DOMESTIC VIOLENCE FATALITY REVIEW TEAM
JUNE 2001 ANNUAL REPORT
EXECUTIVE SUMMARY

Domestic Violence Fatality Review Teams were first formed in Florida in the mid – 1990's. These Teams began as local initiatives supported with federal grant funds. Their goal is to examine in depth cases that resulted in a domestic violence fatality to try to identify potential changes in policy or procedures that might prevent a future death. These Teams work independently and are comprised of representatives from law enforcement, the courts, social services, State Attorneys, Domestic Violence Centers and others who may come into contact with domestic violence victims and perpetrators.

In 2000, the Florida Legislature enacted s. 741.316, F.S., which recognizes the work of these Teams and calls for the Florida Department of Law Enforcement (FDLE) to develop a standard data collection form to gather information from the local Fatality Review Teams to publish in an annual state-level report. After this law became effective on July 1, 2000, FDLE staff worked quickly to establish relationships with the 10 existing Fatality Review Teams and with six new Teams that formed in response to the legislation. In creating a standard data collection tool to be used statewide, FDLE staff researched existing procedures and data collection tools and involved the Teams in the developmental process. Within six months, in January 2001, FDLE provided a standard data collection form and manual, which all 16 teams began using.

Because actual standardized data collection did not begin until this year, the first Domestic Violence Fatality Review Team Annual Report contains very little data. It instead provides background information about the development of Florida's Fatality Review Teams, as well as a progress report on the implementation of the data-reporting program by FDLE.

The data that is published is based on only eight cases and is meant to demonstrate the kind of information that is now being collected and will be available for publication in future years. There should be no attempt to generalize from this data or to draw conclusions about state policy based on this limited and unscientific sample. The report published next summer will contain data from a full year of reviews and should be more illustrative of the issues surrounding domestic violence fatalities.

FDLE wishes to thank the 16 Fatality Review Teams upon whose work this report relies. Their assistance and cooperation at every step of the initial development of this program has been extremely valuable.

This report will be posted on the FDLE web site at www.fdle.state.fl.us.

FATALITY REVIEW TEAM 2001 ANNUAL REPORT

INTRODUCTION

Since data collection on domestic violence incidents began in 1993, approximately 27% of all violent index crimes (Murder, Forcible Sex Offenses, Aggravated Assaults and Aggravated Stalking) recorded by the Uniform Crime Reports (UCR) program are related to domestic issues. [1]

In 2000, out of the 890 murders reported to the UCR program, 168 or 18.9 % were domestic violence related. Of the 168 domestic violence homicides reported, in 104 or 61.9 % of those incidents, the spouse or live-in partner was the victim. Children accounted for 19 or 11.3 % of the victims. [2]

In response to growing awareness of local initiatives addressing domestic violence, the Florida Legislature enacted Florida Statute s. 741.316, effective July 1, 2000. This statute addresses the creation of Domestic Violence Fatality Review Teams and provides a new mission for the Florida Department of Law Enforcement (FDLE) Domestic Violence Data Resource Center (DVDRC). According to section 3 of the above mentioned statute;

> *"Each local domestic violence Fatality Review Team shall collect data regarding incidents of domestic violence. The data must be collected in a manner that is consistent statewide and in a form determined by the Department of Law Enforcement. Each team may collect such additional data beyond that which is prescribed in the statewide data collection form as will assist in the team's review. The Department of Law Enforcement shall use the data to prepare an annual report concerning domestic violence fatalities. The report must be submitted by July 1, of each year to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court."*

This first report documents the activities of the original Fatality Review Teams, the development of new local Fatality Review Teams, and the initial development of the new statewide data collection method by the FDLE.

HISTORICAL PERSPECTIVE

Governor's Task Force on Domestic Violence

Governor Lawton Chiles established the Task Force on Domestic Violence in September 1993. The Task Force was to develop standards for accurately measuring the extent of domestic violence, identify resources available to the State's victims of such violence and recommend strategies to increase public awareness and education on domestic violence

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[1] *Crime in Florida* 2000 Annual Report, Florida Department of Law Enforcement, Uniform Crime Reports, April 2001

[2] IBID

issues. The overall mission of the Task Force was to define those resources necessary to end domestic violence through a statewide coordinated effort.

In 1994, Florida Legislature created Florida Statute s.741.28, which defines "domestic violence" as "any assault, sexual assault, sexual battery, or any criminal offense resulting in physical injury or death of one family or household member by another who is residing in the same single dwelling unit." **A "family or household member" refers to "spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a family, and persons who have a child in common regardless of whether they have been married or have resided together."**

Mortality Review Study

Later in 1994, the Governor's Task Force on Domestic Violence funded a study of domestic fatalities in order to understand, prevent and intervene in these crimes. This study, conducted by Dr's. Byron Johnson and Neil Websdale of Vanderbilt University, resulted in four (4) Fatality Review Teams being established through funding received from the Violence Against Women Grant Office (VAWGO). The four teams were located in Miami-Dade, Volusia/Putnam, Palm Beach and Hillsborough Counties. In 1999, six additional Fatality Review Teams were trained with support from VAWGO funding. These included Broward, Duval, Lee, Orange, Pinellas and Escambia Counties. Many of these newer teams did not start reviewing cases until the year 2000.

Domestic Violence Data Resource Center

In 1997, a workgroup was established by the FDLE at the request of the Governors Task Force to evaluate the feasibility of statewide tracking of domestic violence incidents. After studying the facts and issues related to information concerning domestic violence, the workgroup recommended that the FDLE oversee the development and implementation of this program. As a result, FDLE received funding through the Legislature in October 1998 and created the DVDRC.

- The original purpose of the DVDRC was to create a method to collect information related to domestic violence, report and maintain the information in a statewide tracking system and share the collected data with other involved agencies.

The DVDRC's goals included creating an informational mechanism for collaborative research about domestic violence across domains that come into contact with the victims and perpetrators of such incidents. Both interviews and surveys were conducted to identify data that was available.

The results of the surveys indicate that domestic violence data is being collected at most of the agencies that responded and therefore, it would be feasible to develop a system that would assist in the statewide tracking of domestic violence incidents. However, there are many obstacles that need to be overcome to be successful.

Fatality Review Teams

In 2000, the mission of DVDRC was refocused with the creation of Florida Statute, s.741.316. With this statute, FDLE became responsible for designing a form to provide a uniform reporting standard for existing and newly created Fatality Review Teams, as well as for preparing a statewide report to the Governor and others as required by state statute.

Six new Fatality Review Teams have been created since passage of this legislation, covering the following seven counties: Bay, Brevard, Collier, Desoto, Manatee, Polk, and Sarasota. FDLE has involved all teams, new as well as previously existing, in the construction of the standardized reporting form.

SUCCESSES AND CURRENT STATUS

Governor's Task Force on Domestic Violence

The Governor's Task Force on Domestic Violence was successful in changing the State's view of the domestic violence issue. Years ago, law enforcement agencies dealt with the issue of domestic violence as a family matter rather than a crime. Since the passing of the Federal Violence Against Women Act of 1994, the focus on domestic violence has increased. Florida law enforcement agencies are now treating domestic violence as a crime.

Between 1993 and 1996, important domestic violence legislation has been created, enacted and amended in order to provide certain protective rights for the victims of these types of offenses.

- Florida Statute s.741.29 (1) ensures that all victims of domestic violence offenses are provided information concerning their "rights and remedies" while the officer is on the scene.

- Florida Statute s.741.29 (4)(b) requires the officer to identify the primary aggressor in the incident and ensures that victims of domestic violence who defend themselves, using proportional action, are not arrested along with the offender. This law also allows the officer to make an arrest based on his or her observations rather than the willingness of a victim to cooperate.

- Florida Statute s. 741.30(1)(a) provides the victim the right to file for a domestic violence injunction. This law also provides greater penalties for those offenders that violate the injunction. This statute allows the victim to take part in his or her own safety and protection.

- Florida Statute s. 39.201 makes it mandatory to report all known incidents of child abuse. This forces the law enforcement officers to identify and report cases where a child is a witness of domestic violence and may also be a victim. This law was created in order to prevent further harm to a child and provides a protective environment for the child when required.

These legislative measures have helped identify domestic violence issues, resolve some of the enforcement issues related to these types of offenses and make victims aware of their rights. Fatality Review Team members agreed that this legislation would be enhanced by better training provided to all agencies working with this issue in order to make sure that the impact of these laws is fully realized.

The Governor's Task Force on Domestic Violence continues to hold quarterly meetings, involving state, local and private agencies that work with domestic violence victims, offenders and related matters in discussions on issues of concern.

Mortality Review Study

The Mortality Study of Florida homicides conducted by Dr's. Byron Johnson and Neil Websdale identified different categories of domestic violence homicides that needed to be defined for reviewing purposes. The categories of homicides defined and studied were as follows:

- Intimate partner – the killing of their intimate partner,
- Killing the competition – the perpetrator kills the partner's current lover or vice versa,
- Familicide – killing entire family,
- Killing of children by parents,
- Suicide pact and mercy killing,
- Parricide – the killing of parents by their children, and
- Fratricide and Sororicide – sibling killings. [3]

The key findings of the study reflect that in those circumstances in which a woman is the victim, most of them have had an extensive history of violent victimization prior to being killed. Other important factors included prior threats to kill, escalating abuse and obsessive possessiveness and jealousy on the part of the perpetrator. The overall finding with female victims of domestic homicide is that the death is usually the final incident in a long history of battering.

The study finds that when men are the victims of domestic violence, it is either at the hand of another man involved in a love triangle with a woman or as an act of self-defense from an abused woman, in the defense of herself and/or her children.

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[3] Neil Websdale, Understanding Domestic Homicide, Boston, Northeastern University Press, 1999.

Potential "red flags" were identified in order to recognize the signs of progressive domestic violence behavior. Although not a direct predictor of domestic violence homicide, any combination of these indicators within a relationship could help to identify escalated abusive behavior. The "red flags" identified in the study are:

- Prior history of domestic violence,
- Possessive beliefs on the part of the perpetrator,
- Threats to kill,
- Perpetrator's perception that he has been betrayed by his partner,
- Attempts to break away from the perpetrator,
- Prior police calls to the residence,
- Drug and/or alcohol use before the fatal episode, and
- Prior criminal histories of victims and perpetrators.[4]

As a result of the 1994 study, Fatality Review Teams began to review the domestic violence homicides in their jurisdictions in order to study the sequence of activities that resulted in either the death of a family member or intimate partner. This was done in order to identify common characteristics of victims and offenders, as well as attempting to identify a point at which time the cycle of violence could be broken in order to prevent a homicide from occurring. Due to the local nature of these reviews, the changes of policies or procedures made by the agencies dealing with domestic violence issues usually occurred at the local level without the information being shared with others dealing with the same issues. The number of homicides each team would review varied by jurisdiction and region, as did methodology and data collection.

Domestic Violence Data Resource Center

The assessment report of agencies concerning the feasibility of establishing a statewide domestic violence tracking system resulted in the identification of items that need to be accomplished for a successful program implementation. These required steps include:

- Uniform protocols between data bases must be designed,
- A system that would allow collected data to be transferred into a central location must be created,
- Standardized data elements and drivers that allow for extraction will need to be developed,
- Critical information not available must be made available,
- Fatality Review Teams may need to adapt their review process practices to complete the form,
- Communication barriers between agencies must be broken,

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[4] Byron Johnson, Neil Websdale and Spencer D. Lee, Mortality Review: Final Report, Center for Crime and Justice Policy, Vanderbilt University, Nashville, TN, Vanderbilt Institute for Public Policy Studies, 2000, p. 14

- Agencies not willing to share valuable data must gain the confidence needed to allow for information sharing, and
- Each agency must understand their responsibility to the victim and/or the offender so that individual rights are protected.

All of these are important to develop a successful statewide tracking system of domestic violence incidents. While there remains a need to promote information sharing about domestic violence, the passage of Florida State Statute s.741.316 created a more immediate mandate. The efforts of the DVDRC were redirected to develop a standardized reporting program for the State's Fatality Review Teams.

In order to provide a statewide perspective of the findings of the Fatality Review Teams, the DVDRC of FDLE designed a form that provides a uniform method for collecting information. The form collects pertinent information for identifying strengths, weaknesses or issues related to domestic violence cases which might be useful in identifying strategies to stop the final encounter that results in the death of the victim. The findings and recommendations from the data collected will be compiled in an annual report by the DVDRC and provided to the Governor, President of the Senate, Speaker of the House, and Chief Justice of the Supreme Court annually.

Fatality Review Teams

Currently there are 16 Fatality Review Teams that cover 18 counties of the state. Of the 16 teams, four (4) were involved with the original Mortality Review Study, one (1) worked independently and five (5) more were brought on board prior to the new legislation. The remaining six (6) teams are new teams that were created after the passage of the legislation in 2000. At this time, all but one of the Fatality Review Teams (Miami-Dade) is comprised of voluntary members from the local entities dealing with domestic violence issues. The Miami-Dade Fatality Review Team volunteers are supplemented by a county funded staff as of September 2000, dedicated to the operations of the review process, data collection, and maintenance of the information. The Miami-Dade team has stated the funding allocation has already greatly enhanced their operations and productivity of the team in the first quarter of this year.

The Fatality Review Teams currently consist of members representing the local law enforcement agencies, State Attorney's Office, Clerks of Courts, Court Administrator's Office, Medical Examiner's Office, Domestic Violence Centers, victim services, batterer's intervention program providers, Department of Children and Families (DCF), shelters, other state agencies, business entities, county probation and corrections, local animal shelters, local clergy, and other involved parties. The composition varies from team to team.

The chart below provides a breakdown of the counties covered by the review teams and the volume and percentage of domestic violence homicides that occur in the counties as compared to the state.

FATALITY REVIEW TEAM
COUNTY TOTALS FOR DOMESTIC VIOLENCE HOMICIDES FOR 2000[5]

County	Total	Spouse/ Cohabitant	Parent	Child	Sibling	Other Family	Other
Bay	0	0	0	0	0	0	0
Brevard	7	5	1	0	1	0	0
Broward	13	12	0	0	0	1	0
Collier	1	1	0	0	0	0	0
Miami-Dade	33	16	2	3	0	1	11
Desoto	0	0	0	0	0	0	0
Duval	18	9	2	4	0	1	2
Escambia	5	2	1	1	0	1	0
Hillsborough	24	14	2	4	0	2	2
Lee	0	0	0	0	0	0	0
Manatee	0	0	0	0	0	0	0
Orange	6	3	0	1	0	1	1
Palm Beach	12	8	2	0	0	0	2
Pinellas	5	4	0	0	0	0	1
Polk	3	3	0	0	0	0	0
Putnam	0	0	0	0	0	0	0
Sarasota	2	2	0	0	0	0	0
Volusia	3	2	0	1	0	0	0
FRT TOTAL	132	81	10	14	1	7	19
STATE	168	104	12	19	3	7	23
% OF STATE	79%	78%	83%	74%	33%	100%	83%

Based on the analysis, it is clear that the majority of domestic violence homicides occur in counties having a Fatality Review Team.

The final report of the Vanderbilt University study, for release in early 2001 and covering the period of July 1999 through November 2000 reflects the following findings related to the activities of the existing Fatality Review Teams.

As of October/November, the Tampa team had reviewed a total of 40 domestic violence related homicides; the Miami team around 20 cases and Volusia/Putman 11. The Palm Beach Fatality Review Team began meeting June 1998 and began reviewing cases January 2000. The Duval County team has been reviewing domestic violence homicides since 1997 and has completed reviews of approximately 43 homicides.[6]

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[5] County and Municipal Uniform Crime Report, FDLE, Uniform Crime Reports, April 2001

[6] Byron Johnson, Neil Websdale, Robin Hassler-Thompson, Heather Moss, Katie Smith, Lt Mark Wynn, Captain Craig Broughton and Jennifer Gilbert, , Implementing and Monitoring New Fatality Review Teams: Final Report, Vanderbuilt, University, Nashville, TN, Center for Crime and Justice Policy, Vanderbilt Institute for Public Policy Studies, 2001

The following teams began collecting data during the year 2000: Orange County as of August, Pinellas County as of July, and Broward County as of February (completed 6 reviews during this time): Lee, Collier, Brevard, Bay, Polk and Sarasota Counties began collecting data in January of 2001, using the new FDLE draft form.[7]

The Final Report of the Vanderbilt study stated the following concerning the passage of Florida Statute s. 741.316. "As in other parts of the country, the passage of domestic violence fatality review legislation provided a major stimulus for review activity, assuaged fears concerning the confidentiality of information, offered immunity from civil suit, and so on." [8] Also the report stated that reservations about the legislation were the lack of funding provided to the teams, the potential use of the information provided, and that although the statute provides for immunity against liability, this has not been tested in the courts at this time. [9]

The original Fatality Review Teams, which were involved with the mortality study, have continued to review domestic violence homicides in their regions in order to identify strategies that interagency teams can use to prevent fatalities. Several of those teams provided information on their activities and findings prior to the creation of the statewide program. The findings of those teams are provided below.

The **Hillsborough County Fatality Review Team** reviewed domestic homicides of intimate partners. They found it imperative that the law enforcement agency responding to the call gather as much information as possible in a format that could be made available to the court at the time of first appearance, whether collected manually or electronically. Limitations on sharing between agencies outside of the law enforcement community hamper the ready availability of needed information and resources in making decisions related to individual cases. Education of the public on services available and the expansion of services to accommodate animals and children at shelters would help to ensure more victims seek help. Training officers handling domestic violence cases would help ensure that the judicial process would not further victimize the victim.

The **Duval County Fatality Review Team** has reviewed a variety of domestic homicides, including women killing their male partners, homicides involving same sex

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[7] IBID

[8] Byron Johnson, Neil Websdale, Robin Hassler-Thompson, Heather Moss, Katie Smith, Lt Mark Wynn, Captain Craig Broughton and Jennifer Gilbert, , Implementing and Montoring New Fatality Review Teams: Final Report, Pg 9, Vanderbuilt, University, Nashville, TN, Center for Crime and Justice Policy, Vanderbilt Institute for Public Policy Studies, 2001

[9] Byron Johnson, Neil Websdale, Robin Hassler-Thompson, Heather Moss, Katie Smith, Lt Mark Wynn, Captain Craig Broughton and Jennifer Gilbert, , Implementing and Montoring New Fatality Review Teams: Final Report, Vanderbuilt, University, Nashville, TN, Center for Crime and Justice Policy, Vanderbilt Institute for Public Policy Studies, 2001

partners, and homicide/suicide cases. Their overall findings were that the victims had either not used or were not aware of the legal and social services that were available. The study reflected that their were 14 cases reviewed in which children were present or observed the murder of a parent, yet only one was referred to the local social service program for help. Lastly, it was found that of the cases reviewed that had a history of domestic violence, less than half of the perpetrators were ordered into a batterer's intervention program and of those, only one individual completed the course.

The **Miami-Dade Fatality Review Team** reviewed 14 cases involving in the death of 17 persons, other than the perpetrator. Of these, nine (9) also resulted in the perpetrator committing suicide at the time of the homicide. In half or more of the cases reviewed, the perpetrator had made threats on the life of the victim, had previous allegations of domestic violence, or had criminal histories for non-domestic violence related incidents. Of all the cases, only two (2) of the victims had filed for a protection order against the perpetrator. In four (4) of the cases, records were found in the Department of Children and Families regarding the victim's family. These findings indicate that the "red flags" associated with domestic violence, although present, were not picked up during the documentation of the events.

The **Broward County Fatality Review Teams** findings focused on the safety of victims of domestic violence and how that could be best incorporated into their current operations. Their findings were that victim safety would be enhanced by the following measures:

- The use of a narrative psychosocial report, based on a face to face interview, completed on all batterer's.
- Training for mental health professionals, social workers, physicians, nurses, medical professionals, and law enforcement personnel on the duty to warn and safety planning in cases of domestic violence.
- A mechanism for verifying whether an applicant for a firearm purchase has been adjudicated mentally defective or has been committed to a mental institution.
- A lethality assessment being included in each case file in the civil court system.
- Law enforcement officers incorporating a standardized domestic violence supplement form to include a lethality checklist to be submitted with the probable cause affidavit.
- All victims' advocates using uniform protocols when responding to domestic violence law enforcement calls.
- The periodic use of a uniform instrument evaluating the indication for suicide/homicide behavior in seriously ill geriatric cases.

FATALITY REVIEW TEAM DATA SUBMISSION PROGRAM IMPLEMENTATION

Since July 1, 2000, when Florida Statute s.741.316 was enacted, the FDLE began taking steps to learn about the current operations of the existing Fatality Review Teams. Meetings were held with members of the Governor's Task Force on Domestic Violence and the research team hired with VAWGO funding to perform the initial mortality reviews for a period of three years.

The DVDRC staff met with the existing teams and began reviewing all data collected by the teams, examining the findings of the teams and getting a sense of the function and scope of the teams at the local level. After the law was enacted, several teams were developed at the local level, and these were identified and visited as well.

As a result of the reviews conducted and the defined scope of developing a uniform statewide Fatality Review Team Data Submission form, FDLE began defining the data elements to be collected and designing the format that would be used for data collection. Many of the variables included in the current form were derived from an extremely comprehensive data collection instrument which was designed and tested by the Miami-Dade Fatality Review Team, and which served as a basis for a statewide data collection software program created by Vanderbilt University. The software was distributed to the teams with laptops in January of 2000 at a conference held in Orlando to train six of the new teams in addition to the original four. The Miami-Dade and Palm Beach teams played a key role as faculty at this training, imparting their experiences with operating a team and conducting reviews. Vanderbilt University also used this program in conducting its research on domestic violence fatalities.

Members of the DVDRC met with Doctors Byron Johnson and Neil Websdale and other agencies involved with the initial fatality reviews in order to gain a better knowledge as to the purpose and functions of the teams. Meetings were also held with Department of Health staff to review the Child Fatality Review Database that they created.

During this same period, the data collection forms of existing teams and the form designed by the Miami-Dade Fatality Review Team and the staff from the Vanderbilt University were reviewed. Findings and recommendations of the existing teams were also studied. After a examination of current practices and data collections instruments, the DVDRC staff began meeting with the existing and newly formed Fatality Review Teams in order to define initial data elements and develop a reporting format for the data collection form.

In the fall of 2000, a draft form and reporting manual were designed and presented to all of the participating teams and researchers for review and comments. The feedback received from the teams and researchers was incorporated into a revision of the form, which was provided to all 16 teams in January 2001. The teams were requested to begin collecting data using the pilot form on all fatalities reviewed for the year 2001. At the

current time, all teams are using the forms and comments are being provided with suggestions for a future revision of the form.

FDLE staff recognized that adopting the state's standardized form will require existing teams to alter some of their procedures. In order to assist the teams already familiar with the Miami-Dade form, a conversion chart to the Florida Fatality Review Data Submission Form was created to ensure data could be easily extracted from one form to the other. To assist the newer teams, a data informational source guide was created identifying informational sources for data required for completing the new form. Meetings were conducted with teams in order to provide instructions for data collection and to answer questions concerning liability issues, etc.

The Fatality Review Teams of Florida began collecting data using the standard form at the beginning of this year (2001) for the creation of next year's annual report.

PROGRAM DESIGN AND IMPLEMENTATION

Homicide Review

Many of the newer Fatality Review Teams asked the FDLE to establish guidelines as to what homicides should be reviewed, how to select cases and how to perform reviews. The FDLE did not believe it was within the scope of responsibility or experience of staff to establish such guidelines. Based on research at the outset of the project, staff determined that there are many reasons why a homicide might be selected for review, all of which are valid.

- The death is selected because it involves a long history of domestic violence between the decedent and the perpetrator that did not trigger a more active response from the agencies that were involved.
- The death is selected as a classic domestic violence related death without any prior recorded data from agencies normally involved with domestic violence issues.
- The death is selected due to the involvement of many different agencies, a lot of information is available with which to study the incident and the numerous issues are involved.
- The death is selected because significant events occurred in multiple jurisdictions that have Fatality Review Teams that might be able to identify problems that exist in data sharing and the flow of information that should follow the couple through their relationship.
- The death is selected as a clear example where the system somehow failed the victim.
- The death is selected due to the high profile of the decedent or perpetrator.
- The death is selected due to the horrendous nature of the crime itself.
- The death is selected because it involves homicide/suicide where there are no survivors and no pending criminal or civil actions.
- The death is selected due to the news media high profile coverage of the event.

- The death is selected because it is a cleared case in which the perpetrator has been tried and sentenced or is deceased.
- The death is selected randomly from the domestic violence homicides that occurred within the review team's area of responsibility.
- The death is selected because the victim represents an under-served portion of the population related to domestic violence issues.
- The death is selected due to the large number of different victims involved, i.e., hostages, other family members, work associates, etc.

It was determined that the decision as to what types of homicides are to be reviewed will be decided at the local level. Due to liability issues, many of the teams are restricting themselves to the study of cases in which the perpetrator committed suicide as a part of the homicide incident.

Form Design

According to the statute, FDLE is responsible for designing a standardized reporting form for Fatality Review Teams. The form not only provides a uniform method for collecting information, but also collects pertinent information for identifying strengths, weaknesses or issues in dealing with domestic violence cases in order to improve prevention. **Once FDLE is able to capture its first full year of data (for 2001), findings and recommendations will be compiled in a report by the DVDRC to the Governor, President of the Senate, Speaker of the House, and Chief Justice of the Supreme Court in order to provide data to support statewide policies and legislation related to domestic violence.**

The original form, designed during the mortality review study, was found to be a data extraction tool. The form allowed various participants within the review team to extract data from their individual reports and to place it in a section created specifically for that review team member's input. The information provided by each of the participants was then consolidated on the report by the team's recorder.

The form designed by FDLE collects information related to the case in such a manner that it leads the review team to conclusions that result in findings and recommendations related to each homicide.

The Fatality Review Team Data Submission Form was designed to serve the following purposes.

- Provide standardized method of collecting fatality review team information.
- Ensure that relevant data related to domestic violence homicide is collected.
- Require little narrative reporting.
- Allow data collected to be analyzed for availability, completeness and reliability
- Assist the Fatality Review Teams in identifying and establishing the value of data elements collected.
- Provide information in a format that can be compiled regionally and statewide.

- Support potential recommendations for policy or procedural changes.

Data Sources

The form summarizes information collected by the review team in researching and defining the death(s). In order to assist the new Fatality Review Teams in compiling the needed information for review, the following list of resources was suggested. From law enforcement agencies, it was suggested that the dispatch report, law enforcement officer's report, investigative reports, criminal history reports and current injunction information be requested. It was suggested that personal information be gathered through interviews, newspaper articles, school records, and documentation found at the residence. It was also suggested that reports from paramedics, medical professionals, and medical examiners be used in order to gain insight concerning the physical and mental well being of both the victim and perpetrator. This information includes the cause of death, use of alcohol/drugs, the medical, mental and emotional status of the participants, whether previous abuse was indicated and current medications that were being used by either the victim or the perpetrator. The review of court records was suggested in order to find dispositions of criminal and civil cases, current civil proceeding related to divorce or custody issues, historical injunction information and current criminal incidents.

Data Collection

The Fatality Review Team Data Submission Form is broken down into the following informational sections.

- The Complaint Information section is related to the time the homicide was first reported to the law enforcement agency and the information that was provided the first few minutes of the call.
- The Event Information section continues with what took place after the call was received and law enforcement arrived to begin the initial investigation.
- The Environment Prior to the Fatality section collects data related to the victim and perpetrator's interactions and involvement during their relationship.
- The Decedent Information section collects demographic, historical and personal data solely related to the decedent in the case.
- The Perpetrator Information section collects demographic, historical and personal data solely related to the perpetrator in the case.
- The Perpetrator as Battered Victim section is only completed when a battered victim kills his or her attacker or batterer.
- The Perpetrator Suicide section is only completed when the perpetrator, as part of the fatality incident, commits suicide.
- The Relationship Issues section defines the prior or current relationship of the victim to the perpetrator.
- The Contributing Factors to Incident section collects data related to the incident that actually contributed to the fatality. More than one factor may have

contributed to the homicide occurring, and different categories of factors found in previous studies about domestic violence homicides are provided.

- The Escalating Circumstances section collects information related to the decedent and perpetrator that might have been present but not seen as an indicator of escalated violent behavior.
- The Services Requested, Ordered or Obtained section collects information regarding social and legal services that the community offers both decedents and perpetrators of such crimes but may or may not have been used or provided by either as related to the case.
- The Lethality Indicators section is provided to collect information of indicated behavior that is normally associated with excessive violence. This unique and illustrative section, in particular, was originally conceived and developed by Miami-Dade's Review Team as part of their data collection instrument.
- The Summary section of the form allows the team to identify factors, actions and necessary changes related to the case, and then to make recommendations that would result in better handling of a similar case in the future in order to prevent a potential homicide from taking place.

FINDINGS

Because this form was not developed and provided to the Fatality Review Teams until January 2001, this report cannot provide a full year's data and findings from the teams.

The intent is to publish in mid-2002 a report on all reviews conducted in 2001 and reported to FDLE using the standard form.

The following data is provided to demonstrate the kind of data collected. The data is based on a very limited number of fatality reviews (the reader is cautioned about drawing conclusions from this small sample).

Findings:

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The intent is to publish in mid-2002 a report on all reviews conducted in 2001 and reported to FDLE using the standard form.

The following data is provided to demonstrate the kind of data collected. The data is based on a very limited number of fatality reviews (the reader is cautioned about drawing conclusions from this small sample).

FATALITY REVIEW SUMMARY REPORT

COMPLAINT

Time Received

Morning	0530	0734	0708	1128		
Evening	1340	1934	1459	1716	2300	2323

Day of Week

Monday	1
Tuesday	1
Wednesday	1
Thursday	1
Friday	2
Saturday	1

Call Received:

After event	9
During event	0

*

Person Making Call:

Family member of the decedent	2
Family member of the perpetrator	1
Acquaintance	6

(There was a hang up call to 911 – on call back perpetrator on line)

Summary:
All calls were received after the event and nothing during the receipt of the calls could have prevented the homicides.

EVENT

Offense Type

Homicide	4
Homicide/Suicide	4
Multiple Homicide/Suicide	1

Event Type

Intimate Partner	8
Killing of Children by Parent	1
Killing of the Competition	1 (2 deaths)
Total Victims	11

Cause of Death

Handgun	7
Shotgun	1
Rifle	1
Blunt Object	2

Location Type

Residence of decedent	6
Residence of perpetrator	1
Workplace of decedent	1
Other – behind vacant home	1

Status of Perpetrator

Arrested	4
Committed Suicide	5

Injunction History of Perpetrator

Active Injunction	2
Expired Injunction	1
Previous Injunction	1

Injunction History of Decedent

Active Injunction	1
Expired Injunction	1

Summary:
The majority of deaths were by an intimate partner and cause of death was handgun.

DECEDENT INFORMATION

Sex

Male	3
Female	7

Marital Status

Never Married	1
Married	4
Separated	2
Divorced	2

Race

Black	2
White	6
Unknown	1

Employment

Employed	6
Unemployed	2
Retired	1

Criminal History

Non-violent crime arrest	2
Non-violent crime arrest w/guilty conviction	1

Documented police response to residence 4
Documented police response to residence for DV 1
Victim of other offenses 4
Previous incidents of DV with different partner 2
Was there a history of DV know to family members, friends or co-workers 6

Summary:
Most decedents were employed, white females. Majority of the decedents had a known history of being a victim of domestic violence.

PERPETRATOR INFORMATION

Sex

Male	9

Martial Status

Married	5
Separated	2
Divorced	2

Race

Black	2
White	7

Employment

Employed	2
Unemployed	2
Social Security	1
Retired	3
Unknown	1

Criminal History

Non-violent crime arrest with guilty conviction	4
Non-violent crime arrest with unknown conviction	1
DV crime arrest with guilty conviction	2
DV crime arrest without guilty conviction	2
Other violent crime arrest with guilty conviction	1

Previous incident of DV with different partners 4
Previous history of suicide attempt 2
Known allegations of stalking 3
Previous participation in batterer's intervention program 2
Previous use of drugs 1
Previous use of alcohol 7
Under medication 2
Previous incident(s) of animal abuse 1
Ever appeared in court for DV offense 2
Were DV related charges ever dismissed against the perpetrator 2
Was there a history of DV known to family members friends or co-workers 5
Are there any known incidents of prior child abuse 1

Summary:

PERPETRATOR SUICIDE

Cause of Death:

Gunshot wound	5

Suicide Note Left 0

Suicide appear part of homicide 2

Summary:

All suicides committed by perpetrators involved a gunshot wound.

RELATIONSHIP ISSUES

Relationship of decedent to perpetrator

Spouse	6
Girlfriend	1
Stepchild	1
Ex-spouse	1

Reported prior threats made to decedent by perpetrator

Threat to kill decedent	4
Threat to commit suicide	3

If decedent and perpetrator had a relationship they:

Lived together at some point	9
Lived together at the time of the fatality	1
Were intimate prior to the fatality	1
Had a child/children in common	1
Had children in household, but not in common	1
Had previous report incidents of domestic violence	5
Had a significant change in relationship	5

Summary:

All had lived together at some time. There was a history of domestic violence and/or threats of violence in over half of the cases, and half had a significant change in relationship.

CONTRIBUTING FACTORS TO INCIDENT

Relationship Factors Priority Rating (with 1 being the highest and 8 the lowest)

Decedent and perpetrator in process of separation at time of fatality	4
Decedent and perpetrator had separated	3,5,1
Perpetrator served with divorce papers	4
Decedent had started new relationship	5,1,2,2

Employment/Monetary Factors

Perpetrator had loss of employment recently

Blames decedent	2

Perpetrator had loss of income recently

Blames decedent	2,2

Criminal Justice Interaction Factors

Decedent had filed an injunction on the perpetrator	6,7
Perpetrator had been served with an injunction	3
Perpetrator was arrested for DV on decedent	2

Substance Abuse Factors

Perpetrator had/has used drugs

Prior	1

Decedent had/has used drugs

Prior	1

Perpetrator had/has used alcohol

Prior	2
During	2,1

Decedent had/has used alcohol

Prior	2
During	3,2

Health/Mental Health Factors

Perpetrator had/has mental health problems	2,3,8,3
Decedent had/has mental health problems	3,2

Other Factors

Perpetrator alleged to have committed act to avenge a perceived wrongdoing

Perpetrator alleged to have committed act to avenge a perceived wrongdoing By decedent	 2,1,1,1,1,1

Other:

Jealous of Mother/Son relationship	1
Decedent's child from previous relationship joined household	6

Summary:

Major factor identified in the fatalities is that the act was to avenge a perceived wrongdoing by the decedent. Alcohol/drugs may have contributed to the act.

EXCALATING CIRCUMSTANCES

Did the Decedent:

Express fear of physical danger to themselves or children	5
Express fear of losing custody of children	
Isolate themselves from family and friends	2
Have evidence of physical injury	3
Show frequent signs of Depression Anger Low self-esteem	 1 2 4
Express fear of involvement in the criminal justice system process	2
Show or express signs of sleeping difficulties	1
Express guilty feelings about the failed relationship	1
Show or express history of family abuse	3
Express fear of loneliness	1
Express fear of making a great life change	1
Express belief that partner would change their behavior	1

Did the Perpetrator:

Abuse the decedent in public	2
Keep tabs on or stalk victim	6
Put down the decedent's friends and family	3
Tell decedent, jealousy is a sign of love	1
Make all decisions in the relationship (including finances)	2
Blame decedent for abuse	5
Use intimidation	4
Smash objects and destroy property	2

Summary:

Decedents appeared to suffer from fear of danger to themselves and/or children and from low self-esteem. Perpetrators appeared to stalk/keep tabs on decedents, blamed the decedent for abuse and used intimidation.

SERVICES REQUESTED, ORDERED OR OBTAINED

Domestic Violence Services — Requested — Received

DV counseling services

Decedent	3	2

DV center

Decedent	2	2

Criminal Justice/Legal Assistance

Law Enforcement:

Decedent	3	3
Perpetrator	2	2

Legal Assistance/attorney

Decedent	2	2
Perpetrator	2	2

State Attorney/Prosecutor:

Decedent	1	1

Court/Judges

Decedent	3	3
Perpetrator	1	1

Probation/Parole

Perpetrator	2	2

Other

Batterers Intervention

Perpetrator	1	1

Injunction

Decedent	1	1

R/O

Decedent	1	0

Health Care Provider

EMT/Paramedics:

Decedent	1	1
Perpetrator	2	2

Emergency Room

Decedent	1	1

Emergency room

Decedent	1	1

Physician

Perpetrator	1	1

Mental Clinic

Decedent	1	1

Mental Health program

Decedent	1	1
Perpetrator	2	2

Number prior calls for service to DV centers	6
Number prior calls for service to Law Enforcement	7

Batterer's Intervention Program Completed Yes No

Perpetrator	1	1

Other Court Ordered Programs Completed

Pre-trial Intervention

Perpetrator completed	1	

Number of times Batterer's Intervention Program was attended

Perpetrator attended 6 sessions, 1 session

Number of times Substance Abuse Program was attended

Perpetrator attended 1 session

Other Court Ordered Programs Completed Yes No

Anger Management

Decedent		1
Perpetrator		1

LETHALITY INDICATORS

Emotional/Mental Deterioration	Decedent	Perpetrator
Suicidal		6
Homicidal		6
Loss of function (i.e. not eating, sleeping, working)		2
History of psychiatric problems	1	2
Poor compliance with taking medication	2	2
Depression	2	4
Economic loss	1	4
Loss of family support	2	3

Ownership/Centrality of Victim to Perpetrator	Decedent	Perpetrator
Obsessive about partner or family		6
Extreme jealousy		4
Rage and/or depression over separation		4
Perceived betrayal		6
Perceived rejection after attempt to reconcile		3

Antisocial Behavior

History of DV	1	6
History of assaults on other	3	4
History of criminal activity	2	6
History of stalking		4
History of substance abuse	3	5
Possession of weapons	2	7
History of abusing children (physically or sexually)		1
History of childhood abuse or witnessing violence		1

Failure of Community Control

Violation(s) of restraining order		2
Violation(s) of probation		2
Arrest(s) for DV		2
Fail complete Batterer's Intervention Program		1
Failure to complete Substance Abuse treatment	1	1

Severity of Violence

Used a weapon		7
Death threat		3
Hurt pet		1
Severe injury	2	2
Sadistic/Terrorist act		1
Expressed concerns that she/he would be killed	5	

Summary:
Most perpetrators had possession of weapons. Many had a history of criminal activities, domestic violence and were homicidal/suicidal.

SUMMARY OF REPORTS

Prior to the fatality, were there any indications that the level of abuse was increasing?

Yes	5
No	2
Unknown	1
No information included on form	1

During the relationship of the decedent and perpetrator, which entities had knowledge of domestic violence?

Law Enforcement	3
Family	6
Acquaintances	5
State/County Agencies	5

The final item on the data submission forms asks the teams: What if any, findings or recommendations would this team make as a result of the case review? The following were the responses received on the cases provided.

Prisons should notify decedent of perpetrators release by out-of-state agency (if no policy exist one should be implemented).
Need follow up treatment for substance abuse.
No life skills/gap in mental health.
No treatment for alcohol abuse of perpetrator.
Re-evaluate community out reach and education on domestic violence.
Make it harder for potential perpetrators to have access to weapons.
Look at time line of activity on date of incident (perpetrator and decedent).
"Financial ruin" threat perceived by perpetrator.
Decedent(s) did not follow through/use any services that were available to her/him (i.e., restraining order, counseling, DV shelter)
Homelessness led to vulnerability
Period of incarceration might be only change for rehabilitation services to homeless victims.
Injunction was denied for decedent, hearing set and decedent did no show, perpetrator not served with papers.
Decedent not referred to victim services.
No documented incident of DV but history of stalking/non-compliant with medication.
Perpetrator able to purchase firearm.
Contact with helping agencies was to brief for adequate assessment and intervention.

Are there any significant factors your team came up with that were not addressed in this form?

Tape recordings (no other info provided).
In fact, there appeared to be no duplicative questions.
Look at timeline of activity on date of incident (perpetrator and decedent)
(Decedent refused to press charges).
Failure to respond to hang up – spoke with perpetrator – need better responses
No contact, order lifted – appropriately.
Every victim that applies for an injunction should be supplied with a safety plan and lethality factors.