

**AN EXAMINATION OF
DOMESTIC
VIOLENCE
HOMICIDES AND
NEAR FATALITIES IN
PINELLAS COUNTY
FLORIDA
2005 REPORT**

DEDICATION

This report is dedicated to domestic violence homicide victims, near fatality survivors, and their families.

OVERVIEW OF THE DOMESTIC VIOLENCE FATALITY REVIEW TEAM

Domestic violence is one of the most prevalent legal and social problems in the United States. According to the Bureau of Justice Statistics (BJS), (June, 2005), family violence accounts for about 1 in 10 violent victimizations and police statistics show family violence as 33% of all violence they investigate.

Domestic violence in its worst and ultimate form is homicide. Each year approximately 1400 adults die at the hands of a spouse or intimate partner in the United States. Females are victims of domestic homicide in about 76% of these cases, males are perpetrators in 79% of the cases (BJS, June, 2005).

As our society struggles to address the issue of domestic violence, many initiatives, laws, programs, and policies have been implemented. One such newer effort is the creation of a fatality review process. A fatality review team or committee is a group of individuals from various agencies and professions who convene periodically to review local domestic violence homicide cases. The team operates under the belief that by better understanding how and why a homicide occurred, the community can work to help prevent future deaths.

Pinellas County has been working to improve its Coordinated Community Response to domestic violence. Fatality reviews enhance that response as they provide a forum for discussion of patterns and trends, and issues of system response, social change,

and enhanced coordination among individuals and agencies. Through dissemination of reports and findings, the Fatality Review Team endeavors to encourage all members of the Pinellas County community to recognize risks and work to prevent future deaths.

HISTORICAL BACKGROUND

In August 1999, about fifteen leaders in Pinellas County were invited to discuss convening a Fatality Review Team. Initially, throughout the county, there was great reluctance to become involved in this review process. 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.

Gaining commitment was slow in Pinellas. Eventually several participants from Pinellas attended a conference in Orlando on fatality review teams. 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.

The team was constituted on May 11, 2000 and consisted of several agencies including, but not limited to, the Pinellas County State Attorney's Office, multiple law enforcement agencies, correctional agencies, family service organizations, domestic violence shelters, and others.

At that time, it was decided that the team would 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, 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 one locally, not assign blame, and ask homicide detectives from appropriate agencies to present the case being reviewed if at all possible.

A confidentiality statement was established that is signed at each meeting. The team meets for about two hours and generally reviews one or two cases per meeting. After each review, possible trends are noted and discussed. Prevention and intervention strategies are identified that could have possibly affected the outcome of the current case or future cases. Relevant characteristics of the case are also noted. The reviews have been enlightening and amicable. The team reports on trends at the Domestic Violence Task Force meetings and annual reports are generated and distributed throughout the county. Constituting a Fatality Review Team has resulted in partnerships and enhanced communication between agencies that has not existed in the past. The Team believes that these activities lead to a better coordinated community response to domestic violence.

MISSION AND OBJECTIVES OF THE FATALITY REVIEW TEAM

The purpose or mission of the Fatality Review Team is: To conduct multi-disciplinary reviews of domestic violence fatalities and near fatalities in Pinellas County Florida and to use the data to provide community prevention education and awareness activities as well as to make recommendations for legislative and public policy to reduce domestic violence fatalities and near fatalities.

The objectives of the Fatality Review Team are:

1. To describe trends and patterns of domestic violence related fatalities and near fatalities in Pinellas County Florida.
2. To identify high risk factors, current practices, gaps in systemic responses, barriers to safety in domestic violence situations, and recommend prevention or intervention activities to the Domestic Violence Task Force for implementation.
3. To educate the public, policy makers, and funders about fatalities and near fatalities due to domestic violence and about strategies for intervention.
4. To recommend policies, practices, and services that will encourage collaboration to prevent and reduce fatalities and near fatalities due to domestic violence.
5. To improve the process of sharing information between agencies and offices that work with domestic violence victims.
6. To more effectively facilitate the prevention of domestic violence fatalities and near fatalities through multi-disciplinary collaboration.

2005 CASES REVIEWED

The team reviewed five (5) cases during 2005. It is important to note that reviewed cases are closed cases and therefore did not necessarily occur during 2005. Forty percent (2) were homicide/suicides while 60% (3) were near fatalities. Cases reviewed were from Clearwater, Largo, Pinellas Park, and St. Petersburg.

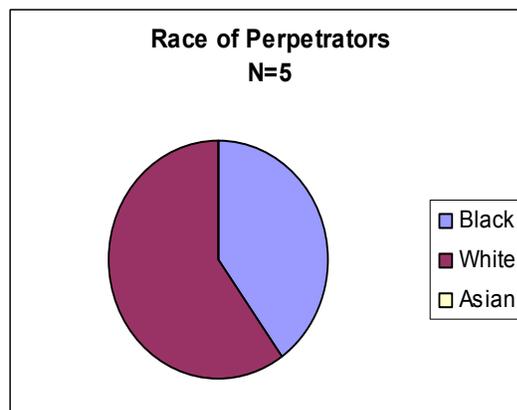
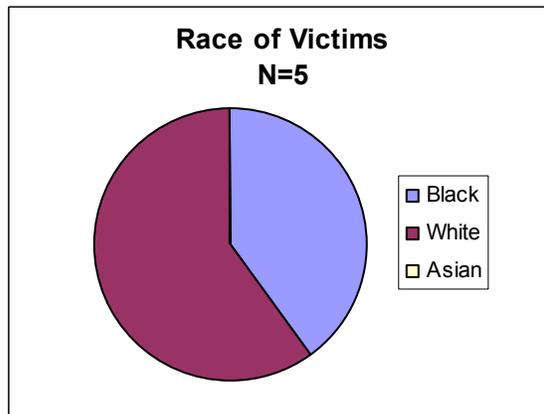
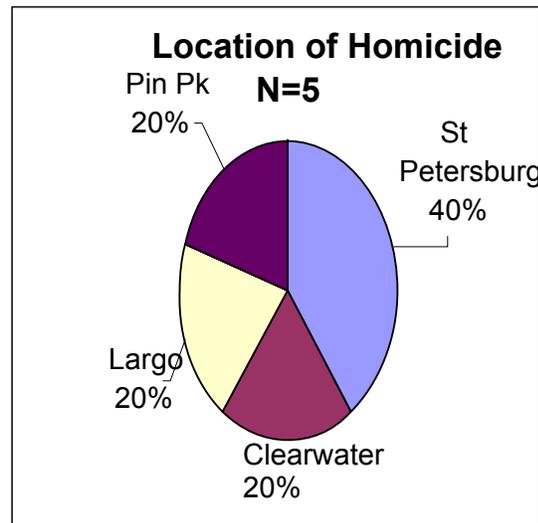
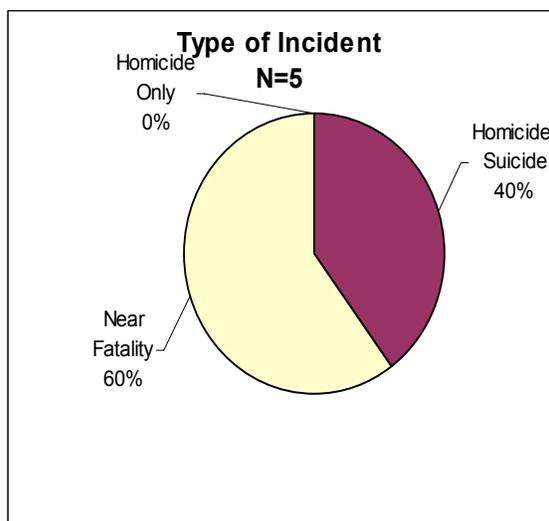
Demographics reveal that 20% (1) of the couples were married, 20% (1) were formerly married, and 60% (3) were co-habiting. The race of 60% (3) of the victims and perpetrators was white and

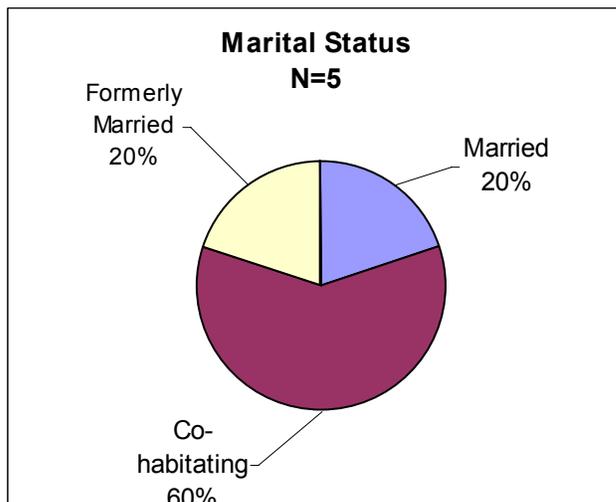
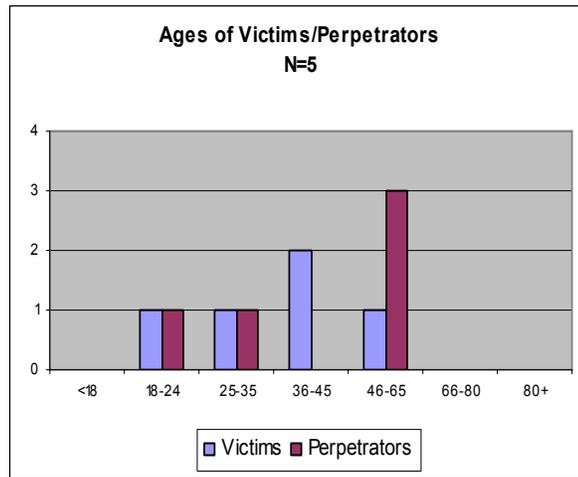
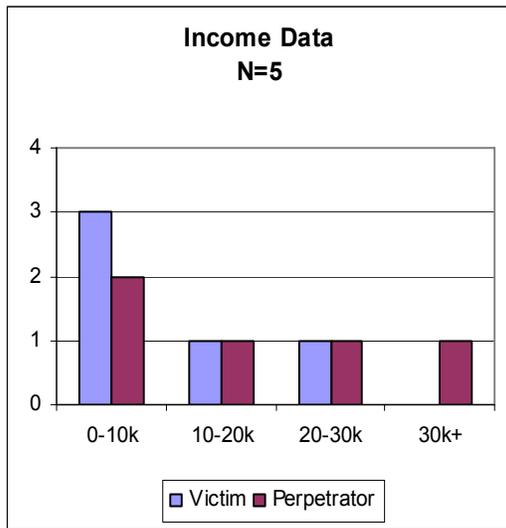
40% (2) was black. The ages of the victims ranged from 21 to 46 years. The ages of the perpetrators ranged from 19 to 58 years. Length of the relationships ranged from 1 year to 7 years.

Sixty percent (3) of the cases involved a firearm, 20% (1) stabbing, and 20% (1) involved a firearm and blunt trauma.

Graphic representations of these and other statistics follow.

DISTRIBUTION OF REVIEWED CASES 2005





RESULTS OF THE REVIEWS

The team evaluates each case and determines if any patterns or trends are present. The following list highlights the patterns or trends identified during 2005:

Pattern or trend	# 2005 cases	% cases
Substance Use	5	100%
Family/friends Knew of Abuse	5	100%
Age Difference 6 or More Years	5	100%
Criminal History (victim & subject)	5	100%
Prior DV Arrests (subject)	4	80%
Firearm Involvement	4	80%
System Involvement	4	80%
Prior DV History in Other Relationship (subject)	4	80%
Prior DV History in This Relationship	3	60%

Several of these patterns or trends are consistently present each year in the cases reviewed, especially substance use, family/friends knowing about the abuse, an age difference of 6 or more years, and firearm involvement.

CUMULATIVE DATA: 2000-2005

In recognition of the fact that 5 cases reviewed in 2005 does not provide statistically significant information on its own, this section reports on the cumulative data from the 57 reviews since the team was formed in 2000.

Of those cases, 33 (58%) were homicides only, 15 (26%) were homicide/suicides, and 9 (16%) were near fatalities which have only been included since 2003. In more than half of the cases the age difference between the victim and the perpetrator was over 5 years. Fifty-three percent of the cases involved firearms, 20% were stabbings, 13% were strangulations, 11% involved blunt trauma, and 5% were from other causes. The relationships between the victim and perpetrator were primarily married (46%) or cohabitating (44%), while just 5 cases (9%) were people no

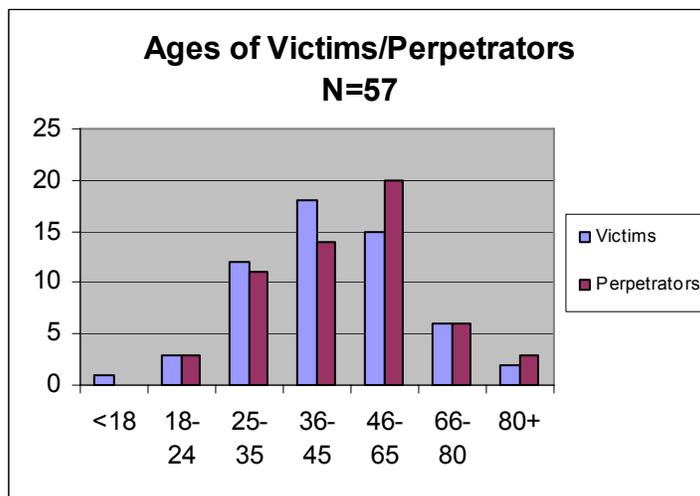
longer in a current relationship. Thirty-five percent of the relationships had experienced a recent separation, which is one expected precursor to an escalation in an already violent relationship.

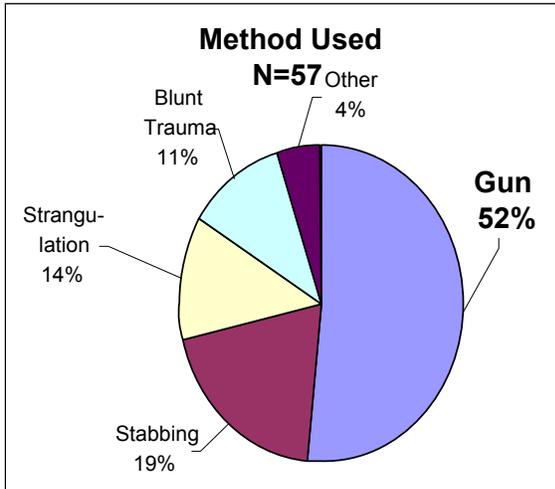
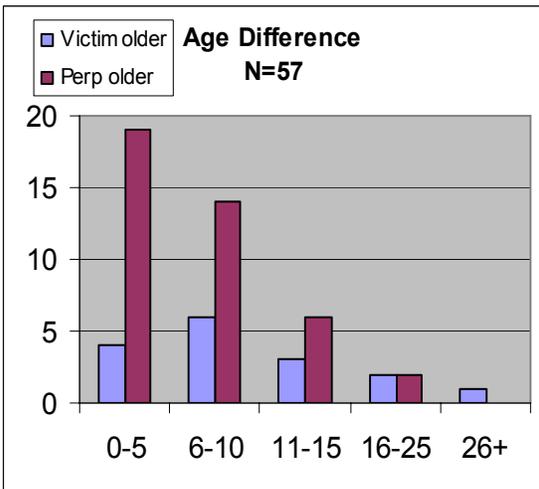
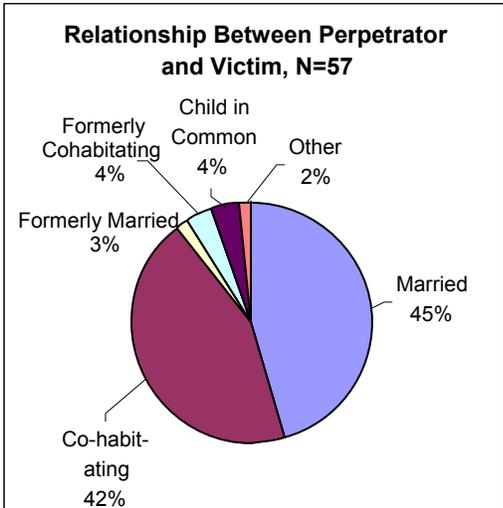
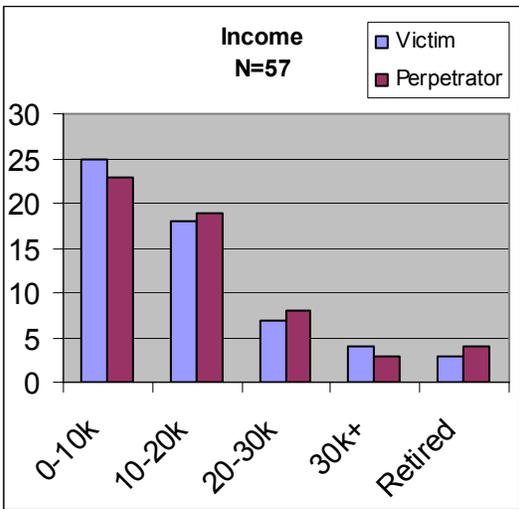
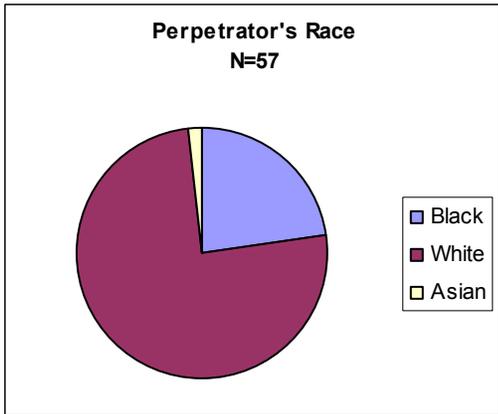
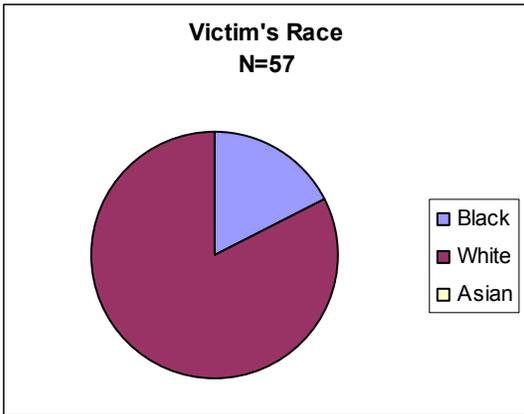
Sixty-eight percent of the cases involved some alcohol or other drug use by either the victim, perpetrator or both parties. In 65% of the cases, it was known that friends and/or family were aware of prior violence. Sixty percent of the perpetrators had a criminal history, and 38% of the victims had a criminal history.

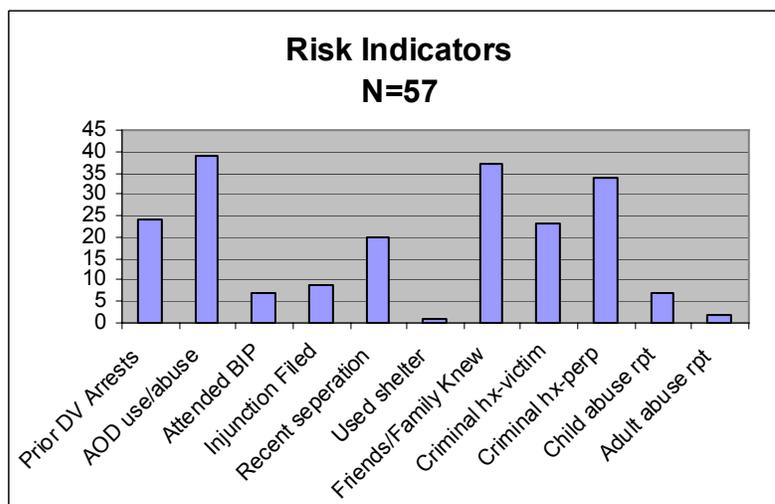
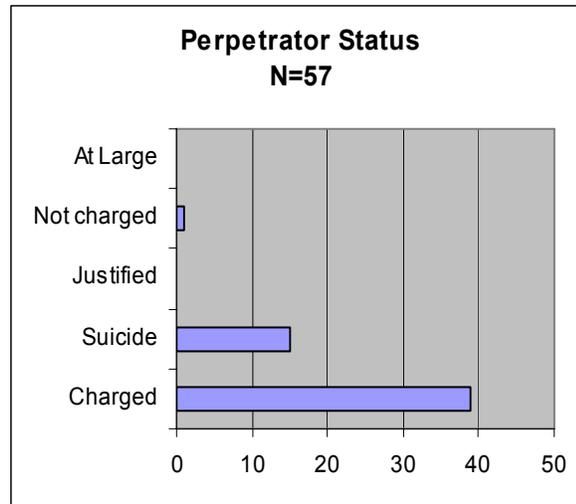
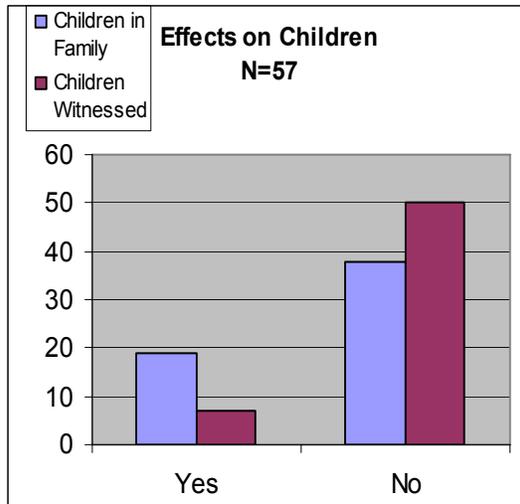
Another useful look at this data is to compare it to the population at large in Pinellas County. Victims and perpetrators between ages 25-45 are represented in these cases to a much higher extent than they are in the general population. This is also true for Black victims and perpetrators, very low income (<\$10,000/year) victims and perpetrators, and residents of St. Petersburg, Largo, and Dunedin.

Graphic representations of these and other statistics follow.

Distribution of Reviewed Cases Cumulative Data: 2000 - 2005







ANALYSIS OF THE CUMULATIVE DATA

The breakdown of the cases noted above are very similar to the cumulative data in recent years, so there seems to be some consistency in the patterns of homicide vs. homicide/suicide, an age difference of over 5 years, the method or weapon used, the relationship between the victim and perpetrator, the involvement of alcohol and other drugs, and whether family and/or friends were aware of the violence.

Further, the profiles of the most likely victim and perpetrator have changed little since reviews began. The most likely victim is still a white female, between 36-65 years old, with an income of less than \$20,000/year and a partner more than five years older than she. The most likely perpetrator can still be described as a white male, in the same age and income bracket as the most likely victim, and older than his victim by more than 5 years. While any domestic violence victim can be killed by their abuser, and any abuser can become a murderer, these profiles help to see 'red flags' when working with victims and perpetrators.

In addition to these consistent factors that create a profile, it is important to note how the demographics of some victims and perpetrators differ from the general population. In Pinellas County, the population between 25-45 years old is 25% of the total whereas that age group represents 52.7% of the victims of these cases and 44% of the perpetrators, virtually double. Also, in Pinellas County, less than 10% of the population lives on an income of under \$10,000 per year, whereas 43.9% of the victims are in this income bracket and 40.4% of the perpetrators are, which is more than 4 times the rate in the general population.

The geographic spread of cases also seems to concentrate in some areas more so than the general population. In St. Petersburg, for instance, only 24.2% of the county's population lives there but 36.8% of these cases took place there. For Largo the statistics are 7% of the population but 21% of the cases, and for Dunedin (while a small actual number) had 3.8% of the population but 8.8% of the cases. Finally, the racial breakdown is also important to note. While the Black population of Pinellas County is 9.8%, the victims in these cases were 17.5% Black and the perpetrators were 22.8% Black.

RECOMMENDATIONS

1. The Fatality Review Team should begin keeping track of the year that cases occurred in an effort to identify any change in incidence rates as well as patterns or trends due to community changes. Likewise, the Team should begin keeping track of community changes such as laws, policies, programs, and funding shifts.
2. The Fatality Review Team should develop a list of important information to gather during a domestic violence homicide investigation, and present this list to homicide detectives and law enforcement agency leaders to both enhance the quality of their investigation and increase the ability to learn from future fatality reviews.
3. The Domestic Violence Task Force should look at the three recommendations from 2004 that were not completed.

CHANGES IMPLEMENTED IN THE COMMUNITY AS A RESULT OF THESE REVIEWS

Out of the seven recommendations made in 2004, four have been implemented. The annual reports are now sent to local homicide and domestic violence units, stalking is tracked if known in these cases, the recommendations are reviewed at least twice a year during Domestic Violence Task Force meetings, and the review reports are now scheduled for spring rather than fall for the previous year.

The 3 remaining recommendations stand as recommendations in this report. Namely that funding be sought to print and distribute brochures for friends and family, that unanswered questions during reviews be used as training opportunities for homicide detectives, and that the Domestic Violence Task Force develop a plan to work

more closely with the alcohol and other drug intervention professionals on improving their screening and interventions related to domestic violence.

A positive outgrowth of these reviews is that one local domestic violence center, CASA, is now regularly offering a friends and family support group. If friends and family usually know about the violence, but don't know what to do, they would benefit – and the victim and perpetrator might also benefit – from knowing more about the dynamics of domestic violence and what they can do to help.

THANKS TO THE FOLLOWING INDIVIDUALS FOR MAKING THIS REPORT POSSIBLE

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

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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.

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For further information on the Pinellas County Domestic Violence Task Force log on to www.dvtf.org