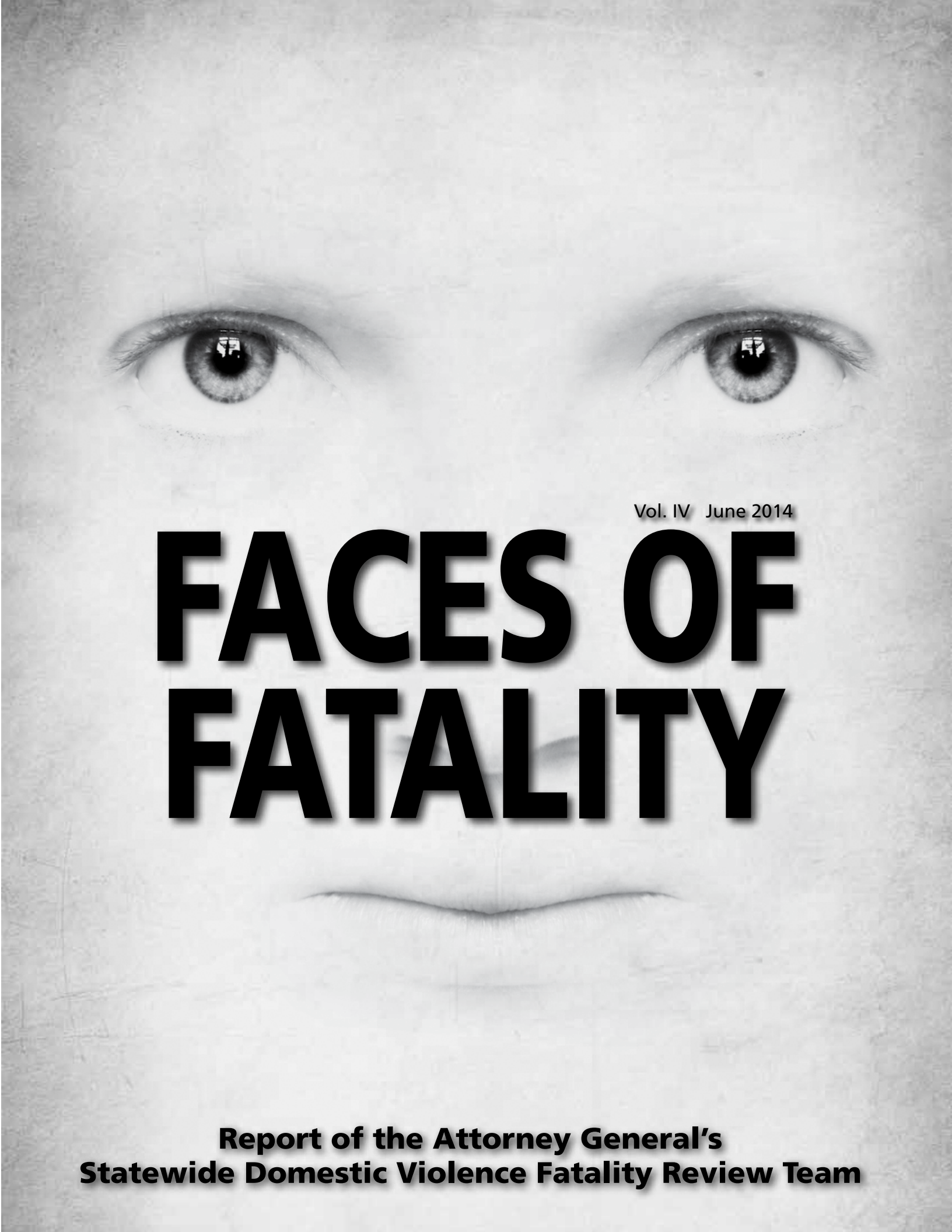

Vol. IV June 2014

FACES OF FATALITY

Report of the Attorney General's Statewide Domestic Violence Fatality Review Team

This report is dedicated to the 187 women, children and men who were killed by an act of domestic violence in Florida last year, to their loved ones, and to those who work every day to prevent these deaths.

"Domestic violence fatality review is an important tool to help us understand why these fatalities occur and identify strategies to keep domestic violence victims and their children safe, and to hold the perpetrators of these crimes accountable. We cannot change the outcome for those we have lost as a result of domestic violence, but the Statewide Domestic Violence Fatality Review Team and local teams work to identify statewide issues and make recommendations for systemic change. I am proud to co-chair the Statewide Team with FCADV and believe this work will help us to better protect Floridians and ultimately find solutions to eliminate domestic violence fatalities."

—Attorney General Pam Bondi

"In Florida, 187 women, children, and men were killed as a direct result of domestic violence during 2013, with tens of thousands of other individuals also impacted by this horrific crime. These are not just statistics – they represent a name, a face, a family, and a story. The work of the Statewide Domestic Violence Fatality Review Team and local county teams helps us understand events leading up to these fatalities and search for answers and solutions to prevent these senseless homicides in the future. We owe the family and friends of those killed by the person who claims to love them the most – answers to unresolved questions. Advocates, legislators, and systems leaders must be informed with the information provided by fatality review teams to create appropriate policy to reduce and prevent future domestic violence homicides. The partnership between FCADV and Attorney General Bondi established the framework to bring together professionals from a myriad of professions to find lasting solutions. The Statewide Domestic Violence Fatality Review Team is committed to continuing the conversation, pushing forward with solutions, and fighting for sweeping policy changes that can prevent domestic violence homicides. There is no better way to honor those we lost than by working tirelessly to ensure a safe future for survivors of domestic violence and their children."

—Tiffany Carr, President/CEO
The Florida Coalition Against Domestic Violence

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EXECUTIVE SUMMARY

In 2013, the Florida Department of Law Enforcement reported in its Uniform Crime Report (UCR) that 170 people were murdered in Florida as a direct result of domestic violence, an 11% decrease from 2012. However, the UCR also reflected that seventeen people died as a result of domestic violence manslaughter, which represents a dramatic 54.5% increase from 2012.

The Attorney General's Statewide Domestic Violence Fatality Review Team, created in 2009, continues to take the lead in addressing systemic issues to prevent domestic violence fatalities. The statewide team is co-chaired by Attorney General Pam Bondi and the Florida Coalition Against Domestic Violence (FCADV). The statewide team includes members representing the continuum of organizations that work with survivors, their children, and perpetrators of domestic violence, including certified domestic violence centers, legal and direct service providers, state agencies, faith-based organizations, law enforcement, probation, parole, corrections, health care, the court system, prosecutors, the defense bar and a survivor. The statewide team is charged with conducting reviews of domestic violence fatalities and near fatalities, and analyzing the data collected by local fatality review teams.

Florida is one of the few states to have a statewide domestic violence fatality review team and local fatality review teams. Currently, there are 24 local teams throughout the state. The purpose of domestic violence fatality review teams is to conduct comprehensive reviews of domestic violence fatalities to assess the various systems that interfaced with the domestic violence victim, the perpetrator and their children, and identify what, if anything, could have prevented the death.[1] Both the state and local teams employ a no shame, no blame approach to identifying common factors in domestic violence homicides, gaps in service provision to survivors, and gaps in accountability systems for perpetrators. This approach enables teams to make recommendations for systemic change that will ultimately prevent domestic violence homicides. When conducting reviews, the teams must comply with statutory mandates to maintain the confidentiality and public records exemptions of any information received. The statute further requires teams to exempt from disclosure the identities of victims and their children. Additionally, all information and records obtained by domestic violence fatality review teams are not subject to discovery or introduction into evidence, and persons attending the meetings may not testify in any civil or criminal action or administrative or disciplinary proceeding if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team.[2] These statutory mandates ensure that team members may freely discuss the circumstances and issues relating to the fatalities.

During fiscal year 2013-2014, the statewide team convened three meetings to conduct a comprehensive review of a 2013 domestic violence double murder/suicide. The team reviewed data submitted by the local fatality review teams relating to 31 domestic violence fatalities and near fatalities that occurred in Florida between 2004 and 2013. The statewide team also monitored the status of its recommendations in prior reports to ensure implementation.

The demographic profile of perpetrators and decedents reflected in the local teams' data in this report shares many similarities with the profiles in the statewide team's 2013 report. For example, perpetrators were predominantly male (93%), and decedents were predominantly female (86%). In addition, perpetrators from the past two review periods were more likely to have histories of substance abuse and more likely to be unemployed as compared to the decedents. Diagnosed mental illness among perpetrators was slightly higher than in prior years (34% in 2014 versus 23% in 2013). Domestic violence and substance abuse histories remain the most common known risk factors associated with fatalities. However, the data in this report also reflected a significant increase from the 2013 report for obsessive behavior (51% versus 31%), weapons use (46% versus 37%), and separation rage (43% versus 29%).

The data collected reinforces that the presence of lethality risk factors are direct indicators of escalation to fatality. The statewide team's review of the double murder/suicide identified nine indicators of high risk of lethality. The local team data revealed that 84% of perpetrators had a known criminal history, domestic violence-related or otherwise, based on criminal records and narrative reports, and 35% of perpetrators had a known criminal history of domestic violence. Approximately half of the perpetrators demonstrated heightened risk factors such as: homicidal tendencies (57%), obsessive behavior (51%), extreme jealousy (51%), suicidal tendencies (46%), and separation rage (43%). Almost half of the fatalities reviewed indicated weapon use by the perpetrators. More than half of perpetrators in these fatalities exhibited 11 or more domestic violence fatality risk factors.[3]

This 2014 report serves as a snapshot summary of the statewide team's key findings, with recommendations to address each of the issues identified, that will increase the probability of preventing domestic violence fatalities in the future. This report serves as an educational document for legislators, state agencies, and community-based organizations to strengthen their understanding of the complexities and factors related to domestic violence homicides. Findings and recommendations should be utilized to assist the executive and legislative branches, stakeholders, and community and statewide organizations when creating policy to prevent domestic violence fatalities in Florida.

[1]In 2000, the Florida Legislature established state and local domestic violence fatality review teams. See s. 741.365, Florida Statutes.

[2]See s. 741.316 and 741.3165, Florida Statutes.

[3]See Lethality Factors: Breakdown of Known Risk Factors Table on page 21.

FINDINGS

These findings are based on an analysis of data submitted to FCADV by local fatality review teams between May 2013 and May 2014. Local teams submitted 31 completed reviews of domestic violence fatalities and near fatalities that occurred between 2004 and 2013. Each team submitted relevant data using a uniform online data collection system that customizes definitions for each data point.

This year's report also includes findings based on a fatality review of a 2013 double murder/suicide conducted by the statewide team. The perpetrator murdered his girlfriend, who was eight weeks pregnant with his child, and her ten-month old child from a previous relationship, ten days after the perpetrator was arrested for domestic battery against the victim and released on bond with a no contact order prohibiting contact with the victim.

Findings from this year's data collection highlight several consistent aspects of victim and perpetrator profiles as well as factors that suggest a heightened risk of lethality:

- The perpetrators were predominately male (93%), and 84% had prior criminal histories.
- 52% of perpetrators had non-domestic violence related criminal histories.
- 35% of perpetrators had a criminal history of domestic violence.
- 19% of perpetrators had criminal "No Contact" orders filed against them, and 10% of perpetrators had a final civil injunction for protection issued against them.
- The decedents were predominately female (86%), and 78% were living with the perpetrator at the time of the fatality. At the time of the fatality, 33% of the decedents were separated from the perpetrator.
- 53% of decedents had children, and 44% had a child from a different relationship.
- Prior to the fatality or near fatality, 32% of cases included known allegations by the decedent of death threats made by the perpetrator to the decedent.
- The decedent reported domestic violence by the perpetrator to the police in 35% of the cases, and in 55% of the cases, family members reported knowing about prior incidents or prior threats of domestic violence by the perpetrator.
- Perpetrators were known by family or friends to carry or possess a weapon in 41% of the cases.
- Perpetrators committed suicide in 41% of the cases and an additional 6% attempted but failed to commit suicide.

Findings based on the fatality review conducted by the statewide team:

- There were several factors that indicated an increased risk of lethality, including:
  - *The perpetrator threatened to kill the victim and the child on multiple occasions.*
  - *The perpetrator threatened suicide on multiple occasions.*
  - *The perpetrator engaged in escalating violent and erratic behavior.*
  - *The victim had a child from a previous relationship.*
  - *The victim was pregnant with the perpetrator's child.*
  - *The perpetrator physically assaulted the victim upon learning of her pregnancy, holding her down with his knee in her stomach, and telling her he did not want the baby.*
  - *The perpetrator was financially unstable and in debt.*
  - *The victim's family lived in another state, the victim was unemployed, and she did not have a local support system.*
  - *The victim was packing the car to leave the perpetrator.*

The perpetrator threatened to kill the victim and the child on multiple occasions.

- The victim and the perpetrator had prior interactions with Florida law enforcement that offered opportunities for law enforcement to:
  - *Identify factors that indicated risk of lethality and ask the victim if she wanted law enforcement to call the domestic violence hotline so she could speak with an advocate.*
  - *Refer the perpetrator to mental health services because of his threats to commit suicide and his threats to kill the victim and her child.*

- In the prior interaction that resulted in the perpetrator's arrest, law enforcement responding to the 911 call received information from the 911 operator about the perpetrator's threats to commit suicide, but were not told that the victim also stated to the 911 operator that the perpetrator had repeatedly threatened to kill the victim and her child.
- The victim told responding law enforcement that she and the perpetrator had argued about the victim's pregnancy and he had physically battered her. The perpetrator confirmed the argument and admitted to the battery, yet the perpetrator was charged with simple battery because the pregnancy was not confirmed by a doctor.
- The victim believed that the no contact order issued by the court at the perpetrator's first appearance prohibited the perpetrator from returning to their home. However, the order only prohibited contact with the victim.
- The victim obtained a pregnancy test from a Florida health care provider which offered the opportunity for health care provider screening for domestic violence and referral to appropriate services.
- There were indications of intergenerational exposure to domestic violence which led to shame and fear of blame.
- A neighbor played a critical role in offering assistance to the victim and her child and contacting law enforcement to request a safety check for the family.

RECOMMENDATIONS

FCADV should seek funding to continue to provide its Advanced Domestic Violence for Law Enforcement Training, endorsed by the Florida Police Chiefs and Florida Sheriffs Associations, so that all Florida law enforcement agencies receive the training. FCADV should seek funding to expand the scope of this training to include 911 dispatchers, law enforcement victim advocates, emergency medical technicians, fire departments, and other first responders.

Training topics should include risk assessment protocols, red flag indicators of increased danger, conducting safety checks, making appropriate service referrals to victims and perpetrators, and making appropriate charging decisions. The training should include these key points:

- When contact is made with a victim of domestic violence, in addition to providing the victim with the domestic violence brochure, law enforcement should offer to call the hotline number for the local certified domestic violence center so a victim may speak with an advocate privately. Once connected with the hotline, domestic violence advocates will conduct confidential safety planning and risk assessment that encompass factors known to indicate an increased risk of danger or lethality to victims and their children. Such factors include, but are not limited to, threats to kill the victim, threatening the victim with a weapon, and suicidal threats by the abuser. A risk assessment also involves asking whether the victim believes the abuser is capable of killing, and other questions about the victim's unique circumstances that may indicate increased danger. FCADV is currently developing a training video for law enforcement on conducting an abbreviated risk assessment which will be included in the advanced law enforcement training series. Conducting this FCADV-developed abbreviated risk assessment helps law enforcement explain to victims why they are in danger and why they should seek immediate assistance from a certified domestic violence center advocate who can then conduct a confidential full risk assessment and comprehensive safety planning.
- When a caller relays information about domestic violence to the 911 dispatcher, no matter the initial reason for the call, the operator must relay that domestic violence information to responding law enforcement to enable them to fully investigate the case, and to protect the safety of both the victim and responding law enforcement.
- 911 dispatchers should understand the heightened dangers for victims of domestic violence and their children when there is a threat of suicide or any threat of the use of weapons, and instruct the caller to safely leave the vicinity of the suicidal person.
- Law enforcement and other first responders should understand the heightened danger for victims of domestic violence and their children when a perpetrator threatens suicide or threatens the use of weapons, and should not rely solely on the perpetrator's assurances that the perpetrator is not suicidal or is not going to harm anyone.

- When law enforcement agency victim advocates contact victims by phone, they must use a phone that conceals the law enforcement agencies' phone identification. Law enforcement victim advocates should ask yes or no questions at the beginning of the phone call to determine whether the victim can speak freely, and to assess whether the victim is at risk.
- Law enforcement victim advocates should help victims of domestic violence identify and seek assistance from support systems such as family members, friends, clergy, or anyone the survivor frequently contacts.

The Florida Legislature should continue to require health care providers to receive initial and continuing education on domestic violence, and should require that students attending medical and nursing schools as well as those seeking degrees in a health care related field receive comprehensive training on domestic and dating violence.

Such training should include screening for domestic violence in the health care setting, high risk indicators for lethality, red flag indicators of increased danger, making appropriate service referrals to victims and perpetrators, and the Affordable Care Act's domestic violence screening requirements. FCADV should conduct a thorough review of the Continuing Education Unit (CEU) training currently provided to health care professionals, and should convene a workgroup of physicians, nurses, representatives of the Council of Florida Medical School Deans, faculty of medical schools, and other relevant partners to assess the viability of requesting that the Legislature mandate domestic violence training for students seeking medical, nursing, or other health care degrees, as well as continued education for current practicing health care professionals. Upon consensus from the workgroup, FCADV should seek legislative support to revise the current domestic violence educational requirements for health care professionals.

The Florida Legislature should amend s. 903.047, Florida Statutes, Conditions of Pretrial Release, to make the order of no contact with the victim effective immediately, and to permit the court to impose special conditions for persons charged with domestic or dating violence.

Such special conditions should include the following prohibited acts: returning to the dwelling that the parties share, unless accompanied by law enforcement to collect belongings; going to, or being within 500 feet of the victim's residence, school, place of employment, or a specified place frequented regularly by the victim and any named family or household member; committing an act of violence or stalking against the victim; committing any other violation of the order through an intentional unlawful threat, word, or act to commit violence against the victim; telephoning, contacting, or otherwise communicating in any manner with the victim directly or indirectly, unless the order specifically allows indirect contact through a third party; knowingly and intentionally coming within 100 feet of the victim's motor vehicle, whether or not that vehicle is occupied; defacing or destroying the

RECOMMENDATIONS

victim's personal property, including the victim's motor vehicle; and refusing to surrender firearms or ammunition if ordered to do so by the court.

Stakeholders, including FCADV, the Florida Department of Law Enforcement, the Florida Sheriffs and Police Chiefs Associations, and local law enforcement agencies should confer to propose an appropriate victim notification system so that the victim is notified immediately about the existence of the no contact order and the conditions imposed on the perpetrator.

The Florida Sheriffs and the Police Chiefs Associations should build on their current partnerships with FCADV to develop a domestic violence curriculum for law enforcement agencies who train citizen volunteers for involvement in Neighborhood Watch and who make presentations to neighborhood associations about crime prevention. This curriculum will educate volunteers and neighborhood associations about domestic violence, and encourage neighbors to call law enforcement if they believe domestic violence is occurring.

Educating communities about domestic violence allows citizens to be the eyes and ears for law enforcement, and also affords an opportunity for neighbors to connect with each other through increased awareness.

The Statewide Domestic Violence Fatality Review Team should form a subcommittee to develop a comprehensive plan for educating the general public, with a specific focus on individuals working within systems that interface with domestic violence victims, their children, and perpetrators, regarding the adverse impact of victim blaming on systemic efforts to protect victims and children, hold perpetrators accountable and prevent domestic violence.

Victim blaming attitudes, beliefs and behaviors marginalize victims and make it harder for them to report abuse to authorities or disclose abuse to those closest to them, including family and friends. Domestic violence victims are aware that society blames them for the abuse and as a result, they often feel shame and do not feel safe or supported in seeking the help they need and deserve. Victim blaming attitudes, beliefs and behaviors also reinforce the abuser's consistent message that it is the victim's fault the abuse is happening. It is critical that individuals working with domestic violence victims and perpetrators, as well as society as a whole, engage in messaging that makes clear that the batterer's behaviors, choices, and decisions are unacceptable. A consistent societal reframing and redirection to focus on batterer responsibility will naturally transcend the conversation from victim blaming to perpetrator accountability.

This fatality review conducted by the statewide team is based on information from law enforcement reports, the homicide case report, a 911 audio tape and 911 transcripts, the medical examiner's report, newspaper articles and the statewide team's in-person interviews with the detective sergeant who investigated the case and a family member of the victims.

In September 2013, D.T., age 23, and her son, F.T., age 10 months, were murdered by her intimate partner, R.K., age 28, who then killed himself.[4] D.T. was eight weeks pregnant with R.K.'s child at the time of her murder. The murders and suicide occurred ten days after R.K. was arrested for domestic battery against D.T. and released on bond with a no contact order prohibiting contact with D.T.

Background on the victims and the perpetrator

D.T. and R.K. met in Ohio in January 2012. D.T.'s and F.T.'s father's relationship ended after she became pregnant with F.T. D.T. went to work as a live-in nanny for R.K's two children. R.K. and his wife were separated and later divorced. During D.T.'s employment as the nanny, she and R.K. began an intimate relationship. D.T. gave birth to her son, F.T., in November 2012. R.K. was present at the birth. At some point between November 2012 and March 2013, R.K.'s wife moved to New Jersey with the two children to reside with R.K.'s parents. D.T. and F.T. continued to live in the house with R.K. R.K. gave D.T. an engagement ring in March 2013. They relocated to Florida in July 2013.

D.T. was raised in Ohio, the youngest of five siblings. D.T.'s parents divorced when D.T. was in the first grade. D.T. was a talented artist and hoped to work in design. D.T. was devoted to F.T. D.T.'s family described F.T. as beautiful, happy, loving and sweet.

R.K.'s parents resided in New Jersey with his younger brother. R.K. earned a culinary arts degree, and had worked as a chef in the past. A police report described R.K. as self-employed. R.K. was having financial difficulties and was in debt. D.T.'s family believed R.K. was polite, generous, and took good care of D.T. and F.T.

Events leading up to the homicides and suicide

On March 23, 2013, R.K. called the police in Ohio to report that his ex-girlfriend, D. T., was refusing to leave the property, and was throwing things at him and verbally abusing him. The responding officer's report reflected that R.K. wanted D.T. and F.T. removed from the property but that she and the child lived there. D.T. did leave with F.T. for the night, and the report stated that the police incident was closed.

On March 31, 2013, while the couple and F.T. were visiting R.K.'s relatives in Florida, law enforcement responded to R.K's call that he was angry at D.T. because she would not return jewelry he had given her. R.K. planned to drive back to Ohio in the morning and was refusing to take D.T. and F.T. with him. Law enforcement reported speaking to R.K. and D.T. at the scene and no further action was taken.

On April 6, 2013, R.K. called police in Ohio and the responding officer's report noted that R.K. and D.T. were arguing, that it was a civil matter, and that the police incident was closed.

In July 2013, R.K., D.T. and F.T. moved to Florida where they rented a home. On the night of August 19, 2013, R.K. told D.T. to leave the house, and when she refused, he grabbed her by the leg. She agreed to leave and he drove her and F.T. to a homeless shelter but it was not open. He then drove them to a law enforcement agency, where they talked to law enforcement and then drove home.

On the morning of August 20, 2013, D.T. called 911 because R.K. was threatening suicide. The 911 operator heard a male voice yelling in the background during the call. D.T.'s phone number did not show up on caller identification, so the operator could not call back when the call was disconnected. The 911 operator listened to the recording of the call after it was disconnected and reported hearing a female say, "He is hitting me," and "I am trying to help you." The 911 operator dispatched law enforcement for a well-being check. Law enforcement went to the residence and spoke with R.K. D.T. and F.T. were not present. The report stated that R.K. told them that D.T. called 911 prior to leaving to pick up her sister at the Tampa airport, that they had only had a verbal dispute, that he was fine and he did not want to harm himself or anyone else. The report

stated that R.K. was not wearing a shirt and no injuries were observed on his body, they did not see any other persons inside the house, and they did not observe any suspicious items. There was no further action taken.

D.T.'s sister arrived in Florida from Ohio on the morning of August 20, 2013. D.T. was an hour late picking her up from the airport, and told her sister that she had been running late.

On August 24, 2013, the day her sister was returning to Ohio, D.T. asked her sister if she could go with her. D.T. told her sister that the night before, when she told R.K. that the home pregnancy test indicated she was pregnant, he held her down on the bed with his knee pushed into her stomach, put his hand over her mouth so she could not scream to her sister for help, and told her he did not want her to have the baby. This was the first time D.T. told her sister about the abuse.

When D.T. told R.K. of her plans to leave, R.K. became angry and took D.T.'s wallet with her identification and items she needed for F.T., and locked himself in the master bathroom. R.K. sent texts to D.T. and her sister from the bathroom saying that he was going to kill himself, and that he wanted them to know he loved them both. R.K. sent a text to DT.'s sister asking her to take care of D.T. and the baby.

D.T. called 911 and stated that R.K. had locked himself in the bathroom with the shower on, had knives with him, and was threatening to kill himself if she left him. D.T. told the 911 operator that R.K. was a chef and had 100 knives in the house. D.T. told the 911 operator that R.K threatened suicide and threatened to kill her and F.T. several times a week. D.T. reported that she was outside with her baby and her sister, and was afraid to go back into the house. The 911 operator instructed D.T. to go back into the house to determine whether she heard any sounds from R.K.

Law enforcement responding to the scene were not informed by the 911 operator that D.T. told the operator that R.K., in addition to threatening to kill himself, had also threatened to kill D.T. and F.T. several times a week. Responding law enforcement spoke to R.K., who denied making suicidal statements, and after interviewing R.K. further, determined he did not meet Baker Act criteria.

At the house, D.T. signed sworn statements about the previous night's battery by R.K. when they argued about the pregnancy, and about past batteries when R.K. pushed her to the floor while she was holding F.T. She stated that R.K. threatened to harm her, and threatened to hold a knife to F.T.'s neck if she did not do what he wanted. She also stated that three times a week she had to pry knives out of R.K.'s hands because he threatened to kill himself, and that R.K. had kicked her and F.T. out of the house six times since August 1, 2013. Law enforcement observed and took pictures of bruises on D.T.'s arm and thigh, and gave D.T. a domestic violence pamphlet.

R.K. told law enforcement that he saw the positive pregnancy test, that he and D.T. argued, and he admitted to the battery. Law enforcement arrested R.K. for domestic battery, and stated in the report that because D.T. did not have a doctor's confirmation of the pregnancy, the battery charge was not enhanced. D.T.'s sister said that as law enforcement was escorting R.K. from the home, R.K. looked very angry and glared at them both. After R.K. left D.T. told her sister that the reason she was late picking her up at the airport was because of R.K.'s threats and the 911 call on August 20, 2013.

On August 24, 2013, D.T.'s sister flew back to Ohio. The following day, D.T. and F.T. flew to Ohio to stay with D.T.'s family.

On August 25, 2013, at R.K.'s first appearance, R.K. is released on bond, and the judge issued a no contact order that prohibited R.K from contacting D.T. The no contact order did not prohibit R.K. from returning to the home. R.K. called law enforcement that same day from their home and stated that he was arrested for battery against his girlfriend and had a no contact order, but his girlfriend had his car. He asked how he could find the car without contacting her. R.K. sent D.T.'s sister several texts while they were in Ohio, stating that he could not contact D.T. directly, and asking for the location of his credit card and car keys.

On September 2, 2013, D.T. and F.T. flew back to Florida. D.T. intended to pack their belongings in their SUV and drive back to Ohio. D.T.'s family said D.T. believed that the no contact order prohibited R.K. from going to the house, so she thought it would be safe to return. D.T. told her family that R.K. had sent her texts after she returned to Florida.

On September 3, 2013, D.T. received written confirmation from her Florida health care provider that she was eight weeks pregnant. On September 4, 2013, a law enforcement victim advocate called a number which she believed was D.T.'s number. A female answered, the advocate identified herself, and the female said "D.T. isn't here."

The Homicides and Suicide

On September 5, 2013, R.K. called his mother in New Jersey at approximately 4:20 p.m. His mother said he sounded upset and talked very fast about D.T. being at the house. R.K called his mother again at 6:20 p.m. using D.T.'s phone and they spoke briefly. His mother was concerned about him and tried to call him three additional times that evening, but did not reach him. R.K.'s parents booked a flight to Florida for the next morning because they were worried.

A neighbor saw R.K., D.T. and F.T. in the front yard of their home at approximately 7:15 p.m. R.K. was talking and waving his arms, and D.T. looked upset, but the neighbor could not hear what R.K. was saying. The SUV was parked in the driveway with its doors and hatch open and there were suitcases, a car seat, and a child's belongings in the yard near the car. D.T. and F.T. were wearing bathing suits. The neighbor saw R.K. go into the house leaving D.T. and F.T. outside. The neighbor approached D.T. and told her that if she was having problems or needed help, she could come to his house. D.T. declined and said there were no problems. The neighbor returned to his home.

At approximately 10 p.m., the same neighbor noticed that the SUV in the driveway was in the same position outside the house with the doors open as it was earlier. The garage door was still open and the house had no lights on. He confirmed with another neighbor that there were no lights on in the back of the house. He called law enforcement for a well-being check. Law enforcement responding to the scene found D.T. and F.T. dead with multiple stab wounds, and R.K. dead of what was later determined to be self-inflicted stab wounds.

D.T.'s family shared a poem written by D.T.

I believe in fate.

I believe in humanity and goodness.

I believe in options and choices.

I believe in God.

I believe in beauty.

I believe there is always something else, something more, something different.

I believe in change.

I believe in taking chances.

I believe in karma.

I believe there's three sides to every story.

I believe there's good in everyone.

I believe in presentation.

[4]Out of respect for the victims, the perpetrator and their families, the initials of the victims and perpetrator have been changed.

LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

The 2014 report includes information from 31 reviews conducted by local teams of fatal or near-fatal domestic violence incidents in Florida that occurred between 2004 and 2013.

YEAR OF INCIDENT	# OF REVIEWS
2004	1
2006	2
2008	1
2009	4
2010	3
2011	4
2012	12
2013	4

For each fatality or near fatality, local teams reviewed and described characteristics of the perpetrator, the decedent, the relationship, criminal records, domestic violence histories and services provided, the fatality, and a range of risk factors. The data points provide descriptive statistics based on the information that teams were able to obtain for the 2014 case pool. Generally, the data points are based on 31 reviews submitted by local teams. Statistics are provided for each of these categories, followed by a brief comparison between this year's data and the information that was collected in 2013 for last year's report. For some data points, the descriptive statistics may not add up to 100% due to rounding in the statistical analysis.

In some instances, however, statistics are based on different totals from the 31 fatalities or near-fatalities reviewed. This is either due to non-applicability or missing information for any given review. The team included the total number of cases for each category that was used to calculate a given statistic in parentheses. This year's case reviews included two cases out of the 31 total cases (6%) for which reviewers perceived the "perpetrator" as a domestic violence victim acting in self-defense. The team excluded those two cases in the descriptive statistics that inquire about specific details of perpetrators or decedents because of the unique circumstances surrounding those cases.

Perpetrator Characteristics

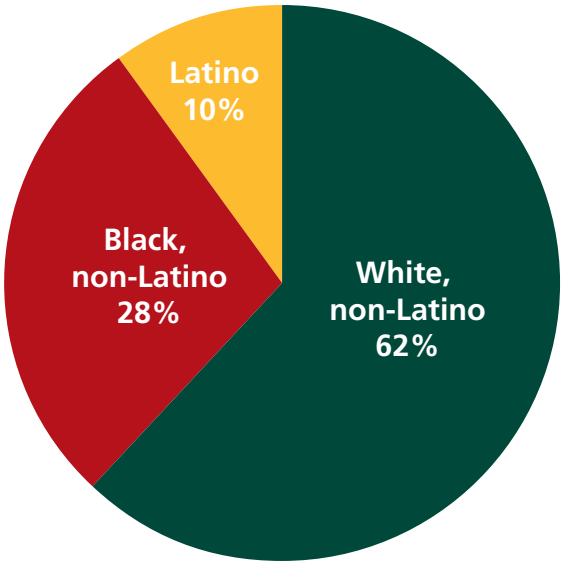
Gender: 93% male (27 of 29), 7% female (2 of 29)

Race/ethnicity:

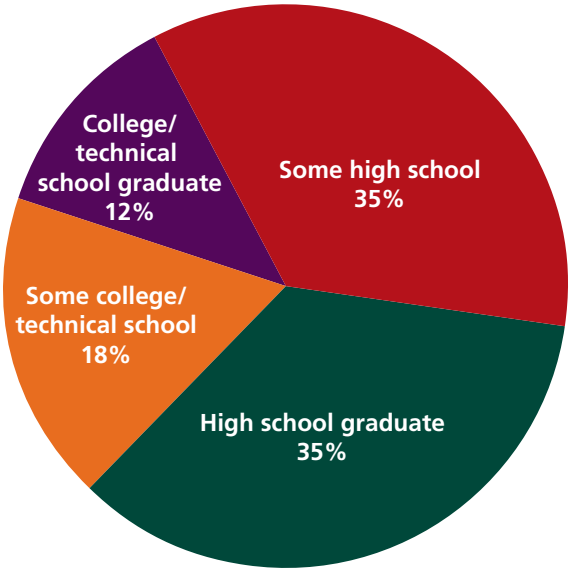
62% White, non-Latino (18 of 29)
28% Black, non-Latino (8 of 29)
10% Latino (3 of 29)

Average age: 40 (min: 18, max: 72)

PERPETRATOR RACE-ETHNICITY



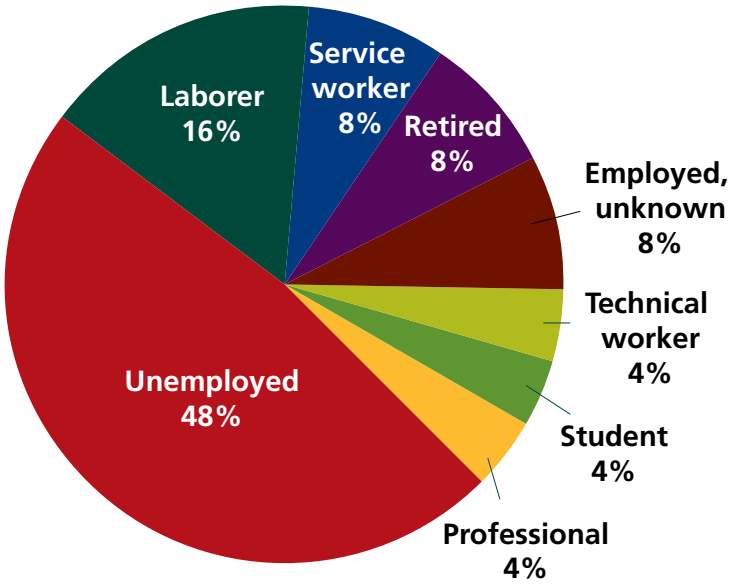
PERPETRATOR EDUCATION LEVEL



Education level:

35% some high school (6 of 17)
35% high school graduate (6 of 17)
18% some college/technical school (3 of 17)
12% college/technical school graduate (2 of 17)

PERPETRATOR EMPLOYMENT STATUS



Employment type:

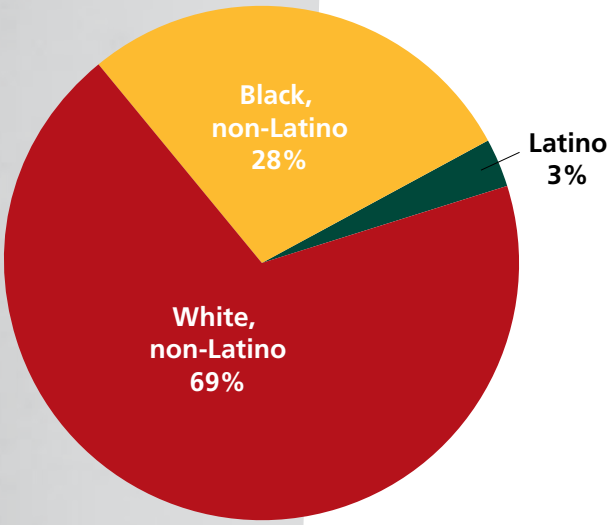
48% unemployed (12 of 25)
16% laborer (4 of 25)
8% employed, type unknown (2 of 25)
8% service worker (2 of 25)
8% retired (2 of 25)
4% technical/skilled worker (1 of 25)
4% student (1 of 25)
4% professional (1 of 25)

LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

Other known perpetrator characteristics:

- In 52% of cases (15 of 29), reviewers identified evidence of substance abuse of some kind based on various sources (e.g., DUI records, police reports, substance abuse services, personal narratives from self, family, friends, or co-workers).
- In 34% of cases (10 of 29), reviewers found evidence of medically diagnosed mental health disorders.
- In 41% of cases (12 of 29), reviewers learned that the perpetrator was known, by family or friends, to carry or possess a weapon.
- In 28% of cases (8 of 29), reviewers found evidence of prior stalking behavior on the part of the perpetrator.

DECEDENT RACE-ETHNICITY



Decedent Characteristics

Gender: 14% male (4 of 29), 86% female (25 of 29)

Race/ethnicity:

69% White, non-Latino (20 of 29)
28% Black, non- Latino (8 of 29)
3% Latino (1 of 29)

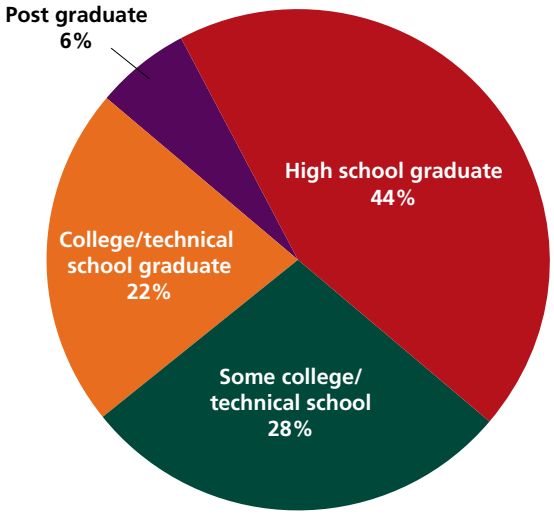
Average age: 39 (min: 6, max: 76)

Decedent Education Level

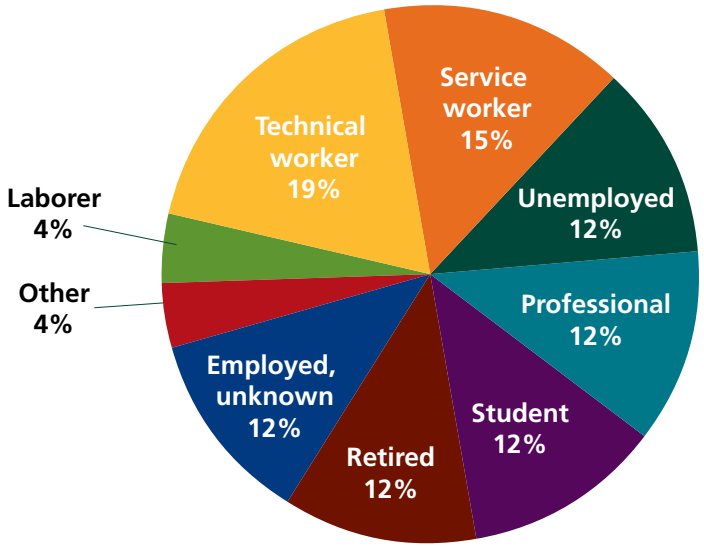
Education Level:

44% high school graduate (8 of 18)
28% some college/technical school (5 of 18)
22% college/technical school graduate (4 of 18)
6% post graduate (1 of 18)

DECEDENT EDUCATION LEVEL



DECEDENT EMPLOYMENT STATUS



Employment type:

19%	technical/skilled worker (5 of 26)
15%	service worker (4 of 26)
12%	employed, type unknown (3 of 26)
12%	professional (3 of 26)
12%	unemployed (3 of 26)
12%	student (3 of 26)
12%	retired (3 of 26)
4%	laborer (1 of 26)
4%	other (1 of 26)

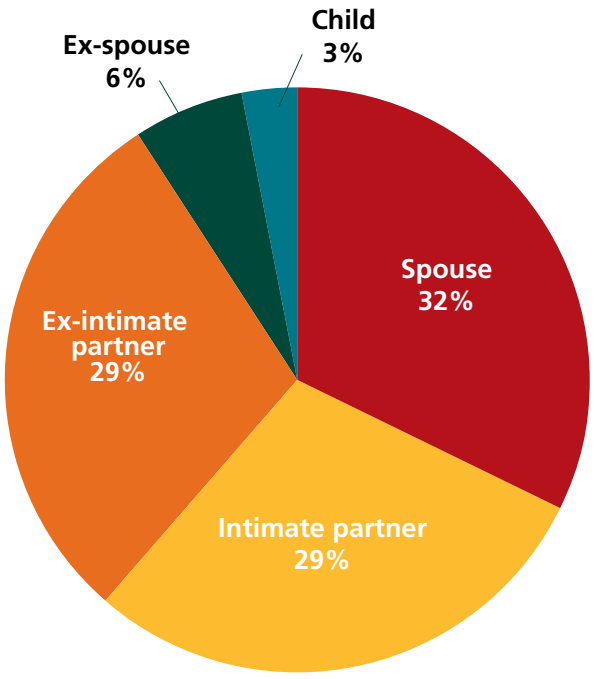
In this year's reviews, 41% of the perpetrators committed suicide and an additional 6% attempted but failed to commit suicide.

Relationship Characteristics

53% of decedents (16 of 30) had children:

19%	1 child (3 of 16)
50%	2 children (8 of 16)
19%	3 children (3 of 16)
13%	4 children (2 of 6)

RELATIONSHIP TYPE



Relationship of perpetrator to decedent:

32%	spouse (10 of 31)
29%	intimate partner (9 of 31)
29%	ex-intimate partner (9 of 31)
6%	ex-spouse (2 of 31)
3%	child (1 of 31)

Mean length of relationship: 9 years

LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

Relationship Characteristics

Of decedents with children, 44% (7 of 16) had children outside of their relationship with the perpetrator. The perpetrator was the natural parent of all of the decedent's children in 56% of cases reviewed in which the decedent was known to have children.

Prior living arrangements and separation:

- In 70% of cases (21 of 30), couples previously lived together full time, and in 20% of cases (6 of 30), couples were known to have been living together "off and on."
- In 78% of cases (21 of 27), couples were known to have been living together at the time of the incident. In 22% of cases (6 of 27), couples were known not to have been living together at the time of the incident.
- Reviewers found evidence of separation at the time of death (marital, separate households, or both) in 33% of cases (9 of 27).
- The average length of separation, when known, was approximately .98 years (min=0, just separated, max=10).

Threats, Stalking and Harassment:

- In 32% of cases (6 of 19), there was known allegations by the decedent of death threats made by the perpetrator towards the decedent, prior to the incident.
- In 16% of cases (3 of 19), there was known harassment of the decedent, by the perpetrator, at the decedent's workplace.

Criminal Records

Perpetrator:

- 52% (16 of 31) of perpetrators had a known, non-domestic violence related criminal history.
- 35% (11 of 31) of perpetrators had a known criminal history of domestic violence.
- 84% (26 of 31) of perpetrators had a known criminal history—domestic violence-related or otherwise—based on criminal records and narrative reports.
- In 35% of cases (11 of 31), there were known prior reports to the police by the decedent, alleging domestic violence by the perpetrator.
- In 55% of cases (17 of 31), family members reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator.
- In 19% of cases (6 of 31) there was a known "No Contact" order issued against the perpetrator.

- In 10% of cases (3 of 31) there was a known permanent injunction filed against the perpetrator by the decedent.
- In 13% of cases (4 of 31) there was a known permanent injunction filed against the perpetrator by someone other than the decedent.
- There were no injunction violation arrests discovered by reviewers.

Decedent:

- 13% of decedents (4 of 31) had a known history of domestic violence, based on criminal records and narrative reports.
- In 3% of cases (1 of 31) there was a known "No Contact" order issued against the decedent.
- There were no known permanent injunctions filed against the decedent by the perpetrator.

Domestic Violence and Social Services

- In 32% of cases (10 of 31), there was known contact between the Florida Department of Children and Famililes (DCF) and the decedent or her/his family.
- In 21% of cases (6 of 29), there was known contact between the decedent and victim support services.
- In 7% of cases (2 of 29), there was known contact between the decedent and a domestic violence shelter.
- 6% of perpetrators (1 of 16) with a prior history of domestic violence were currently or had been previously enrolled in a Batterers' Intervention Program (BIP).

Fatality Characteristics

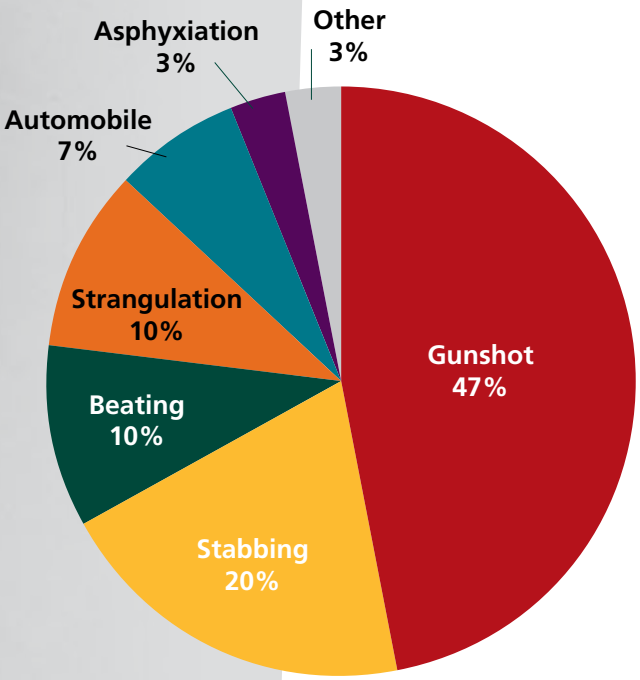
- 41% of perpetrators (12 of 29) committed suicide and an additional 6% (2 of 35) attempted but failed to commit suicide.
- There was known substance use by the perpetrator in 48% of fatalities. (This information is based on self-reports by the perpetrator and medical toxicology reports.) The breakdown is as follows:

30%	alcohol (7 of 23)
9%	drugs and alcohol (2 of 23)
9%	drugs (2 of 23)
52%	no evidence of substance abuse (12 of 23)

- 10% of fatalities (3 of 29) had a collateral victim (i.e., a victim other than the decedent which does not include perpetrator suicides).
- There were known child witnesses in 13% (4 of 31) of cases.

LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

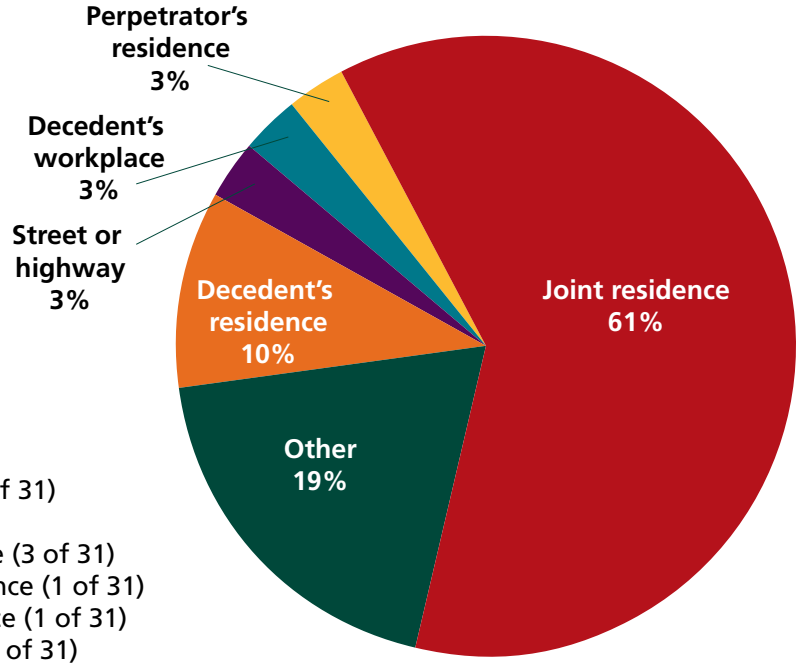
MANNER OF DEATH (INCLUDES ATTEMPTED)



Manner of death (includes attempted):

47%	gunshot (14 of 30)
20%	stabbing (6 of 30)
10%	strangulation (3 of 30)
10%	beating (3 of 30)
7%	automobile (2 of 30)
3%	asphyxiation (1 of 30)
3%	other (1 of 30)

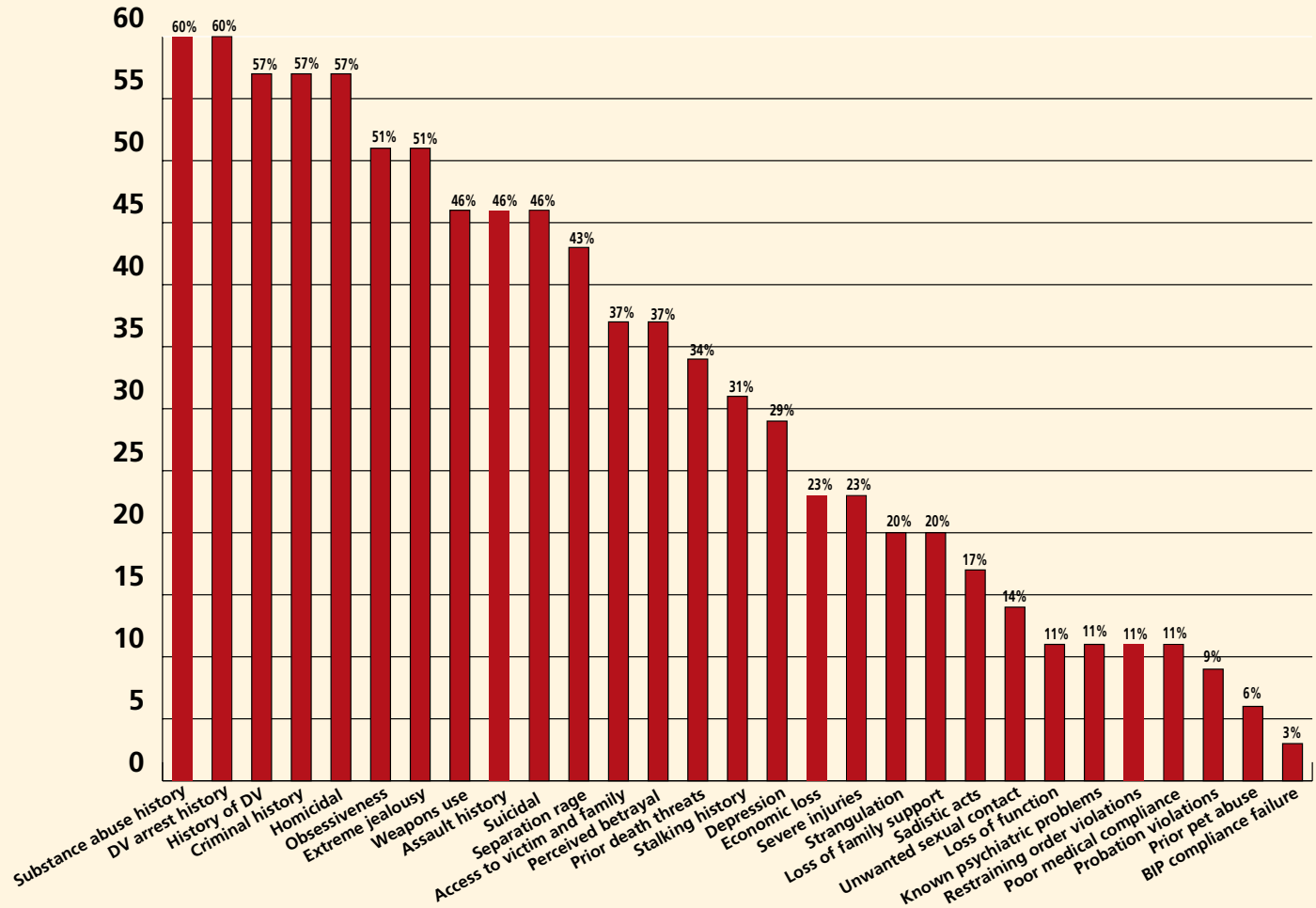
PLACE OF INCIDENT



Place of fatality:

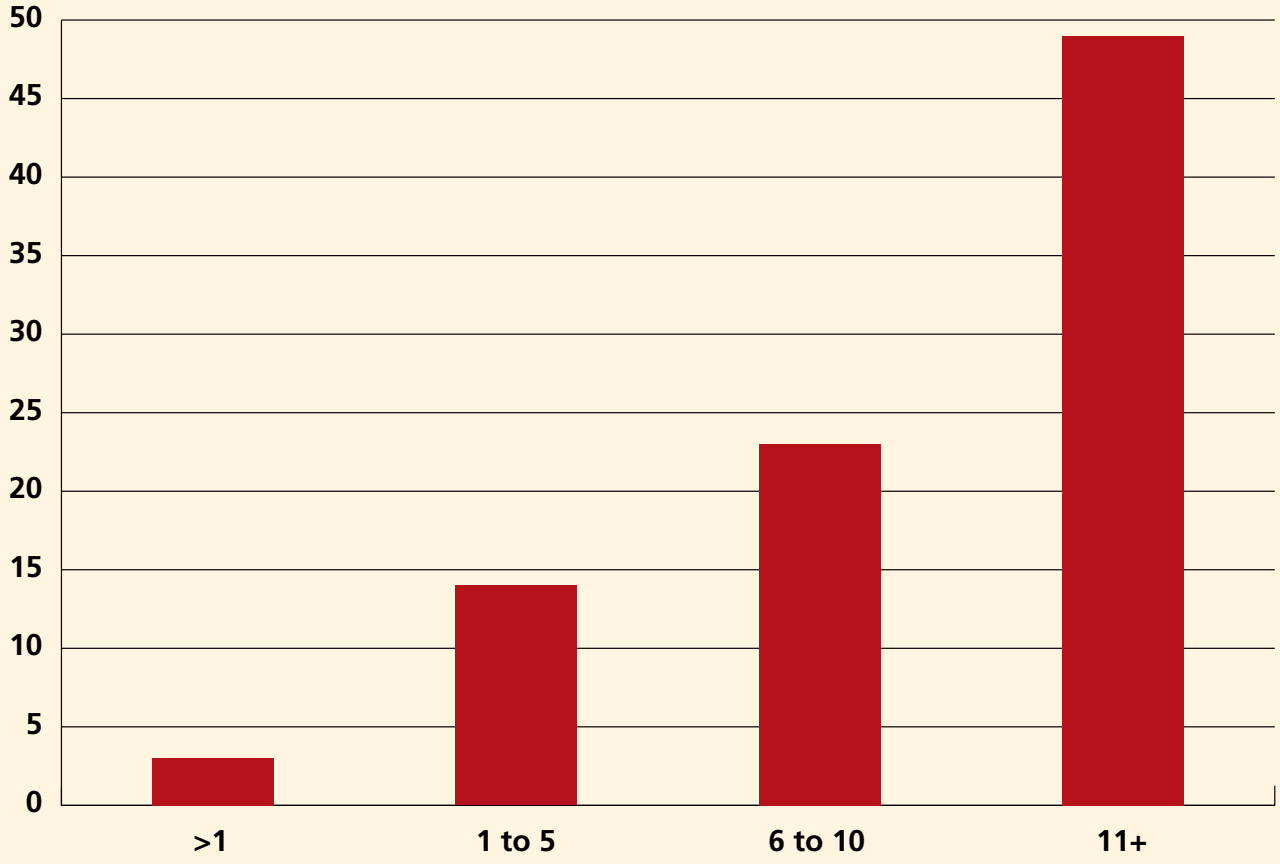
61%	joint residence (19 of 31)
19%	other (6 of 31)
10%	decedent's residence (3 of 31)
3%	perpetrator's residence (1 of 31)
3%	decedent's workplace (1 of 31)
3%	street or highway (1 of 31)

BREAKDOWN OF KNOWN RISK FACTORS



LETHALITY FACTORS

PERCENT OF CASES BY TOTAL KNOWN RISK FACTORS PRESENT



Many known risk factors were found in this year's reviewed cases including significantly higher rates of perpetrator separation rage when the decedent attempted to leave in 43% of cases versus 29% in 2013.

NOTABLE COMPARISONS

- The demographic profile of perpetrators and decedents are largely similar in this year's cases compared to last year. For example, in each year perpetrators were mostly male and decedents were mostly female, and both were, on average, close to 40 years of age. In addition, perpetrators from the past two review periods were more likely to have histories of substance abuse and be unemployed compared to the decedents.
- For the first time, reviewers were able to review and identify educational histories for both the perpetrator and decedent which allowed for those statistics to be included in this year's annual report.
- Diagnosed mental illness among perpetrators was slightly higher than in prior years (34% in 2014 versus 23% in 2013).
- For the past two years, reviewers did not identify any perpetrators with known injunction violation arrest histories.
- Similar to prior review periods, gunshot wounds followed by stabbings are the most common causes of domestic violence homicides.
- Reviewers identified a significant decrease in cases with known child witnesses.
- Domestic violence and substance abuse histories remain the most common known risk factors associated with fatalities. However, the 2014 case reviews also reflected a significant increase in obsessive behavior (51% in 2014 versus 31% in 2013), weapons use (46% in 2014 versus 37% in 2013), and separation rage (43% in 2014 versus 29% in 2013), among other factors.

STATUS OF PRIOR RECOMMENDATIONS

Status of the Statewide Team's 2013 Recommendations

Recommendation: FCADV should continue training state and local partners on the critical need to hold domestic violence perpetrators accountable within the criminal justice system.

Status: Since July 1, 2013, FCADV has provided seven full days of training at law enforcement agencies around the state. Attendees included representatives from 27 law enforcement agencies, federal probation officers, victim advocates, DCF, child welfare workers, teachers, chaplains and other state and local stakeholders. FCADV also conducted two days of training for representatives from five different State Attorney Offices and one day of training for judges.

Recommendation: FCADV should identify a county in which to consider replicating the Palm Beach County Domestic Violence Information System (DVIS).

Status: DVIS provides a centralized repository for information about domestic violence perpetrators to increase batterer accountability and facilitate more effective interventions for victims and their children by promoting collaboration among the courts, law enforcement, domestic violence victim advocates, child protective services, and other social services providers. Proactive, coordinated responses and information sharing are critical tools in preventing domestic violence homicides. One of the chief components of DVIS is the ability of community partners to monitor offenders' progress or lack of compliance with court orders, simultaneously and in real time, to enable immediate and effective interventions to protect victims and hold batterers accountable. FCADV is currently conducting a DVIS pilot project in Bay County and is negotiating with two additional counties for DVIS expansion. The lessons learned from these communities will be utilized to assess the feasibility of the statewide implementation of DVIS.

Recommendation: FCADV, the Department of Children and Families, the Office of the State Courts Administrator and other stakeholders should continue to identify venues to provide training to judges, service providers and other personnel involved with drug and dependency, domestic violence and family courts on the unique correlation between substance abuse and domestic violence.

Status: In 2013, FCADV sponsored four regional trainings, *The Dynamics of Domestic Violence and Substance Abuse*, conducted by Patricia J. Bland from the National Center on Domestic Violence, Trauma & Mental Health.

Status of the Statewide Team's 2012 Recommendation

Recommendation: The statewide team should obtain information from survivors, victim advocates, judges and court personnel, state and local service providers and others to develop specific recommendations to address the heightened danger to victims when the court denies an ex parte petition and sets a hearing, with notice to the respondent, to determine whether to issue a final injunction. Section 741.30 (5)(b), Florida Statutes, requires the court to set a hearing within 15 days when the only basis for denial of a petition for injunction against domestic violence is no appearance of immediate and present danger of domestic violence. The respondent will receive notice of the hearing. However, there is no temporary injunction in place to protect the petitioner during the time period prior to the hearing, and in numerous cases petitioners were killed or harmed by respondents after the respondents receive notice of the hearing.

Status: FCADV received funding to contract with Dr. Neil Websdale and Northern Arizona State's Family Violence Institute to conduct focus group interviews about this issue with survivors, certified domestic violence center executive directors and victim advocates, local fatality review team members, law enforcement, judges and other community stakeholders in six Florida counties, and provide FCADV with a written report of their findings by June 30, 2014. FCADV will present the report to the statewide fatality review team to assist them with rendering appropriate recommendations.

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Victim Services and Criminal Justice Programs
Florida Office of the Attorney General

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Fatality Review Team Coordinator
U.S. Department of the Navy

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Miami-Dade County Domestic Violence Fatality Review Team

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April Cross
Florida Department of Law Enforcement

Gria Davison
Florida Department of Education

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Intimate Partner Violence Assistance Program
University of Florida Levin College of Law

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Another Way, Inc.

Joseph P. George, Jr., Esq.

Sgt. Kyle Haas
Palm Beach County Sheriff's Office

Dr. Michael Haney, Ph.D, NCC, CISM, LMHC
Forensic and Mental Health Consultant

Nancy S. Hardt, M.D.
University of Florida College of Medicine

Christina Harris
Bureau of Advocacy and Grants Management
Florida Office of the Attorney General

John Hogenmuller
Florida Prosecuting Attorneys Association

Jean Itzin*
Florida Department of Law Enforcement

Richard F. Joyce, Esq.

Mary Marotta
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Florida Department of Law Enforcement

Chief Chris Nelson
Auburndale Police Department

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Florida State University Institute For Family Violence Studies

Elizabeth Parker, Esq.

Tena Pate, Chair/Commissioner
Florida Parole Commission

Rose Patterson
Office of the State Courts Administrator

Ann Perko
Florida Legal Services, Inc.

Rod Reder
National Institute of Crime Prevention Inc.

Cynthia Rubenstein, MS, LMHC
Wesley House Family Services

Nancy Slater
Brevard County Medical Examiner's Office

Bob Smedley
Orange County Probation Domestic Violence Team

Kathleen Tailer
Office of the State Courts Administrator

Pastor J. R. Thicklin
Destiny by Choice, Inc.

Chief Philip Thorne, President
Florida Police Chiefs Association

Child Death Review Committee Liaisons
Major Connie Shingledecker
Manatee County Sheriff's Office

Special Agent Terry Thomas
Florida Department of Law Enforcement

Barbara Wolf, M.D.
Office of the District 5 Medical Examiner (Leesburg)

Data Analysis Consultant
Joshua Cochran, Ph.D, University of South Florida

Florida Coalition Against Domestic Violence Staff Support
Vince Mazzara, Jennifer Guy and Leisa Wiseman

** Adrienne Celaya has accepted a post-doc position with Dr. Neil Websdale at the Northern Arizona University Family Violence Institute. The team thanks her for her active participation and hard work, and wishes her the very best in her future endeavors.*

** Jean Itzen is retiring and will no longer serve on the team. Jean has been an active member of the statewide team since it was established in 2009, and the team thanks her for her dedication to protecting survivors of domestic violence and their children.*

The statewide team would like to acknowledge the hard work and dedication of Florida's local domestic violence fatality review teams in the following counties:

Alachua
Bay
Brevard
Broward
Collier
Duval
Escambia
Hernando
Highlands
Hillsborough
Indian
Martin
St. Lucie
Okeechobee
Lee
Leon
Manatee
Miami-Dade
Orange
Palm Beach
Pasco
Pinellas
Polk
Santa Rosa
Sarasota
Seminole
St. John's

In Memoriam

We are deeply saddened to report that Gria Davison passed away in 2013. Gria was a dedicated member of the team, and will be greatly missed.

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