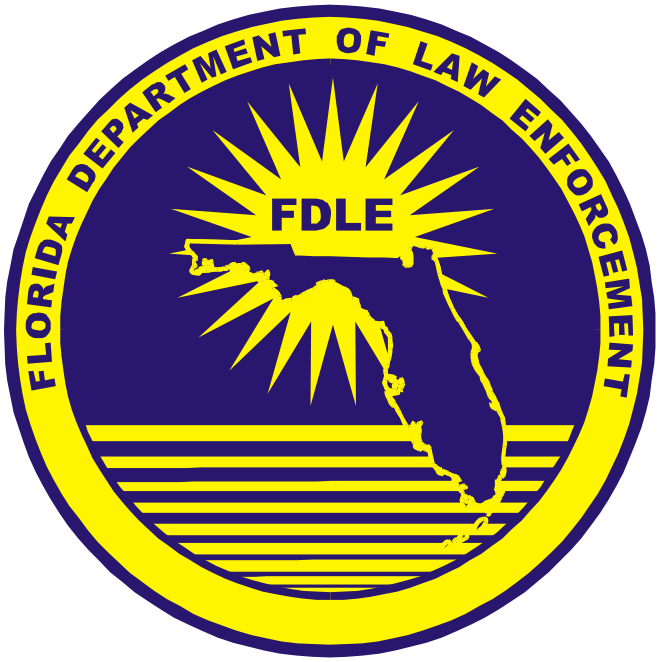
FLORIDA DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL REPORT 2002



DOMESTIC VIOLENCE FATALITY REVIEW TEAM
2002 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 future deaths. 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 Domestic Violence Fatality Review Teams to publish in an annual state-level report.

The data published in this report is based on 45 cases which were specifically selected by the fatality review teams, occurred during different years, and are not meant to statistically represent all domestic violence deaths in Florida. Care should be taken before attempting to generalize or draw conclusions about state policy based on this limited and unscientific sample.

Highlights of the domestic violence fatality report are:

Age of perpetrator: average adult age of perpetrator was 48.
Age of decedent: average adult age of decedent was 46.
Sex of perpetrators: 41 (89%) male, 5 (11%) female (there were two perpetrators in one case).
Sex of decedents: 11 (23%) male, 36 (77%)female (there was more than one victim in some cases).
Location: 35 of the 47 fatalities occurred in/at the decedent's residence.
Weapons: In 25 of the 45 cases, a firearm was involved in the fatality.
Relationship: In 29 of the 45 cases, the parties lived together at time of death.
History: In 18 of the 45 cases, prior domestic violence had been reported.

Major findings related to domestic violence fatalities from the review teams were:

1) Untreated or under-treated drug and/or alcohol abuse.
2) Easy access to firearms.
3) Failure to use services or service providers effectively.
4) Need for more or better training on domestic violence and available services.

FDLE wishes to thank the Domestic Violence Fatality Review Teams upon whose work this report relies. Their assistance and cooperation has been extremely valuable.

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

FORWARD

Florida this year joined 29 other states in expanding its injunction statute to include dating relationships of six months in the definition of domestic violence laws. Governor Jeb Bush signed the legislation which also eliminates filing fees for protective orders.

In the state's continued efforts to reduce domestic violence crimes, Governor Bush initiated Violence Free Florida! in 2002, aimed at reducing domestic violence through greater public awareness of this crime, increased services for its victims and additional public/private partnerships for greater community involvement in these efforts.

In 2001, the legislature approved and Governor Bush signed into law the "Family Protection Act" which required a 5-day mandatory jail term for any crime of domestic battery in which the perpetrator deliberately injured the victim. The law also makes a second battery crime a felony offense, which will effectively treat repeat offenders as serious criminals. The Family Protection Act also requires persons convicted of violent crimes to pay a $201 surcharge to offset the costs of local incarceration and support domestic violence shelters.

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DOMESTIC VIOLENCE FATALITY REVIEW TEAM 2002 ANNUAL REPORT

DOMESTIC VIOLENCE IN FLORIDA

According to the Uniform Crime Reports Annual Report Crime in Florida, a total of 124,016 domestic violence incidents were reported in 2001. Domestic violence accounted for 26.6 % of all comparably reported violent offenses.

Domestic violence accounted for 22.3 % (193) of the State's 867 murders during the same reporting period. The spouse or live-in partner was the victim in 58.6 % of these offenses. Children accounted for 14.0 % of the victims.

As of June 3, 2002, there were 92,510 Domestic Violence Injunctions in the Florida Department of Law Enforcement's Florida Crime Information Center.

DATA SUBMISSION FORM

With the passage of Florida Statute s. 741.316, effective July 1, 2000, the Domestic Violence Fatality Review Teams along with the Florida Department of Law Enforcement (FDLE) developed a standardized reporting form.

This report will reflect the results of the data submitted by the state's Domestic Violence Fatality Review Teams for the year 2001.

During the year 2001, the pilot test draft of the Domestic Violence Fatality Review Team Data Submission Form was used to record the Teams' reviews conducted for the year. As a result of feedback provided by the Domestic Violence Fatality Review Teams, enhancements were made both in data collection elements and the form design. In February, the final version of the form and reporting manual were provided to participating teams for data collection beginning in 2002.

The Domestic Violence Fatality Review Team Data Submission Form was designed to serve the following purposes:

- Provide a standardized method of collecting Domestic Violence Fatality Review Team information.
- Ensure that relevant data related to domestic violence homicides is collected.
- Require little narrative reporting.
- Allow data collected to be analyzed for availability, completeness and reliability.
- Assist the Domestic Violence 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.

ANNUAL SUMMARY FORM

A Domestic Violence Fatality Review Team Annual Summary Form was provided in order to ensure that the appropriate findings and recommendations, derived from the reviews that the teams have conducted, are provided to the Governor, President of the Senate, Speaker of the House of Representatives and the Chief Justice of the Supreme Court. This form provides a mechanism for teams to highlight findings or issues that might not come to the forefront when data from all reviews are summarized. The form is broken down into the following informational sections:

- The most significant findings from Team reviews.
- The changes in policy and/or procedure that were made as a result of Team reviews, where they occurred and how they were implemented.
- The change(s) in law, policy or procedure the Team recommended for consideration at the state level.
- Additional comments or concerns.

THE DOMESTIC VIOLENCE FATALITY REVIEW PROCESS

Domestic violence fatality review refers to the "deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence, for examination of the systematic interventions into known incidents of domestic violence occurring in the family of the deceased prior to the death, for consideration of altered systematic response to avert future domestic violence deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to eradicate domestic violence."[1]

By publishing this information, it is hoped that strategies can be established to assist in intervening in domestic violence incidents before a death occurs. This can only occur when common elements can be identified and defined for domestic violent fatalities. With this information, awareness programs can be developed to ensure all entities working with this issue can see the potential of a homicide occurring and work to prevent it.

DOMESTIC VIOLENCE FATALITY REVIEW TEAMS

Purpose of the Domestic Fatality Review Teams

"The common purpose of the Domestic Violence Fatality Review Teams is to better understand, intervene and aid in the prevention of domestic homicide. The goal is to educate the community in general, and women in particular, about the heightened risk of lethal domestic violence so that victims of domestic violence may make more informed

[1] Barbara Hart, Legal Committee, Domestic Violence Death Review, February 9, 1995, National Council of Juvenile and Family Court Judges.

choices about their survival strategies and enable service providers to assist them more effectively."[2]

Philosophy of the Domestic Violence Fatality Review Teams

"Although the perpetrator of domestic homicide bears the ultimate responsibility for the killing, many agencies that work with victims of domestic violence might have become more involved, perhaps saving a life. The failure to prevent deaths through inaction, negligence, malfeasance, corruption, the inability to better coordinate service delivery, and so on, is common in many walks of life where the safety and security of the public is at stake. It is essential that review teams gather information to make informed decisions about how to introduce changes to prevent domestic violence. In other words, the review team works with a philosophy of kindness and concern, a philosophy that respects the rights of surviving family members, but with a philosophy that recognizes that better agency coordination can save lives. The "no blame and shame" philosophy does not remove the need for agency accountability."[3]

Domestic Violence Fatality Review Team Members

Each Domestic Violence Fatality Review Team currently consists of members representing the local law enforcement agencies, State Attorney's Office, Clerk of Court, Court Administrator's Office, Medical Examiner's Office, Domestic Violence Center, 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 shelter, local clergy, child death review teams and/or other involved parties. The composition varies from team to team.

Florida's Domestic Violence Fatality Review Teams

Currently, there are 15 Domestic Violence Fatality Review Teams that cover 18 counties of the state. At this time, all but one of the Domestic Violence Fatality Review Teams (Miami-Dade) is comprised totally of voluntary members from the local entities dealing with domestic violence issues. The Miami-Dade Domestic Violence 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.

As of the beginning of the year 2001, the following counties had active Domestic Violence Fatality Review Teams: Bay County, Brevard County, Broward County, Charlotte County, Collier County, Duval County, Escambia County, Lee County, Orange County, Palm Beach County, Pinellas County, Polk County, Putnam/Volusia County and Sarasota/Manatee/Desoto County,. The Hillsborough County Domestic Violence Fatality Review Team was dissolved this year.

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[2] Johnson, Byron, Websdale, Neil; **Fatality Review: An Implementation Guide for Establishing Local Teams;** Office for the Study of Prevention of Domestic Violence; University of Pennsylvania; 2001

[3] ibid

Participating Teams: Fatality Reviews

The following nine teams submitted Domestic Violence Fatality Review Team Data Submission Forms in compliance with Florida Statute s. 741.316 for inclusion in this year's annual report. The team and the number of reviews conducted and submitted are reflected below.

TEAM	Reviews
Bay	4
Broward	2
Collier	4
Escambia	1
Lee	2
Palm Beach	2
Pinellas	21
Polk	5
Sarasota/Manatee/DeSoto	4

Participating Teams: Summary Report

A summary of findings was provided by six of the existing Domestic Violence Fatality Review Teams. All of these teams provided individual case review information. The summary is an overview of the critical findings resulting from their reviews conducted this year.

OVERVIEW OF DOMESTIC VIOLENCE FATALITY REVIEW TEAMS' FINDINGS, RECOMMENDATION, COMMENTS OR CONCERNS

The following data was gathered from annual summary evaluation forms that were provided to the Domestic Violence Data Resource Center by the participating Domestic Violence Fatality Review Teams. Other findings, changes and recommendations can be found on pages 51-53, where individual case reviews are summarized.

Findings:

The most significant findings from the reviews are:

1) Domestic violence laws are much stronger now and there are more resources available to victims of domestic violence, however, in most cases, the victims and others who knew of the abuse did not reach out to the various resources that might have provided assistance/intervention.
2) There were cases involving drug and/or alcohol abuse in which the decedent and/or perpetrator did not use any of the services provided by the community.
3) Perpetrators were able to obtain/keep a firearm with little or no problem.

Changes:

The majority of the reporting teams reported that no changes were made as a result of the reviews. However, the teams that made changes in policy(s) and/or procedure(s) reported the following: 1) more collaboration between the various agencies/entities that are involved in various aspects of domestic violence abuse cases; 2) more training in domestic violence for law enforcement and other professionals especially concerning events that would be considered "red flags"; and 3) more efforts to link the surviving family members with needed services.

Recommended Changes:

The following are changes in law(s), policy(s) and/or procedure(s) recommended by the teams:

1) Strengthen firearm purchase laws including mental health screenings.
2) Increase public awareness by developing flyers and having statewide public service announcements to enable others to know what they should do when they become aware of domestic violence situations.
3) Enact stiffer penalties for those who commit domestic violence abuse, limit number of times they can opt to attend a batterer's intervention program course and increase number of sessions they must attend.

Comments or Concerns:

The teams had the following comments and/or concerns:

1) Review is a valuable process for looking at local domestic violence fatalities.
2) There is a need to look at suicides that may have resulted from domestic violence.
3) Interventions must consider the result that witnessing domestic violence has on children.

DOMESTIC VIOLENCE DATA REVIEW

The following data is from 45 cases provided to the Domestic Violence Data Resource Center (DVDRC) by the participating Domestic Violence Fatality Review Teams. The cases were not selected based on any specific date, time frame or circumstance. Because the data is from nine teams covering 11 counties and the number of reviews completed by each team varies, the reader is cautioned about drawing conclusions from this data.

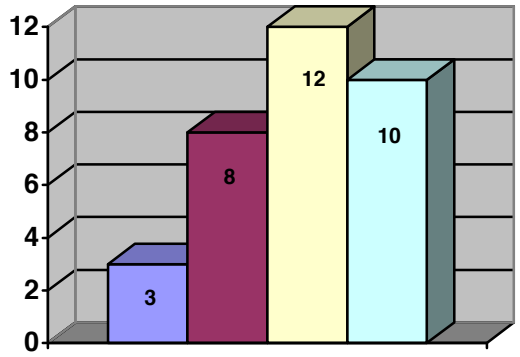
HIGHLIGHTS OF THE DOMESTIC VIOLENCE FATALITY REPORT

Age of perpetrator: average adult age of perpetrator was 48 (female average age of 37 and male average age of 50).
Age of decedent: average adult age of decedent was 46 (female average age of 45 and male average age of 50).
Sex of perpetrators: 41 male, 5 female (there were two perpetrators in one case).
Sex of decedents: 11 male, 36 female (there was more than one victim in some cases).
Location: 35 of the 47 fatalities occurred in/at the decedent's residence.
Weapons: In 25 of the 45 cases, a firearm was involved in the fatality.
Relationship: In 29 of the 45 cases, the parties lived together at time of death.
History: In 18 of the 45 cases, prior domestic violence had been reported.

THE FOLLOWING SECTIONS CONTAIN SUMMARIES OF DATA SUBMITTED BY THE TEAMS

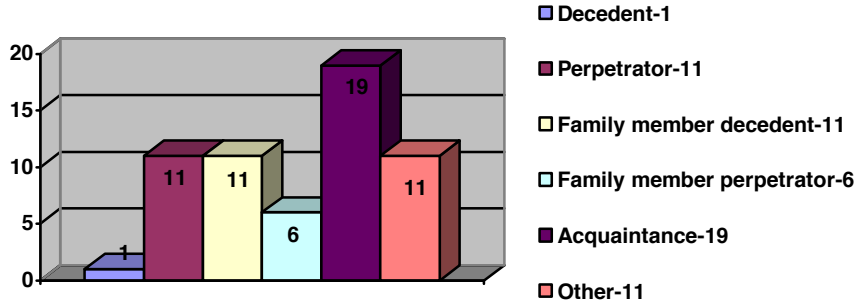
COMPLAINT INFORMATION - This information relates to the notification of law enforcement when an offense has occurred and is usually taken from the dispatch data collected.

Time Frame



Of the 45 case review forms submitted, 33 contained information under this category.

Call Received From



Call Received in Relation to Event

After Event	43
During Event	3

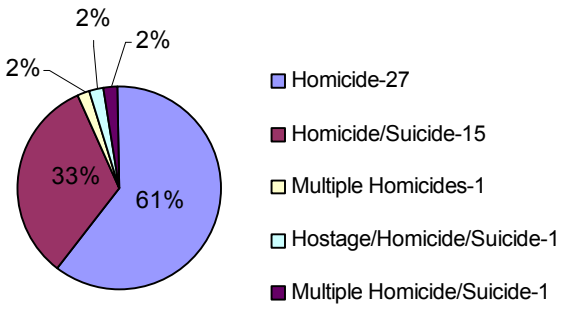
***Note: Calls Received From category contains multiple selection fields and the review forms may contain more than one response for this category.**

Summary:

The data provided did not indicate a specific day of week that was predominant in the fatalities reviewed. Two-thirds of the calls, in which information was provided, were received during the hours of 12:00 Noon and 12:00 Midnight. Thirty-two percent of the calls were received from an acquaintance of either the perpetrator or decedent and 29 % were received from a family member of either the perpetrator or the decedent. The perpetrator of the fatality made 19% of the calls. One call was received from the decedent prior to the fatality. The majority of the calls were received after the event and nothing during the receipt of the calls could have prevented the homicide.

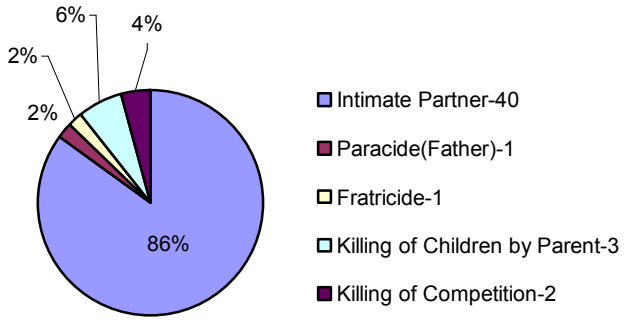
EVENT INFORMATION—This information is a general overview of the offense itself from the type of offense, activities, parties involved, weapon, injury types and the current status of the perpetrator of the offense. This information is usually taken from the law enforcement initial offense or case report.

Offense Type



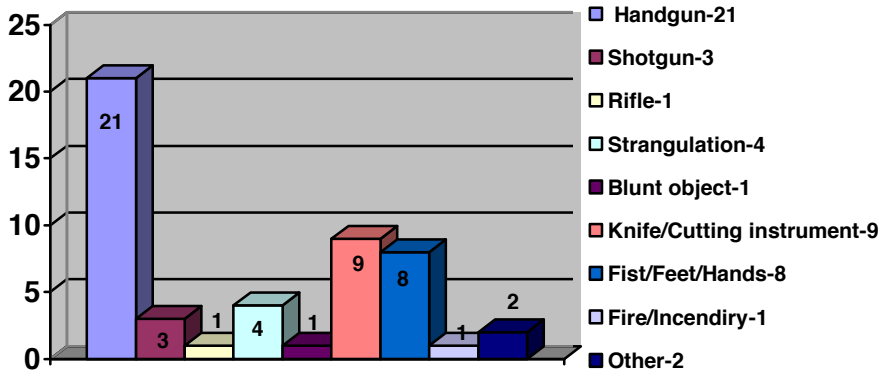
When the teams were originally created, homicide/suicide fatalities were selected due to liability issues. Although the teams have since expanded their scope to include other types of domestic violence fatalities, this chart appears to reflect the choice of cases to review rather than the actual nature of the domestic violence fatality offense types.

Event Type (of fatalities)



For this offense category one fatality review reflected that the perpetrator killed her brother and child and another reflected that the perpetrator killed his intimate partner and the competition. Both of these resulted in two event types being reported for one fatality review. One of the offenses resulted in the killing of an adult stepchild.

Weapon Type/Cause of Death



"Other" consist of: one vehicle used as weapon and one by asphyxiation using a plastic bag.

Location of Fatality

Residence of decedent and perpetrator	15
Residence of decedent	20
Residence of perpetrator	1
Residence of other family members	3
Workplace of decedent	1
Other	5

Children at Scene of the Fatality

Children heard fatal occurrence	7
Children observed fatal occurrence	5
Children may have heard fatal occurrence	1
Children may have observed fatal occurrence	1

Summary:

The 45 cases reviewed had two cases with multiple victims, resulting in a total of 47 fatalities. Firearms accounted for 53% of the deaths. Most victims, 74%, were killed in their own residences.

ENVIRONMENT PRIOR TO FATALITY—This information is related to the environmental history of the perpetrator and the decedent as it related to children and domestic violence injunctions. This information will usually be available from an investigative follow-up report done by the law enforcement agency.

Custody of Children

Decedent had legal and physical	5
Both had legal and physical	4
Other had physical	4
Perpetrator had legal and other had physical	1
Not applicable (N/A)	31
No information provided	1
Unknown	1

Injunction History of Perpetrator

Active injunction	5
Previous injunction	6
Injunction denied	1
Expired injunction	1

Injunction History of Decedent

Of the 45 cases reviewed there was one active injunction that had been issued on the decedent.

Summary:

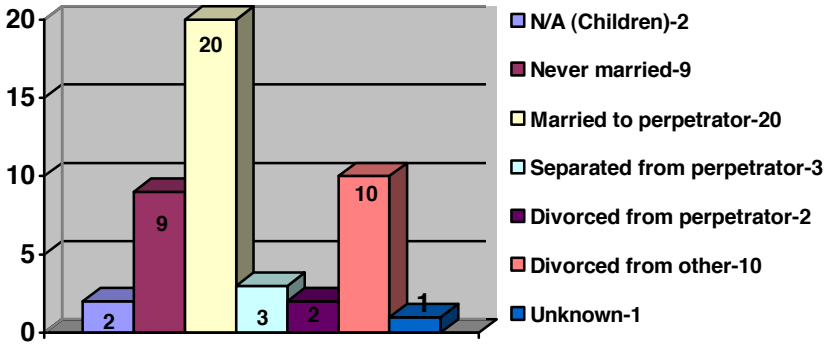
Of the 45 cases reviewed, no information relating to child custody was applicable or provided in 73% of the cases. Active injunctions filed on the perpetrator were present in 11% of the cases, previous injunctions had been present in 13% of the 45 cases reviewed, and an injunction was denied in one case. The decedents had one active injunction filed at the time of the fatality.

DECEDENT INFORMATION—This information is related to the decedent of the offense. This information will be available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and personal interviews with persons that knew the decedent.

Decedents' Sex

Of the 45 cases reviewed two had multiple victims resulting in a total of 47 decedents. Of the 47 decedents, 36 were female (77%) and 11 male (23%).

Decedents' Marital Status

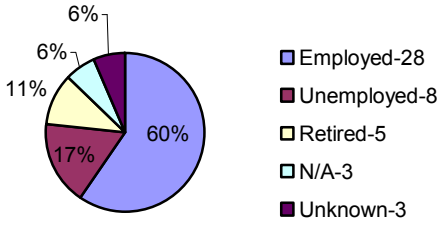


Information was provided for all 47 decedents in this category. One case reflected the killing of an adult stepchild.

Decedents' Race

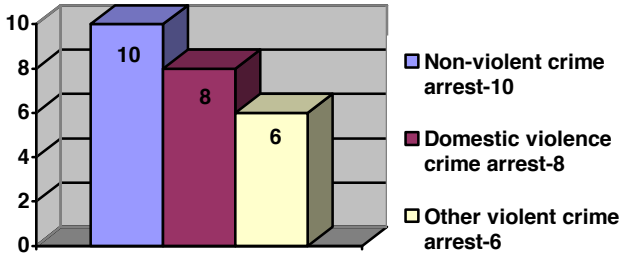
Of the 47 decedents, 43 were white (91%) and 4 were black (9%).

Employment Status



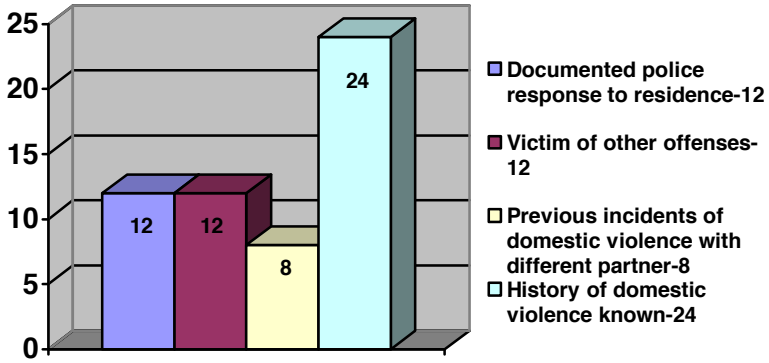
Information was provided for all 47 decedents in this category.

Decedents' Criminal History*



Of the 45 case review forms submitted, 13 contained information under this category.

Decedents' Other Related History*



Of the 45 case review forms submitted, 29 contained information under this category.

***Note: Criminal History and Other Related History categories contain multiple selection fields and the review forms may contain more than one response for these categories.**

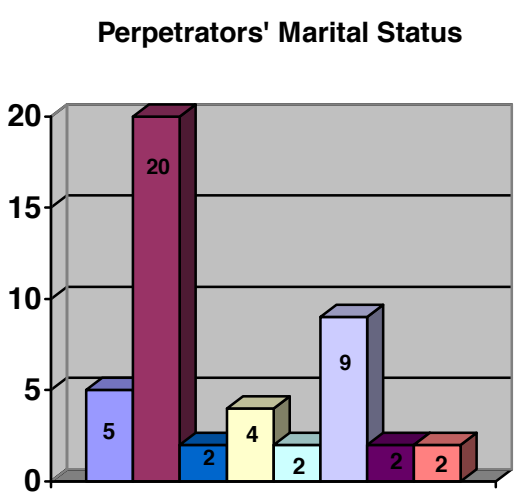
Summary:

Of the 47 fatalities reported, 77% of the victims were female. The marital status indicated that 20 of the victims were married to the perpetrator. The racial breakdown of the cases reviewed reflected that 91% of the victims were white. A total of 60% of the victims were employed at the time of their death. For the 45 reviews, the decedents had ten non-violent arrests, eight domestic violence arrests and six arrests for other violent crimes. Police had responded to the residence for some reason in 12 cases. The decedent was the victim of another crime 12 times and had been the victim of previous domestic violence with a different partner eight times. In 24 cases, others knew of a history of domestic violence.

PERPETRATOR INFORMATION - This information is related to the perpetrator of the offense. This information will be available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and personal interviews with persons that knew the perpetrator.

Perpetrators' Sex

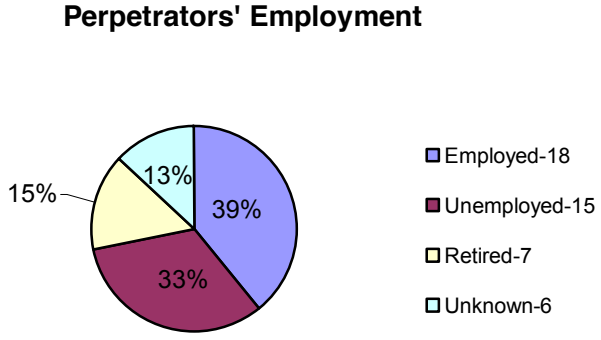
Of the 45 cases reviewed one had multiple perpetrators resulting in a total of 46 perpetrators. Of the 46 perpetrators 5 were female (11%) and 41 male (89%).



Information was provided for all 46 perpetrators in this category.

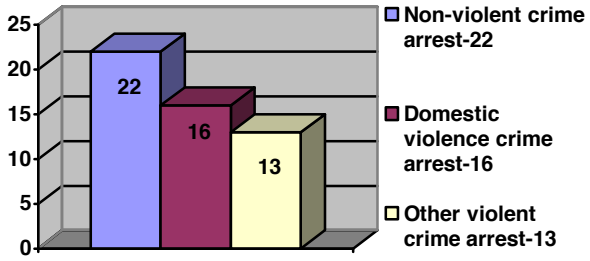
Perpetrators' Race

Of the 46 perpetrators, 41 were white (89%) and 5 were black (11%).



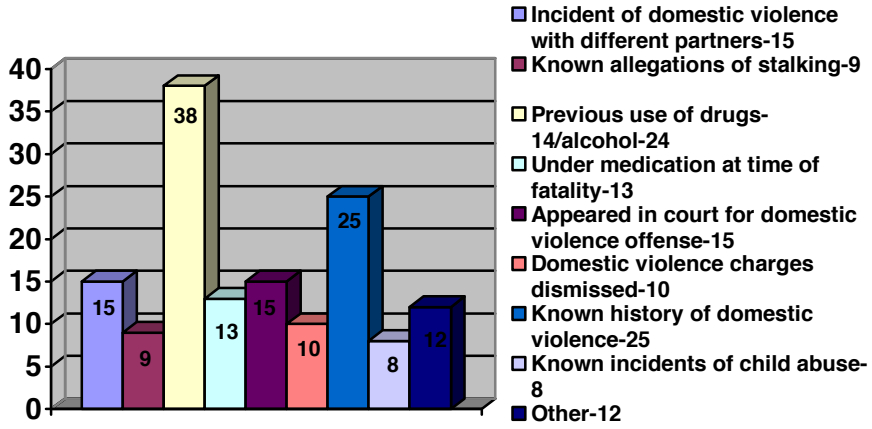
Information was provided for all 46 perpetrators in this category.

Perpetrators' Criminal History*



Of the 45 case review forms submitted, 23 contained information under this category.

Perpetrators' Other Related History



Of the 45 case review forms submitted, 38 contained information under this category.

"Other Incidents" consist of: three that had previous participation in batterer's intervention program, one previous incident of animal abuse, five that had a previous history of attempted suicide and three suspected or charged in death of former intimate partner.

***Note: Criminal History and Other Related History categories contain multiple selection fields and the review forms may contain more than one response for these categories.**

Summary:

Of the 47 fatalities reported, 89% of the perpetrators were male. The marital status indicated that 43% of the perpetrators were married to the decedent at the time of the fatality. The racial breakdown of the cases reviewed reflected 89% of the perpetrators were white. A total of 39% of the perpetrators were employed at the time of the fatality. Of the 46 perpetrators, 22 had non-violent arrests, 16 had domestic violence arrests and 13 had arrests for other violent crimes. The perpetrator had a previous domestic violence incident with a different partner in 15 cases; in ten cases, domestic violence charges against the perpetrator were dismissed. Child abuse was reported in eight cases. Drugs, alcohol and medication were present in many of the cases. In three cases, the perpetrator had been suspected or charged in the death of a former intimate partner. In 25 of the cases reviewed, others had an historical knowledge of domestic violence in the life of the perpetrator.

PERPETRATOR AS A BATTERED VICTIM—This information is collected in the event the perpetrator is the victim of a domestic violence battery by the decedent, e.g., the victim kills the batterer. This is usually available from the law enforcement agency's investigative report. There was one case in which the decedent threatened to kill the perpetrator and one case in which the decedent threatened to commit suicide.

PERPETRATOR SUICIDE—This information is collected in the event the perpetrator of the fatality commits suicide as a part of the incident. This will be available through the law enforcement agency's investigative report.

Cause of Death:

Gunshot	14
Other	5

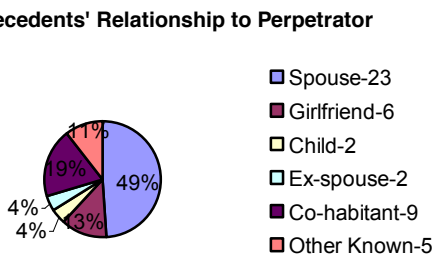
"Other" consist of: 1 by drugs, 2 by blunt trauma, one by asphyxiation and one by knife.

***Note: Two perpetrators committed suicide after the fatality and after an arrest had been made on the perpetrator. These suicides had not been reported in previous sections related to suicide of the perpetrator.**

Suicide:

Suicide note left	3
Suicide appeared to be part of homicide	11

RELATIONSHIP ISSUES—This information explains the relationship between the decedent and the perpetrator of the incident. This is usually available from the law enforcement agency's investigative report.

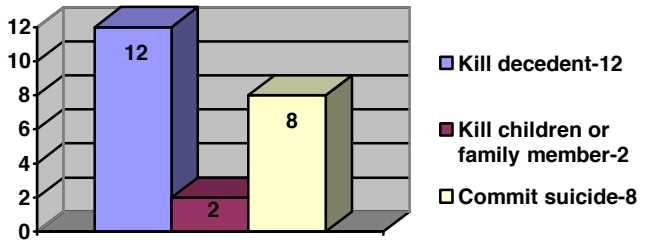


Spouses, ex-spouses, girlfriends and co-habitants made up 85% of the relationships involved in the fatalities.

One incident involved the death of an adult stepchild.

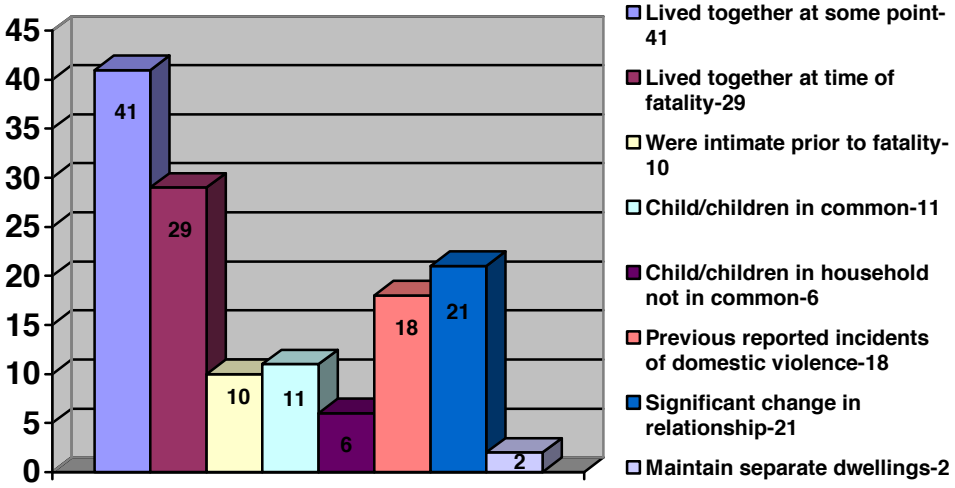
"Other Known" consist of two friends of ex-spouses, one brother of perpetrator, one parent, and one stepchild.

Prior Threats to Decedent by Perpetrator*



Of the forty-five case review forms submitted, 14 contained information under this category.

Relationship Issues*



There was one case review form involving a parricide (killing of a parent) that did not contain information under Relationship Issues.

One case involved the death of the ex-partner's new partner.

***Prior Threats and Relationship Issues are categories that contain multiple selection fields and the review forms may contain more than one response for these categories.**

Summary:

The victim in 49% of the fatalities was the spouse of the perpetrator and in 32% of the fatalities the victim was either the girlfriend or co-habitant of the perpetrator. Prior threats to kill the decedent occurred in 26% of the cases. Previous incident reports of domestic violence had been reported for 40% of the cases. A significant change of relationship had occurred between the decedent and perpetrator in 47% of the cases.

CONTRIBUTING FACTORS TO THE INCIDENT—This information concerns the factors that may have contributed to the violence escalating to the point where a homicide resulted. The factors are given a numerical rating by the review teams, with a rating of one being the major contributing factor; the higher the rating the less it contributed to the fatality. This information will be available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and interviews with persons that knew the perpetrator and/or decedent.

Major Contributing Factors To The Fatalities were:

1) Perpetrator alleged to have committed act to avenge a perceived wrongdoing by decedent - 19 times.
2) Perpetrator had/has used alcohol - 15 times.
3) Perpetrator had/has mental health problems - 12 times.
4) Decedent and perpetrator in process of separation at time of fatality - 12 times.
5) Decedent had started a new relationship – 11 times.
6) Decedent had used alcohol - nine times.
7) Decedent and perpetrator had separated - eight times.

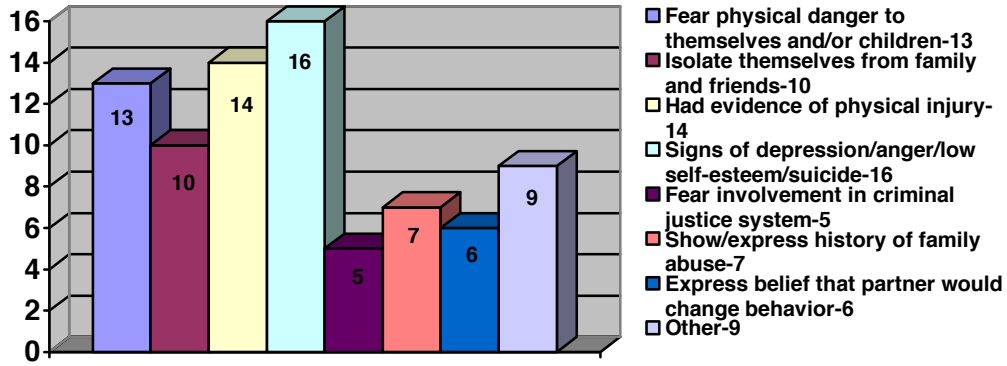
***Contributing Factors category contains multiple selection fields and the review forms may contain more than one response for this category.**

Summary:

The two major contributing factors to the fatalities identified by the Domestic Violence Fatality Review Teams were: 1) Perpetrator alleged to have committed act to avenge a perceived wrongdoing by decedent, and 2) Perpetrator had/has used alcohol. In 44% of the reviewed cases, a separation was or had taken place in the relationship. Other factors that were noted were the perpetrator having mental health problems and the perpetrator and/or decedent using alcohol and/or drugs.

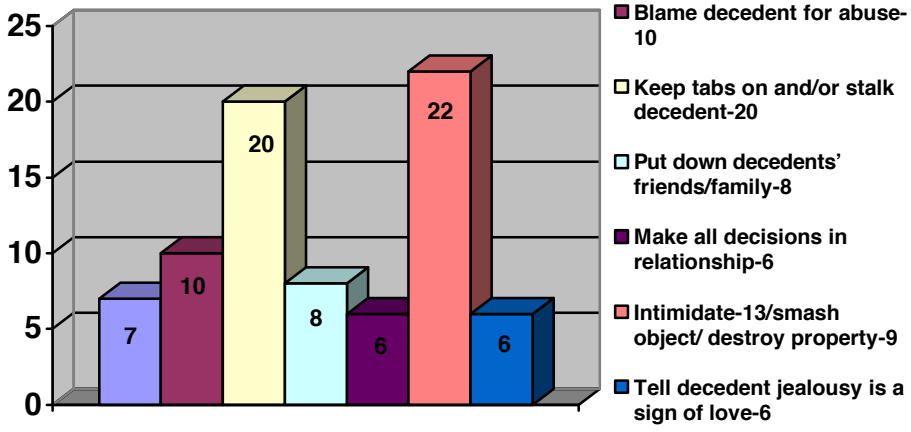
ESCALATING CIRCUMSTANCES—This information relates to the circumstances surrounding the homicide that might have caused the level of violence to escalate to the point where a homicide occurred. It also addresses the awareness that the violence was increasing in the relationship. This information will be available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and personal interviews with persons that knew the perpetrator and decedent.

Escalating Circumstances Decedent*



Of the 45 case review forms submitted, 35 contained information under this category. "Other" consists of: one expressed fear of losing custody of children, one showed signs of sleeping difficulties, two had guilty feelings about failed relationship, one expressed fear of loneliness and four expressed fear of making a great life change.

Escalating Circumstances Perpetrator*



Of the forty-five case review forms submitted, 26 contained information under this category and three were marked unknown.

***Escalating Circumstances category contains multiple selection fields and the review forms may contain more than one response for this category.**

Summary:

The three escalating circumstances that occurred most for the decedent were the fear for themselves and their children, isolation from family and friends and signs of physical injuries. The three most frequent escalating circumstances noted for

perpetrators were stalking of the victim, use of intimidation on the victim and blaming the victim for the abuse they inflicted.

SERVICES REQUESTED, ORDERED OR OBTAINED—This information relates to the decedents' and perpetrators' interactions with services, legal aid and medical organizations as it related to the domestic violence issues. This information is available through the actual agency logs and service records maintained by the individual entities. Some of this information may also be available through interviews of persons that knew the perpetrator or decedent.

Domestic Violence Services

- Domestic Violence Counseling Services – A service designed to provide advice or guidance to domestic violence victims.

- Domestic Violence Center – A center that provides various services to domestic violence victims whether certified or uncertified.

- Religious Community/Church – A group that teaches, believes and practices a specific religion.

- Children Services – An entity designed to provide services to children.

- Supervised Visitation Center – A designated neutral place that provides supervision for visitation of children or spouses.

- Other – Any other entity designed to provide service(s) to domestic violence victims not mentioned above.

Domestic Violence Services – of the cases reviewed, there were prior requests/orders for domestic violence services for eight decedents and four perpetrators.

Criminal Justice/Legal Assistance

- Law Enforcement – A person appointed to enforce the law (e.g., police officer, state law enforcement officer or sheriff's deputy).

- Legal Assistance/Attorney – A person selected or appointed to provide legal aid/counsel on someone's behalf.

- State Attorney/Prosecutor – An attorney that is representing the State in its case against a defendant.

- Court/Judges – A person or body whose task is to hear and submit a decision on cases at law.

- Family Court – A person or body whose task is to hear and submit a decision on family cases at law.

- Probation/Parole – The conditional/supervised early release of a convicted offender before the expiration of his/her term.

- Other (Specify) – Any criminal justice or legal assistance received by the decedent and/or the perpetrator not mentioned above. Specify in the space provided.

Criminal Justice/Legal Assistance – of the cases reviewed, there were prior requests/orders for criminal justice/legal services for 30 decedents and 23 perpetrators.

Health Care Provider

- EMT/Paramedics – An individual trained to provide emergency medical treatment or to assist physicians.

- Ambulance Service – A service especially designed to transport the sick and wounded to health care facilities.

- Emergency Room – An area in the hospital designed to provide treatment for emergency cases.

- Physician – A person trained and licensed to practice medicine.

- Mental Health Clinic – A facility designed to provide treatment for individuals with mental illness.

- Mental Health Program – A program designed to help mental health patients.

- Other (Specify) – Any other service, person or facility designed to treat physical or mental illness. Specify the service, person or facility in the space provided.

Health Care Providers – of the cases reviewed, there were prior requests/orders for health care services for 15 decedents and 18 perpetrators.

Children and/or Families

- Department of Children and Family Services (DCF)

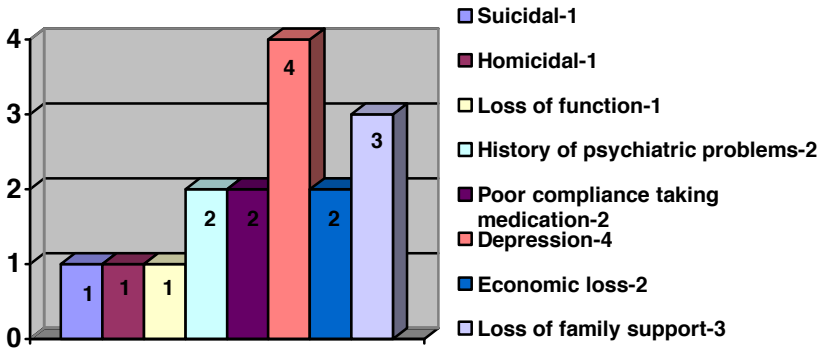
- The school system, or a similar entity.

- Children Services – An entity designed to provide services to children.

Children/Family Services – of the cases reviewed, there were prior requests/orders for children and/or family services for three decedents, two perpetrators and four for children of the decedent and/or perpetrator.

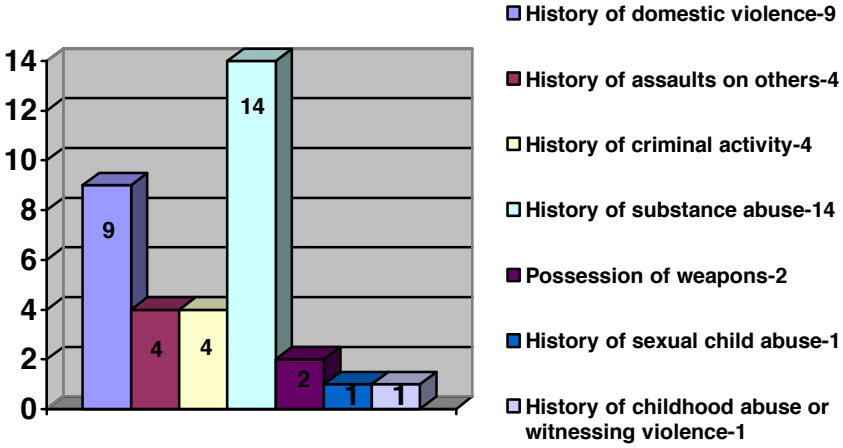
LETHALITY INDICATORS – These factors have been identified based on previously studied domestic violence fatalities and focus on elements considered to be the most prevalent in domestic homicides. This information will be available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and personal interviews with persons that knew the perpetrator and decedent.

Decedents' Emotional/Mental*



Of the forty-five case review forms submitted, 8 contained information under this category.

Decedents' Antisocial Behavior*



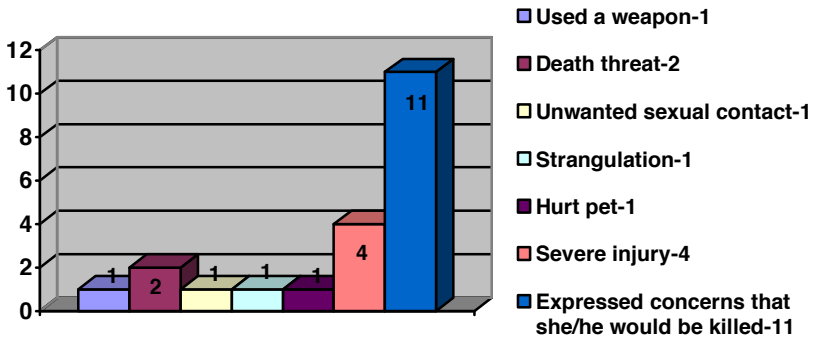
Of the 45 case review forms submitted, 17 contained information under this category.

Decedents' Failure of Community Control*

Violation of probation	1
Arrest for domestic violence	6
Failure to complete substance abuse treatment	1

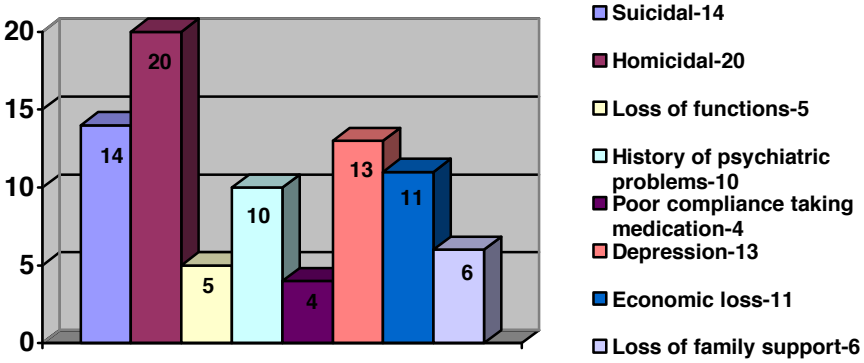
Of the 45 case review forms submitted, seven contained information under this category.

Decedents' Severity of Violence*



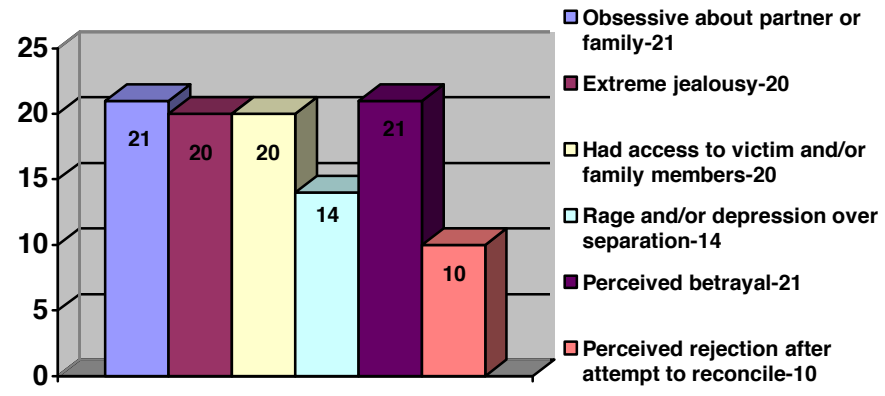
Of the 45 case review forms submitted, 15 contained information under this category.

Perpetrators' Emotional/Mental*



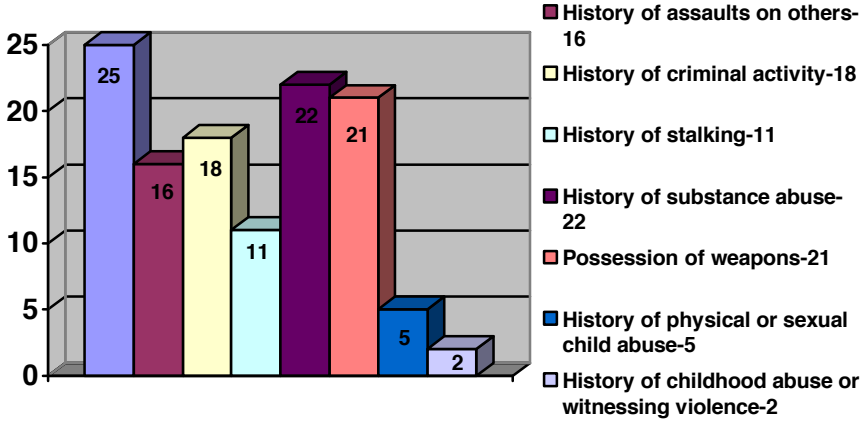
Of the 45 case review forms submitted, 28 contained information under this category.

Perpetrators' Ownership/Centrality*



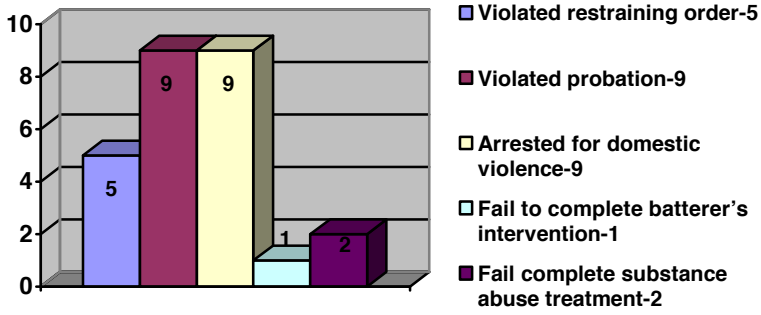
Of the 45 case review forms submitted, 34 contained information under this category.

Perpetrators' Antisocial Behavior*



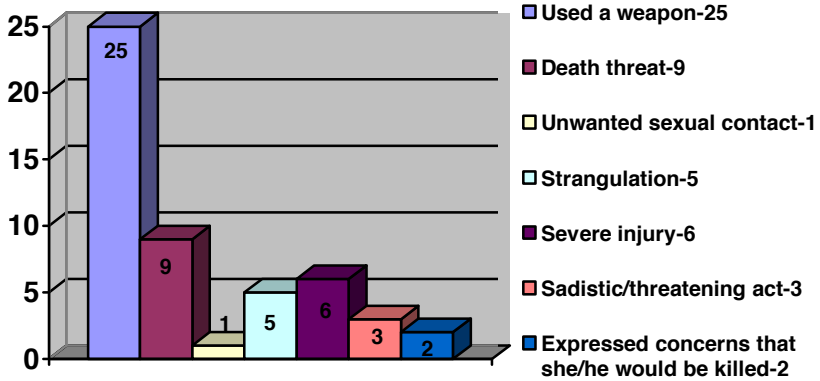
Of the 45 case review forms submitted, 37 contained information under this category.

Perpetrators' Failure of Community Control*



Of the 45 case review forms submitted, 16 contained information under this category.

Perpetrators' Severity of Violence*



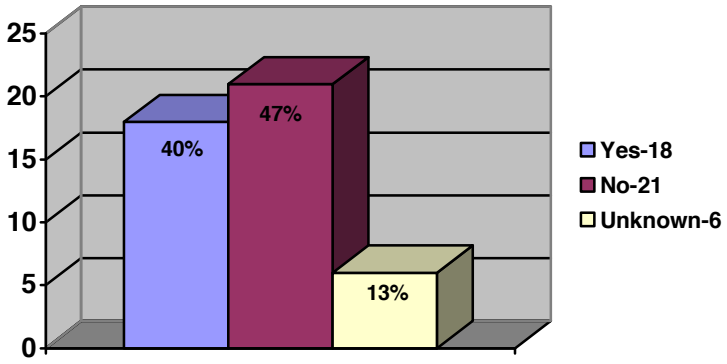
Of the 45 case review forms submitted, 28 contained information under this category.

"Other" consists of two unwanted sexual contact and one hurt pet.

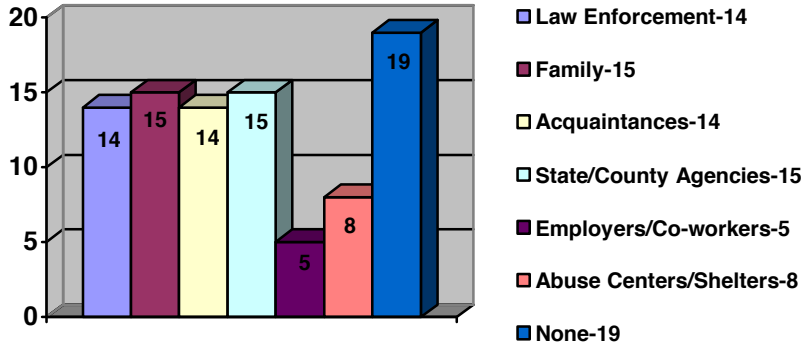
*** Lethality Indicators (Decedent and Perpetrator) category contains multiple selection fields and the review forms may contain more than one response for this category.**

FATALITY TEAMS SUMMARY—This portion of the data collection process allows the Domestic Violence Fatality Review Team to summarize their overall findings and recommendations that relate to the specifically reviewed domestic violence fatality. This information is derived from a careful analysis of the information contained in the related informational breakdowns presented above.

Indications that Abuse Was Increasing



Entities with Knowledge of Abuse*



State, county and law enforcement agencies make up 41% of the entities that had knowledge of the domestic violence.

Nineteen case review forms indicated no one had any knowledge of the abuse.

*** Entities With Knowledge category contains multiple selection fields and the review forms may contain more than one response for this category.**

Appendix A

Domestic Violence Fatality Review Teams' Annual Summary Evaluations

Collier Domestic Violence Fatality Review Team Annual Summary Evaluation

The most significant findings from reviews

- Our team reviewed three cases in 2001. All of the cases reviewed were closed cases. The most recent domestic violence homicide reviewed took place in 1997. The team concurred that many systematic changes have taken place in the intervening years and that there is greater awareness of domestic violence and the possibility for fatal consequences. Domestic violence laws are much stronger and there are more resources available to victims of domestic violence.

- In most of the cases reviewed, the victim did not reach out on any significant level to agencies that might have provided assistance/intervention. The domestic violence had often been going on for some time with only limited or no outside involvement. Family, friends and co-workers to whom the victim turned were often not pro-active in directing the victim to helping resources. Nor were those who knew about the perpetrator's abuse likely to talk to or confront this type of behavior.

- In two of the cases reviewed, a firearm was used. The team agreed that there needs to be a heightened sensitivity and extensive investigation when a domestic violence complaint references a firearm.

- Despite increased awareness, the team noted that ongoing and mandatory domestic violence training is an essential component for those assisting victims.

Changes in policy(s) or procedure(s) made as result of reviews

- Heightened awareness and implementation of mandatory reporting requirements around cases of child abuse.

Change(s) in law, policy or procedure (if any) that team recommended for consideration at state level

- More significant consequences for perpetrators of domestic violence (i.e. stiffer penalties).

Additional comments or concerns

- Our team is relatively new (just over a year). We have struggled to set up our protocols and to work with the reporting tools.

Bay Domestic Violence Fatality Review Team Annual Summary Evaluation

The most significant findings from reviews

- A major breakdown in the notification system that should have provided release information prior to a violent partner's release from prison in another state caused at least one death.

Changes in policy(s) or procedure(s) made as result of reviews

- Policy changes were made to address the situation mentioned above.

Change(s) in law, policy or procedure (if any) that team recommended for consideration at state level

- None

Additional comments or concerns

- In our first year as a team, we worked four cases in which the fatalities occurred between 1992 and 1996. The team recognizes that many significant changes have occurred in domestic violence laws, policies and procedures between 1992 and 2001. We anticipate getting into somewhat more recent cases in our next year as a team and believe that may impact our findings.

Escambia Domestic Violence Fatality Review Team Annual Summary Evaluation

The most significant findings from reviews

- The fact that both victims and perpetrators involved in these cases obviously had problems with drug and alcohol abuse and/or anger management, but did not avail themselves to the services in place in the community. The team sees a need for greater publicity of services available in our area that are open to all individuals.

Changes in policy(s) or procedure(s) made as result of reviews

- None

Change(s) in law, policy or procedure (if any) that team recommended for consideration at state level

- Emphasis on statewide policies that would increase public awareness of services that are available.

Additional comments or concerns

- It is the perception that we are still missing the true impact of Domestic Violence Fatalities because the state does not count suicides that may be a result of Domestic Violence.

Sarasota/Manatee/Desota Domestic Violence Fatality Review Team Annual Summary Evaluation

The most significant findings from reviews

- That many victims did not reach out for help.

Changes in policy(s) or procedure(s) made as result of reviews

- None

Change(s) in law, policy or procedure (if any) that team recommended for consideration at state level

- Gun control for individuals being treated for mental health – depression.
- Companies need to be more responsive to threats – coordinate with law enforcement.

Additional comments or concerns

- None

Palm Beach Domestic Violence Fatality Review Team Annual Summary Evaluation

The most significant findings from reviews

- All cases had relationships in some state of separation.
- Family and friends knew of abuse and it is unclear why it was not reported to law enforcement or service providers.
- Victims were not involved with domestic violence centers or other local service providers, with the exception in a few cases of assistance in applying for restraining order, according to the documentation obtained by the Team.
- Approximately 60% of the cases involved child witnesses and all of the witnessing children had pre-existing and/or subsequent behavioral and/or health problems.
- Firearms were involved in a majority of cases.
- Problems occurred with obtaining and enforcing order of protection (i.e. in one case a couple was allowed to get married with an active restraining order in place).
- Child abuse statutes are not consistently being enforced (i.e. Department of Children and Families is not being notified of child maltreatment).

Changes in policy(s) or procedure(s) made as result of reviews

- Department of Children and Families and law enforcement are collaborating to improve reporting and investigating of domestic violence and child maltreatment cases.
- Palm Beach County Fatality Review materials are now used at Department and law enforcement trainings.
- Agencies with limited participation in other community coordination efforts are now invested in the Team, resulting in increased involvement, and input and presence in the family violence prevention and intervention system.
- Training in domestic violence for law enforcement and other professionals reflects the findings of the Team. Members of the Team conduct the sessions and include scenarios from actual cases (omitting names of individuals and agencies). The "red flags" are also reviewed as a tool in the decision-making process for intervention.
- Surviving family members have been linked with needed services as a result of the work of the Team.

Change(s) in law, policy or procedure (if any) that team recommended for consideration at state level

- Statewide public service announcements similar to what was done to combat child abuse to increase public understanding of the dynamics of domestic violence and how to seek assistance.

- Mental health screenings before the purchase of firearms.
- Clarify current statute FS 39.01(30)(2)(i) to define harm and require law enforcement to notify the Department of Children and Families when a child is present in any domestic violence incident.
- Increase funding so that Domestic Violence Fatality Review Teams can have support staff in this important endeavor.

Additional comments or concerns

- This team values our approach of reviewing each case in-depth, including speaking to family members. We feel we put a human face to the case and not just report statistics. We were recently able to link a survivor with services.
- An adult witness to one of the domestic homicide cases reviewed by the Team was subsequently convicted of murdering his biological father and attempted murder of the father's girlfriend. The Team thought this was significant in terms of the effects of witnessing violence on adults.
- The strong supportive network created by the Team members assists in the prevention of compassion fatigue and burnout.
- In addition to policy changes, the work of the Team has produced results that while not necessarily quantifiable, are equally important.

Pinellas Domestic Violence Fatality Review Team Annual Summary Evaluation

The most significant findings from reviews

- Patterns:
  Alcohol/Substance use.
  Large age differences existed between victim and perpetrator.
  Family and/or friends knew of abuse prior to homicide.
  Firearm use.

Changes in policy(s) or procedure(s) made as result of reviews

- **None**

Change(s) in law, policy or procedure (if any) that team recommended for consideration at state level

- Recognition that divorce in a domestic violence relationship is not the norm and is an extremely dangerous time for victims.
- Creation of domestic predator database similar to sexual predator information.
- Strengthen firearm purchase laws.
- Increase number of Batterer's Intervention Program sessions required.
- Limit the number of times an abuser can opt to attend B/P versus being prosecuted.

Additional comments or concerns

- Valuable process for looking at local deaths. Following recommendations made to the local Domestic Violence Task Force (team is a subcommittee of the task force)
  1) Develop three flyers that describe what someone should do if they see or know about domestic violence – one for the general population, one for senior citizens, and one for youth. These flyers could be very similar to each other with just appropriate changes for the age group. They are designed to reach the family and friends of potential victims since many of the situations reviewed indicated that someone knew about the violence prior to the homicide. These flyers should include information about alcohol use and large age gaps in couples as two potential red flags noticed in many domestic homicides. These one-page handouts could be given in a copy-ready format to all Task Force members for use in any appropriate outreach activities in which they are involved.
  2) Agree to regularly discuss at Task Force meetings any grant opportunities that would assist Task Force members with promoting domestic violence prevention or intervention messages. This addresses the issue from the reviews that most of the victims and perpetrators involved in the reviews

had virtually no contact with the domestic violence system. Further, it is recommended that Task Force members be asked to indicate if they are interested in applying alone, partnering with others, or applying as a lead agency in a partnership for such grants. This list of interest could be held by the Chair or her designee, and members could consult the list if they become aware of grants between meetings.

3) Discuss ways in which to integrate various other groups and issues into the Task Force utilizing the broad categories that were seen by the Domestic Violence Fatality Review Team to be most in need of attention. This is based on the assumption that domestic fatalities are at the worst end of the spectrum of violence, and are a good indicator of what victims of other violence might need. A long-term goal might be to organize the Task Force into a committee structure following those categories, which are: Education; Legislative Reform; Outreach; Elderly; Youth and Schools; Health Care; Law Enforcement; and Substance Use and Domestic Violence. These committees would all meet between Task Force meeting and utilize bi-monthly Task Force meeting.

Appendix B

Synopsis of Data from 45 Domestic Violence Fatality Reviews Submitted to FDLE for 2001

Fatality Review Profile

Date of Fatality	Decedent(s)	Perpetrator(s)	Decedent's Relationship to Perpetrator	Cause of Death	DV History
10/31/92	White female age 31	White male age 50	Spouse/separated	Gunshot (9 times)	Yes
1/17/00	Black male age 37	Black male age 67	Stepson	Gunshot (4 times)	No
3/14/00	White female age 39	White male age 47	Spouse/separated	Gunshot	Yes
4/26/99	Black female age 35	Black male age 39	Spouse	Gunshot	Yes
2/3/95	White female age 42	White male age 62	Spouse/separated	Gunshot	Yes
9/17/99	White female age 35	White male age 43	Girlfriend	Blunt trauma/strangulation	Yes
4/11/99	White female age 57	White male age 54	Spouse	Gunshot	Yes
5/10/95	White female age 69 & 1 white male	White male age 73	Spouse/divorced 1 male unrelated	Blunt trauma/1 male gunshot	Yes
11/6/00	White female age 40	White male age 49	Spouse/separated	Gunshot	Unk
12/25/95	White female age 31	White male age 33	Girlfriend	Strangulation	No
12/13/96	White female age 64	White male age 66	Spouse	Bludgeoned/strangled/cut throat	No
2/25/97	White female age 74	White male age 79	Spouse	Gunshot	No
6/16/99	White male age 42	White female age 35	Spouse	Stab wound	No
3/13/97	Black female age 23	Black male age 36	Girlfriend	Stab wounds	Yes
2/17/99	White female age 32	Black male age 37	Co-habitant	Gunshot	No
6/12/98	White female age 57	White male age 69	Girlfriend	Stab wounds	No
9/22/96	White male age 56	White female age 33	Spouse	Stab wounds	Yes
3/13/98	White female age 45	White male age 37	Co-habitant	Gunshot	Yes
5/26/97	White female age 65	White male age 36	Girlfriend	Stab wounds	No
5/29/00	White female age 48	White male age 50	Co-habitant	Blunt trauma/beating	Yes
7/20/97	White female age 28	White male age 26	Co-habitant	Gunshot	Yes
7/3/00	Black female age 19	Black male age 24	Girlfriend	Gunshot	Yes
2/23/94	White male age 11 months	White male age 28	Son	Beating	Yes
8/8/96	White female age 25	White male age 42	Girlfriend	Gunshot	Yes
3/7/97	White female age 83	White male age 87	Spouse	Gunshot	No
4/13/99	White male age 71	White female age 46	Spouse	Gunshot	Yes
1/9/99	White male age 29	White female age 36	Co-habitant	Stab wound	Yes
7/31/97	White female age 34	White male age 36	Spouse	Blunt trauma/beating	Yes
2/12/01	White female age 82	White male age 83	Spouse	Asphyxiation/plastic bag	No
11/24/98	White female age 32	White male age 23	Co-habitant	Strangulation	Yes
3/20/01	White female age 40	White male age 47	Spouse	Vehicle multiple injuries	Yes
7/24/95	White female age 36	White male age 46	Spouse	Gunshot	Yes
2/25/96	White female age 42	White male age 50	Spouse	Gunshot	No
9/17/00	White female age 34	White male age 43	Spouse	Beating	No
4/10/99	White female age 54	White male age 55	Spouse	Gunshot	Yes
8/10/99	White female age 51	White male age 47	Spouse	Gunshot	Yes
4/11/97	White female age 74	White male age 74	Spouse	Stab/gunshot	No
1/5/92	White female age 36	White male age 38	Ex-spouse	Strangulation	Yes
1/12/98	White female age 37	White male age 51	Spouse	Beating	Yes
3/28/98	White female age 40	White male age 47	Co-habitant	Gunshot	Yes
2/2/98	White male age 45	White male age 15(2)	Parent	Knife/hands/fist/feet	N/A
6/9/00	White male age 32	White male age 45	Ex-spouse's friend	Gunshot	N/A
10/15/96	White female age 56	White male age 56	Spouse	Gunshot	No
8/18/01	White female age 41	White male age 60	Co-habitant	Gunshot	Yes
10/4/98	White males ages 11 and 7	White female age 35	Brother and son	Fire/incendiary	Yes

APPENDIX C

Raw Data From 45 Domestic Violence Fatality Team Reviews Submitted to FDLE for 2001

Findings:

The following data is from the cases that were provided to the DVDRC by participating teams. Because the data is from nine teams covering only 11 counties the reader is cautioned about drawing conclusions from this data.

COMPLAINT

Time Received:

Morning	0230	0235	0530	0708	0723	0736	0739	0758	1013
	1128	1154							
Evening	1206	1220	1225	1330	1330	1340	1400	1425	1459
	1530	1716	1800	1833	1932	1934	1945	2205	2300
	2307	2312	2323	2330					

Day of Week:

Monday	3
Tuesday	4
Wednesday	4
Thursday	2
Friday	5
Saturday	3
Sunday	4
None given	20

Person Making Call:

Decedent	1
Perpetrator	11
Family member of the decedent	11
Family member of the perpetrator	6
Acquaintance	19
Other	11

*Multiple answers in ten cases reviewed

Call Received:

After event	43
During event	3

EVENT INFORMATION

Offense Type:

Homicide	27
Homicide/Suicide	15
Multiple Homicides	1
Multiple Homicide/Suicide	1
Hostage/Homicide/Suicide	1

Event Type:

Intimate Partner	40
Parricide	1
Killing of Children by Parent	3
Killing of the Competition	2
Fratricide and Sororicide	1
Total Victims	47

Weapon Type/Cause of Death:

Handgun	21
Shotgun	3
Rifle	1
Strangulation	4
Blunt Object	1
Knife/Cutting instrument	9
Fist/Feet/Hands (Beating)	8
Fire/Incendiary	1
Other: (Plastic bag-1/Vehicle-1)	2

Note: Five fatalities involved multiple weapons

Location Type:

Residence of decedent and perpetrator	15
Residence of decedent	20
Residence of perpetrator	1
Residence of other family members	3
Workplace of decedent	1
Other	5

Children at Scene of Fatality:

Children heard fatal occurrence	7
Children observed fatal occurrence	5
Children may have heard fatal occurrence	1
Children may have observed fatal occurrence	1

Status of Perpetrator:

Arrested	26
Committed suicide	17
Deceased	3

ENVIRONMENT PRIOR TO FATALITY

Custody of Children:

Decedent had legal and physical	5
Both had legal and physical	4
Other had physical	4
Perpetrator had legal and other had physical	1
N/A	31
No information provided	1
Unknown	1

Injunction History of Perpetrator:

Active injunction	5
Previous injunction	6
Injunction denied	1
Expired injunction	1

Injunction History of Decedent:

Active injunction	1
Previous injunction	0

DECEDENT INFORMATION

Sex:

Male	11
Female	36

Marital Status:

N/A (Children)	2
Never married	9
Married to perpetrator	20
Separated from perpetrator	3
Divorced from perpetrator	2
Divorced from other	10
Unknown	1

Race:

Black	4
White	43

Employment:

Employed	28
Unemployed	8
Retired	5
Unknown	3
N/A	3

Criminal History:

Non-violent crime arrest w/guilty conviction	3
Non-violent crime arrest w/o conviction	1
Non-violent crime arrest conviction withheld	3
Non-violent crime arrest unknown	3
Domestic violence crime arrest w/guilty conviction	2
Domestic violence crime arrest w/o conviction	1
Domestic violence crime arrest w/o disposition	2
Domestic violence crime arrest unknown	3
Other violent crime arrest w/guilty conviction	1
Other violent crime arrest unknown	4
Other violent crime arrest w/o disposition	1

Other Related History:

Documented police response to residence	12
Decedent victim of other offenses	12
Previous incidents of domestic violence with different partner(s)	8
History of domestic violence known to others	24

PERPETRATOR INFORMATION

Sex:

Male	41
Female	5

Martial Status:

Never married	5
Married to decedent	20
Married to other	2
Separated from decedent	4
Divorced from decedent	2
Divorced from other	9
Widowed	2
Unknown	2

Race:

Black	5
White	41

Employment:

Employed	18
Unemployed	15
Retired	7
Unknown	6

Criminal History:

Non-violent crime arrest with guilty conviction	11
Non-violent crime arrest with unknown conviction	3
Non-violent crime arrest w/o conviction	2
Non-violent crime arrest w/conviction withheld	1
Non-violent crime arrest unknown	5
DV crime arrest with guilty conviction	7
DV crime arrest without conviction	6
DV crime arrest/unknown	3
Other violent crime arrest with guilty conviction	4
Other violent arrest /unknown	3
Other violent arrest w/o conviction	5
Other violent arrest conviction withheld	1

Other Related History:

Previous incident of domestic violence with different partners	15
Previous history of suicide attempt	5
Known allegations of stalking	9
Previous participation in batterer's intervention program	3
Previous use of drugs	14
Previous use of alcohol	24
Under medication	13
Previous incident(s) of animal abuse	1
Appeared in court for domestic violence offense	15
Domestic violence related charges dismissed against perpetrator	10
Suspected or charged in death of former intimate	3
History of domestic violence known to family, friends or co-workers	25
Known incidents of prior child abuse	8

PERPETRATOR AS BATTERED VICTIM

Reported Prior Threats Made to Perpetrator by Decedent:

Threat to kill perpetrator	1
Threat to commit suicide	1

PERPETRATOR SUICIDE*

Cause of Death:

Gunshot wound	14
Other	5

Suicide:

Suicide note left	3
Suicide appear part of homicide	11

Two suicides reported in this section occurred after the fatality and an arrest had been made on the perpetrator. These suicides had not been reported in previous sections related to suicide of the perpetrator.

RELATIONSHIP ISSUES

Relationship of Decedent to Perpetrator:

Spouse	23
Parent	1
Girlfriend	6
Stepchild	1
Child	2
Ex-spouse	2
Brother/Sister	1
Co-habitant	9
Other Known	2

Reported Prior Threats Made to Decedent by Perpetrator:

Threat to kill decedent	12
Threat to kill children or family member	2
Threat to commit suicide	8

Circumstances Applicable to the Decedent's and Perpetrator's Relationship:

They lived together at some point	41
They lived together at the time of the fatal incident	29
They were intimate prior to the fatal incident	10
They had a child/children in common	11
They had children in household, but not in common	6
They had previous reported incidents of domestic violence	18
They had a significant change in relationship	21
They maintained separate dwellings	2

CONTRIBUTING FACTORS TO INCIDENT

Note: Many of the agencies did not rank the factors but placed the same numeric value on many factors for the same event. As such, the rankings as provided did not allow any factor to be identified as the number one cause of domestic violence fatalities.

Relationship Factors Priority Rating:

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

Employment/Monetary Factors:

Perpetrator had loss of employment recently blames decedent	2,5,1
Perpetrator had loss of income recently blames decedent	2, 2,1,1,1

Criminal Justice Interaction Factors:

Decedent had filed an injunction on the perpetrator	6,7,1,1
Perpetrator had been served with an injunction	3,1,1
Perpetrator was arrested for domestic violence on decedent	2
Perpetrator was arrested for domestic violence on another partner	2,2,2

Substance Abuse Factors:

Perpetrator had/has used drugs	3,2,1,2,5,10,1
Decedent had/has used drugs	3,10,1
Perpetrator had/has used alcohol	3,2,4,3,1,1,2,2,1,1,2,1,1,10,2
Decedent had/has used alcohol	4,3,1,1,2,1,10,2,5

Health/Mental Health Factors:

Perpetrator under medication at time of fatality	2,2,5
Decedent taking nonprescription medication at time of fatality	5,10
Medication prescribed for perpetrator at time of fatality	2,2,5
Medication prescribed for decedent at time of fatality	10
Perpetrator taking prescribed medication at time of fatality	5
Decedent taking prescribed medication at time of fatality	10
Perpetrator taking psychiatric medication at time of fatality	4,2
Decedent taking psychiatric medication at time of fatality	10
Perpetrator had/has mental health problems	3,2,3,8,2,3,1,2,2, 1,5,1
Decedent had/has mental health problems	2,3,10
Perpetrator attempted to commit suicide	5,6,1,10

Other Factors:

Perpetrator alleged to have committed act to avenge a perceived wrongdoing by decedent	1,1,5,1,1,2,2,1,2,4, 4,1,1,1,1,1,1,1,2
Perpetrator jealous of mother/son relationship	1
Decedent's child from previous relationship joined household	6
Perpetrator possibly facing jail time	3
Anger/Rage/Jealousy	1
Alcoholism	3

ESCALATING CIRCUMSTANCES

The Decedent:

Express fear of physical danger to themselves or children	13
Express fear of losing custody of children	1
Isolated themselves from family and friends	10
Had evidence of physical injury	14
Showed frequent signs of:	
Depression	3
Anger	6
Low self-esteem	6
Suicidal thoughts	1
Expressed fear of involvement in the criminal justice system process	5
Showed or expressed signs of sleeping difficulties	1
Expressed guilty feelings about the failed relationship	2
Showed or expressed history of family abuse	7
Expressed fear of loneliness	1
Expressed fear of making a great life change	4
Expressed belief that partner would change their behavior	6

The Perpetrator:

Abused the decedent in public	7
Kept tabs on or stalked victim	20
Put down the decedent's friends and family	8
Told decedent, jealousy is a sign of love	6
Made all decisions in the relationship (including finances)	6
Blamed decedent for abuse	10
Used intimidation	13
Smashed objects and destroyed property	9

SERVICES REQUESTED, ORDERED OR OBTAINED

Domestic Violence Services:

	Requested	Received
Decedent	8	10
Perpetrator	4	5

Criminal Justice/Legal Assistance:

Decedent	30	23
Perpetrator	23	37

Health Care Provider:

Decedent	15	16
Perpetrator	18	19

Children Services:

Decedent	3	8
Perpetrator	2	3
Child of decedent	2	1
Child of perpetrator	2	5

Batterer's Intervention Program Completed: Yes No

Decedent	1	0
Perpetrator	2	1

Substance Abuse Program Completed: Yes No

Decedent	2	0
Perpetrator	2	1

Prior Calls for Service to Domestic Violence Centers: 12*
Prior Calls for Service to Law Enforcement: 55*
Prior Calls for Service Concerning Child Abuse: 17

Programs Ordered and Completed	Decedent	Perpetrator
Anger Management Ordered	0	0
Batterer's Intervention Ordered	1	2
Substance Abuse Ordered	2	2
Other Court Ordered (Specify)	0	1 Pre-Trial Intervention and 1 Unknown
Number of Batterer's Intervention Attended	1	2 ½
Number of Substance Abuse Attended	2 ½	6
Number of Court Ordered Completed (Specify)	0	1 Pre-Trial Intervention and 1 Unknown

Note: one case involved numerous calls to domestic violence center and one case involved numerous calls to law enforcement (no actual count was given in either case).

LETHALITY INDICATORS

Emotional/Mental Deterioration:	Decedent	Perpetrator
Suicidal	1	14
Homicidal	1	20
Loss of function (i.e. not eating, sleeping, working)	1	5
History of psychiatric problems	2	10
Poor compliance with taking medication	2	4
Depression	4	13
Economic loss	2	11
Loss of family support	3	6

Ownership/Centrality of Victim to Perpetrator:	Decedent	Perpetrator
Obsessive about partner or family	1	21
Extreme jealousy	2	20
Access to victim and/or family members	2	20
Rage and/or depression over separation	2	14
Perceived betrayal	2	21
Perceived rejection after attempt to reconcile	0	10

Antisocial Behavior:	Decedent	Perpetrator
History of domestic violence	9	25
History of assaults on other	4	16
History of criminal activity	4	18
History of stalking	0	11
History of substance abuse	14	22
Possession of weapons	2	21
History of physical or sexual child abuse	1	5
History of childhood abuse or witnessing violence	1	2

Failure of Community Control:	Decedent	Perpetrator
Violation(s) of restraining order	0	5
Violation(s) of probation	1	9
Arrest(s) for domestic violence	6	9
Failed to complete batterer's intervention program	0	1
Failure to complete substance abuse treatment	1	2

Severity of Violence:	Decedent	Perpetrator
Used a weapon	1	25
Death threat	2	9
Unwanted sexual contact	1	1
Strangulation	1	5
Hurt pet	1	0
Severe injury	4	6
Sadistic/threatening act	0	3
Expressed concerns that she/he would be killed	11	2

SUMMARY OF REPORTS

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

Yes	18
No	21
Unknown	5
No information provided	1

Entities that had knowledge of the domestic violence:

Law Enforcement	14
Family	15
Acquaintances	14
State/County Agencies	15
Employers/Co-workers	5
Abuse Centers/Shelters	8
None Reported	19

RECOMMENDATIONS/FINDINGS/SUGGESTIONS MADE BY THE FATALITY TEAMS AS A RESULT OF THE CASES REVIEWED

Drugs/Alcohol Abuse:

- Need follow up treatment for substance abuse.
- No treatment provided for alcohol abuse of perpetrator.
- Referral to an agency for his/her chemical dependency would have been appropriate.
- Repeated alcohol/drugs involvement.

Weapons:

- Make it harder for potential perpetrators to have access to weapons.
- Perpetrator was able to purchase firearm. Easy access to handguns is a problem.
- There needs to be a heightened awareness and extensive investigation when a domestic violence complaint references a firearm.

Services:

- Prisons should notify victims when perpetrators are released by out-of-state agency (if no policy exists one should be implemented).
- Decedent(s) did not follow through/use services that were available to her/him (i.e., restraining order, counseling, and domestic violence shelters).

- Perpetrator's suicidal indications left untreated.
- Perpetrator's family did not receive services.
- Need for probation officers/social service workers to report domestic violence when aware of abuse.
- Services offered are often not accepted.
- Time/personnel not available to follow up after perpetrator.
- Many services were available and not utilized; not much more could have been done.
- "System" was woefully inadequate in making any intervention.
- One opportunity was missed when he told his friends about wanting to kill his father.
- Homelessness leads to vulnerability. Contact with helping agencies was too brief for adequate assessment and intervention. If incarcerated, this may be only chance to offer rehabilitation services to homeless victims.
- Abuse not reported to Department of Children and Families. If a mandatory report had been made this child may have been removed from abusive home.
- Failure of all agencies to provide information as to resources reference domestic violence.
- Need for health care to respond to people with major health concern/assess depression.

Training:

- Re-evaluate community outreach and education on domestic violence.
- Need more education on domestic violence in bar scene – suggestion is for coasters with domestic violence hotline information to be placed in bars.
- More intervention needed with adolescents involved in potentially abusive relationships with young adults (especially those with a large age difference).
- Family and/or friends had knowledge of the abuse but did not intervene – increased need for community (public) awareness and education.
- Increased need for training with halfway houses – assist in monitoring violence, making referrals to anger management.
- Continue training on primary aggressor in the community(s).
- Lack of knowledge of lethality factors (decedent).
- Need more education/intervention for the elderly. There is a need for community education through American Association of Retired People (AARP), mobile home park offices and community centers.
- Lack of knowledge of assistance regarding domestic violence for decedent and his/her children.
- Every victim that applies for an injunction should be supplied with a safety plan and lethality factors.

Other:

- Study pattern trends: Age difference, prior history of domestic violence (ex-wife), substance abuse involvement, children witnessed violence, short-term relationship.
- Look at time-line of activity on date of incident (perpetrator and decedent).

- Failure to respond to hang up – spoke with perpetrator – need better responses.
- This was a very tempestuous relationship, but there were no outside indications of violence.
- Include a category on the fatality review form for assumptions or conclusion as result of case review.
- Security departments within companies notify law enforcement of any security concerns or threats.
- No life skills/gap in mental health.
- Need for those who have been abused to press charges and see them through.
- No attempt on part of her/his co-workers to assist victim relative to sexual abuse/domestic violence.

POLICIES OR PROCEDURES CHANGED AS A RESULT OF THE CASES REVIEWED BY THE TEAMS:

- Recommendation to "homeless" service providers and increase outreach efforts to non-compliant "uncooperative" clients.
- After an incident, a domestic violence checklist and a three party approval procedure was established at State Attorney's Office reference intake procedures for warrants.
- The State Attorney's Office now picks up all domestic violence charges with or without consent.
- Power to arrest even if there are no witnesses.
- Laws are much stronger now with regard to domestic violence than prior to the cases reviewed.
- All interacting agencies should have more information on domestic violence.
- Increased training.
- Increased resource availability and increased understanding of domestic violence.
- Recommended random breath & urine testing as a condition of probation for people who are on probation as a result of a domestic violence case.

Appendix D

Domestic Violence Fatality Teams' Contacts

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Appendix E
Florida Statute 714.316

741.316 Domestic violence fatality review teams; definition; membership; duties; report by the Department of Law Enforcement.

(1) As used in this section, the term "domestic violence fatality review team" means an organization that includes, but is not limited to, representatives from the following agencies or organizations:

(a) Law enforcement agencies.

(b) The state attorney.

(c) The medical examiner.

(d) Certified domestic violence centers.

(e) Child protection service providers.

(f) The office of court administration.

(g) The clerk of the court.

(h) Victim services programs.

(i) Child death review teams.

(j) Members of the business community.

(k) County probation or corrections agencies.

(l) Any other persons who have knowledge regarding domestic violence fatalities, nonlethal incidents of domestic violence, or suicide, including research, policy, law, and other matters connected with fatal incidents.

(m) Other representatives as determined by the review team.

(2) A domestic violence fatality review team may be established at a local, regional, or state level in order to review fatal and near-fatal incidents of domestic violence, related domestic violence matters, and suicides. The review may include a review of events leading up to the domestic violence incident, available community resources, current laws and policies, actions taken by systems and individuals related to the incident and the parties, and any information or action deemed relevant by the team, including a review of public records and records for which public records exemptions are granted. The purpose of the teams is to learn how to prevent domestic violence by intervening early and improving the response of an individual and the system to domestic violence. The structure and activities of a team shall be determined at the local level. The team may determine the number and type of incidents it wishes to review and shall make policy and other recommendations as to how incidents of domestic violence may be prevented.

(3) 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.

(4) The Governor's Task Force on Domestic Violence shall provide information and technical assistance to local domestic violence fatality review teams.

(5)(a) There may not be any monetary liability on the part of, and a cause of action for damages may not arise against, any member of a domestic violence fatality review team or any person acting as a witness to, incident reporter to, or investigator for a domestic violence fatality review team for any act or proceeding undertaken or performed within the scope of the functions of the team, unless such person acted in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) This subsection does not affect the provisions of s. 768.28.

(6) All information and records acquired by a domestic violence fatality review team are not subject to discovery or introduction into evidence in any civil action or disciplinary proceeding by any department or employing agency if the information or records arose out of matters that are the subject of evaluation and review by the domestic violence fatality review team. However, information, documents, and records otherwise available from other sources are not immune from discovery or introduction into evidence solely because the information, documents, or records were presented to or reviewed by such a team. A person who has attended a meeting of a domestic violence fatality review team may not testify in any civil or disciplinary proceedings as to any records or information produced or presented to the team during meetings or other activities authorized by this section. This subsection does not preclude any person who testifies before a team or who is a member of a team from testifying as to matters otherwise within his or her knowledge.

(7) The domestic violence fatality review teams are assigned to the Department of Children and Family Services for administrative purposes.