FATALITY REVIEW TEAM
ANNUAL REPORT 2007-2009

An Examination of Intimate Partner Violence Homicides in Hillsborough County, Florida

Created by:
Hillsborough County Domestic Violence Fatality Review Team
A subcommittee of the Hillsborough County Domestic Violence Task Force

Executive Summary

The Hillsborough County Domestic Violence Fatality Review is a subcommittee of the Domestic Violence Task Force of Hillsborough County, and partners with the Child Abuse Death Review. The team began with its first meeting in May of 2008; reviewing cases from 2007.We are not searching to find someone or some agency to blame. The abuser bears the full burden of fault for a death resulting from domestic violence. Rather, our purpose is to critically examine the sequence of events prior to the domestic violence-related death.

According to the Florida Department of Law Enforcement (FDLE) data on domestic violence offenses in Hillsborough County there was a total of 8,841 offenses in 2007; 7,824 in 2008; and 7,486 offenses in 2009. There were also a total of 45 domestic violence homicides during that three year period in Hillsborough County. The Hillsborough County Domestic Violence Fatality Review Team has reviewed 20 cases that occurred between 2007 and 2009.

It is our intention to use the information gained to make improvements in the system that serves victims of domestic violence. In our first year of reviews, we noticed that over half of the victims, and their perpetrators, were immigrants. It was also noted that they were all killed in the University of South Florida area, not the farms where the migrant workers lived, as one may assume. When we compared that to the statewide number of about 5%, we knew that we had to act. We notified the Latino Coalition of our findings, they were very interested in sharing this information. Members of the Domestic Violence Fatality Review Team presented the findings at the annual Latino Coalition conference, and also provided training about domestic violence issues.

Over time, it was also noted that many children were traumatized by domestic violence. Many of them had witnessed their parent being killed, and now were living without a mother and often times without their father as well, as there were many murder-suicides. They could have also lost their father as he was now serving prison time for the homicide. There were also cases where the child was the one to find their parent dead, and one where three children witnessed their mother's boyfriend being killed by law enforcement in the front seat of a car while they were in the back seat. The team was horrified to also learn from the records that could be found, not one of these children had received counseling. Staff from the school system, child welfare system, victim assistance office, and others were invited to the table to craft a plan to assure that children and families were given support during this traumatic time. This plan is now being utilized as a model around the State. The Domestic Violence Fatality Review Team will continue to examine cases, and look for ways to improve the system serving victims of domestic violence.

Highlights:

-Over a three year span (2007-2009), a total of 20 cases were reviewed. There were 14 female victims and 6 male decedents.

- 6 of the victims were known to be immigrants, although some had legal documentation.

- 7 of the victims were Caucasian (non-Hispanic), 6 were Caucasian (Hispanic), 6 were African American, and 1 was Asian.

-12 of the female victims had children, 1 male victim had a child. 6 children were present at the time of death. In 7 of the cases, it was unknown if the decedent had children.

- Cause of Death: Gunshot wound- 8; strangulation- 5; stabbing- 3; blunt trauma-2. One male decedent was killed by law enforcement as he was attempting to kill his girlfriend; his data is not included as a victim of domestic violence. Another male decedent was killed by his girlfriend as he was attacking her; this was ruled as justified homicide. His data will also not be included as a victim.

With regard to method of killing, Hillsborough has some differences when compared to the state wide numbers reported. For example:

-Hillsborough had 42% by firearm vs. 70% statewide
-Hillsborough had 26% by strangulation vs. 4% by hands/fist/feet (some of which are likely strangulation, but different reporting sources record categories differently)

There were also several similarities. For example,

-Hillsborough had 16% by stabbing vs. 15% Statewide
-Hillsborough had 10.5% by blunt trauma vs. 11% Statewide.

-7 perpetrators (38%) committed suicide after killing the victim. In 3 of those cases, it is known that the perpetrator made threats to commit suicide prior to the incident.
-In 13 cases, it is known that family, friends, and/or co-workers were aware of the abuse prior to the homicide.
-There is evidence in 1 case of the victim accessing victim support services.
- In 9 cases, the perpetrator had prior domestic violence criminal charges.
- 15 of the perpetrators (79%) had a history of substance abuse. 4 decedents had a known history of substance abuse.
- All 14 female victims were, or had been, in an intimate relationship with the murderer. All of the female victims were killed in their own home- the one place we should all feel the safest.

Observations/Recommendations:

In looking back, the lethality indicators clearly evidenced a high risk for a serious DV incident, including the risk for a fatality, in most of the cases. One observation that was evident across the case reviews is that in the majority of victims' friends, families and/or co-workers were aware of the domestic violence prior to the fatalities. Risk assessments are a useful tool, but if there were a way to educate more of the community about the risks associated with these indicators, it might be even more helpful in the prevention of domestic violence homicides.

Another consistent observation is that very few of the decedents had accessed social, psychological, domestic violence or other community services. While this may suggest services are protective, we as a community may consider increasing outreach efforts to inform survivors of services rather than waiting for the survivor to contact services on her own.

Although in many cases it was unknown whether the perpetrator had children (and sometimes whether the decedent had children) there was evidence of children being involved in some of the cases. This serves as a reaffirmation that our efforts to reach children who have been exposed to domestic violence are important efforts.
The high level of substance abuse involved in fatalities, especially the high level of abuse among perpetrators, is a concerning challenge. Recommendations are difficult. One consideration would

be to increase training efforts in the community to provide information to service providers about this risk indicator. It may also be helpful to increase the capacity of substance abuse treatment agencies, so that they could meet the need for this service.

It is very clear that domestic violence is a violence against women issue. Of the 18 victims who were killed, 14 of them were women. Of the 4 men, one was a friend of the female victim, another was a new boyfriend of the female victim, one was in a same sex relationship, and the other was killed in self defense. The only female perpetrator was ruled to be a justified homicide, as he was trying to kill her. Most homicides happened at the victim's home, the one place we should all be able to feel safe.

Domestic violence fatalities are especially heart breaking because they are preventable. However, there are many caring people working hard every day to help victims and get them to safety. The statistics speak for themselves – there is a great need to address this issue and work together with various partners out in the community to have as much of a positive impact as possible. We know that nearly every fatality (and suspect that all) had experienced domestic violence prior to their death.

TABLE OF CONTENTS

Domestic Violence Defined

Domestic violence is most often thought of as when a husband or boyfriend physically abuses his wife or girlfriend. But domestic violence is actually much more than this narrow definition and much more complex.

Florida Statute defines “domestic violence” as "any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.”

Social service professionals recognize that domestic violence goes far beyond this legal definition. Domestic violence occurs when there is a pattern of one partner having power over the other through the use of fear, intimidation and control. Frequently, physical abuse is part of this, although this is not true in all cases. Many women who are being threatened, controlled and intimidated do not realize they are victims of domestic violence because they are not being physically beaten.

Men can also be victims of domestic violence, as can same-sex partners. Domestic violence can happen to anyone of any race, age, gender, sexual orientation, or religion. It can happen with couples who are married, were married, living together or dating; and it affects people of all education and financial levels.

Mission and Objectives

The overall mission of domestic violence fatality review team is to reduce and ultimately eliminate homicides resulting from domestic violence.

Our objectives are multiple and interrelated. We are not searching to find someone or some agency to blame. The abuser bears the full burden of fault for a death resulting from domestic violence. Rather, our purpose is to critically examine the sequence of events prior to the domestic violence-related death. Clearly we are attempting to identify common indicators that would help us identify the level of danger for potential victims in the future. We are attempting to improve upon our skills to correctly recognize the level of danger prior to a fatality. What we are able to learn will be incorporated into training for professionals who deal or may come into contact with domestic violence. An adjunct objective to that is to identify a point (or points) in the preceding sequence of events where we might attempt to intervene in the appropriate manner to prevent a fatality.

Certainly another important goal of fatality reviews is to determine whether there were gaps in service delivery. If so, what were they and what can we do to change that? Questions such as, “was there sufficient and efficient communication between the various parties involved?” is an appropriate area of examination and discussion. Also we will be trying to determine whether there were services or interventions needed but not available.

Another purpose of fatality reviews is to access the expertise of professionals from various backgrounds, knowledge and perspectives. This will increase the likelihood that we can improve our service delivery system with an eye toward developing a seamless service delivery system. As history has illustrated, an uncoordinated or disjointed intervention effort may result in a fatality.

Hillsborough County Domestic Violence Statistics

According to the Florida Department of Law Enforcement (FDLE) data on domestic violence offenses in Hillsborough County there was a total of 8,841 offenses in 2007; 7,824 in 2008; and 7,486 offenses in 2009.

The FDLE database categorizes those domestic violence offenses as follows:

	2007	2008	2009
Murder	8	2	9
Manslaughter	0	0	2
Forcible Rape	54	30	41
Forcible Sodomy	23	30	41
Forcible Fondling	70	5	13
Aggravated Assault	1265	1393	1242
Aggravated Stalking	6	1	2
Simple Assault	7296	6259	6023
Threat/Intimidation	72	97	103
Stalking	47	30	34

Historical Background and Process

The Hillsborough County Domestic Violence Fatality Review is a subcommittee of the Domestic Violence Task Force of Hillsborough County, and partners with the Child Abuse Death Review. The team began with its first meeting in May of 2008, reviewing cases from 2007. There is a small team that tracks all domestic violence cases through the legal system, flagging them for review once they have completed trial. Members of this team also attempt to interview a family member of the homicide victim when possible, although it is sometimes difficult to locate them. Family members who can be reached usually want to talk about their loved one, and often express their hope that the information provided helps prevent someone else from going through what they went through. These interviews continue to remind us of the human tragedy of domestic violence. One mother, whose only child was killed, remarked that she did not feel that she was a mother anymore.

The information gathered in these interviews, from police reports, medical examiner reports and others is presented in the Domestic Violence Fatality Review Team, which is held quarterly. Please note that these reviews are not always comprehensive, depending on what records are able to be attained and if family members are available for interviews. Membership is made up of law enforcement agencies, prosecution, medical examiner, advocates, staff from the animal shelter, MacDill Air Force Base, local mental health agencies and many others. This team of volunteers works together to learn all we can from the reviews so that we can prevent future homicides.

In our first year of reviews, we noticed that over half of the victims, and their perpetrators, were immigrants. It was also noted that they were all killed in the University of South Florida area, not the farms where the migrant workers lived. When we compared that to the statewide number of about 5%, we knew that we had to act. We notified the Latino Coalition of our findings, they were very interested in sharing this information. Members of the Domestic Violence Fatality

Review Team presented the findings at the annual Latino Coalition conference, and also provided training about domestic violence issues and best practices.
Over time, it was also noted that many children were traumatized by domestic violence. Many of them had witnessed violence in their homes, and now were living without a mother. Often, they were also now without a father, as many of the perpetrators committed suicide after the murder, or they were in prison for many years. Several of these children were the ones who discovered their parents' dead, and some even witnessed the homicides. The team was horrified to also learn that, from the records that could be found and interviews with family members, not one of these children had received counseling. Staff from the school system, child welfare system, victim assistance office and others were invited to the table to craft a plan to assure that children and families were given support during this traumatic time. This plan is now being utilized as a model around the State.
The Domestic Violence Fatality Review Team will continue to examine cases, and look for ways to improve the system serving victims of domestic violence.

2007 Cases Reviewed

There were 9 domestic violence homicides in 2007, although FDLE reports 8. One was not an intimate partner homicide, and one has been ruled incompetent to stand trial, so the Fatality Review Task Force reviewed seven (7) cases for the year 2007. Of those fatalities six (6) were women and one (1) was a man. Ages ranged from 24 to 56, but four (4) of those killed were in the age range of 30-48, what we often think of as middle-aged. The oldest victim (age 56) was the male; he was in a same sex relationship. Five (5) of seven (7) decedents were married; two (2) were single. In addition, four (4) fatalities were Caucasian; the two (2) youngest were Hispanic/Latino; and the male was the only African American. As well, the two youngest women were immigrants, one of them was undocumented, and both were working. Two (2) other women were immigrants from Argentina and Cuba, it is unknown whether their immigrant status was legal. There were a total of four (4) immigrant fatalities in 2007. Five (5) of the six (6) women had children; the male did not. The perpetrators were equally as likely to be or not to be a biological father of the children. All perpetrators were the same race as their victims.

Only one (1) of the decedents appeared to have a history of substance abuse. Five (5) of the seven (7) were in intimate relationships at the time of the murder and the other two (2) had been in intimate relationships in the past. Only the male was in a short-term relationship at the time of death. Four (4) of the women were killed by gunshot, usually a handgun. One (1) woman was killed by stabbing and one (1) by manual strangulation; the male was killed by blunt trauma. All were killed in the decedent's home, even when the perpetrator lived elsewhere. Death's occurred at various times, indicating no clear pattern in times of death. The Tampa Police Department handled five (5) of the murders and the Hillsborough County Sheriff's Department investigated the other two. Five (5) of the seven (7) perpetrators committed suicide prior to being arrested. In one incident children did witness the murder.

In five (5) of the seven (7) cases the decedents had previously alleged domestic violence by their perpetrator to law enforcement. Also five (5) of the seven (7) decedents (but not the same five (5) mentioned above) had made reports to family, friends, coworkers – people in the community. Some of those reports included reports to family members of the perpetrator and a Pastor. In

more than half the cases it is known the decedent had received prior domestic violence injuries prior to their deaths. Three of the perpetrators had prior DV charges, apparently against someone other than the decedent. Only two (2) of the perpetrators had unrelated criminal histories, indicating that the lack of non-violent criminal activity or not spending time in prison was not a protective factor in these 2007 cases of domestic violence fatality. In one (1) case it is known that the perpetrator had a prior injunction, but not related to the decedent.

There did not seem to be a strong connection between Department of Children & Families' (DCF) involvement with the decedent's family as there was only one case that appeared to have some prior involvement with DCF. That same case is also the only one where there was evidence of prior involvement with a Batterers Intervention Program (BIP), and records indicated the perpetrator appeared to have done well and completed the group. Only one decedent was known to have utilized victim support services prior to her death. There was no evidence of prior use by the decedents of psychological services, however, one perpetrator had received treatment at a community mental health center and at some point had a re-commitment order imposed on him. In general, interaction, contact with, or utilization of the various other community resources is not in evidence.
In 2007 the domestic violence fatalities occurred in the following zip codes: 33610; 33612; two (2) in 33614; 33615; 33619; and 33647. In 2007 the youngest victim was 24 and the oldest was 56 years of age. The youngest perpetrator was 24 and the oldest was 65 years.

Family members or friends and sometimes coworkers were the most likely people to be aware of the existence of prior domestic violence. Clearly, looking back over the cases we can see that the likelihood of the incident occurring was convincing. What would be helpful to these victims is if those people most likely to know about prior abuse were aware of these lethality indicators and the risk that accompanies them; and were aware of how to access services.

2008 Cases Reviewed

There were 18 domestic violence homicides in 2008, although FDLE reports 2. Eight (8) were not intimate partner homicides, and two(2) have not stood trial, so the Fatality Review Task Force reviewed eight (8) cases for the year 2008.
One of those cases does not meet the legal standard of domestic violence homicide; the perpetrator broke into his estranged wife's residence and killed her new boyfriend. One (1) of the males was killed while attacking his female partner, she stabbed him in self defense and that decedent will not be included in the data. In 2008: five (5) decedents were female and two (2) were male. One of these males was not an intimate partner, he was African American, was 43 years of age and did not have children. Ages of decedents ranged from 26 to 53, however, two (2) of these cases were in their 20's, (1) one in her late 30's, four (4) were in their 40's, and one was age 53. Three (3) of the decedents were African American; two (2) were Caucasian; two (2) were Hispanic; two were immigrants. Three (3) were employed, two (2) were not, the others employment status was unknown and two (2) were disabled. Some were professionals and some were hourly workers. Five (5) of the decedents had living children and two (2) did not. Only one (1) perpetrator was a natural parent of a child with the decedent although three (3) perpetrators had children with someone other than the decedent. One (1) decedent had a known history of

mental health issues, one (1) did not, six (6) were unknown; two (2) had a known history of substance abuse, one did not and the others were unknown regarding substance abuse. Seven (7) of the seven (7) perpetrators were male. There was a female perpetrator who was not arrested since it was deemed self defense or justifiable homicide by the State Attorney's Office. Three (3) of the perpetrators were African American, two (2) were Caucasian, and two (2) were Hispanic. Four (4) of the perpetrators were single, two (2) were separated and one (1) was married. Two (2) perpetrators were employed and four (4) were unemployed; employment status of the other is unknown. One (1) perpetrator had a known mental health diagnosis; the same man was killed by law enforcement the same day. The mental health status of the others is unknown. Six (6) of the perpetrators had a known history of substance abuse. Most used illegal drugs and one (1) used alcohol. Five (5) of the perpetrators were in an intimate relationship with the decedent, one (1) was in a relationship with the decedent in the past and the other one (1) did not have an intimate relationship with the decedent, he killed his estranged wife's new boyfriend. Most relationships, past or present, had lasted for 12 months or more. One lasted only one (1) month. At the time of death three (3) were currently living together in an intimate relationship resulting in the decedents' death; two (2) were still in a relationship though not living together; and two (2) were past relationships, not living together.

Unlike in 2007 only one (1) decedent was killed by gunshot; three (3) were killed by strangulation; one (1) by stabbing ; one (1) by puncture wound through the eye; and one (1) by blunt trauma to the torso resulting in internal damage (in other words, she was beaten to death.) Only one (1) murder, a male victim, did not occur at the decedent's residence; that fatality did not involve an intimate relationship between decedent and perpetrator, this decedent was an acquaintance of the intimate partner victim. In two (2) cases it is known that the decedents' deaths were related to the separation or threatened separation between the decedent and perpetrator and those two (2) murders were particularly violent according to the coroner's report.

Three (3) of the decedents had previously alleged domestic violence, including 911 calls, two (2) experienced injury prior to the fatality, and six (6) of the seven (7) decedents' family, friends, neighbors and coworkers were aware of the existence of the domestic violence, similar to the cases in 2007, it was unknown in two (2) cases whether others were aware. In two (2) cases children witnessed the incident. Three decedents are known to have alleged previous death threats from the perpetrator, two (2) perpetrators had made suicide threats, and one (1) perpetrator had a history of abuse towards animals. Four (4) of the seven (7) perpetrators are known to have a prior DV related criminal history; there were two (2) stay away orders. In these 2008 cases five (5) of seven (7) perpetrators had fairly extensive non-domestic violence related criminal histories, totaling 32 past offenses. In addition, two (2) of the decedents in 2008 also had domestic violence related criminal histories for a total of eight (8) domestic violence offenses.

Two (2) decedents had filed for and received a temporary injunction on the perpetrator, and one of those cases was a particularly violent murder according to the coroners report. A permanent injunction was not granted in that case because of failure to appear in court as she had been murdered prior to the hearing date. Only one perpetrator had injunctions for protection granted against him by someone other than the decedent. Those were granted to an ex-wife and the perpetrator's brother, although the perpetrator's sister also filed for one.

In one case, the other particularly violent one, the child welfare system was involved because they had placed the decedent's sister's child in the decedent's home. They were not involved with the decedent's own children. None of the perpetrators had ever been involved in a Batterers Intervention Program nor had any of the decedents. Similar to 2007 there is no record of any involvement in any Victim Support Services by the decedent, perpetrator, or children. There was no record for any decedent's involvement in psychological services; however, two (2) decedents were taking such medications as antidepressants, anti-anxiety, antipsychotics and pain medications. There was one perpetrator involved with psychological services and that perpetrator was diagnosed as schizophrenic and was prescribed Risperdal and Seroquil.

One (1) decedent was involved in substance abuse services for marijuana; that decedent's perpetrator was also involved in services for marijuana. Neither decedents nor perpetrators were reported to have been to any domestic violence shelters. There was no evidence of decedents receiving medical care for DV related injuries and no evidence of decedents receiving other social services. One decedent and her intimate partner perpetrator had involved a religious institution regarding the domestic violence. The supervisor of this decedent was aware of the existence of domestic violence. The families, children, coworkers or friends of six (6) of the seven (7) decedents were aware of prior domestic violence.

Regarding lethality indicators in the area of perpetrator de-compensation there was evidence that three (3) perpetrators had a history of suicidal ideation; one (1) homicidal; two (2) loss of functioning (for example, not sleeping, not working etc; two (2) history of psychiatric issues; three (3) depression and loss of income; and one (1) loss of family support. Concerning feelings of ownership over the decedent three (3)perpetrators exhibited possessiveness over their partner; five (5) showed extreme jealousy; three (3) had access to the victim and/or family and rage over separation; and two(2) perceived betrayal. In the area of antisocial behavior three (3) had a history of domestic violence, assaults on others, and history of non-domestic violence criminal activity; two (2) perpetrators had a history of stalking; and seven (7) perpetrators had a history of substance abuse issues. Regarding perpetrators already involved with the legal system, there was one (1) perpetrator who violated a restraining order and two (2) with arrests for domestic violence. Finally, in the area of severity of violence there was one (1) perpetrator who initiated unwanted sexual contact; two (2) had a history of strangulation; three (3) perpetrators used a weapon and made death threats; and five (5) had inflicted severe injury prior to the fatality.

The 2008 domestic violence fatalities occurred in the following zip codes: 33606; 33607; 33610; 33614; 33617; and two (2) in 33634. In 2008 the youngest victim was 27 and the oldest victim was 53 years old. The youngest perpetrator was 22 and the oldest was 56 years old.

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2009 Cases Reviewed

There were 18 domestic violence homicides in 2009, although FDLE reports 9 homicides and 2 manslaughters. Eight (8) were not intimate partner homicides, and five (5) have not stood trial, so the Fatality Review Task Force reviewed five (5) cases for the year 2009. Two of those cases do not meet the legal standard of domestic violence homicide; the boyfriend of a domestic violence victim was killed in one case. In the other, the Survivor had approached law

enforcement as her boyfriend had threatened her. She later waved them off, but the officer followed her as he sensed her fear. Law enforcement then saw them struggle over a gun that the perpetrator had pulled; he then deployed his Taser which was not effective. The officer then shot the boyfriend. The Survivor believes law enforcement saved her life. Her son reported that they had stayed at The Spring in the past, the mother says she stayed with the abuser because she was afraid he would kill her if she left him.

The Fatality Review Team reviewed five (5) domestic violence homicides for the year 2009. One (1) decedent was Asian, one (1) was Caucasian and three (3) were African American. The Asian victim was 37 years of age and one African American victim was 26, one was 27 and the other 32, and the Caucasian victim was 57; three (3) were female and two (2) African American victims were male (the 32-year old and 27-year old). One (1) African American was of Hispanic ethnicity. One (1) decedent was married, one was single; one (1) was separated and the other two (2) had no intimate involvement with the perpetrator. Two (2) decedents were employed and the employment status of the others is unknown. One (1) victim had some college education. The employed victims worked in the service industry. Two (2) decedent had living children; one did not and it is unknown if the other two (2) had living children. In one (1) case it is known that the perpetrator was also the father of the children. One (1) decedent was known to have a diagnosis of mental illness but no history of substance abuse and one (1) decedent had a history of substance abuse. One decedent was an immigrant.

One of the decedents was a perpetrator of domestic violence who was killed by law enforcement as he had pulled a gun on his girlfriend. While his information is included as a decedent, he is not a victim of domestic violence. He was a 32 year old, single, African American male with an extensive criminal history.

All homicides were committed by males. One perpetrator was responsible for two (2) homicides. One homicide was justifiable, and was committed by law enforcement to save the life of the survivor; his data will not be included as a perpetrator. One perpetrator was 31, one was 44 and the other 53. One (1) was Asian, and two (2) were Caucasian. Two (2) perpetrators were deceased by suicide. One (1) Caucasian perpetrator was also of Hispanic ethnicity. All perpetrators were employed, one (1) was professional and two (2) were laborers. One perpetrator recently got off disability; one was known to have children in his custody. One (1) perpetrator was married but the decedent was planning to divorce; (1) one was single and (1) one was separated. The perpetrator of the second murder had no intimate relationship with that victim, it was the new boyfriend of the ex-girlfriend. Three (3) were in a relationship with the decedent at the time of death.

Three (3) decedents were killed by gunshot wound in their homes; one (1) decedent died in the home either by strangulation or internal bleeding; and a fifth decedent was killed by gunshot by law enforcement.

One decedent and perpetrator had paperwork for a divorce; after shooting the decedent he went to a parking lot and shot himself. The other deceased perpetrator killed his ex-girlfriend, her boyfriend and then himself in the decedent's home. Both decedents were shot in the head. One decedent had alleged domestic violence to the police several times prior to the DV fatality. It is

known that one (1) decedent had revealed the domestic violence to a sister and co-worker and the family/and or friends of one decedent was aware of prior domestic violence issues. One perpetrator had a known history of violence toward animals and he also had a history of stalking. One decedent alleged that death threats were made by her perpetrator.

Two (2) of the three (3) perpetrators had a record of domestic violence criminal history and other criminal activity; there were no stay away orders. None of the decedents had filed for injunctions against their perpetrators or against anyone else. There was no evidence of any involvement in a BIP; no involvement with psychological services, but one decedent may have been diagnosed with Tourettes Syndrome as a child; and there was no evidence of perpetrator involvement with a substance abuse program. There also was no evidence of involvement with DV shelters. There was no known record of medical care for domestic violence related injuries or known involvement with other social service agencies, or known involvement of a religious organization about an incident of domestic violence.

One decedent had been harassed at her workplace and her supervisor was aware of the domestic violence issue and paid for the decedent to stay in a hotel room because she was afraid to go home. This decedent's sister also tried to help by allowing the decedent to stay in her home.

Regarding known lethality indicators in the area of de-compensation of perpetrator one (1) perpetrator exhibited homicidal tendencies; one (1) had a history of psychiatric problems, depression, and economic loss. In the area of ownership over victim two (2) perpetrators exhibited obsessive behaviors towards their partners, extreme jealousy, access to their victims and/or family members, rage over separation, and perceived betrayal. Regarding antisocial behavior three (3) had a history of domestic violence; three (3) had a history of assaults on others; two (2) had a history of stalking; two (2) had histories of non-domestic violence criminal activity; one (1) had a history of substance abuse; two (2) a history of stalking; and one (1) had a substance abuse history.

In cases where the perpetrator had past history with the legal system one (1) had a violation of a restraining order; one (1) had a violation of probation; and two (2) had arrests for domestic violence. Regarding severity of violence two (2) used a weapon; two (2) had made death threats; one (1) had unwanted sexual contact; one (1) had a history of hurting a pet; and (1) caused severe prior injury. Again, we must be mindful of the fact that there are many unknowns when it comes to lethality indicators. For one (1) of the decedents all lethality indicators were unknown.

Two (2) of the perpetrators committed suicide and one was killed by law enforcement, possibly saving the lives of the domestic violence survivor and her children.

Fatalities occurred in the following zip codes: 33614, 33618, and 33619. The fifth fatality was a law enforcement shooting. In 2009 the youngest victim was 26 and the oldest was 57 years. The youngest perpetrator was 31 and the oldest was 53 years of age.

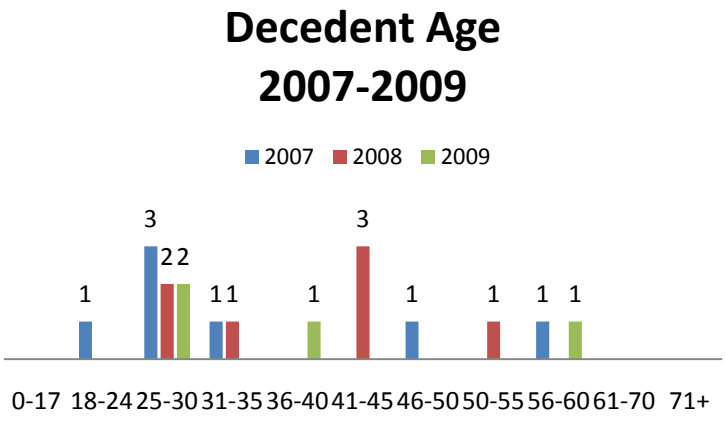
Cumulative Data

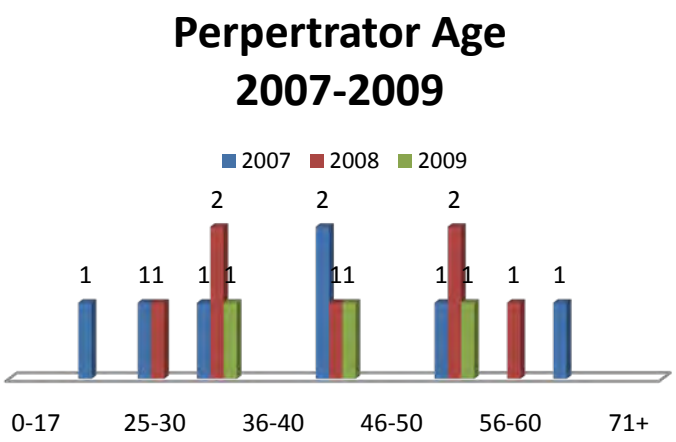
Over the three year span, 2007-2009, a total of 20 cases were reviewed. There were 14 female fatalities and 6 male. However, one of the males was killed by law enforcement and not a victim of domestic violence. Another male was killed in self defense by his female partner, and two were the friend/boyfriend of a female domestic violence victim. Only 2 of the six males who were killed were in an intimate relationship with the murderer, both were in same sex relationships. All 14 female victims were or had been in intimate relationships with their murderer, all were killed in their own home.

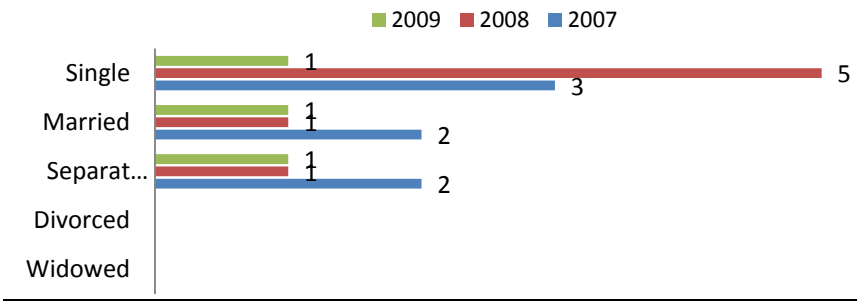
Six (6) of the fatalities were known to be immigrants although some had legal documentation. One homicide victim had achieved citizenship two months prior to her death. One of the immigrant decedents was known to be undocumented. There were two (2) cases in which the perpetrators were immigrants but the immigration status of their decedents is unknown. Seven (7) of the victims were Caucasian, six (6) Hispanic/Latino, six (6) were African American and one (1) was Asian. Twelve (12) of the 14 female victims had children, one male had children with someone other than the homicide victim and in seven (7) cases it is unknown whether the decedents had children. Six (6) children were present at the time of the fatalities.
Eight (8) of the victims died by gunshot wounds, five (5) by strangulation, three (3) by stabbing, two (2) by blunt trauma, one by a puncture, and one (1) by a screwdriver to the eye. Seventeen of the fatalities occurred in the victim's home. Seven (7) of the perpetrators committed suicide and three (3) made suicide threats prior to the fatality.
Ten (10) of the perpetrators were employed. Employment status was unknown for two (2) perpetrators and eight (8) were unemployed, two of those were on disability.
Nine (9) of the decedents were known to have alleged abuse to the authorities (including 911 calls) or an agency prior to their fatality. One (1) of those had called the police several times. Family, friends and/or co-workers were aware of the domestic violence in 13 of 18 cases (law enforcement killing is not included). One (1) decedent is known to have utilized victim support services prior to her death. There was no evidence in any of the other cases of utilization of support services, psychological services or other social services.

In nine (9) cases perpetrators had prior domestic violence criminal histories; two (2) decedents had prior DV criminal histories. Four (4) decedents had known histories of substance abuse; 15 perpetrators (79%) had a known substance abuse history.

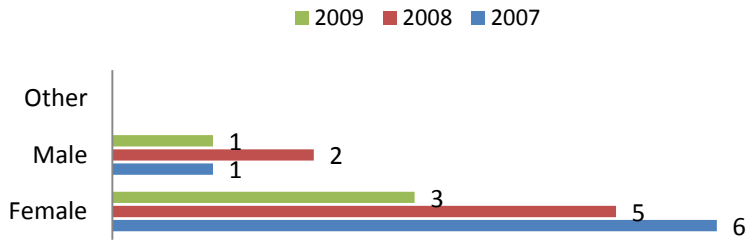
Cumulative Graphic Representation



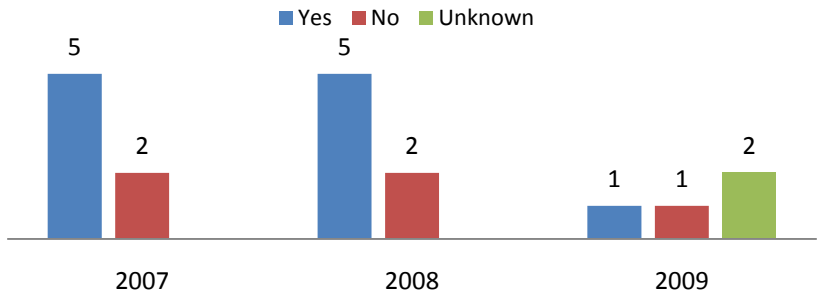




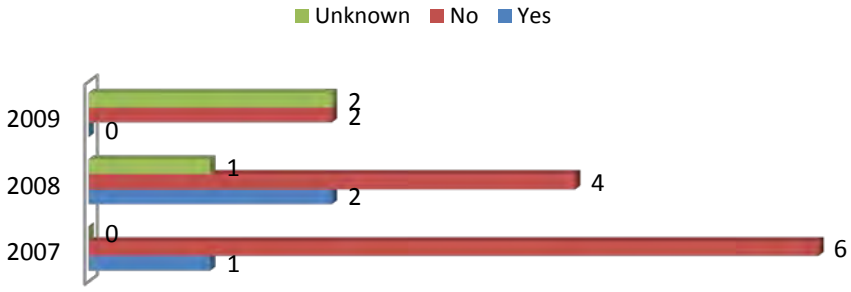
Victim Gender
2007-2009



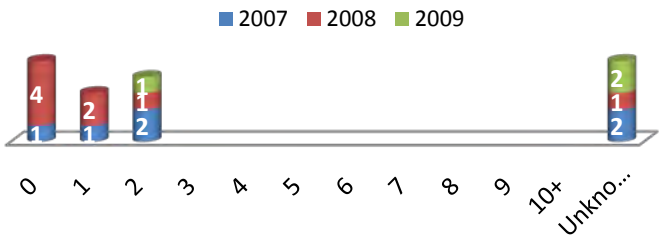
Vicitims with Living Children
2007-2009



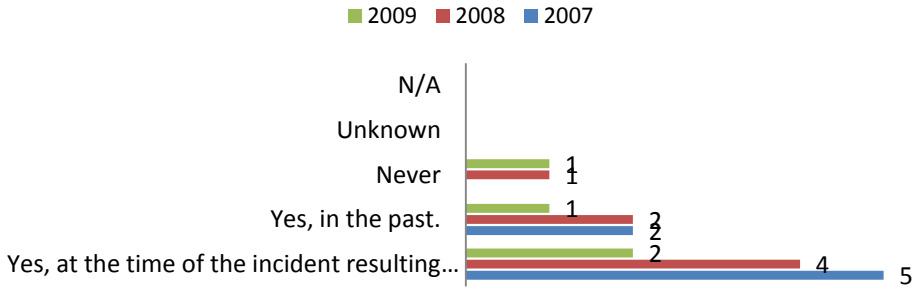
Children's Trauma
Number of Cases Where Children Witnessed Homicide
2007-2009



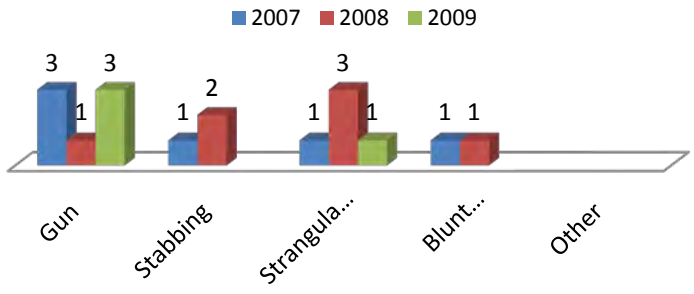
Number of Perpetrators Biological Children 2007-2009

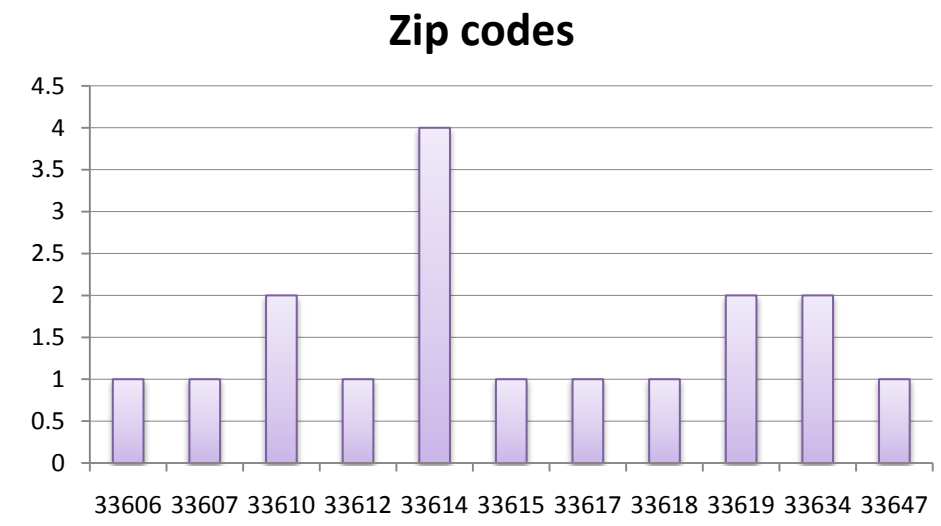


Decedent and Perpetrator Intimate Status 2007-2009



Cause of Death 2007-2009





Statewide Comparison

The average age of perpetrators was 42.47 years for the three-year period; average age of decedents was 37.35 years. Comparing the average age of Hillsborough for years 2007 and 2008 to the statewide average for those same years (2009 report not available) reveals the following:

	2007	**2008**
Hillsborough		
Perpetrator	41.71	43
Victim	35.86	41
Statewide		
Perpetrator	41	38
Victim	40	34

The average age difference for 2007- 2009, Hillsborough County, between perpetrator and decedent is about five (5) years. Over that same 3-year period the youngest victim was 24 and the oldest was 57 years. The youngest perpetrator was 22 and the oldest was 65 years of age.

With regard to method of killing, Hillsborough has some differences when compared to the state wide numbers reported. For example:

-Hillsborough had 42% by firearm vs. 70% statewide

-Hillsborough had 26% by strangulation vs. 4% by hands/fist/feet (some of which are likely strangulation, but different reporting sources record categories differently)

There were also several similarities. For example,

-Hillsborough had 16% by stabbing vs. 15% Statewide

-Hillsborough had 10.5% by blunt trauma vs. 11% Statewide.

Over a three-year period 85% of the victims in Hillsborough were killed in their homes. The most recent statewide data is for the year 2008. In that year 77% of the decedents statewide were killed in their homes and in Hillsborough in 2008 87.5% of decedents were killed in their home. The justified killing is included in this percentage because the DV incident started with the decedent trying to kill the "perpetrator" but it should be made clear that the decedent was not a victim of domestic violence but rather the perpetrator of domestic violence. (The boyfriend killing is not included in this percentage.) However the perpetrator's wife's boyfriend was killed at the wife's residence; and the justified homicide also occurred in the wife's mother's house.

Observations/Recommendations

One observation that was evident across the case reviews is that in the majority of cases friends, families and/or co-workers were aware of the domestic violence prior to the fatalities. In looking back, the lethality indicators clearly evidenced a high risk for a serious DV incident including the risk for a fatality. Risk assessments are a useful tool, but if there were a way to educate more of the community about the risks associated with these indicators it might be even more helpful to the DV community and potential victims.

The other consistent observation is that very few of the decedents had accessed social, psychological, domestic violence or other community services. From a prevention standpoint it might be helpful to better understand why this is the case.
While this may suggest services are protective, we as a community need to consider increasing outreach efforts to inform survivors of services rather than waiting for the survivor to contact services on her own.

Although in many cases it was unknown whether the perpetrator had children (and sometimes whether the decedent had children) there was evidence of children being involved in some of the cases. This serves as a reaffirmation that our efforts to reach children who have been exposed to domestic violence are important efforts. Given what we know about the cycle of violence this is a critical prevention focus for the domestic violence community.

The high level of substance abuse involved in fatalities, especially the high level of abuse among perpetrators, is a concerning challenge. Recommendations are difficult. One consideration would be to increase training efforts in the community to provide information to service providers about this risk indicator. It may also be helpful to increase the capacity of substance abuse treatment agencies, so that they could meet the need for this service.

It is very clear that domestic violence is a violence against women issue. Of the 18 victims who were killed, 14 of them were women. Of the 4 men, one was a friend of the female victim, another was a new boyfriend of the female victim, one was in a same sex relationship, and the other was killed in self defense. The only female perpetrator was ruled to be a justified homicide, as he was trying to kill her. Most homicides happened at the victim's home, the one place we should all be able to feel safe.

While a sample of 20 cases is respectable and certainly is a good start, a larger sample size would help us feel more confident about our conclusions and the most appropriate strategies for

the prevention of domestic violence fatalities. A sample size of 30 for the 2011 annual report would be a great goal. However, there are a lot of factors involved with the number of cases reviewed, such as the status of criminal case as we do not review cases until the criminal case is concluded and the number of meetings able to be held. Certainly, we can keep an eye on increasing our reviewed cases sample size as much as possible for 2011, and do as much as we are able to do toward that end.

Finally, the high volume of services from various community DV agencies provided to those DV victims who do seek help reinforces the need to continue to provide and build on these services. Judging by the fact that none but one of the fatalities had sought help from DV services, we may be helping to prevent fatalities. It is especially sad to note that several of the victims lived within walking distance of specialized services, but did not reach out for help.

Conclusion

During the three-year period we are reporting domestic violence homicides are not on the decline. Despite the number of DV homicides reported by law enforcement we know there were nine (9) DV homicides in 2007; 18 in 2008 and 18 DV homicides in 2009. It is imperative to continue tracking what we know to be domestic violence homicides to strengthen our understanding of what more effective interventions are necessary.

Domestic violence fatalities are especially heart breaking because they are preventable. However, there are many caring people working hard everyday to help victims and get them to safety. The statistics speak for themselves – there is a great need to address this issue and work together with various partners out in the community to have as much of a positive impact as possible. We know that nearly every fatality (and suspect that all) had experienced domestic violence prior to their death.

For More Information

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