AN EXAMINATION OF
DOMESTIC VIOLENCE
HOMICIDES IN PINELLAS
COUNTY FLORIDA
2004 REPORT
HISTORY

In August 1999, about fifteen leaders in Pinellas County concerned about domestic violence were invited to discuss convening a Fatality Review Team. The first meeting, called by Linda Osmundson at CASA’s outreach office, included attorney Robin Thompson, former Executive Director of the Governor’s Task Force on Domestic Violence and researchers Neil Websdale, Ph.D. and Byron Johnson, Ph.D. The researchers described the preliminary findings for their project which was commissioned to review domestic fatalities in Florida for 1994 and 1995, funded by the Governor’s Task Force. Six Florida fatality review teams had already convened to investigate domestic fatalities in their counties. Pinellas County was invited to convene our own Fatality Review Team.

Initially, there was great reluctance to become involved in this review process. Many in the room needed to return to their respective organizations or agencies to discuss the proposal. All were concerned about confidentiality. There was much discussion about the purpose of a fatality review team. There was certainly evidence of mistrust between the various organizations represented. Individuals addressed fears that their organization or agency might be blamed after the fact for perceived mistakes. Some were especially concerned about time, resources, and other costs that might be required to be involved. Some saw no useful purpose for the team. We left the meeting with only a commitment to discuss the proposal with the leadership of the organizations and agencies we represented and respond back to Ms. Osmundson regarding future involvement from the groups we represented.

Gaining commitment was slow in Pinellas. The domestic violence centers, CASA and The Haven of RCS, were committed from the beginning, but other organizations and agencies took time to consider the proposal. The Pinellas County Sheriff’s Office was the first law enforcement agency to make a commitment to join the team. Those representing public agencies were especially concerned about the public discussion of homicide cases that could become a political liability. There was much discussion that occurred behind the scenes between agencies. Obviously, we needed a commitment from the State Attorney’s Office and at least the major law enforcement agencies to have a real team. We were encouraged by phone contacts between the researchers and Ms. Osmundson. The researchers returned for a small meeting to discuss our progress towards organizing a team. Several from Pinellas attended a conference in Orlando on fatality review teams. We attended as the “Pinellas Team” even though we had not yet agreed to become a team. Working together to discuss hypothetical cases at the conference helped some to develop more enthusiasm for the potential of forming a team in Pinellas.

Probably the most significant event that allowed the State Attorney’s Office in Pinellas to feel more positive about joining the team was the Florida Legislature’s passage of legislation protecting fatality review teams.

We met again on May 11, 2000 at the Largo Police Department. CASA, The Haven of RCS, police representatives from Tarpon Springs, St. Petersburg, Pinellas Park, St. Pete Beach, and the Sheriff’s Department, the Pinellas County Health Department, Help A Child, Inc., The Administrative Office of the Court, the State Attorney’s Office, Bay Pines VA, The Salvation
Army Correctional Services, and Family Service Centers attended. While some in attendance still could not commit their agencies, we agreed to continue as if we were all committed to the team.

We made the following agreements at the May 11, 2000 meeting:

We will…
- Become a subcommittee of the Pinellas County Domestic Violence Task Force.
- Only review cases involving violence between intimate partners.
- Not attempt to re-open the investigation.
- Look at cases from 1996 forward.
- Only review closed cases.
- Look at murder/suicides that are domestic related.
- Consider all domestic violence related homicides.
- Not interview friends, family or neighbors during our reviews.
- Be closed to the media.
- Review confidentiality statements from other teams in an effort to establish our own.
- Not assign blame.
- Meet once per month at Family Service Centers. (this was later changed to every other month when we “caught up” on old cases and had fewer new cases to review)
- Ask homicide detectives from appropriate agencies to present case if at all possible.

At this meeting, Beverly Andringa from the State Attorney’s Office agreed to provide an overview of the new legislation at the following meeting. We even chose our first case to review at our next meeting that happened to involve two police agencies.

From this cautious beginning, we have evolved to a fairly efficient Fatality Review Team. We established a confidentiality statement that we sign at each meeting. The Team meets for about two hours and generally reviews one to two cases per meeting. After each review we note any trends and discuss what, if anything, could have been done to prevent this particular homicide. We note particular characteristics of the case and potential trends. The reviews have been enlightening and amicable. All agree that we have learned a lot about our respective agencies and organizations. At the end of each meeting, we choose the next cases so that Team members can bring pertinent information and records to the next meeting. We report on trends at Domestic Violence Task Force meetings. As a result, members of the Team have become more educated about domestic homicides in Pinellas County. An added advantage has been that closer working relationships, especially between individuals representing the State Attorney’s Office, the domestic violence centers, and law enforcement, have been established.
MEMBER AGENCIES

Administrative Office of the Court
Area Agency on Aging
CASA (Community Action Stops Abuse)
Clearwater Police Department
Department of Veteran Affairs Medical Center, Bay Pines
Family Service Centers, Inc.
Florida Department of Children and Families
Gulfcoast Legal Services
Gulfport Police Department
The Haven of RCS
Help A Child, Inc.
Largo Police Department
Officer of Clerk of Circuit Court
Pinellas County Health Department
Pinellas County Medical Examiner’s Office
Pinellas County Sheriff’s Office
Salvation Army Correctional Services
State Attorney’s Office, Sixth Judicial Circuit
St. Petersburg Police Department

2004 CASES REVIEWED

The team reviewed seven cases between January 2004 and December 2004. Fifty-seven percent (4) of the cases were homicides and 43% (3) were attempted homicides or near fatalities. Cases reviewed were from St. Petersburg, Oldsmar, Palm Harbor, and Largo. The cases are shown graphically on upcoming pages.

The demographics reveal that 57% (4) of the couples were married and 43% (3) were cohabitating. The race of 57% (4) of the victims and perpetrators was white and 43% (3) was black. Age of the victim ranged from 26 years to 50 years. Age of the perpetrators ranged from 25 years to 54 years. Length of relationship ranged from a few weeks to 20 years.

Fourteen percent (1) of the cases involved a firearm, 44% (3) stabbing, 14% (1) strangulation, 14% (1) blunt trauma, and 14% (1) other.
Distribution of Reviewed Cases 2004

Location of Homicide

- St Petersburg: 29%
- Largo: 29%
- Other (1 Oldsmar; 2 Palm Harbor): 42%

Type of Incident

- Homicide Only: 57%
- Near Fatality: 43%

Demographics for Reviewed Cases - 2004

Ages of Victims/Perpetrators

Income Data
Race of Victims
N=7
- Black
- White
- Asian

Race of Perpetrators
N=7
- Black
- White
- Asian

Marital Status
N=7
- Co-habiting 43%
- Married 57%

Notable Trends - 2004

Age Differences
N=7

Method
N=7
- Stabbing: 44%
- Strangulation: 14%
- Blunt Trauma: 14%
- Gun: 14%
- Other: 14%

Victim older
Perp older
Effects on Children
N=7

Children in Family

[Bar graph showing distribution of children in family]

Children Witnessed

[Bar graph showing distribution of children witnessed]

Perpetrator Status
N=7

Charged 100%

Relevant History
N=7

[Bar graph showing distribution of relevant history]

Legend:
- Yes
- No
RESULTS OF THE REVIEWS

The team evaluates each case and determines if any patterns or trends are present. During the past three years, several of these have emerged as consistent indicators. The following list highlights these patterns or trends:

<table>
<thead>
<tr>
<th>Pattern or trend</th>
<th># 2004 cases</th>
<th>% of 2004 cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Involvement</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>Substance Use</td>
<td>6</td>
<td>86%</td>
</tr>
<tr>
<td>Family/friends/coworkers Aware</td>
<td>6</td>
<td>86%</td>
</tr>
<tr>
<td>Separation Issues*</td>
<td>4</td>
<td>57%</td>
</tr>
<tr>
<td>Prior Domestic Violence History (this relationship)</td>
<td>4</td>
<td>57%</td>
</tr>
<tr>
<td>Age Difference of 6 Years or More</td>
<td>3</td>
<td>43%</td>
</tr>
<tr>
<td>Possible Mental Health Issues</td>
<td>3</td>
<td>43%</td>
</tr>
</tbody>
</table>

(*Separation issues is indicated where a victim was attempting to leave, had recently left, or was indicating that they were going to leave the relationship.)

For the fourth year in a row, several patterns or trends were consistently present. First, a large percentage of the cases involved substance use. In 2004, it was 86% (6) of our cases. In addition, as we have found in previous years, friends and family are often aware of the violence. In 2004, this was evident in 86% (6) of the cases we reviewed. Next, separation issues contributed in 57% (4) of the cases. And, in 43% (3) of the cases there was an age difference of six years or more. We also found that 57% (4) of the cases involved prior incidents of domestic violence.

It is interesting to note that this is the second year that firearm involvement was lower than 50%. This year only one case involved a firearm. For 2004, stabbing was the highest percentage at
44%. In 2003, firearms were used in 40% of the cases. In 2002, firearms were used in 64% of the cases we reviewed. In 2001, that percentage was 59.

In addition, injunctions for protection were sought in 43% of the cases. Furthermore, none of the victims had utilized domestic violence shelter/center services.

All seven cases in 2004 had some form of system involvement. This factor is different than prior years. In the past, our team has found a large number of cases that had no contact with the system, eliminating the possibility for information sharing and intervention.

**CUMULATIVE DATA: 2000 – 2004**

Our team has recognized that analyzing seven to ten cases at a time provides limited outcomes. Therefore, we are pleased to provide the cumulative results of the last four years. The total is fifty-two cases, shown graphically on the next pages. Of those cases, 63% are homicides, 25% are homicide/suicides, and 12% are near fatalities. Fifty-three (53) percent of the cases had an age difference of six years or more between the victim and perpetrator. Fifty (50) percent of the cases involved a firearm, 19% stabbing, 14% strangulation, 11% blunt trauma, and 6% other. And, 48% of the individuals were married, 42% cohabitating, 4% formerly cohabitating, 4% child in common, and 2% other.

Sixty-five (65) percent of the cases involved substance use. In 62% of the cases, friends, family or coworkers knew about the abuse. Also, perpetrators had a criminal history in 56% of the cases and had prior domestic violence arrests in 38% of the cases. In addition, separation issues were present in 38% of the cases.

From the cumulative data, we have developed several recommendations which can be reviewed in the Recommendations section.

**Demographics for Reviewed Cases**

**Cumulative Data: 2000-2004**

<table>
<thead>
<tr>
<th>Location of Homicide</th>
<th>N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Petersburg</td>
<td>36%</td>
</tr>
<tr>
<td>Largo</td>
<td>22%</td>
</tr>
<tr>
<td>Clearwater</td>
<td>10%</td>
</tr>
<tr>
<td>Dunedin</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>22%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Incident</th>
<th>N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide Only</td>
<td>63%</td>
</tr>
<tr>
<td>Homicide/Suicide</td>
<td>25%</td>
</tr>
<tr>
<td>Near Fatality</td>
<td>12%</td>
</tr>
</tbody>
</table>
Ages of Victims/Perpetrators  
N=52

Victims  Perpetrators
0 2 4 6 8 10 12 14 16 18 20+ 24 25+ 35 36+ 45 46+ 65 66+ 80+

Income
N=52

Victim  Perpetrator
0-10k 20-30k 30k+ Retired

Perpetrator’s Race  
N=52

Black  White  Asian

Victim’s Race  
N=52

Black  White  Asian

Relationship Between Perpetrator and Victim, N=52

Married 48%
Co-habiting 42%
Formerly Co-habiting 4%
Child in Common 4%
Other 2%

Notable Trends
Cumulative Data: 2000 - 2004

Age Difference
N=52

Method Used
N=52

Effects on Children
N=52

Perpetrator Status
N=52
ANALYSIS OF THE CUMULATIVE DATA

An analysis of the cumulative data reveals a profile that the most likely victim of domestic homicide or near fatality in Pinellas County will be in the 36 to 65 year old bracket, white, lower income, married or co-habitating, with a six year or more age difference from their perpetrator. The perpetrator will generally be older than the victim. There will likely be substance use/abuse in the household, the perpetrator will have a criminal history of some sort and/or have committed prior domestic violence, and the death will occur as a result of a firearm. Family, friends, or coworkers will know that the violence is occurring. This profile is very similar to the one developed at the conclusion of 2003.

It is important to note that while this profile evolves from the data, the data in these cases vary widely. Any individual in a domestic violence relationship could become a victim of homicide or near fatality. The data simply provide us red flags and information for conducting risk assessments.

RECOMMENDATIONS

1. Seek funding to cover the cost of printing the friends and family brochure previously created as well as to design and implement a friends and family awareness campaign.
2. Highlight pertinent information and insure that local law enforcement homicide units and domestic violence units receive our annual reports.
3. For the upcoming year, track questions that could not be answered during the review and use them as training opportunities with local law enforcement.
4. Track the presence of stalking as a part of reviews.
5. Review fatality review team recommendations at least twice each year during regular Domestic Violence Task Force meetings (to remind members and not lose momentum in implementing changes).
6. In future years, present and disseminate the annual fatality review reports in March versus October.
7. The task force should develop a plan of action to address the first recommendation made in the 2003 annual report. That recommendation was: Due to the high incidence of substance use, share findings with substance abuse professionals and encourage continued education on the dynamics of domestic violence. Work with said professionals to develop and/or implement screening tools related to domestic violence and risk assessment.

**CHANGES IMPLEMENTED IN OUR COMMUNITY**

As a result of the experience of conducting fatality reviews, several changes have been implemented in our community. These changes evolved through discussions and a recognition that small changes could ultimately impact the cases we would review in the future. First, recognizing that children are effected by witnessing domestic violence and violence in general, a videotape on the effects of witnessing violence on children runs periodically in the holding cell area at the Pinellas County jail. This provides much needed awareness education to arrestees. Similarly, after it was identified that friends, family, and coworkers frequently knew about domestic violence but did not know what to do about it, we created a brochure specifically geared toward these individuals. We also saw a significant incidence of seniors in our cases and created a brochure about domestic violence specifically geared toward seniors. Next, a few of the homicide detectives in our county now ask additional questions which focus on the dynamics of domestic violence. Prior to our reviews and discussions, these questions would not have been thought of nor asked. In addition, several of the law enforcement victim advocates in our county review domestic violence reports with a slightly different eye now. These individuals look for the patterns and trends our reviews have identified consistently as they review police reports. When those patterns or trends exist, extra attention and effort are put into follow-up with victims, safety planning, and resource building. Furthermore, members of our team continue to educate others around them about the patterns and trends. As such, constant education occurs. Finally, the agencies involved on the Team have built stronger relationships, greater respect for each other, and a more collaborative spirit. With these kinds of changes and efforts, we hope to change the face of domestic fatalities in the future.

**THANKS TO THE FOLLOWING INDIVIDUALS FOR MAKING THIS REPORT POSSIBLE**

Wendy Loomas, Violence Prevention Office, Pinellas County Health Department, for creating the graphs in this report and serving on the report committee.

Laura Scott, Pinellas County Sheriff’s Office, for serving on the report committee.

Linda Amidei, The Haven of RCS, for serving on the report committee.

Family Service Centers, Inc. for providing the Team with a meeting space and morning beverages.
All of the Fatality Review Team members for their hard work, dedication, perspective, determination, and vision.

All of the detectives, officers, and victim advocates from local law enforcement agencies who have made presentations at our meetings.

**FOR FURTHER INFORMATION**

For further information on the Pinellas County Domestic Violence Task Force and/or Fatality Review Team, please contact:

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