessment, counseling, and case management services to children who have been exposed to trauma. Providers of these services include domestic violence service providers and community service providers.
- DMHSAS conducted trainings on best practice trauma specific interventions. As a result, several of our mental health providers began offering trauma counseling services to children and adults.
- DMHSAS required their certified community mental health centers to collect psychosocial information during intake for a client. The psychosocial information includes family, educational, domestic violence or sexual assault, etc.

MENTAL HEALTH RESPONSE

By Janet Sullivan Wilson, PhD, RN

Over the past four years the Board has had the opportunity to review several cases in which the perpetrator and/or victim had contact with a mental health provider prior to the homicide. In response, a mental health practitioner on the Board developed the following suggestions for others in the field to incorporate in their practice.

Presenting Mental Health Problem	**Standard Mental Health Practices**	**Emerging Intimate Partner Violence Practice Recommendations**
Depression, suicidal thoughts, thought disorder	Assessment of suicide/ homicidal ideation: e.g., Are you thinking about suicide? Homicide? Do you have a plan for suicide or homicide? What are the voices telling you to do? Who are the voices telling you to harm? -Mental status exam -Medications for depression, anxiety -Individual, group, family counseling referral for outpatient -sometimes a no-suicide/ homicide contract Discharge to outpatient counseling	1. Ask all women: Do you feel safe in your present relationship? Has anyone ever forced you to have sex when you didn't want to? If yes, who? Do you currently have contact with him? Have you ever been kicked, slapped, punched, choked, forced to do something you didn't want to do? If yes, by whom? Do you have current contact with him? (Use danger assessment if she does not feel safe.) 2. Use alternative words other than suicide/homicide. Focus on behaviors, e.g., Have you thought of hurting yourself or others? How? By what means? When? Who else do you want to see hurt? Have you ever forced someone to do something they didn't want to do? Have you ever kicked, slapped, punched, choked someone or an animal? Have you made threats to other people, now or ever? Have you tried to hurt yourself now or ever? Tell me about what happened and how you tried to hurt yourself/others before. 3. Screen men for hurtful behaviors toward partners. Men who are depressed, alcohol users, or victims of childhood abuse are at a higher risk for violence against partners (Oriel & Fleming, 1998) Use Conflict Tactics Scale (CTS) to screen 4. Even if a client says there is no plan to hurt self and/or others, assess for presence and access to weapons: Do you or your partner have access to guns? Other weapons? How many guns do you own or are in your house? Do you or your partner have access to guns through other people? Where are the guns located? Where do you keep the ammunition? Do you have a license for the guns? Have you been in the military? Do you know how to use a gun? 4. Couples counseling where there has been possible or known intimate partner violence is contraindicated. 5. Recommend counselors who are trained in trauma/ violence specific therapy

MENTAL HEALTH RESPONSE

Presenting Mental Health Problem	Standard Mental Health Practices	Emerging Intimate Partner Violence Practice Recommendations
Grief, depression after a relationship break up, separation, divorce	Assessment and documentation of grieving process; group, individual therapy, medications; grief, divorce support groups	1. Ask about any relational break-ups, transitions, changes in past year or past years. 2. Ask, do you feel safe planning your leaving (separation or divorce)? 3. If not, do danger assessment and give safety plan, referrals, resources, and hotline numbers [OK SAFELINE (800-522-SAFE); National Domestic Violence Hotline (800-799-SAFE)] http://www.ocadvsa.org/ and document • Description of event in woman's own words • Body diagrams with descriptions • If possible, Polaroid photos of visible injuries if present incident • Observations of woman's mood or affect • Results of danger assessment 4. Refer to American Bar Association Safety Plan http://www.abanet.org/tips/dvsafety.html
Relational difficulties, especially before, during, after separation, disengagement involving triangular relationship	Assessment usually is not done for this dynamic	1. Especially when there is a separation, divorce, break-up (recent or past), transition, ask how he/she reacted and ask if there is a third party involved with the couple break up. 2. Ask if a third party is involved 3. Explore comments such as, "lost my temper," and "fighting" ("Give me an example of what happened.") 4. Assess felt degree of betrayal, obsessiveness, possessiveness toward the partner 5. Ask, "have you ever tried to force your partner to do anything he/she did not want?"
History of physical, sexual, emotional abuse, domestic violence, in current, prior relationships	Usually asked on intake assessment; question asked, "Do you have a history of abuse?"	Obtain descriptive information about relational history. Avoid using words such as, abuse, violence, rape, domestic violence, intimate partner violence, child abuse, elder abuse, etc. Focus on behaviors e.g., Tell me what happens when you and your partner argue. How were you or your partner hurt? How did you hurt your partner, by what method(s)? How do you show your anger? Have you been forced or forced another to have sex? Have you been accused of forcing your partner to have sex? Have you ever grabbed, punched, hit, slapped, thrown furniture at another person? Have you ever had been grabbed, punched, hit, slapped, had furniture thrown at you? Have you ever been choked or choked someone else? Have you ever been forced or have you ever forced someone to do something they didn't want to do?

MENTAL HEALTH RESPONSE

Presenting Mental Health Problem	Standard Mental Health Practices	Emerging Intimate Partner Violence Practice Recommendations
Family history of violence	Sometimes assessed with one question, "Do you have a history of family abuse?	1. Ask if client has received prior treatment for childhood and/or adult trauma and if not, what prevented. Recommend trauma specific treatment 2. Ask for description of violence. (Give me an example of what it was like.)
Substance Abuse	Questions asked related to drug/ alcohol history; if admitted for substance abuse problems history questions will be more extensive	1. Find out drug of choice, what when, how, where, by whom substance was used and how affected client's impulse control 2. Ask women: have you ever used alcohol or drugs to numb the pain, injury from a partner? 3. Have you ever been violent under the influence of a substance? Give me an example.
Danger Assessment	Level of danger is usually assessed by an either/or question: i.e., if no plan, no danger; if plan, danger Use of validated tools rarely done	1. Use validated danger assessment scale to adjudge the level of danger to client http://www.dangerassessment.org/ WebApplication1/ 2. Give safety plan http://www.womenslaw.org/ safety.htm http://www.abanet.org/tips/dvsafety.html 3. Give phone hotlines: OK SAFELINE (800-522-SAFE) and the national DV Hotline (800-799-SAFE). These are 24/7 numbers that all pro-fessionals should have at their fingertips. 4. Give resources, referrals: http://www.ocadvsa.org/ 4. Warn victims not to share information with abuser – it could endanger her. 5. Document all the above on the health care chart (never on a discharge summary) and the following: • Description of event in woman's own words • Body diagrams with descriptions • If possible, Polaroid photos of visible injuries if present incident • Observations of woman's mood or affect • Results of danger assessment

Remember:

1. Mental health professionals see both victims and perpetrators of IPV but most often clients will not disclose the violence but will present with problems of depression, substance abuse, suicidal ideation or relational problems. Women are at a higher risk for IPV than men but both can be victims and perpetrators.
2. Always ask about a legal history and trouble with the law that might have been expunged (e.g., DUI,

MENTAL HEALTH RESPONSE

Victim Protection Orders, Domestic Violence charges that might have been dropped, etc.)

3. Risk Factors or Red flags: prior history of domestic violence; disengagement from the relationship; obsessive-possessiveness of the perpetrator; prior police, criminal involvement of the perpetrator; threat to kill (verbal and/or written); substance abuse problems; protective orders; acute perceptions of betrayal; child custody disputes; mental illness of the perpetrator (depression); hostage-taking; children are hers, not his; change in circumstances (unemployment); her fear (Campbell, et al., 2003; Johnson, Lutz, & Websdale, 2000; McFarlane, et al., 2005; Oriel & Flemming; 1998)

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DOMESTIC VIOLENCE FATALITY REVIEW BOARD MEMBERS

Office Represented	Member	Designee
Listed Directly In Statute		
Chief Medical Examiner	Jeffery Gofton, M.D.	Sharon Asher
Commissioner of the Department of Mental Health & Substance Abuse Services	Terry Cline, Ph.D.	Julie Young
State Commissioner of Health	James Crutcher, MD, MPH, FACPM	Sue Vaughan Settles, L.S. W. (Co-Chair)
Director of the Criminal Justice Resource Center	K.C. Moon, Director	Carol Furr, J.D.
Chief of Injury Prevention Service, OSDH	Shelli Stephens-Stidham, MPA, Chief	Sheryll Brown, MPH
Oklahoma State Bureau of Investigation Director	DeWade Langley, Director	David Page, Division Director (7/01-11/05) Rusty Featherstone, Division Director
Office of the Attorney General	Designee of the Victim Services Unit	Susan Krug, Assistant Attorney General
Appointed by the Commissioner of the Oklahoma Department of Mental Health & Substance Abuse Services for two-year terms (prior to 7/05) *Appointed by the Attorney General of Oklahoma for two-year terms (after 7/05)*		
Oklahoma Sheriffs Association	County Sheriff	Jimmie Bruner, Sheriff
Oklahoma Association of Chiefs of Police	Chief of Police	Fred Savage, Chief (Chair)
Oklahoma Bar Association	Private Attorney	G. Gail Stricklin, J.D.
District Attorneys Council	District Attorney	Richard Smothermon, District 23 (7/03-7/05) Tim Harris, District 14
Oklahoma State Medical Association	Physician	Robert Ryan, M.D.
Oklahoma Osteopathic Association	Physician	Julie Thomas, D.O.
Oklahoma Nurses Association	Nurse	Janet Wilson, Ph.D., RN
Oklahoma Coalition Against Domestic Violence & Sexual Assault	Domestic Violence Survivor Citizen	Juskwa Burnett Marcia Smith, OCADVSA Director

OKLAHOMA DOMESTIC VIOLENCE FATALITY REVIEW BOARD

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Full Report on the Web! www.ocjrc.net/

Please go to http://www.ocjrc.net/to review:

- This report
- Enabling Legislation
- The DVFRB Mission, Purpose and Definitions
- Methods and Limitations of data collection and data
- History of the Board

Publication prepared by the Oklahoma Criminal Justice Resource Center on behalf of the Oklahoma Domestic Violence Fatality Review Board, 2005.
Written by: Brandi Woods-Littlejohn, MCJ, Project Director
Janet Sullivan Wilson, PhD, RN
Jennifer Taylor, Project Assistant
Carol Furr, J.D.

If you or someone you know needs help in a Domestic Violence situation, please call:

Safeline – 1-800-522-SAFE (7233)

If you need general information about Domestic Violence, please call:
Oklahoma Coalition Against Domestic Violence
and Sexual Assault – (405) 524-0700

If you need more information about the Oklahoma Domestic Violence Fatality Review Board, please call:
Oklahoma Criminal Justice Resource Center – (405) 524-5900

If you are in an emergency situation please dial 911 immediately.

ACKNOWLEDGEMENTS

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- Oklahoma State Bureau of Investigation
- Office of the Chief Medical Examiner
- Oklahoma Department of Human Services
- Oklahoma State Department of Health

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