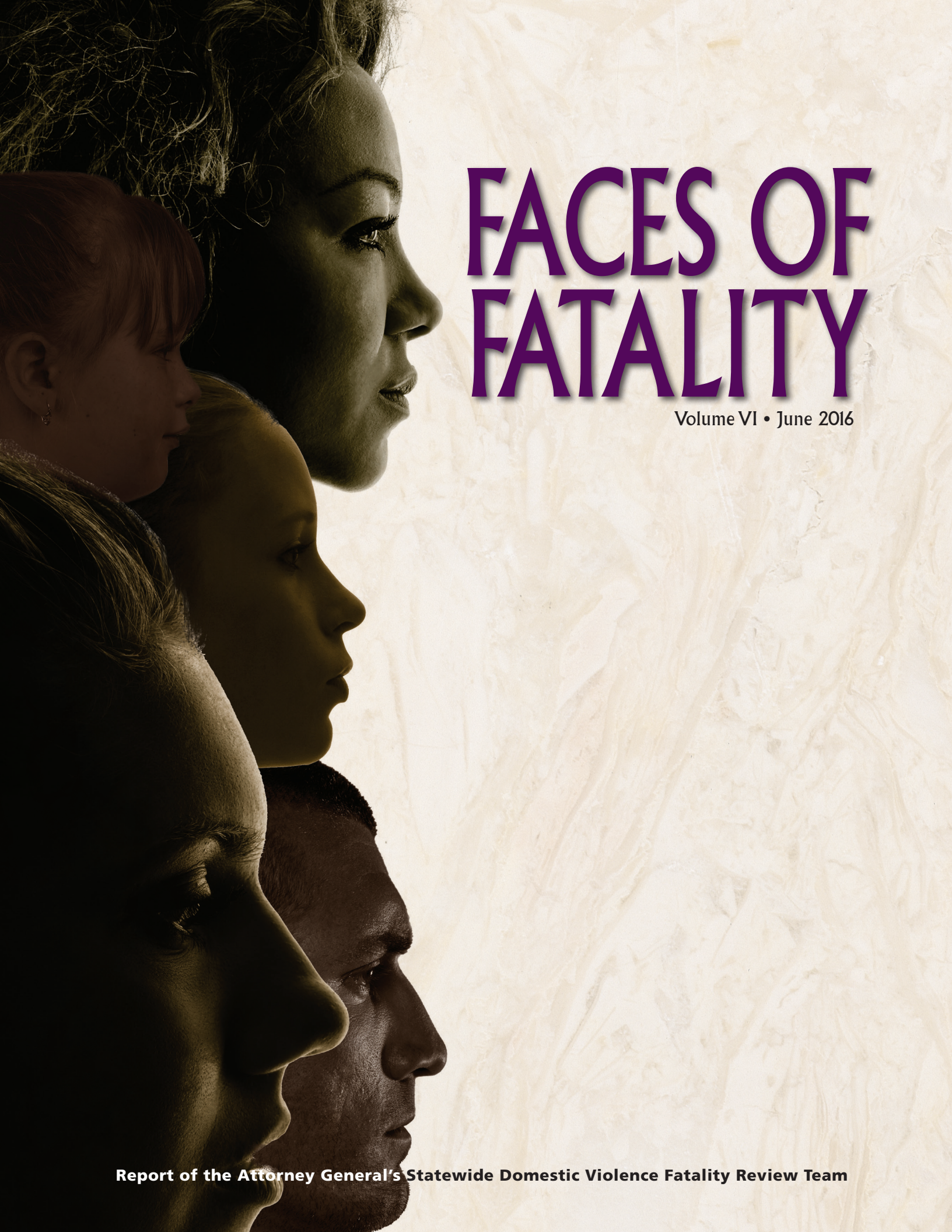




FACES OF FATALITY

Volume VI • June 2016

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

This report is dedicated to the 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 homicides represent approximately 20 percent of all homicides in the state of Florida. Each death is a reminder that we must do all we can to understand why these fatalities occur, work collaboratively to find solutions that keep survivors of domestic violence and their children safe, and hold perpetrators accountable for their crimes. I am proud to partner with the Florida Coalition Against Domestic Violence in co-chairing the Statewide Domestic Violence Fatality Review Team, and our great state attorneys who work tirelessly to protect victims, as we work together to find solutions to reducing and preventing domestic violence deaths in Florida."

—Attorney General Pam Bondi

"Domestic violence homicides are occurring at a tragic and alarming rate. Far too often, domestic violence homicides dominate the news in our communities, our state, and our country. Each of these devastating murders represents a victim(s) that was murdered by the person that supposedly loved them the most. This past year, I met too many people that are grieving the loss of a mother, sister, friend, or a loved one. The work of the Statewide Domestic Violence Fatality Review Team and local fatality review teams is critical to finding answers and seeking solutions to these senseless deaths. We are honored to partner with the Office of Attorney General Pam Bondi and we are grateful to the dedicated and committed professionals who work diligently to end to these horrific crimes. By working together we can ensure a safer future for survivors of domestic violence and their children."

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

CONTENTS

Executive Summary	4
Findings	6
Recommendations	8
Fatality Review	10
Local Fatality Review Team Data Analysis	12
Lethality Factors	19
Notable Comparisons	20
Status of Prior Recommendations	21

EXECUTIVE SUMMARY

In November 2015, the Florida Department of Law Enforcement (FDLE) released the 2015 Semi-Annual Uniform Crime Report (UCR)¹. The report reflected that while overall reported domestic violence incidences increased a total of 1.7 percent, domestic violence homicides increased 8.7 percent in the first six months of 2015; this startling increase is in addition to the 10.2 percent increase reported in 2014. In the past 18 months, a shocking 304 women, children and men have died as a result of domestic violence.

The Florida Attorney General's Statewide Domestic Violence Fatality Review Team was created in 2009 in response to a dramatic increase in domestic violence homicides statewide. Since that time, the team has reviewed domestic violence fatalities to identify systemic gaps in the coordinated community response to domestic violence and provides recommendations to systems, agencies and the general public regarding interventions designed to protect survivors and their children and hold perpetrators accountable for their violence. Statewide team members include representatives of state and local agencies and organizations that have contact with survivors, their children, and perpetrators such as the court system, law enforcement, probation, parole, faith-based organizations, educators, certified domestic violence centers, legal providers, healthcare providers and the defense bar. The team is co-chaired by Attorney General Pam Bondi and the Florida Coalition Against Domestic Violence (FCADV), and meets semi-annually to conduct a comprehensive review of domestic violence homicides with the goal of ultimately preventing these tragic deaths.

Florida represents one of nine states that have a Statewide Domestic Violence Fatality Review Team and local teams that conduct ongoing reviews of domestic violence fatalities occurring in their communities. There are currently 25 local teams reviewing fatalities that occur in rural and urban communities that are reflective of Florida's diverse population. All teams comply with the required statutory mandates specific to maintaining the confidentiality and public records exemptions when reviewing fatality related information.² Additionally, teams employ a "no blame, no shame" philosophy, working from the premise that the entire community plays a role in finding solutions to prevent domestic violence homicides.

In 2014, the United States Department of Justice Office on Violence Against Women awarded a three year grant to the Department of Children and Families that enables FCADV to provide comprehensive training and technical assistance to local fatality review teams and other stakeholders. The purpose and intent of this training is to increase knowledge of risk indicators that often precede a domestic violence homicide, enhance the fatality review team process and improve community collaborations to prevent domestic violence.

Faces of Fatality VI, the 2016 report of the Statewide Domestic Violence Fatality Review Team, includes the statewide team's review of a 2015 double murder/suicide, and analysis of data from reviews of domestic violence homicides completed by Florida's local fatality review teams. The fatalities that were reviewed by local teams occurred primarily between

¹http://www.fdle.state.fl.us/cms/FSAC/UCR/2015/2015SA_CIF.aspx

²See s. 741.316 and s 741.3165, F.S.

2010 and 2015. The local team data creates a demographic profile of the decedents and perpetrators in these deaths. The report also reflects that 95 percent of perpetrators were male and 87 percent of decedents were female. Data from the local teams' reviews indicate disparities between perpetrators and decedents in age, occupational status, and years of formal education. On average, perpetrators were slightly younger than the victims, were more likely to be unemployed, and less likely to have completed high school and/or college. In the case reviewed by the statewide team, the victim was eight years older than the perpetrator.

The data from the local team reviews highlight a pattern of high-risk indicators that often occur prior to domestic violence homicides. These indicators include the perpetrators' use of weapons, substance use and jealousy. Forty-five percent of perpetrators were known to carry or possess a gun or other weapon and 47 percent of homicides occurred when the perpetrators were abusing substances. Eleven percent of the fatalities reviewed in this report involved children who were also killed and 68 percent of the homicides reviewed occurred in a residence shared by the perpetrator and decedent. Nearly 60 percent of family members were aware of prior incidents or threats of domestic violence made by the perpetrator.

The presence of high-risk indicators reflected in the statewide team's 2016 findings emphasize the ongoing and critical need for a coordinated community response to develop policies and proactive interventions to increase safety for survivors and their children, while holding perpetrators accountable. This report contains information for legislators, state agencies, social service organizations and communities to strengthen their awareness and knowledge of domestic violence and to assist them with developing and implementing policies to prevent domestic violence homicides in Florida.



FINDINGS

Faces of Fatality VI includes descriptive statistics of domestic violence homicides based on data collected by Florida's local fatality review teams between April 2015 and April 2016. The deaths reviewed occurred between 1997 and 2015, with the majority of fatalities occurring between 2010 and 2015. Local fatality review teams submitted 62 reviews that comprise the aggregate data in this report. Utilizing a uniform data collection instrument, the teams carefully reviewed and considered characteristics of the perpetrator, the decedent and their relationship, including any known domestic violence histories, criminal records, and a range of observable risk factors. Through this review process, the teams concluded that in two reviews the perpetrator of the homicide was in fact the victim of domestic violence and was acting in self-defense.

The report also includes a case study and findings based on a fatality review conducted by the statewide team of a double murder/suicide that occurred in 2015. The case study indicated that two months after she ended the relationship, the perpetrator murdered his former girlfriend, her male friend, and then committed suicide. The deaths occurred a few days after the perpetrator made threats to the victim's family member that he would kill the victim and himself if he witnessed her in the company of another man. This review by the statewide team, in addition to the local team data, provides a framework for the 2016 recommendations.

Findings from the 2015-2016 local fatality reviews highlight several themes regarding victim and perpetrator profiles, as well as factors that suggest a heightened risk of lethality:

- 27% of perpetrators were unemployed at the time of the homicide.
- 43% of perpetrators were reported to have substance abuse histories.
- 30% of perpetrators were reported to have a medically diagnosed mental health disorder.
- In 17% of deaths, there was evidence of prior stalking behavior on the part of the perpetrator.
- In 50% of the fatalities, there was at least one of the following indicators present prior to the homicide: history of prior domestic violence, substance abuse and/or non-domestic violence criminal history by the perpetrator.
- 35% of perpetrators were known by family or friends to carry or possess a weapon.
- 23% of decedents and perpetrators were separated at the time of the homicide and the average length of separation (when known) was approximately three months.

- 22% of fatalities included known allegations of death threats by the perpetrator towards the decedent.
- 50% of perpetrators had a known, non-domestic violence-related criminal history.
- 47% of perpetrators had a known criminal history of domestic violence and in 32% of fatalities, there were known prior reports to the police by the decedent, alleging domestic violence by the perpetrator.
- 62% of perpetrators had a known criminal history domestic violence-related or otherwise, based on criminal records and narrative reports. This represents a combination of the two previous indicators.
- In 57% of the fatalities, family members reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator.
- In 24% of the fatalities, there was a known no contact order issued against the perpetrator.
- In 7% of the fatalities there was a known permanent Injunction for Protection filed against the perpetrator by the decedent; in 22% there was a known permanent Injunction for Protection filed against the perpetrator by someone other than the decedent.
- 30% of perpetrators completed suicide, and an additional 3% attempted but failed to complete suicide.

*Domestic violence
incidences increased
a total of 1.7 percent,
domestic violence
homicides increased
8.7 percent in the first
six months of 2015.*

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

There were several indicators of increased risk for lethality including:

- The perpetrator had access to weapons.
- The victim had children from previous relationships.
- The perpetrator had a known criminal history including domestic violence.
- The perpetrator repeatedly appeared at the decedent's home unannounced and made repeated attempts to reach her by phone (stalking her).
- The family members reported that the perpetrator used tactics of coercive control including stalking, physical violence and terrorizing the decedent.
- The decedent applied for and was denied an Injunction for Repeat Violence.
- The perpetrator made threats to kill the decedent.



RECOMMENDATIONS

FCADV should develop a pilot project that will enhance the Intimate Violence Enhanced Service Team (InVEST) model to increase participation by state attorneys' office victim advocates in the ongoing review of domestic violence police reports and partner with prosecutors on cases where risk factors were identified.

InVEST was created specifically to reduce and prevent domestic violence homicides in Florida. Since the program's inception, there have been no homicides of InVEST participants. This program is designed to encourage local law enforcement agencies and their community partners to treat domestic violence, dating violence, sexual assault and stalking as serious violations of law requiring the coordinated involvement of the entire criminal justice system. Advocates and law enforcement partners engage in daily collaborative reviews of police reports in an effort to identify potential high-risk domestic violence cases and make contact with survivors to determine if they are interested in participating in the program. FCADV conducts educational training of all partners involved in the project including, but not limited to, domestic violence advocates, law enforcement officers, prosecutors, judges, and parole/probation officers. FCADV's InVEST training for criminal justice partners focuses on the use of evidence-based investigations and prosecutions of domestic violence perpetrators, the use of an abbreviated risk assessment tool that does not place survivors at further risk of harm, and survivor centered practices to connect survivors and their children to domestic violence services. The perpetrator in the murder/suicide reviewed by the Statewide Domestic Violence Fatality Review Team possessed an extensive criminal history, including domestic violence perpetration, and the local team data identified 47 percent of perpetrators also had prior criminal histories of domestic violence perpetration.

FCADV and the Statewide Domestic Violence Fatality Review Team should develop a domestic violence media guide for journalists and reporters to reduce and prevent framing domestic violence incidences and homicides with a victim-blaming lens. The guide should include education regarding the role of victim-blaming statements and sentiments in perpetuating inaccurate stereotypes while simultaneously negating community efforts to hold perpetrators accountable for their crimes.

Due to the overwhelming concern regarding inappropriate narratives created about domestic violence victims, the Statewide Domestic Violence Fatality Review Team created a victim-blaming subcommittee that focused its initial efforts on educating law enforcement first responders on the adverse effects of victim-blaming. Such education continues to be an ongoing component of the training FCADV provides to law enforcement and other partnering agencies. The subcommittee determined that the next critical step to dismantling the stigma attached to the actions of the victim, was to create a guide specifically tailored to the media that will educate the journalists and reporters on the adverse effects and unintentional consequences of messaging, including victim blaming. Media coverage should refrain from characterizing incidents of domestic violence as “marital spats,” “a marriage deteriorated” or “a distraught husband” and consistently message that domestic violence is a crime, the perpetrator is responsible for the abuse, and it is never the fault of the survivor. A media guide that provides education on these issues and includes referral numbers and resources for services for survivors could be used by media outlets throughout the State.

Florida’s child welfare agencies should improve collaboration with community partners when there are surviving children.

This year’s data indicates 70 percent of the decedents had children, and there were known child witnesses in 19 percent of the deaths, including in the murder/suicide reviewed by the statewide team. It is critical for Florida’s child welfare agencies to collaborate with community partners to ensure that surviving children are referred to and offered appropriate services to address trauma. The Statewide Domestic Violence Fatality Review Team is convening a workgroup comprised of victim advocates from entities including, but not limited to, law enforcement, state attorneys and certified domestic violence centers to develop a protocol for providing referrals for counseling services for surviving children. The workgroup will develop an informational document that includes referral services and coordinate with child welfare agencies to distribute this information to family members or foster families with whom the children are placed.

FATALITY REVIEW

The statewide team convened three meetings during the 2015-2016 fiscal year. In addition to reviewing data from the local teams and discussing recommendations, the team conducted a review of a 2015 double murder/suicide. The review is based on information from law enforcement and media reports, as well as the statewide team's interview with the law enforcement agency that investigated the murders.

In January 2015, V. E., age 38, was murdered in the parking lot of a local business by S.W., age 30, a man with whom she had a previous relationship which ended approximately two months prior to the murder.³ S.W. also shot and killed V.E.'s male friend who was with her, and S.W. subsequently killed himself at the scene. Two weeks prior to the homicide, S.W. attempted to break into V.E.'s home by climbing through a window while she was there with her children. S.W. fled before law enforcement arrived and he removed and stole a window curtain that he had bled on. S.W. was charged with burglary of an occupied dwelling and petit theft, but he was not prosecuted. A few days before the murder, S.W. told a relative of V.E. that he would kill V.E. if he found out she was involved with another man.

Background on the victim and perpetrator

V.E. and S.W. dated intermittently for at least five years. They did not reside together. V.E. had five children and the team could not determine whether S.W. was the biological father of the children. He did not maintain regular employment, but helped with his family's business (a nightclub) and may have worked odd jobs. S.W. had criminal charges filed against him for a battery of V.E. on at least three occasions. In 2010, he was arrested for domestic battery against V.E., and was issued a trespassing warrant for unauthorized presence on public housing authority property. The case was not prosecuted. In 2012, S.W. was arrested for battery after striking V.E. while she was holding her 3-year-old child who was also injured. This case also was not prosecuted. A year later, V.E. called law enforcement to report that S.W. was outside of her residence and had punctured the tires of her vehicle. S.W. made threatening statements before cutting the tires and asked her to come outside because he wanted to give her something. He left before law enforcement arrived and law enforcement was unable to locate him. S.W. was charged with criminal mischief but was not prosecuted. The day after the 2013 incident, V.E. filed for an Injunction for Protection for Repeat Violence that was denied by the court. The petition was denied because it did not contain allegations of two incidents of repeat violence, the legal standard for a Repeat Violence Injunction for Protection.⁴

³Out of respect for the victim, the perpetrator, and their families, the initials of the victim and perpetrator have been changed.

⁴See s.784.046 F.S. "Repeat violence" means two incidents of violence or stalking committed by the respondent, one of which must have been within six months of the filing of the petition, which are directed against the petitioner or the petitioner's immediate family member.

⁵See s. 741.325, F.S.

Events leading up to the homicide and suicide

After the relationship ended sometime near November 2014, S.W. continued to either come to V.E.'s residence or call her, but she did not allow him inside and never responded to his phone contacts. S.W.'s stalking and violence towards V.E. were known for a long period of time by her family members. A few months prior to the homicide, V.E. reported to a family member that S.W.'s behavior changed and that he had become increasingly aggressive. A few days prior to the homicide, S.W. was outside of V.E.'s home and spoke to the relative who was picking up one of the children. He stated to the relative that he loved V.E. and if he saw her with another man he would kill her and then himself. The relative advised him that since they were no longer together he should move on. The relative stated that she did not believe that S.W. would carry out his threats because she had known him since he was a child and did not believe he was capable of killing V.E. However, the relative then called V.E. the morning before she was killed and advised her to be careful due to S.W.'s recent threats. S.W. initiated over 70 phone contacts to V.E. in the three days leading up to the homicide. On the day of the murder, V.E. and a male friend were leaving a restaurant parking lot when a vehicle in which S.W. was a passenger pulled into the lot. S.W. exited the vehicle, shot and killed V.E. and her friend, and then killed himself. Family members described V.E. as a creative person and loving family member.

LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

The descriptive statistics in the 2016 report are based on the information that teams obtained from reviewing domestic violence homicides in their local area. The reviews may include both intimate partner homicides and other domestic violence deaths. When possible, the data points are based on information collected from all 62 reviews submitted by local teams. In some instances however, statistics are based on different totals—this is either due to non-applicability or missing information for any given review. Therefore, the totals may not always equal 100. The total number of cases used to calculate given statistics are in parentheses following corresponding percentages.

This year's data includes two out of the 62 total reviews in which reviewers identified the perpetrator of the homicide as acting in self-defense to domestic violence. These reviews were excluded in the descriptive statistics that inquire about specific details of perpetrators or decedents because of the unique circumstances surrounding those deaths.

YEAR OF INCIDENT	# OF REVIEWS
1997	1
1998	1
2002	1
2004	2
2006	2
2007	1
2008	2
2010	7
2011	2
2012	6
2013	7
2014	20
2015	6
Not specified by reviewers	4
Total	62

PERPETRATOR CHARACTERISTICS

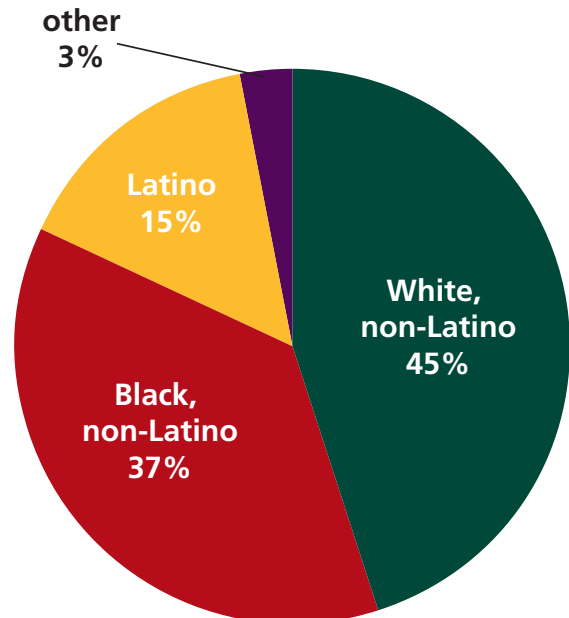
Gender: 95% male (57 of 60), 5% female (2 of 60)

Race/ethnicity:

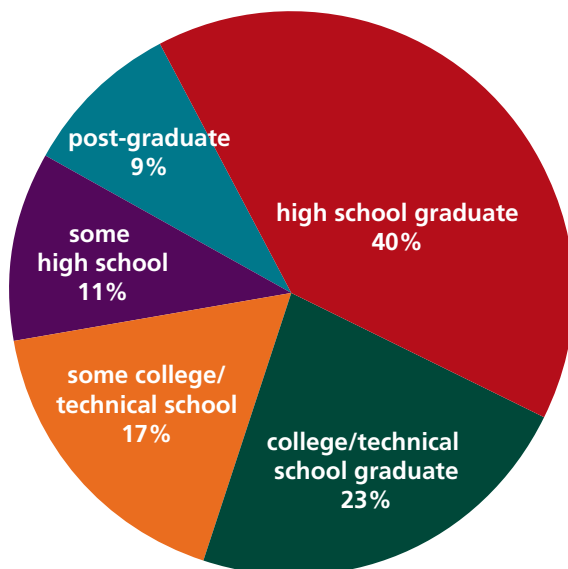
45% White, non-Latino (27 of 60)
37% Black, non-Latino (22 of 60)
15% Latino (9 of 20)
3% other (2 of 60)

Average age: 41 (min: 15, max: 86)

PERPETRATOR RACE-ETHNICITY



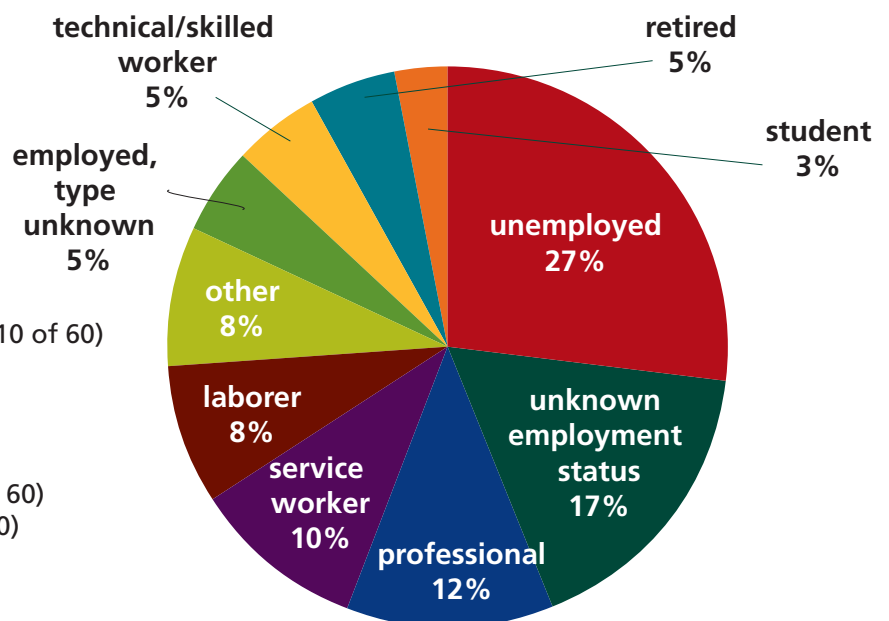
PERPETRATOR EDUCATION LEVEL



Education level:

40% high school graduate (14 of 35)
23% college/technical school graduate (8 of 35)
17% some college/technical school (6 of 35)
11% some high school (4 of 35)
9% post-graduate (3 of 35)

PERPETRATOR EMPLOYMENT STATUS



Employment type:

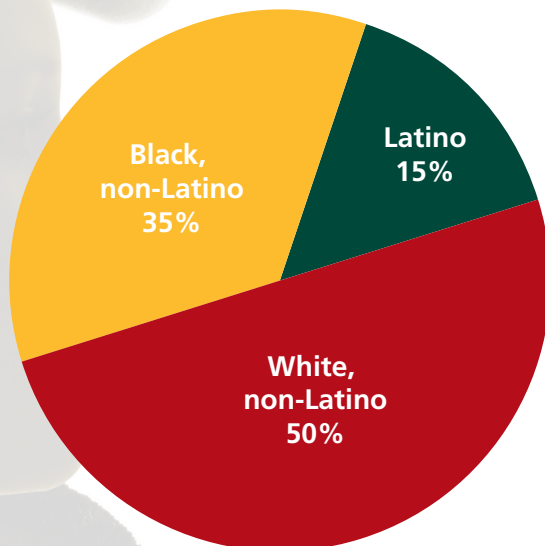
27% unemployed (16 of 60)
17% unknown employment status (10 of 60)
12% professional (7 of 60)
10% service worker (6 of 60)
8% laborer (5 of 60)
8% other (5 of 60)
5% employed, type unknown (3 of 60)
5% technical/skilled worker (3 of 60)
5% retired (3 of 60)
3% student (2 of 60)

LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

Other known perpetrator characteristics

- Reviewers identified evidence of substance abuse with 43% (26 of 60) of perpetrators based on various sources (e.g., driving under the influence records, police reports, substance abuse services, personal narratives from self, family, friends, or co-workers).
- Reviewers found evidence of medically diagnosed mental health disorders in 30% (17 of 56) of perpetrators.
- Reviewers found evidence that 17% (10 of 60) perpetrators exhibited prior stalking behavior.
- Reviewers reported that 35% (21 of 60) perpetrators were known by family or friends, to carry or possess a weapon.

DECEDENT RACE-ETHNICITY



Decedent Characteristics

Gender: 13% male (8 of 60), 87% female (52 of 60)

Race/ethnicity:

50% White, non-Latino (30 of 60)
35% Black, non-Latino (21 of 60)
15% Latino (9 of 60)

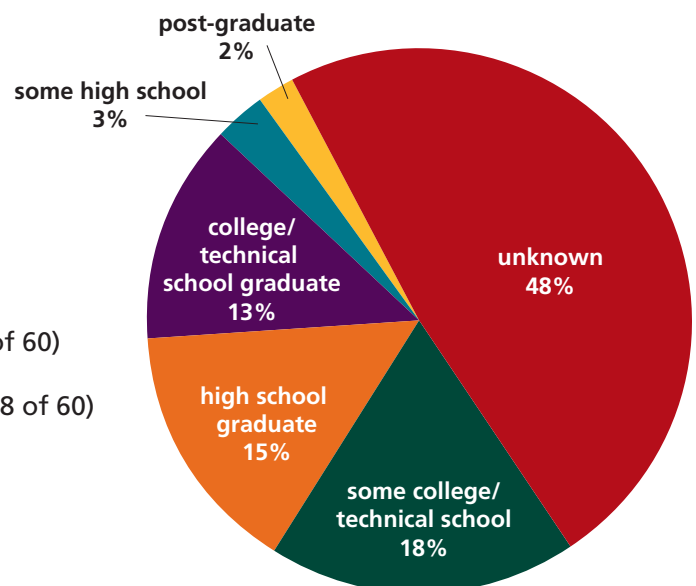
Average age: 42 (min: 19, max: 92)

Decedent Education Level

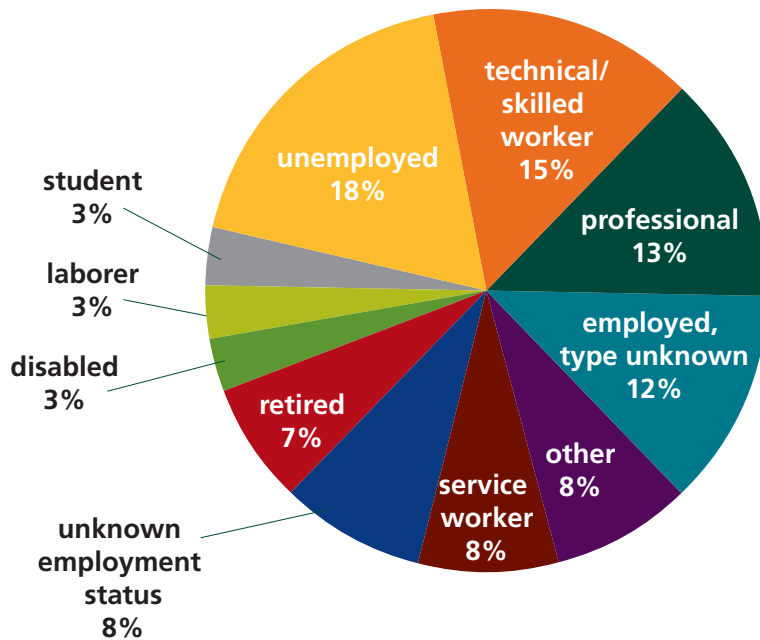
Education Level:

48% unknown (29 of 60)
18% some college/technical school (11 of 60)
15% high school graduate (9 of 60)
13% college/technical school graduate (8 of 60)
3% some high school (2 of 60)
2% post graduate (1 of 60)

DECEDENT EDUCATION LEVEL



DECEDENT EMPLOYMENT STATUS



Employment type:

18%	unemployed (11 of 60)
15%	technical/skilled worker (9 of 60)
13%	professional (8 of 60)
12%	employed, type unknown (7 of 60)
8%	other (5 of 60)
8%	service worker (5 of 60)
8%	unknown employment status (5 of 60)
7%	retired (4 of 60)
3%	disabled (2 of 60)
3%	laborer (2 of 60)
3%	student (2 of 60)

Relationship Characteristics

70% of decedents (42 of 60) had children.

42%	1 child (18 of 42)
19%	2 children (8 of 42)
29%	3 children (12 of 42)
7%	4 children (3 of 42)
2%	5 children (1 of 42)

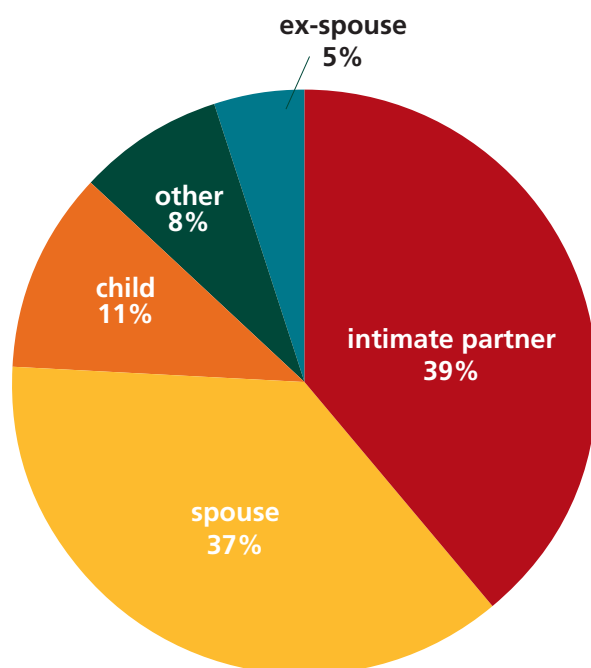
Of decedents with children, 60% (25 of 42) were known to have children outside of their relationship with the perpetrator.

Relationship of perpetrator to decedent:

39%	intimate partner, unmarried (24 of 62)
37%	spouse (23 of 62)
11%	child (7 of 62)
8%	other (5 of 62)
5%	ex-spouse (3 of 62)

Mean length of relationship:
10.9 years (min = .25, max = 63)

RELATIONSHIP TYPE





LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

RELATIONSHIP CHARACTERISTICS

Prior living arrangements and separation:

- 75% (47 of 62) of couples were known to have previously lived together full time, 18% (11 of 62), of couples were known to have been living together "off and on," and 6% (4 of 62) of couples were not known to have lived together at any point.
- 75% (42 of 56) of couples were known to be living together at the time of the fatality. 25% (14 of 56), of those couples, were known to have lived together previously, but not to have been living together at the time of the death.
- Reviewers found evidence of separation at the time of death (marital, separate households, or both) in 23% (13 of 56) of couples.
- The average length of separation, when known, was approximately .28 years or 3-4 months (min = 0, max = 1.5).
- There were known allegations by 22% (13 of 60) decedents of death threats made by the perpetrator towards the decedent, prior to the incident.
- There was known harassment of the decedent, by 5% (3 of 56) perpetrators at the decedent's workplace.

Immigration Status

- 13% (8 of 60) of perpetrators were identified as documented immigrants to the U.S.

CRIMINAL RECORDS

Perpetrator:

- 50% (29 of 58) of perpetrators had a known, non-domestic violence-related criminal history.
- 47% (28 of 60) of perpetrators had a known criminal history of domestic violence.
- 62% (37 of 60) of perpetrators had a known criminal history of any kind, domestic violence-related or otherwise, based on criminal records and narrative reports.
- 32% (19 of 60) of perpetrators had known prior reports to the police by the decedent, alleging domestic violence by the perpetrator.
- 57% (34 of 60) of family members reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator.
- 24% (14 of 58) of perpetrators had a known "no contact" order issued against the perpetrator.

- 7% (4 of 60) of perpetrators had a known permanent Injunction for Protection filed against them by the decedent.
- 22% (13 of 59) of perpetrators had a known permanent Injunction for Protection filed against them by someone other than the decedent.
- 3% (2 of 60) of perpetrators, had a known Injunction for Protection violation arrest.

Decedent:

- 17% of decedents (10 of 60) had a known history of domestic violence, based on criminal records and narrative reports.
- 5% (3 of 60) of decedents had a known “no contact” order issued against them.
- 3% (2 of 60) of decedents had a known Permanent Injunction for Protection filed against them by the perpetrator.

Domestic Violence and Social Services

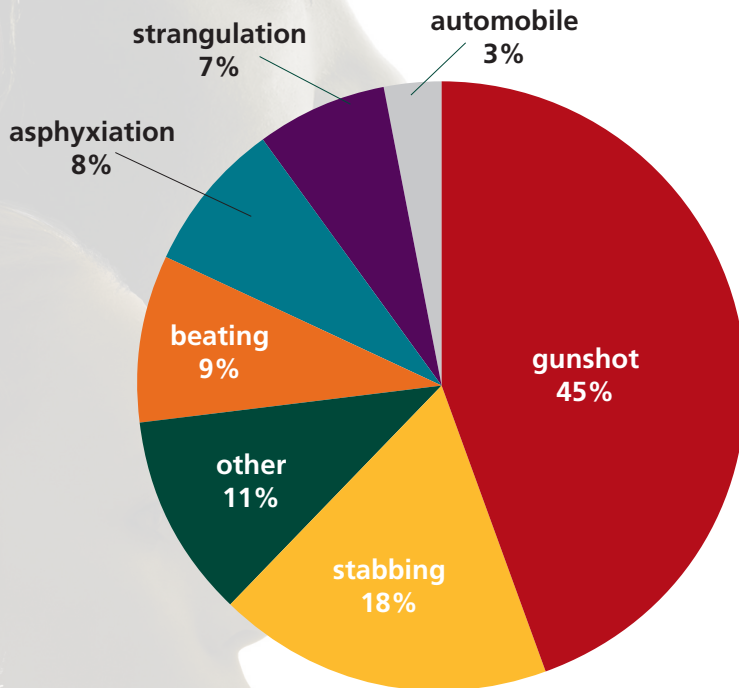
- 20% (12 of 60) of decedents or his/her family had known contact with the Department of Children and Families.
- 15% (9 of 60) of decedents had known contact with victim support services.
- 3% (2 of 60) of decedents had known contact with a certified domestic violence center.
- 12% of perpetrators (4 of 33) with a prior history of domestic violence were currently or previously enrolled in a Batterer’s Intervention Program (BIP).

Fatality Characteristics

- 30% of perpetrators (18 of 60) completed suicide and an additional 3% (2 of 60) attempted but failed to complete suicide.
- At the time of the fatality or near fatality, there was known substance abuse by 47% of perpetrators. This information is based on self-reports by the perpetrator and medical toxicology reports. The breakdown is as follows:
 - 28% alcohol (10 of 36)
 - 11% drugs (4 of 36)
 - 8% drugs and alcohol (3 of 36)
 - 53% no evidence of substance abuse (19 of 36)
- 5% of fatalities (3 of 60) included a collateral victim (i.e., a victim other than the decedent; does not include perpetrator suicides).
- There were known child witnesses in 19% (12 of 62) of the fatalities.

LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

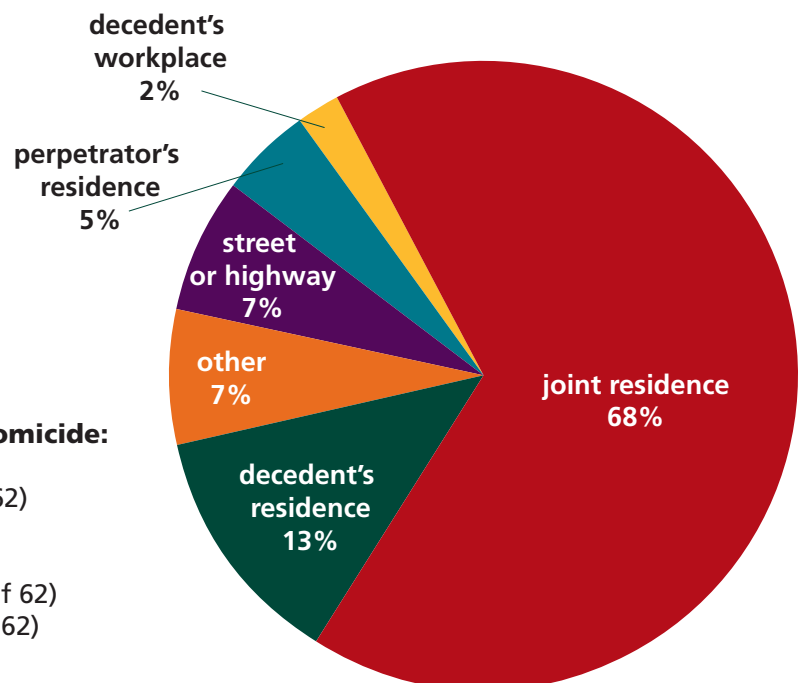
MANNER OF DEATH



Manner of death (includes attempted):

45%	gunshot (28 of 62)
18%	stabbing (11 of 62)
11%	other (7 of 62)
9%	beating (5 of 62)
8%	asphyxiation (5 of 62)
7%	strangulation (4 of 62)
3%	automobile (2 of 62)

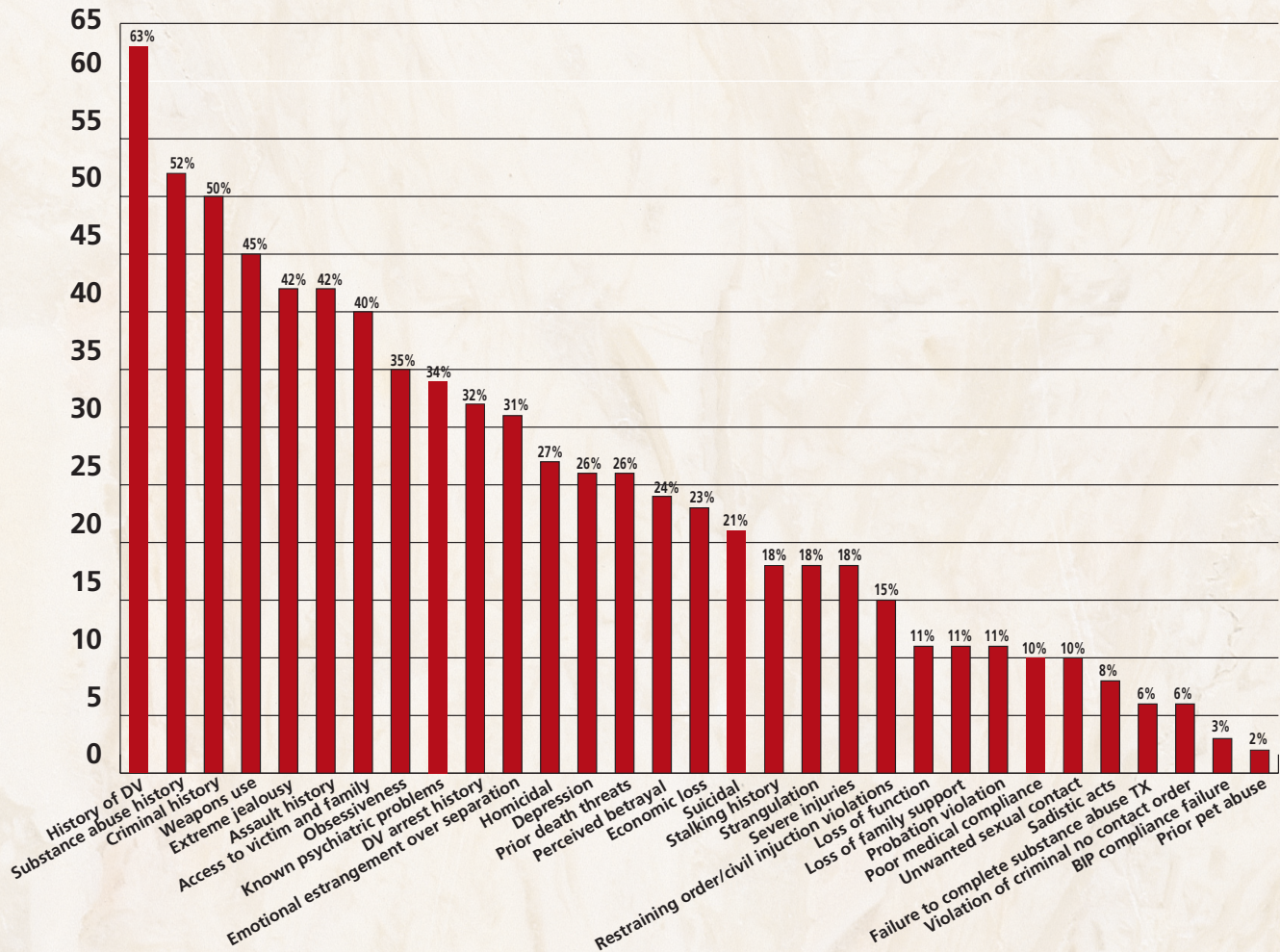
PLACE OF INCIDENT



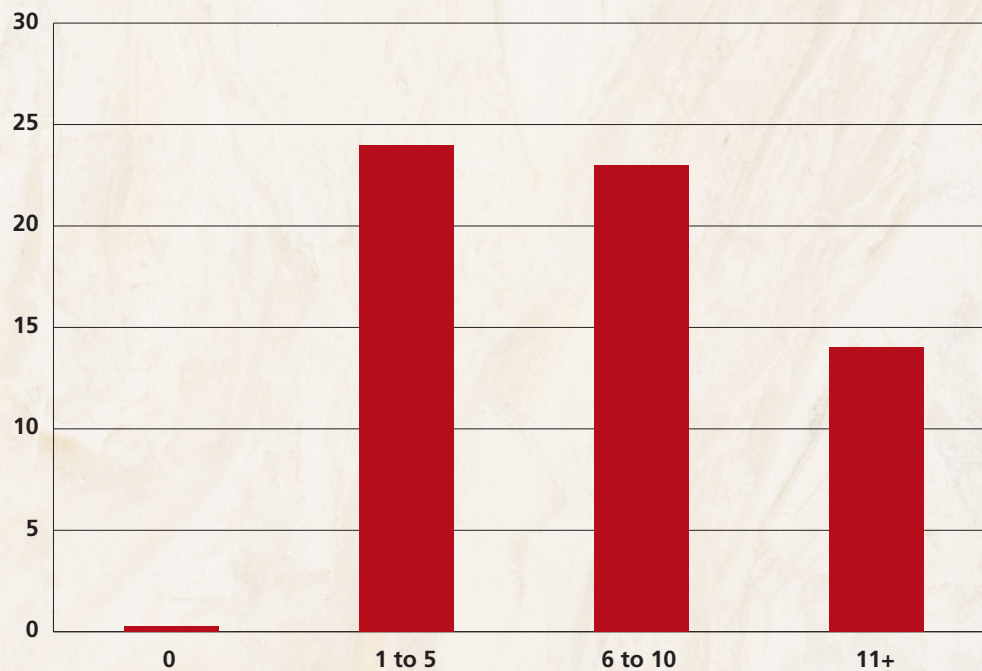
Location of homicide or near homicide:

68%	joint residence (42 of 62)
13%	decedent's residence (8 of 62)
7%	other (4 of 62)
7%	street or highway (4 of 62)
5%	perpetrator's residence (3 of 62)
2%	decedent's workplace (1 of 62)

BREAKDOWN OF KNOWN RISK FACTORS



PERCENT OF CASES BY TOTAL KNOWN RISK FACTORS PRESENT



Many of this year's risk factors were found at significantly higher rates including the history of domestic violence perpetration (63%) versus (55%) in 2015.



NOTABLE COMPARISONS

- The 2016 report noted a substantial decline in the prevalence of stalking. This year's reviews identified evidence of stalking by a perpetrator in 17 percent of deaths, compared to 50 percent in 2015.
- The 2015 report did not include any reviews of incidents with child decedents. By contrast, 11 percent of this year's cases involved child decedents.
- 60 percent of decedents in the 2015-2016 fiscal year reviews were known to have children outside of their relationship with the perpetrator, compared to only 46 percent of cases reviewed in 2014-2015.
- The current reviews identified a substantially higher percentage of substance abuse by the perpetrator at the time of the fatality (47 percent compared to 30 percent in 2015).
- 68 percent of fatalities reviewed this year occurred in the joint residence of a perpetrator and decedent representing a substantial increase from previous reports. Last year's report reflected that 29 percent of the deaths occurred at the joint residence with 32 percent occurring at the decedent's home.

STATUS OF 2015 RECOMMENDATIONS

FCADV should build upon its Florida Domestic Violence Enhancements and Leadership Through Alliances (DELTA) Project to include training for school personnel on adult intimate partner violence. The training should include information on community resources, safety planning and red flag indicators of increased danger.

School nurses received training on teen dating violence in Orange and Pasco Counties. The trainings were conducted by Harbor House of Central Florida and Sunrise of Pasco, the certified domestic violence centers that participate in the Centers for Disease Control and Prevention and FCADV funded DELTA Project. FCADV will conduct training on preventing teen dating violence to School Resource Officers at the Florida Association of School Resource Officers in July 2016. In addition, FCADV is currently creating two videos for School Resource Officers that will include information on the statutory requirements for school districts related to teen dating violence, community resources, safety planning and red flag indicators of increased danger. Those videos will be complete and available for distribution by July 2016.

FCADV should convene a workgroup of stakeholders to consider expanding FCADV's Violence Against Women Act STOP-funded Legal Clearinghouse Project to provide assistance to *pro se* survivors with completing and filing Injunction for Protection petitions.

FCADV's workgroup identified a new potential funding source for the Legal Clearinghouse Project, and applied for additional funding to expand the Project to provide lawyers to assist *pro se* survivors with completing and filing Injunction for Protection petitions and represent survivors at final injunction hearings.

FCADV should convene a workgroup with the Florida Sheriffs Association, the Florida Police Chiefs Associations, the Office of the State Courts Administrator, agencies that work with immigrant communities, faith-based representatives and other stakeholders to develop a plan for increasing outreach to immigrant communities and increasing access to certified interpreters for survivors seeking assistance from law enforcement as well as seeking Injunctions for Protection.

FCADV's workgroup members convened a meeting to develop a plan to increase access to services for immigrant survivors seeking assistance. One initial step included in the plan was focused on increasing outreach to immigrant survivors by sharing information regarding the FCADV Legal Hotline with agencies and faith-based organizations that provide services to immigrant communities. FCADV is engaging the workgroup members to accomplish this activity and to implement relevant activities in their respective work plans for the upcoming fiscal year.

FCADV's Batterer Intervention Program (BIPs) Workgroup should make formal recommendations to establish a system to monitor BIPs to ensure courts refer perpetrators to BIPs that comply with Florida statutes⁵ governing length of program, methodology, and other requirements.

The BIP Workgroup's recommendation included training BIP providers and allied agencies on best practices in batterer interventions. Sponsored by FCADV, David Garvin, co-founder of the Batterer Intervention Services Coalition of Michigan (BISC-MI), conducted a one-day training on Batterer Intervention Effectiveness to the Attorney General's Statewide Domestic Violence Fatality Review Team and the FCADV Batterer Intervention Workgroup. FCADV conducted two regional trainings for BIP facilitators on best practices in working with domestic violence perpetrators and six regional trainings for child welfare partners on working with fathers who are perpetrators of domestic violence. In addition, FCADV developed an updated brochure explaining the differences between batterer intervention programs, anger management, couples counseling and treatment for addiction for distribution to community stakeholders.

⁵s. 741.325

STATEWIDE DOMESTIC VIOLENCE FATALITY REVIEW TEAM MEMBERS

Nina Zollo, Esq.

Florida Coalition Against
Domestic Violence

Emery Gainey

Director of Law Enforcement
Relations
Victim Services and Criminal
Justice Programs
Florida Office of the Attorney
General

Samantha Curry

Orange County Probation
Intensive Supervision Team

Angela Diaz-Vidaillet

Victim Response Inc./The Lodge

Grace Diez-Arguelles

Office of the State Attorney,
15th Judicial Circuit

Sergeant Erick Dominguez

Palm Beach Sheriff's Office

Joseph P. George, Jr., Esq.**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

Richard F. Joyce, Esq.**Cecille Lucero**

Florida Legal Services

Mary Marotta

Florida Department
of Children and Families

Tabitha McDonald

Florida Sheriffs Association

Amy Mercer

Florida Police Chiefs Association

**Dr. Leonel Mesa, Jr., Psy.D.
LMHC**

Next Era Energy, Inc.

Karen Oehme, JD

Florida State University Institute
for Family Violence Studies

Elizabeth Parker, Esq.**Tena Pate, Chair/Commissioner**

Florida Commission on
Offender Review

Rod Reder

National Institute of Crime
Prevention Inc.

Bob Smedley

Florida Coalition Against
Domestic Violence

Steven Strivelli

Palm Beach Sheriff's Office

Kathleen Tailer

Office of the State Courts
Administrator

Pastor J. R. Thicklin

Destiny by Choice, Inc.

Chief Jerome Turner

Midway Police Department

Lauren Villalba, MPA

Miami-Dade County Domestic
Violence
Administrative Office of the
Courts

Iris Williams, MSW

Florida Department of
Education

Keith Wilmer

Florida Department of Law
Enforcement

Data Analysis Consultant

Joshua Cochran, Ph.D.,
University of South Florida

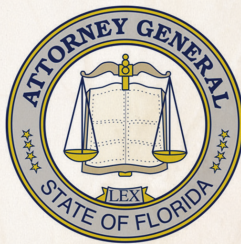
**Florida Coalition Against
Domestic Violence Staff
Support**

Cynthia Rubenstein and
Jodi Russell

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





FCADV
Florida Coalition Against Domestic Violence

This project was supported by Grant No. 2014-WE-AX-0012 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the state or the U.S. Department of Justice, Office on Violence Against Women.

Sponsored by FCADV and the State of Florida, Department of Children and Families.