DOMESTIC VIOLENCE FATALITY REVIEW TEAM
2003 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 Section. 741.316, Florida Statutes, which recognized the work of these teams and called 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 60 cases which were independently 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 reports for the years 2002 and 2003 are:

	2002	2003
Average age of perpetrator:	48	42
Average age of decedent:	46	41
Sex of perpetrators:	41 (89%) male 5 (11%) female *(there were two perpetrators in one case)*	51 (85%) male 9 (15%) female
Sex of decedents:	11 (23%) male 36 (77%) female *(there were more than one victim in some cases)*	11 (16%) male 56 (84%) female *(there were multiple victims in five cases: three in two cases and two in three cases)*
Location:	35 (74%) of the 47 fatalities occurred in/at the decedent's residence	34 (57%) of the 60 fatalities occurred in/at the residence of the decedent and perpetrator
Weapons:	In 25 (56%)of the 45 cases, a firearm was involved in the fatality	In 38 (63%) of the 60 cases a firearm was involved in the fatality
Relationship:	In 29 (64%) of the 45 cases, the parties lived together at the time of death	In 31 (52%) of the 60 cases, the parties lived together at time of death
History:	In 18 (40%) of the 45 cases, prior domestic violence had been reported	In 24 (40%) of the 60 cases, prior incidents of domestic violence had been reported

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

1) Provide more funding for Mental Health Programs and Domestic Violence Programs
2) Mandate local law enforcement to employ victim advocate(s) in every law enforcement agency
3) Provide outreach to the general public on what steps to take when they are aware of an abusive relationship in the family or with friends
4) Mandate judicial training
5) Implement stricter laws requiring batterers to be sentenced to a certified batterer's intervention program
6) Implement changes in Florida law to allow for the issuance of a capias upon the filing of a not-in-custody, misdemeanor or domestic violence case

Recommendations - continued

7) Mandate the continuous enrollment of the defendant in a certified batterer's intervention program while on probation (failure to comply should result in an immediate violation)
8) Increase funding for domestic violence issues, programs, etc
9) Make the criminal history record (state and national) of the respondent available at the injunction for protection civil hearings
10) Recognize recidivism of convicted habitual domestic violence perpetrators

All data and recommendations are the products of the participating Domestic Violence Fatality Review Teams, compiled and reported by FDLE in compliance with Section 741.316, F.S.

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

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

FOREWORD

On May 7, 2003, the Governor signed House Bill 1099, relating to Domestic Violence Centers. This bill removes the requirement that the Department of Children and Families approve or reject applications for funding received from domestic violence centers; provides for provision of technical assistance and distribution of funds for said centers by a statewide association whose primary purpose is to provide technical assistance to certified domestic violence centers; and provides requirements for contracts between said association and certified domestic violence centers.

In the state's continued efforts to reduce domestic violence crimes, Governor Bush initiated Violence Free Florida! in 2002. This program is 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 2002 the legislature approved and Governor Bush signed into law Senate Bill 716 (s. 741.28, F.S.) which clarified that people who have a child in common, or who are in a dating relationship, are not required to have resided together to be eligible for an injunction for protection against violence. Senate Bill 716 also eliminated the filing fee for protective orders (s. 741.30, F.S.) and allowed certified domestic violence advocates, prosecution, or law enforcement advocates to be present during injunction hearings.

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. This law also makes a second battery crime a felony offense, which will effectively treat repeat offenders as serious criminals. The Family Protection Act also required 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 2003 ANNUAL REPORT

DOMESTIC VIOLENCE IN FLORIDA

According to the Uniform Crime Reports Annual Report, Crime in Florida, a total of 121,834 domestic violence incidents were reported in 2002. Domestic violence accounted for 26.5 % of all comparably reported violent offenses.

Domestic violence accounted for 188 (21 %) of the State's 906 murders during the same reporting period. The spouse or live-in partner was the victim in 52 % of these offenses. Children accounted for 16 % of the victims.

As of June 11, 2003, there were 116,991 Domestic Violence Injunctions in the FDLE's Florida Crime Information Center's (FCIC) database.

DATA SUBMISSION FORM

Since the passage of Section 741.316, Florida Statutes, effective July 1, 2000, the Domestic Violence Fatality Review Teams have used the standardized collection form provided by the FDLE to collect and record their findings of reported domestic violence related cases. During the first months of 2003, the FDLE's Domestic Violence Data Resource Center (DVDRC) traveled throughout the state, visiting 12 of the Domestic Violence Fatality Review Teams. These visits allowed the FDLE's DVDRC to observe the unique format of each team, answer procedural questions the teams had as a result of completing review forms, foster and maintain a close working relationship with the various team members, and provide assistance to the newly formed teams. Additionally, the visits provided a forum for the team members to discuss the overall effectiveness of the standardized reporting form developed by the FDLE's DVDRC. During the meetings the team members were asked to evaluate the reporting form and provide the FDLE's DVDRC with their findings. The FDLE's DVDRC will use the teams' findings to assess training needs that will enhance their ability to complete the standardized form, as well as to modify the form according to the teams' recommendations.

ANNUAL SUMMARY FORM

A Domestic Violence Fatality Review Team Annual Summary Form was provided to each team in order to ensure that the appropriate findings and recommendations, derived from the reviews that the teams 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 and/or issues that might not come to the forefront when data from all reviews are summarized. The form is broken down into the following 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 changes in law, policy or procedure that the teams recommend for consideration at the state level
- Additional comments and/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 intervene in domestic violence incidents before a death occurs. This can only occur when common elements can be identified and defined for domestic violence 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 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]

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[1] Barbara Hart, Legal Committee, **Domestic Violence Death Review**, February 9, 1995, National Council of Juvenile and Family Court Judges.
[2] Byron Johnson and Neil Websdale; **Fatality Review: An Implementation Guide for Establishing Local Teams;** Office for the Study of Prevention of Domestic Violence; University of Pennsylvania; 2001
[3] ibid

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

As of the beginning of the year 2002, the following counties had active Domestic Violence Fatality Review Teams: Bay County, Brevard County, Broward County, Collier County, Dade County, Duval County, Escambia County, Lee County, Orange County, Palm Beach County, Pinellas County, Polk County and Sarasota/Manatee/Desoto Counties. The Putnam/Volusia County Review Team is currently inactive. The Collier County Review Team went on inactive status mid-year, 2003. Columbia County established a new Review Team in March, 2003 and will participate in the 2004 annual report.

The following 12 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	5
BREVARD	3
BROWARD	7
COLLIER	1
DUVAL	5
ESCAMBIA	7
LEE	9
ORANGE	8
PALM BEACH	8
PINELLAS	2
POLK	2
SARASOTA/MANATEE/ DESOTO	3

Participating Teams: Summary Report

A summary of findings was provided by all of the active Domestic Violence Fatality Review Teams. All of the teams, except for Miami-Dade, 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, RECOMMENDATIONS AND COMMENTS OR CONCERNS

The following data was gathered from the Annual Summary Evaluation Forms that were provided to the FDLE's DVDRC by the participating Domestic Violence Fatality Review Teams. Other findings, changes and recommendations can be found on pages 26-58, where the Fatality Review Teams' individual case reviews are summarized.

The most significant findings from the reviews are:

1) In most cases family and friends were aware of the violence.
2) Alcohol/drug abuse, separation issues and mental capacity were significant factors in accelerating the abuse.
3) In most cases neither the decedent nor perpetrator sought help from the various intervention programs available to them.

4) There is a need for collaboration between the community, law enforcement and social services to educate the victims of domestic violence as well as their family and friends on the lethality indicators of domestic violence, the various intervention programs available and how to obtain services from the resources that are available to them. The family and friends of these individuals would benefit from education on how to help someone in an abusive relationship.

Changes as a result of the reviews are:

Most of the teams reported that there were no changes made as a result of their reviews. Some teams reported that informal/verbal agreements were made with collaborating agencies and community partners who provide services to domestic violence victims. The teams that made changes in policy and/or procedure reported the following: 1) devotion of one edition of its monthly publication to domestic violence education by a county medical association; 2) expansion of the scope of case management services to petitioners for domestic violence injunctions by a county court administration's family court; 3) declaration of domestic violence as a public health issue; 4) administration of in-depth training to the county health care district and elementary school social workers as well as to various organizations and agencies to provide information on team findings; 5) writing and submission of articles to the local newspaper to educate both the editors and readers on the dynamics of domestic violence that contribute to fatalities; and 6) linking surviving family members with needed services.

Comments or concerns as a result of the reviews are:

1) Funding should be provided for domestic violence fatality review teams
2) Review of near fatalities has provided a wealth of information, which may not be present or obtainable in fatality cases

DOMESTIC VIOLENCE DATA REVIEW

The following data is from 60 cases provided to the FDLE's DVDRC by the participating Domestic Violence Fatality Review Teams. **The cases were not selected based on any specific date, time frame or circumstance. The data is from 12 teams covering only 14 counties, and the number of reviews completed by each team varies.** Therefore, the reader is cautioned about drawing conclusions from this data.

HIGHLIGHTS OF THE DOMESTIC VIOLENCE FATALITY REPORT

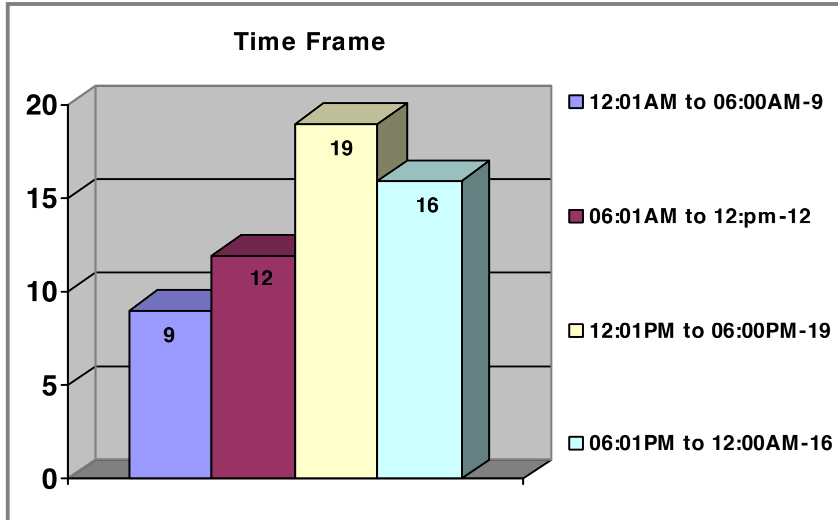
Average age of perpetrator: 42
Average age of decedent: 41
Sex of perpetrators: 51 (85%) were male, 9 (15%) were female
Sex of decedents: 11 (16%) were male, 56 (84%) were female *(there were multiple victims in five cases: three in two cases and two in three cases)*
Location**:** 34 (57%) of the 60 cases occurred in/at the residence of the decedent and perpetrator
Weapons: In 38 (63%) of the 60 cases a firearm was involved in the fatality
Relationship: In 31 (52%) of the 60 cases, the parties lived together at time of death
History: In 24 (40%) of the 60 cases, prior incidents of domestic violence had been reported

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

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

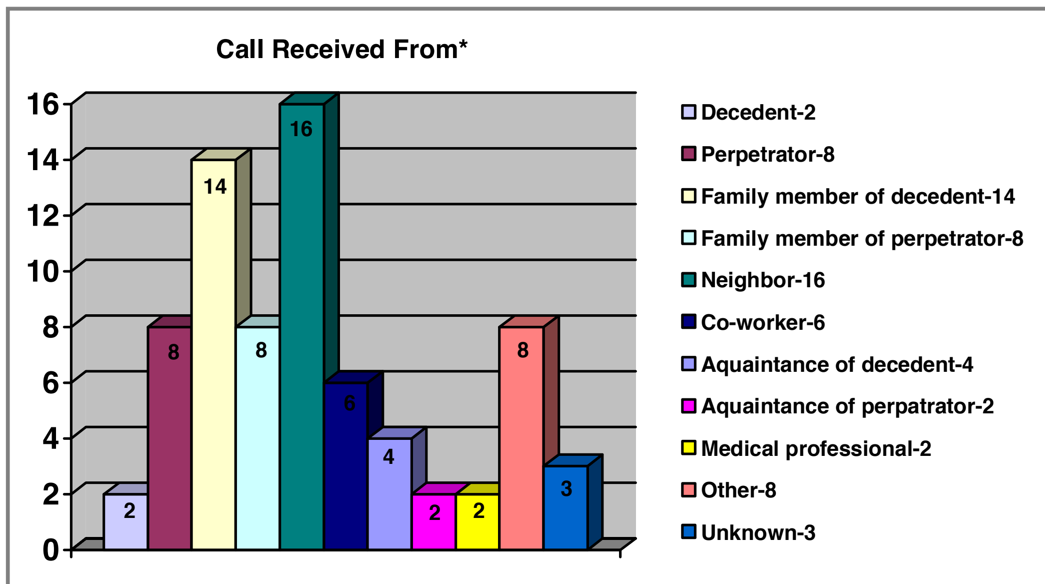
THE FOLLOWING SECTIONS CONTAIN SUMMARIES OF DATA SUBMITTED BY THE TEAMS

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



Of the 60 case review forms submitted, 56 contained information under this category.

Two review forms reflected unknown and two review forms did not contain information for this category. As such the four reports referenced above are not included in this chart.



73 telephone calls were received regarding the 60 domestic violence fatality reports reviewed. This was due to multiple complainants.

The category of "Other" consists of: one employer, one friend of sister, one attorney, one building manager, one intimate partner, two strangers and one not specified.

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

Call Received in Relation to Event

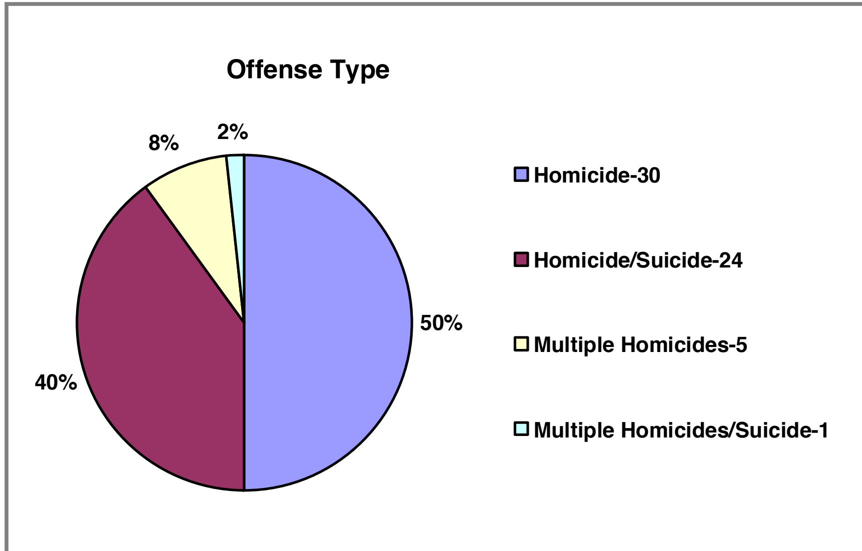
After Fatality	45
During Fatality	13
No information provided	2

There was no information provided on two of the review forms for this category.

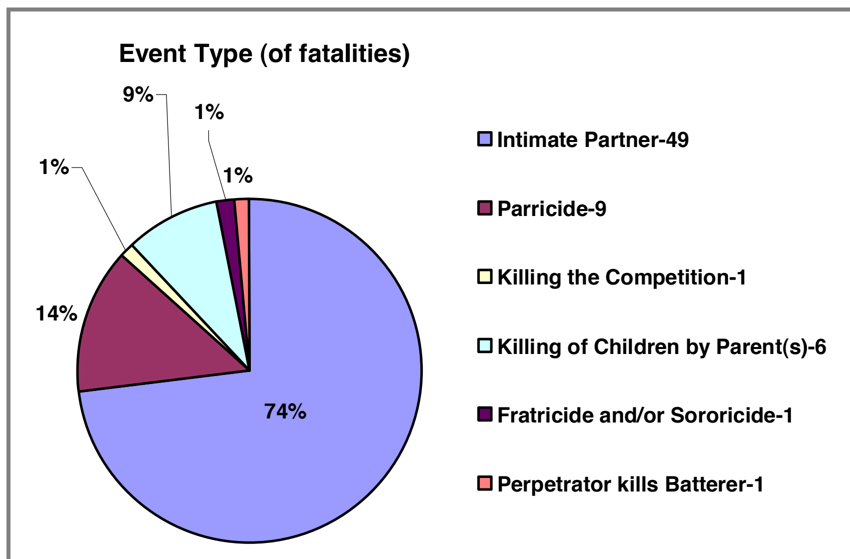
Summary:

The data provided did not indicate a specific day of week that was predominant in the fatalities reviewed. Over half of the calls, in which information was provided, were received during the hours of 12:00 Noon and 12:00 Midnight. Thirty percent of the calls were received from a family member of either the perpetrator or the decedent and 22% of the calls were received from a neighbor. The perpetrator of the fatality made 11% of the calls. Two calls were received from the decedent prior to the fatality. The majority of the calls were received after the event.

EVENT INFORMATION - This information is a general overview of the fatality itself from the type of offense, activities, parties involved, weapon, injury sustained during fatality (both to the decedent and the perpetrator), 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.



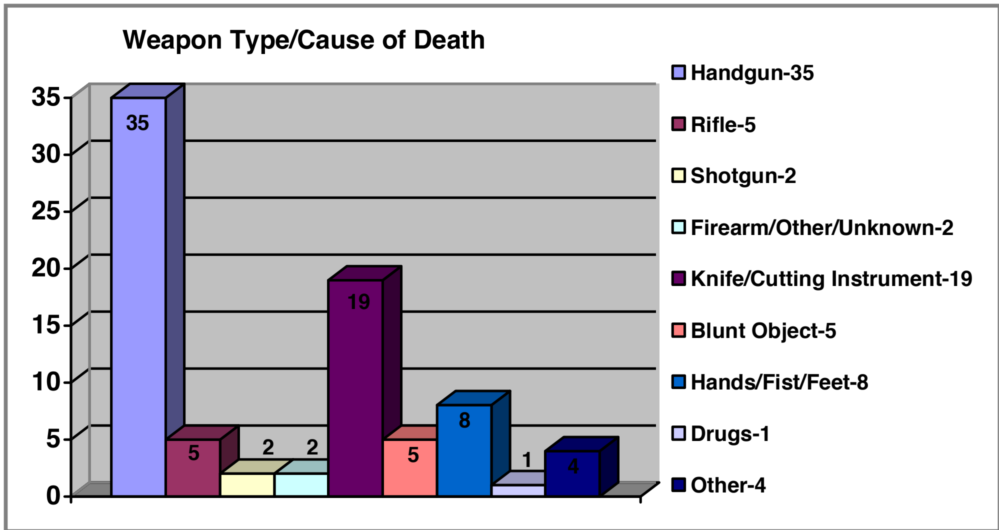
When the teams were originally created, homicide/suicide fatalities were selected due to liability issues. Although the teams have since expanded their scope to include other types of domestic violence fatalities, this chart depicts the type of cases selected for review rather than the nature of the domestic violence fatality offenses as a whole.



There were a total of 67 victims in the 60 incidents reported.

For this offense category five fatality review reports reflected that the perpetrator killed multiple victims. The review forms reflected three victims in two reports and two victims in three reports.

The category of killing of children by parent includes one event in which the perpetrator killed the child of his ex-girlfriend and one event in which the perpetrator killed the child of her son's girlfriend.



This category depicts the type of weapon used to carry out the fatality for the 67 victims. However, some of the review forms reflected multiple weapons for some reports.

Eight cases reflected two weapons, one case reflected three weapons and one case reflected four weapons, for a total of 81 weapons

"Other" consists of the following items being used as a weapon to carry out the fatality: rope, shower curtain tie-backs, t-shirt as rope and concrete stairs.

Location of Fatality

Location	Count
Residence of decedent and perpetrator	34
Residence of decedent	12
Residence of perpetrator	4
Residence of other family members	1
Workplace of decedent	3
Other	6

"Other" consists of the following locations: two review forms reflected street as the location, one reflected convenience store, one reflected health and rehabilitation center, one reflected wildlife refuge and one did not specify a location.

Children at Scene of the Fatality

Children at scene	Count
Child(ren) heard fatal occurrence	7
Child(ren) observed fatal occurrence	6
Child(ren) may have heard fatal occurrence	1
Child(ren) may have observed fatal occurrence	0

Summary:

The 60 cases reviewed had five cases with multiple victims, resulting in a total of 67 fatalities. Firearms accounted for 66% of the deaths. Most victims, 69%, were killed in their own residences.

ENVIRONMENT PRIOR TO FATALITY - This information is related to the 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

Both had physical and legal custody	2
Unknown as to who had physical and/or legal custody	1
Decedent had physical and legal custody	6
Both had physical and unknown as to who had legal custody	2
Decedent had physical and unknown as to who had legal custody	1
Decedent had physical and both had legal custody	2
Decedent had physical and no information provided as to who had legal custody	1
Perpetrator had physical and both had legal	1
Not Applicable	40
No information provided	4

Injunction History of Perpetrator

Active injunction	7
Previous injunction	13
Injunction denied	1

Injunction History of Decedent

Active injunction	2
Previous injunction	3

Summary:

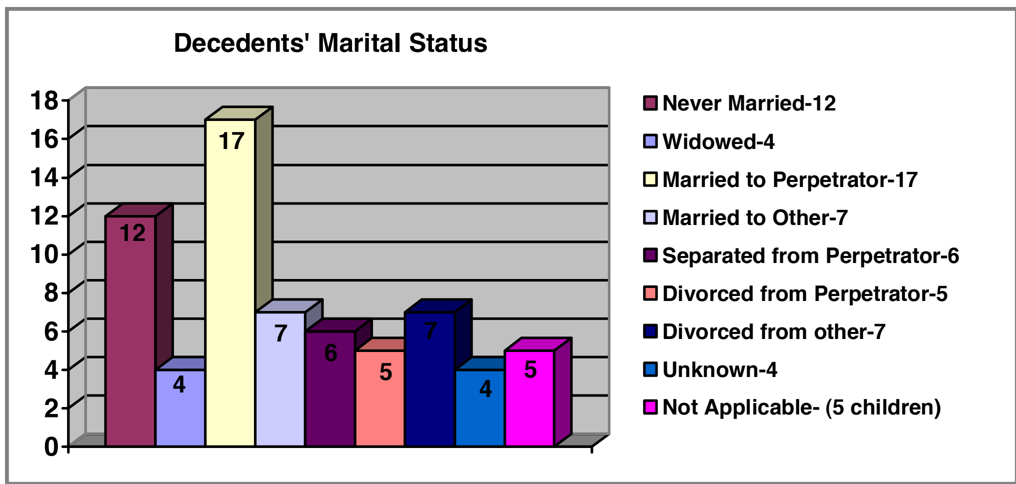
Of the 60 cases reviewed, no information or a response of not applicable was provided in 73% of the cases relating to child custody. Active injunctions filed on the perpetrator were present in 12% of the cases, previous injunctions had been present in 22% of the 60 cases reviewed, and an injunction was denied in one case. The decedents had two active injunctions filed at the time of the fatality and three previous injunctions.

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 60 cases reviewed five had multiple victims resulting in a total of 67 decedents. Of the 67 decedents, 56 were female (84%) and 11 male (16%).

Decedents' Marital Status

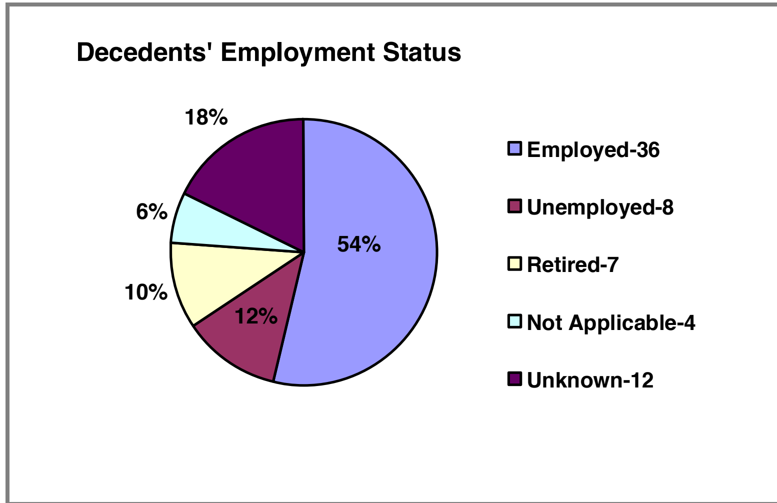


Information was provided for all 67 decedents in this category.

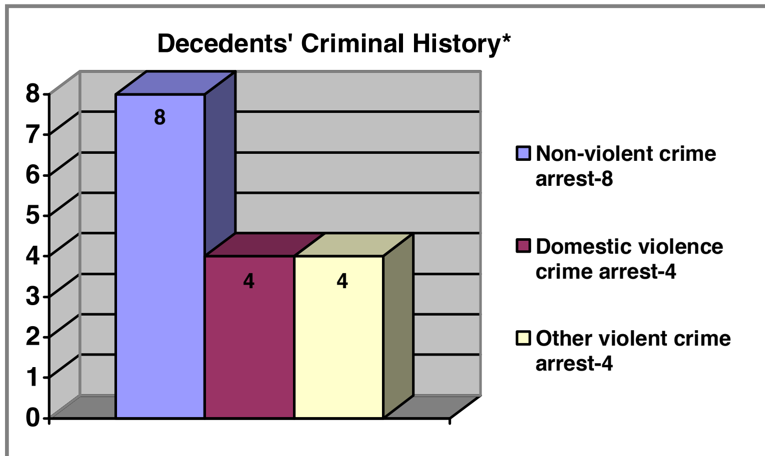
Decedents' Race

Of the 67 decedents, 53 were white (79%) and 14 were black (21%).

Decedents' Employment Status



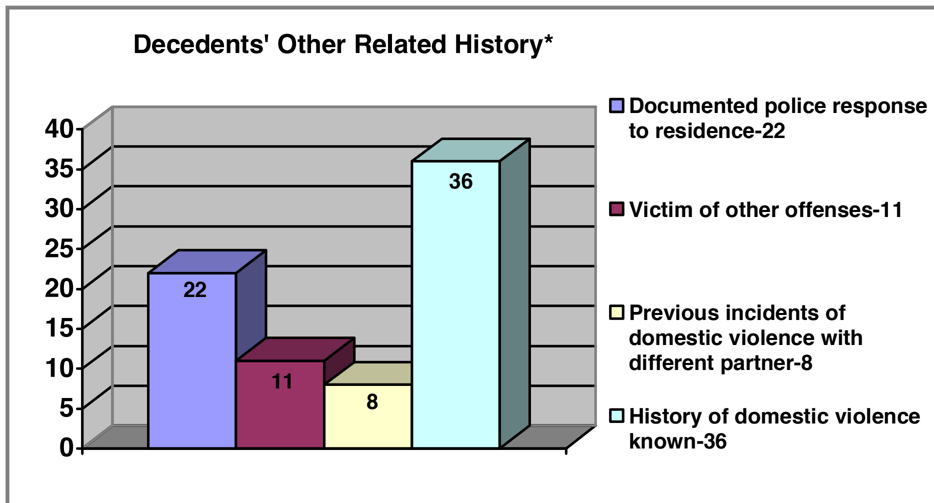
Decedents' Criminal History



Of the 60 case review forms submitted, 10 contained information under this category.

***Note: The Decedents' Criminal History category contains multiple selection fields and the review forms may contain more than one response for these categories.**

Decedents' Other Related History



Of the 60 case review forms submitted, 41 contained information under this category.

***Note: The Decedents' Other Related History category contains multiple selection fields and the review forms may contain more than one response for these categories.**

Summary:

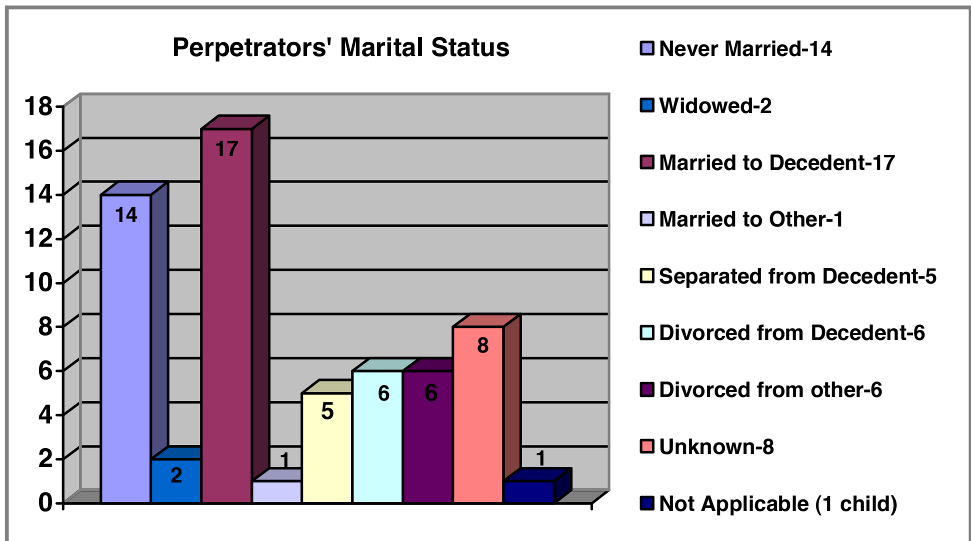
Of the 67 fatalities reported, 84% of the victims were female. The marital status indicated that 17 of the victims were married to the perpetrator. The racial breakdown of the cases reviewed reflected that 79% of the victims were white. A total of 54% of the victims were employed at the time of their death. For the 60 reviews, the decedents had eight non-violent arrests, four domestic violence arrests and four arrests for other violent crimes. Police had responded to the residence for some reason in 22 cases. The decedent was the victim of another crime 11 times and had been the victim of previous domestic violence with a different partner eight times. In 36 cases, others knew of a history of domestic violence.

PERPETRATOR INFORMATION - This information is related to the perpetrator of the fatality. 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 60 perpetrators 9 were female (15%) and 51 male (85%).

Perpetrators' Marital Status

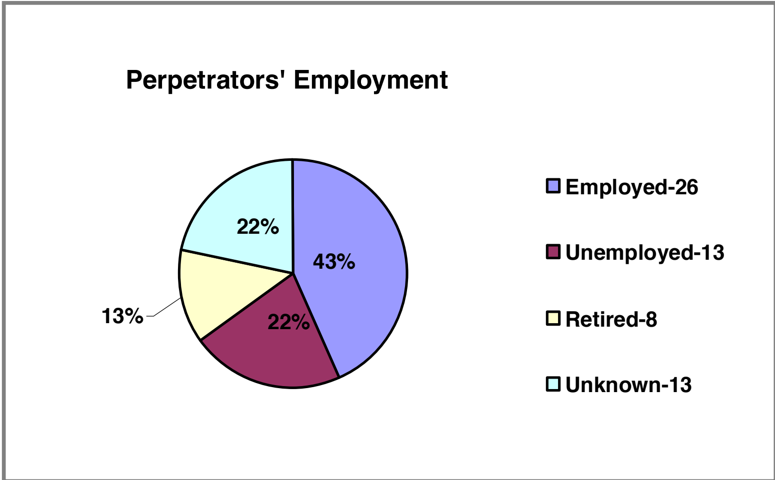


Information was provided for all 60 perpetrators in this category.

Perpetrators' Race

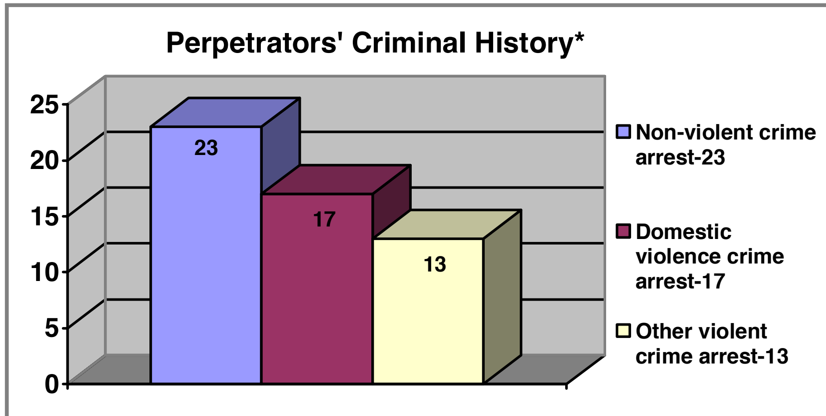
Of the 60 perpetrators, 45 were white (75%) and 13 were black (22%) and one was asian/pacific. One of the fatality review reports reflected a race of unknown for the perpetrator.

Perpetrators' Employment



Information was provided for all 60 perpetrators in this category.

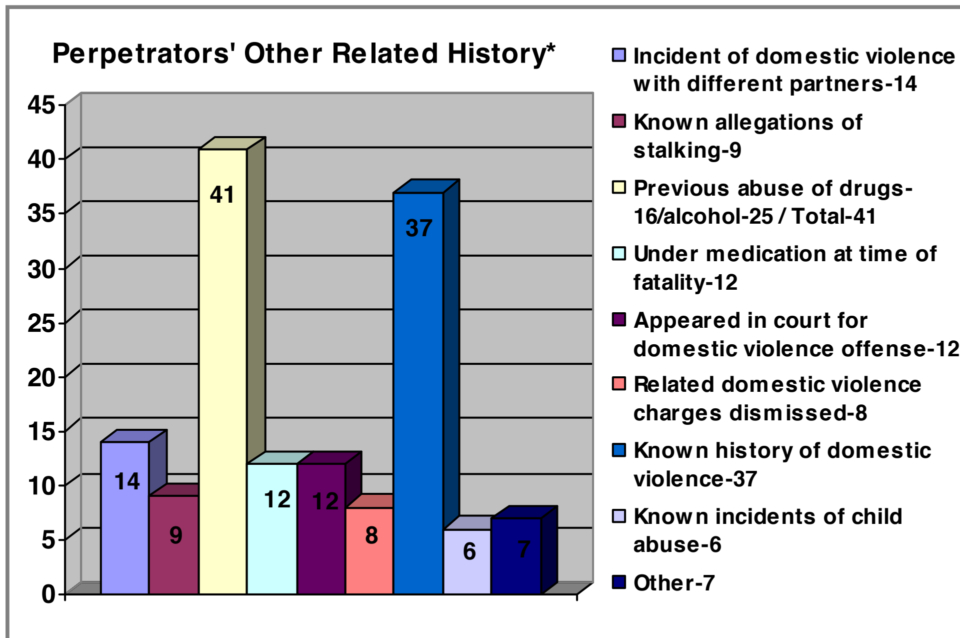
Perpetrators' Criminal History



Of the 60 case review forms submitted, 33 contained information under this category.

*Note: The Perpetrators' Criminal History category contains multiple selection fields and the review forms may contain more than one response for these categories.

Perpetrators' Other Related History



Of the 60 case review forms submitted, 45 contained information under this category.

"Other" consists of: one that had previous participation in batterer's intervention program, two previous incident of animal abuse and four that had a previous history of attempted suicide.

*Note: The Perpetrators' Other Related History category contains multiple selection fields and the review forms may contain more than one response for these categories.

Summary:

Of the 67 fatalities reported, 85% of the perpetrators were male. The marital status indicated that 28% of the perpetrators were married to the decedent at the time of the fatality. The racial breakdown of the cases reviewed reflected 75% of the perpetrators were white. A total of 43% of the perpetrators were employed at the time of the fatality. Of the 60 perpetrators, 23 had non-violent arrests, 17 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 14 cases; in eight cases, domestic violence charges against the perpetrator were dismissed. Child abuse was reported in six cases. Drugs, alcohol and medication were present in 53 of the cases. In 37 of the cases reviewed, others had 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 were five cases in which the decedent threatened to kill the perpetrator, one case in which the decedent threatened to commit suicide and one case in which the decedent stalked and harassed the perpetrator.

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:

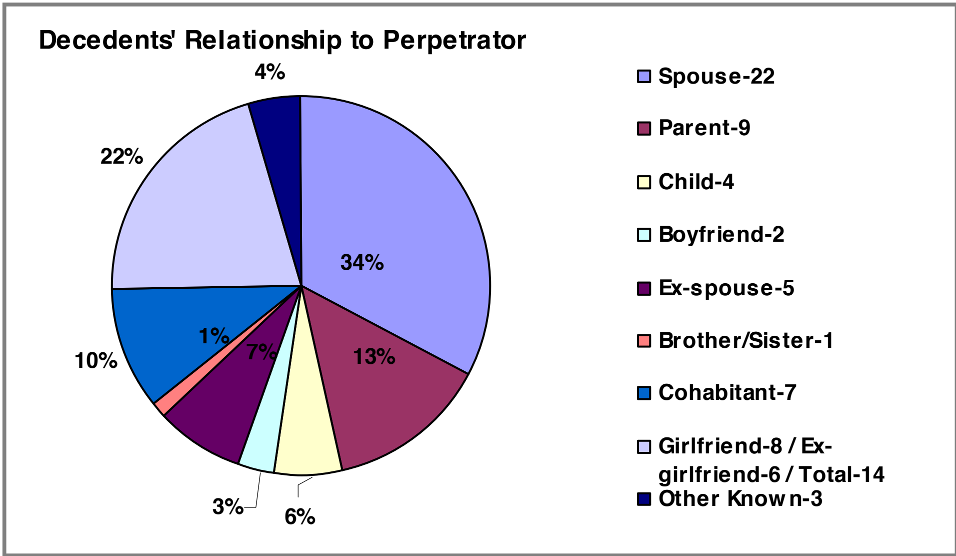
Gunshot	21
Other	7

28 perpetrators committed suicide. "Other" consists of: one by strangulation, two by stab wounds, three by hanging and one by carbon monoxide.

Suicide:

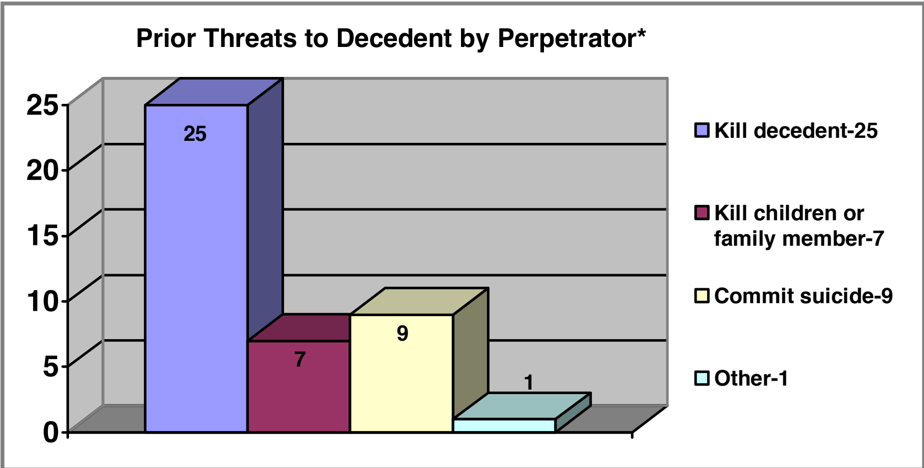
Suicide note left	12
Suicide appeared to be part of homicide	15

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



Spouses, ex-spouses, girlfriend, ex-girlfriend, boyfriend and co-habitant made up 75% of the relationships involved in the fatalities.

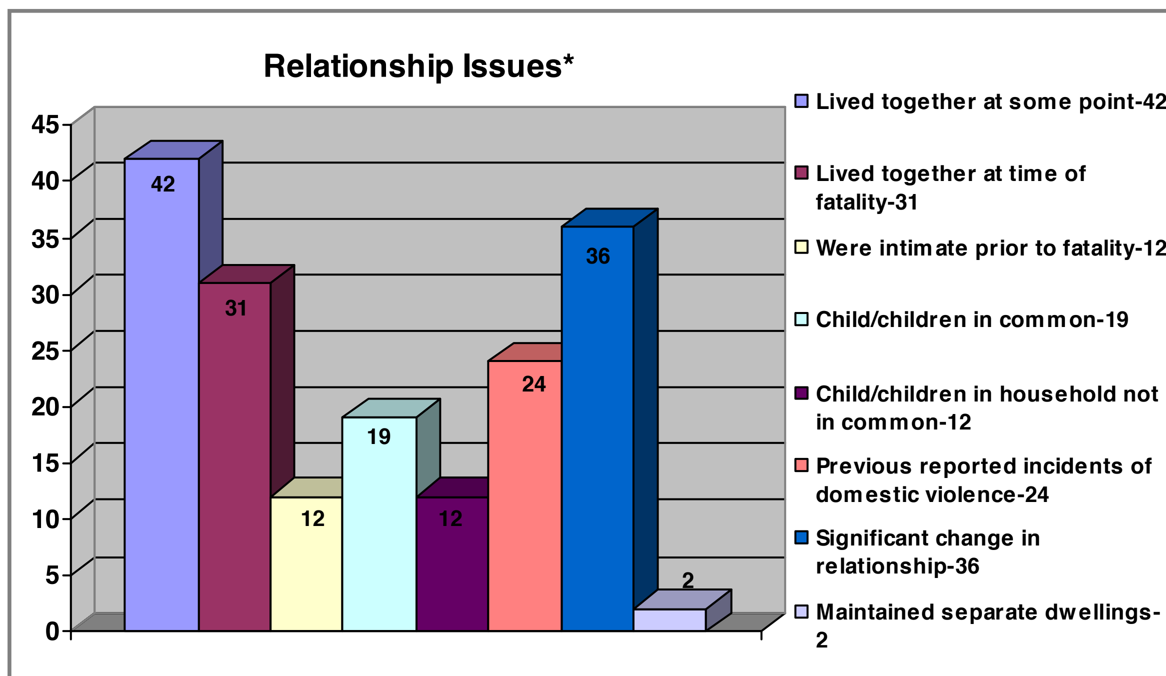
"Other Known" consists of one child of son's girlfriend and one event, with two victims, in which the perpetrator killed the competition and the child of the ex-girlfriend.



Of the 60 case review forms submitted, 28 contained information under this category.

The category of "Other" consists of a threat by perpetrator to send decedent back to Haiti.

***The Prior Threats to Decedent by Perpetrator category contains multiple selection fields and the review forms may contain more than one response for these categories.**



***The Relationship Issues category contains multiple selection fields and the review forms may contain more than one response for these categories.**

Summary:

The victim in 34% of the fatalities was the spouse of the perpetrator and in 25% of the fatalities the victim was either the girlfriend, boyfriend or co-habitant of the perpetrator. Prior threats to kill the decedent occurred in 37% of the fatalities. Previous incidents of domestic violence had been reported for 36% of the fatalities. A significant change of relationship had occurred between the decedent and perpetrator in 54% of the fatalities.

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 greater the numerical 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:

(the following factors were given a priority rating of one, two or three by team members)

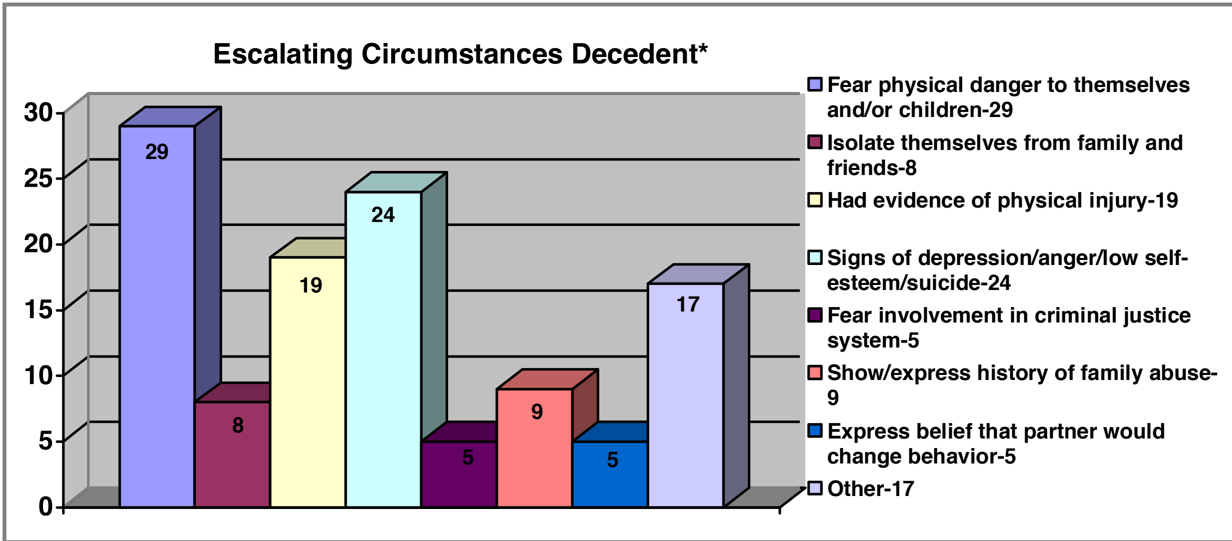
1) Perpetrator alleged to have committed act to avenge a perceived wrongdoing by decedent - **20** times.
2) Decedent and perpetrator in process of separation at time of fatality - **17** times.
3) Decedent and perpetrator had separated - **ten** times.
4) Perpetrator had/has abused alcohol - **nine** times.
5) Perpetrator had/has mental health problems - **nine** times.
6) Perpetrator blamed decedent for recent loss of income – **eight** times.

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

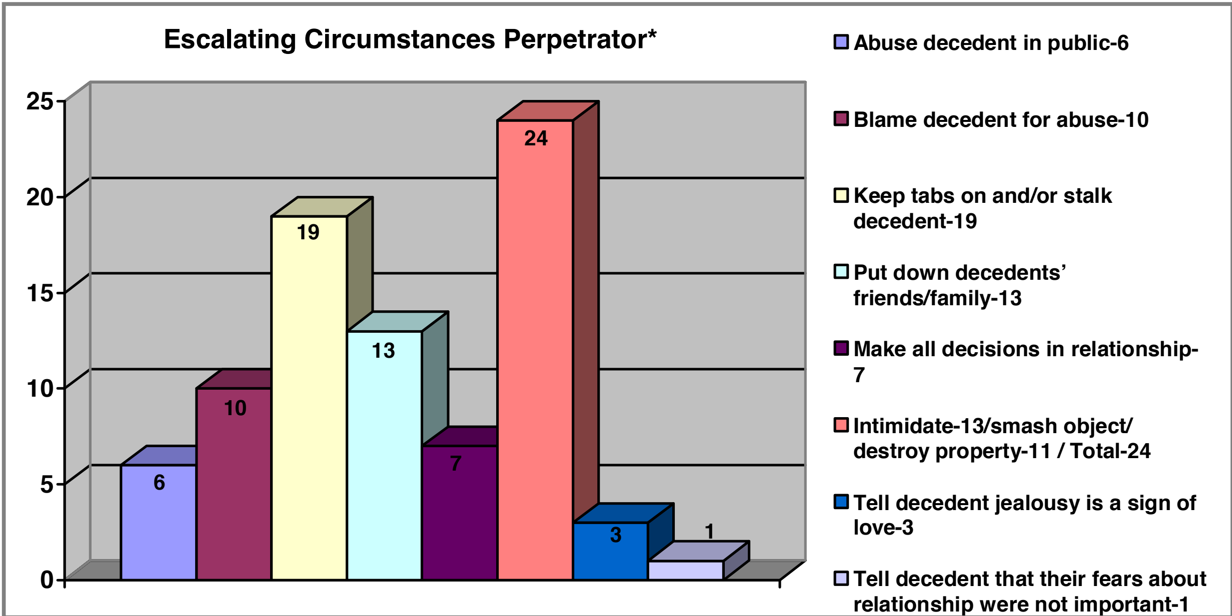
Summary:

The two major contributing factors to the fatalities identified by the Domestic Violence Fatality Review Teams were: 1) Perpetrator alleged to have committed the act to avenge a perceived wrongdoing by decedent, and 2) Decedent and perpetrator in process of separation at time of fatality. In 48% of the reviewed fatalities, a separation was taking place or had already taken place in the relationship.

ESCALATING CIRCUMSTANCES - This information relates to the circumstances surrounding the fatality 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.



***The Escalating Circumstances Decedent category contains multiple selection fields and the review forms may contain more than one response for this category. Of the 60 case review forms submitted, 53 contained information under this category and seven were marked unknown. "Other" consists of: two expressed fear of losing custody of children, one showed signs of sleeping difficulties, six had guilty feelings about failed relationship, three expressed fear of loneliness and five expressed fear of making a great life change.**



***The Escalating Circumstances Perpetrator category contains multiple selection fields and the review forms may contain more than one response for this category. Of the 60 case review forms submitted, 41 contained information under this category and 19 were marked unknown.**

Summary:

The three escalating circumstances that occurred most for the decedent were: 1) express fear of physical danger to themselves and/or child(ren), 2) exhibit signs of anger/depression/low self-esteem and 3) have evidence of physical injury. The three most frequent escalating circumstances noted for perpetrators were: 1) keep tabs on or stalk decedent, 2) put down the decedent's friends and family, and 3) use intimidation by instilling fear through looks and gestures.

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 Finding:

Of the cases reviewed, there were prior requests/orders for domestic violence services for 12 decedents. The review revealed that all 12 decedents received domestic violence services. Additionally, one perpetrator received services from a non-specified domestic violence service provider.

- **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.

Criminal Justice/Legal Assistance Finding:

Of the cases reviewed, there were prior requests/orders for criminal justice/legal services for 59 decedents and 26 perpetrators. The review revealed that 57 decedents and 39 perpetrators received 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** – Any criminal justice or legal assistance received by the decedent and/or the perpetrator not mentioned above. Specify in the space provided.

Health Care Provider Finding:

Of the cases reviewed, there were prior requests/orders for health care services for 16 decedents and 17 perpetrators. The review revealed that 10 decedents and 12 perpetrators received health care services.

- **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.

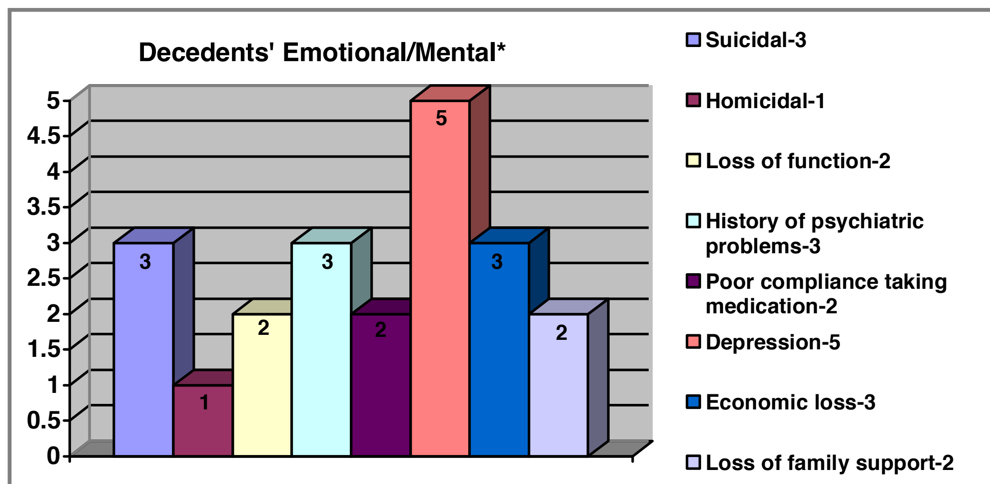
- **Other** – Any other service, person or facility designed to treat physical or mental illness. Specify the service, person or facility in the space provided.

Children and/or Families Services Finding:

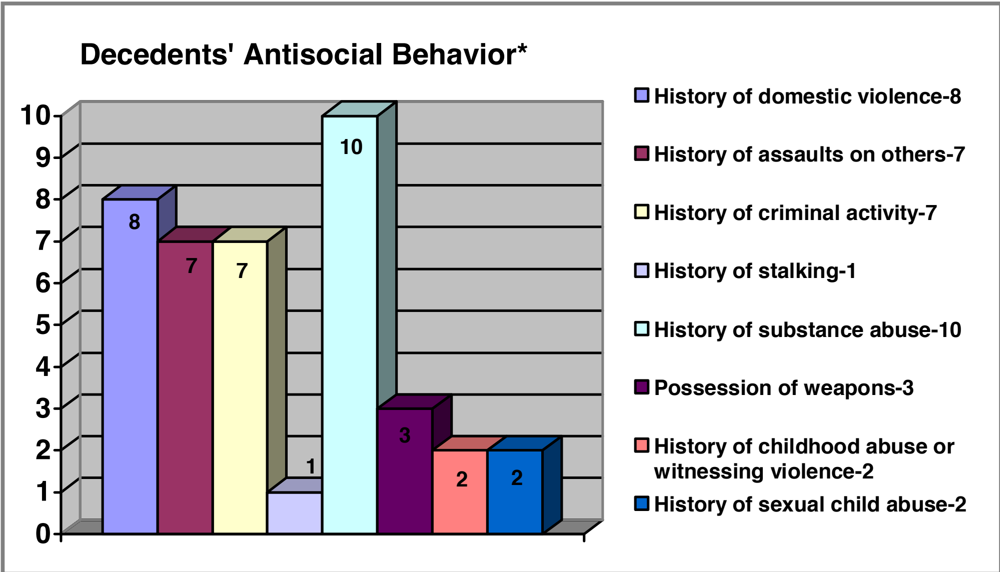
Of the cases reviewed, there were prior requests/orders for children and/or family services for three decedents, four for perpetrators and three for children of the decedent and/or perpetrator. The review revealed that two decedents, two perpetrators and two of the children of the decedent and/or perpetrator received children and/or family services.

- **Department of Children and Family Services (DCF)**
- **The school system, or a similar entity.**
- **Children Services** – An entity designed to provide services to children.

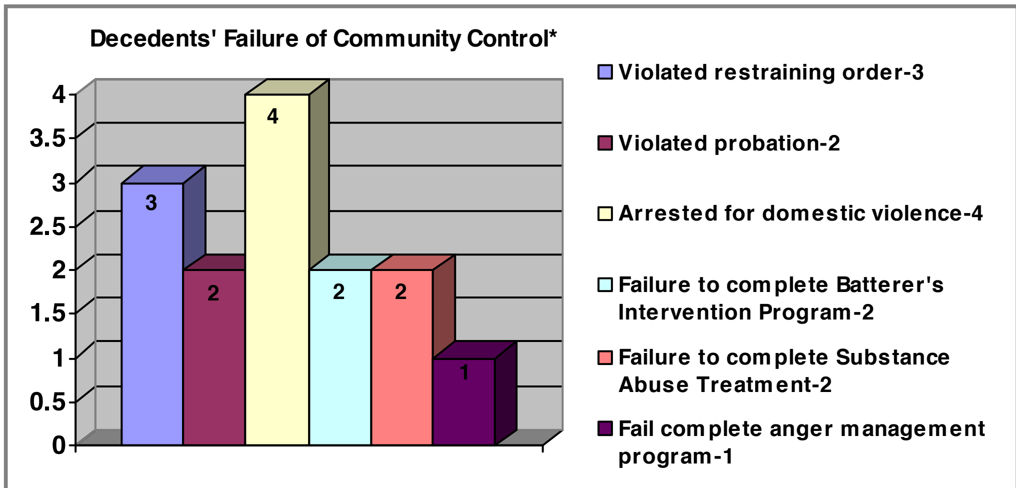
LETHALITY INDICATORS – These factors have been identified based on previously studied domestic violence fatalities and focus on elements considered to be the most prevalent in domestic homicides. This information will be available through law enforcement investigative reports, possible service agency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



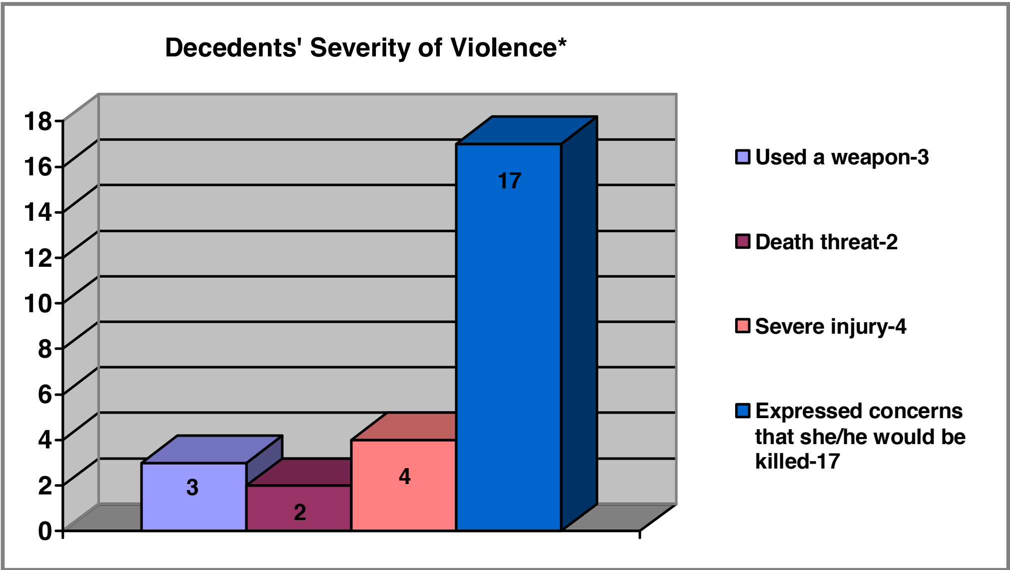
Of the 60 case review forms submitted, 13 contained information under this category.



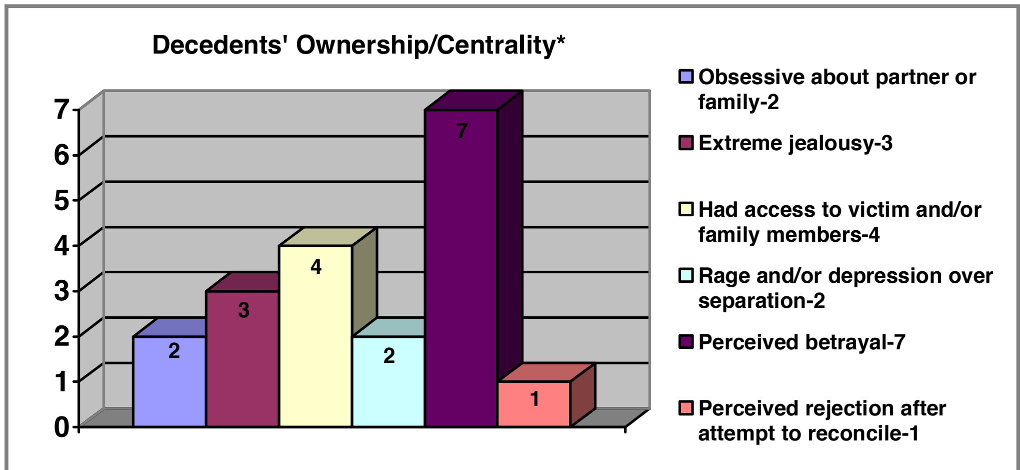
Of the 60 case review forms submitted, 20 contained information under this category.



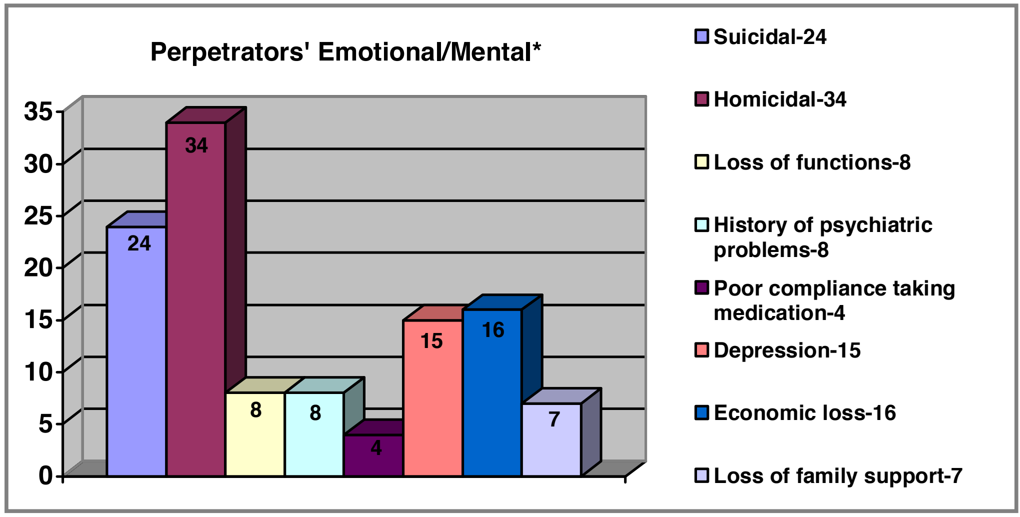
Of the 60 case review forms submitted, eight contained information under this category



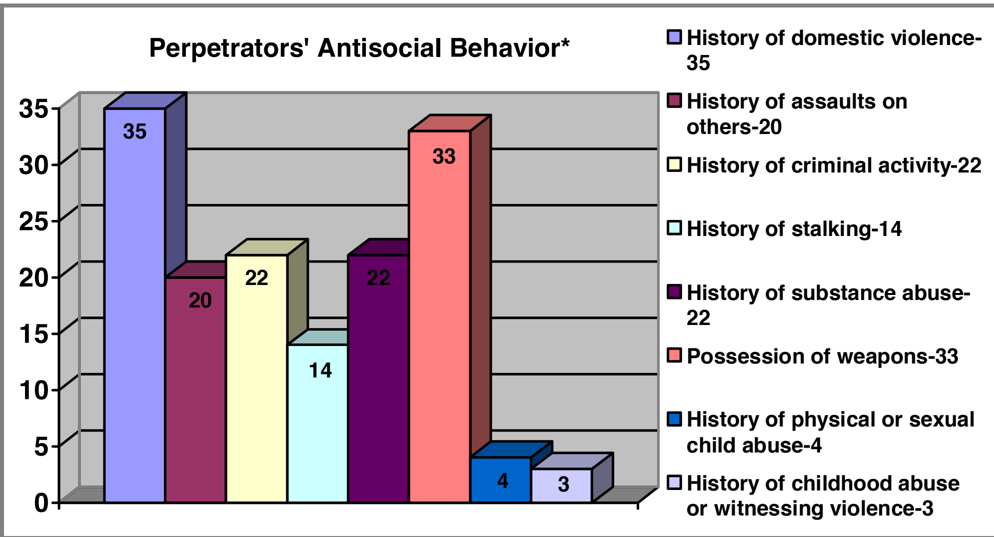
Of the 60 case review forms submitted, 23 contained information under this category.



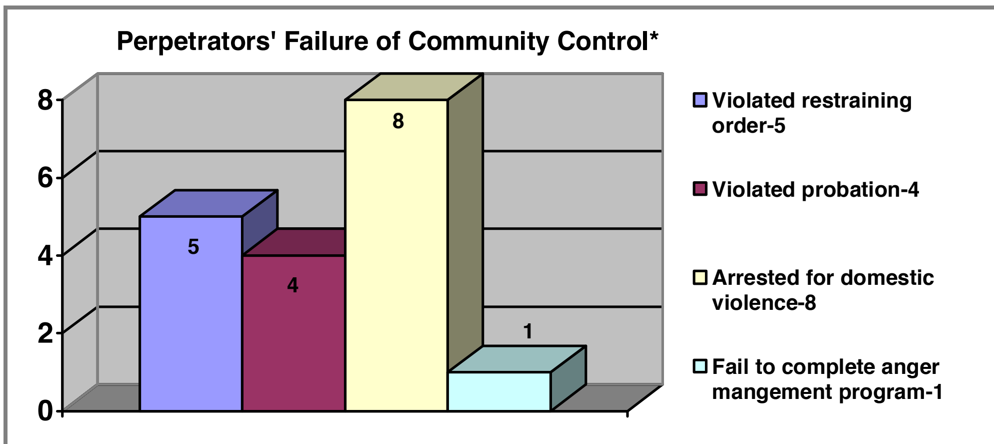
Of the 60 case review forms submitted, 41 contained information under this category.



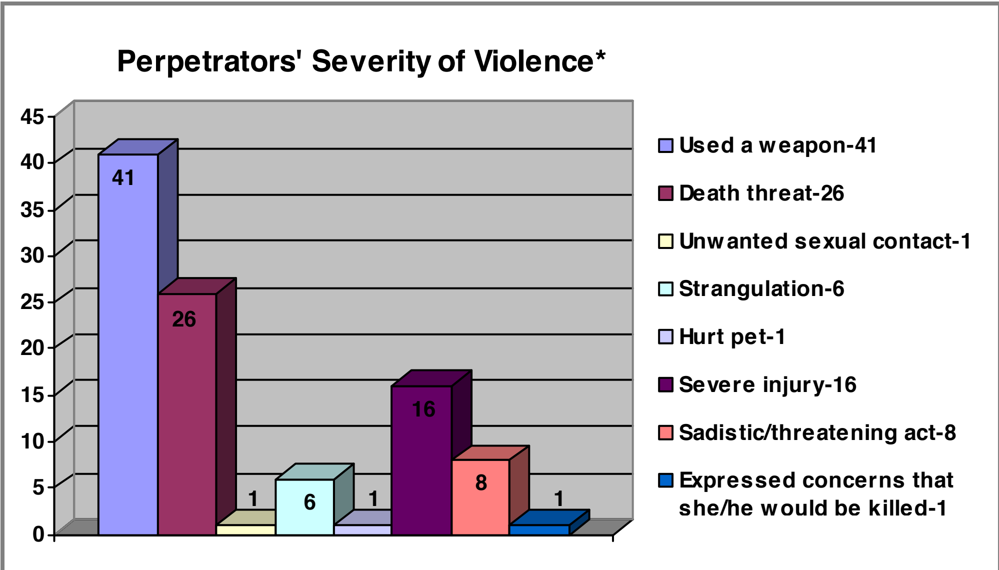
Of the 60 case review forms submitted, 46 contained information under this category.



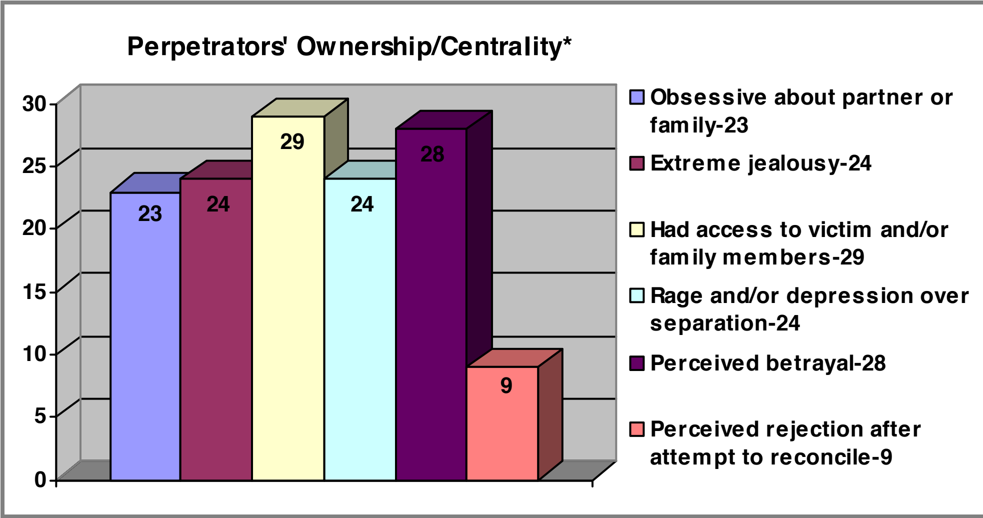
Of the 60 case review forms submitted, 51 contained information under this category.



Of the 60 case review forms submitted, 16 contained information under this category.



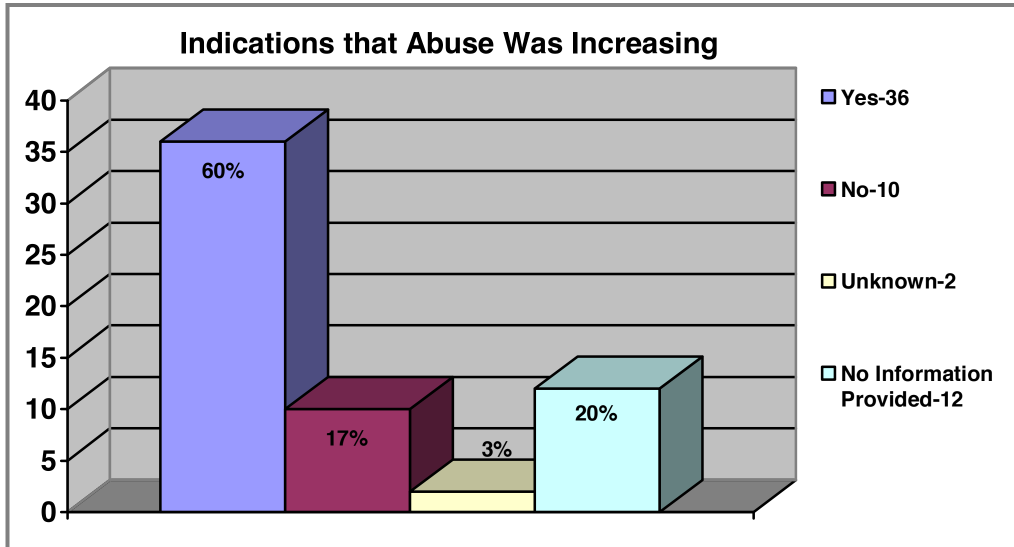
Of the 60 case review forms submitted, 52 contained information under this category.

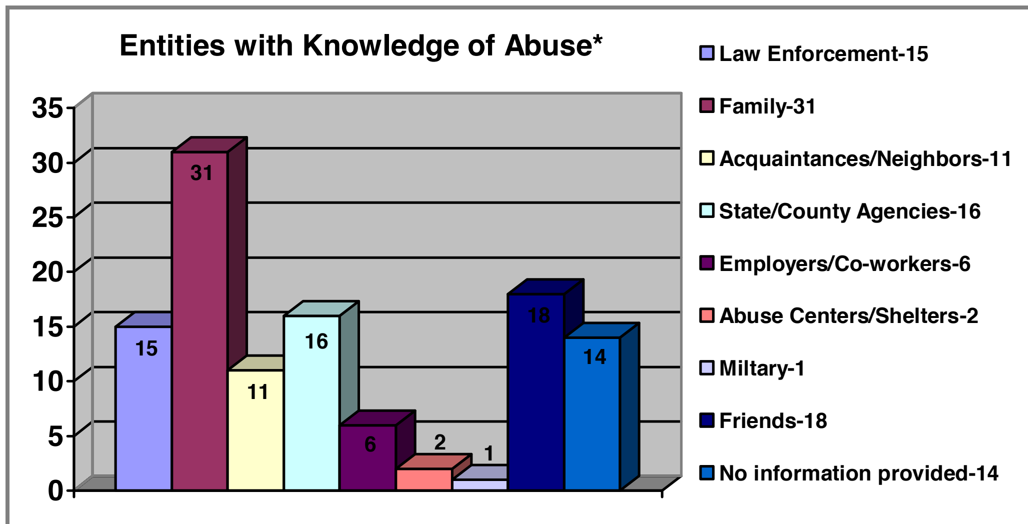


Of the 60 case review forms submitted, 41 contained information under this category.

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

FATALITY REVIEW TEAM'S 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 available during the review.





State, county and law enforcement agencies made up 31% of the entities that had knowledge of the domestic violence.

14 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 and Team Histories Submitted to FDLE for 2002

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

BAY COUNTY FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

Drug and/or alcohol use plays a significant factor in moving an unsettled relationship to a violent relationship. Law enforcement personnel cannot force a victim to partake of the services easily available to victims of domestic violence.

What changes in policy or procedure (if any) were made as a result of your reviews? None

What changes in law, policy or procedure (if any) do your team recommend for consideration at the state level? None

Additional comments or concerns.

Our most shocking finding in numerous cases is that repeated pleas by law enforcement to the victim encouraging additional levels of intervention went unheeded. Short of locking up the victim, there were no strategies that law enforcement could offer, or did offer, to provide a higher level of victim safety and we all accept that locking up the victim is an option only in our imaginations!

DOMESTIC VIOLENCE FATALITY REVIEW TEAM HISTORY

BAY COUNTY FATALITY REVIEW TEAM

Agency representation (types of agencies)

Medical Examiner's Office, Legal Services of Northwest Florida, County Health Department, Salvation Army Domestic Violence Office, Police Departments, Sheriff's Office, Salvation Army Probation Office (misdemeanor), Public Safety Academy (Gulf Coast Community College).

Number of members:

Team consists of 10 members.

How long has team been meeting?

Team has been meeting for more than two years.

Open or closed meeting (why)? Open meeting – we never turned away any interested party.

Where are the meetings held and what time?

Bay County Health Department on the first Tuesday of every month at 10:30 am.

Types of cases reviewed (why)?

Homicide/Suicide initially since they are "closed" cases. Now we are working on homicide cases where the perpetrator pled or was found guilty and sentenced to prison.

Greatest benefits derived from reviews?

Agency interaction and networking

Are you funded and if not why keep going?

We are not funded but will continue – opportunity for positive impact when it comes to changing procedures and laws.

Would team be interested in writing up a composition of team for annual report?

Our "dream team" would be expanded to include at least one judge. A representative from EACH local law enforcement agency, Department of Children and Families, Department of Corrections, Probation and Parole, School district and military base.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

BREVARD COUNTY FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

Resources are now available which were not at time of the fatality (1997-1998); history of violence; family, friends, and/or co-workers knew of the violence; history of drug abuse including alcohol; availability of firearms

What changes in policy or procedure (if any) were made as a result of your reviews?

Policy already changed regarding how petitioners are notified whether they received an injunction for protection or not. Making sure pamphlet information regarding available services is available at Clerk of Courts where injunctions are requested.

a) **Where did they occur?**
   Clerk of the Courts
b) **How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?**
   Informally able to get information available through verbal agreement with the Clerk of Courts and providers.

What changes in law, policy or procedure (if any) do your team recommend for consideration at the state level?

Having state and national criminal history of respondent at Injunction for Protection civil hearings.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM HISTORY

BREVARD COUNTY FATALITY REVIEW TEAM

Agency representation (types of agencies)

Our team consists of members from the Counseling Center, Domestic Violence Shelters, Court Administration, Clerk of Courts, School Board, State Attorney's, Law Enforcement, Elder Care, Medical Examiner, Department of Children and Families, Probation.

Number of members:

Team consists of 15 members.

How long has team been meeting?

N/A

Open or closed meeting (why)?

Our team has closed meetings to preserve confidentiality

Where are the meetings held and what time?

We meet approximately every 6 weeks from 8:30 am to 10:30 am at the Medical Examiner's Office.

Type of cases reviewed (why)?

We review cases that cannot be appealed so members feel free to discuss specifics of the case.

Greatest benefits derived from reviews?

Networking and finding out about resources. Immediately being able to communicate and change procedures.

Brevard County Team History – continued

Are you funded and if not why keep going?

We are not funded but will continue to meet because we believe that one life may be saved.

Would team be interested in writing up a composition of team for annual report?

N/A

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

BROWARD COUNTY FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

- Victim safety would benefit from community education regarding lethality indicators and available safety resources.
- Victim safety would benefit by educating the public regarding criminal history records availability and providing increased accessibility to them.
- Victim safety would benefit from the education of faith based leaders of underserved communities regarding depression, suicide, and domestic violence.
- Victim safety would benefit from the education of community, cultural, and social leaders of underserved populations, regarding depression, suicide, and domestic violence.
- When a restraining order is issued, victim safety would benefit from follow-up support and long term case management to facilitate petitioners' understanding of and ability to respect the conditions of the order.
- Victim safety would benefit from physician participation in educational training on at-risk domestic violence cases.
- Victim safety would benefit from the distribution of domestic violence warning signs information by the Clerk of Court's Office to all parties to divorce and paternity cases.
- Victim safety would benefit by creating a centralized intake process to enhance respondent compliance with court orders and to accelerate the enrollment time of the respondent into a court mandated program.
- Victim safety would benefit from domestic violence providers, law enforcement, and judicial access to a centralized database containing civil and criminal case information.
- Victim safety would benefit from changes to Florida law to allow the issuance of a capias upon the filing of a not-in-custody, misdemeanor, domestic violence case; because the current practice of issuing a summons may increase the anger of the perpetrator and the lethality to victims.
- Victim safety would benefit from faith based leaders expanding their efforts to educate their congregations on domestic violence issues, including the detrimental effects on victims and children, the cycle of violence, signs, interventions, and available resources.
- Victim safety would benefit from private companies providing regular training on domestic violence issues, including the cycle of violence, signs, effects on victims, children, and the workplace, as well as, interventions and available resources.

What changes in policy or procedure (if any) were made as a result of your reviews?

The Broward County Medical Association devoted one edition of its monthly publication to domestic violence education. Broward County Court Administration's Family Court Services has expanded the scope of case management services to petitioners for domestic violence injunctions.

a) Where did they occur?

Broward County Family Court Services and the Broward County Medical Association.

b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?

Programmatic change, BCMA-Informal agreement

What changes in law, policy or procedure (if any) do your team recommend for consideration at the state level?

Victim safety would benefit from changes to Florida law to allow the issuance of a capias upon the filing of a not-in-custody, misdemeanor, domestic violence case, because the current practice of issuing a summons may increase the anger of the perpetrator and the lethality to victims.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM HISTORY

BROWARD COUNTY FATALITY REVIEW TEAM

Agency representation (types of agencies)

Law Enforcement, Medical Examiner, State Attorney, Attorney General, Domestic Violence Coalition, Mental Health (batterers' intervention provider), Probation, Family Court Services (Court Administration), Domestic Violence Shelter & Counseling Provider (victim and perpetrator).

Number of members:

Team consists of 11 members.

How long has team been meeting?

Team has been meeting for 3 years, 4 months (First official review 2/21/00).

Open or closed meeting (why)?

Meetings are closed to facilitate group process. However, no outside request to attend a review has been denied.

Where are the meetings held and what time?

Meetings are held monthly at the Office of the Medical Examiner at times convenient to the members.

Types of cases reviewed (why)?

Homicide/Suicide cases are reviewed so as not to interfere with the prosecution of domestic violence homicide perpetrators.

Greatest benefits derived from reviews?

Improvements to our community's response to domestic violence. Fatality prevention. Improvement to intra-agency communication and cooperation.

Broward County Team History – continued

Are you funded and if not why keep going?

The team is supported by the in-kind donations of its members' agencies.

Our mission: to reduce the incidence of domestic violence deaths by examining and evaluating the circumstances of domestic homicide/suicide cases, by developing findings from these death reviews, and by expanding, increasing or enhancing the involvement, coordination and communication among agencies and systems is valuable and morally imperative.

Would team be interested in writing up a composition of team for annual report?

N/A

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

MIAMI-DADE COUNTY FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

- The reviews found that gunshot wounds were the cause of death for the majority of domestic homicides. In addition, although surrender of firearms may be ordered as a condition of an injunction, surrender may never take place because possession may be denied.
- The finding that guns are the most prevalent weapon used to commit domestic fatalities, indicates that laws which allow for adequate time to perform background checks, such as the 30-day waiting period that the General Accounting Office suggests, should be supported.
- Victims need further information about the availability of assistance and should be encouraged by family and friends to access these support services. Transportation, housing, and childcare care extremely significant in facilitating access to services.
- Community awareness in the form of public announcements is needed to bring resources to the cognizance of the victims and families. Further, educational awareness of death threats should be a training topic to focus upon throughout the community as well as service providers.
- A clear finding is that separation increases risk for domestic homicide, and that in particular, the first six months of separation is the highest risk group. As such, safety planning after separation is critical.
- Although traditionally not viewed as a form of domestic violence, professionals should recognize the impact of suicide on the family, particularly when the suicide takes place within a family with a history of domestic violence.
- All professionals that work in the domestic violence field should be trained to recognize and respond to suicidal threats by offenders and should take appropriate steps insuring victim safety.
- Professionals should have specialized training with respect to domestic violence issues, including child abuse. Professionals should also have knowledge on how to assess for risk, in a consistent and uniform manner between agencies, and should know how to implement safety planning for victims.
- Mental health professionals should be proficient in Baker Act Laws, which allow for a person to be involuntarily committed if they are gravely disabled meaning they are unable to care for themselves.
- There should be a uniform method between police departments to determine whether a case is domestic violence-related once the definition of domestic violence has been broadened in Florida Statutes.
- More communication is needed between police departments regarding domestic violence-related cases.

Miami - Dade County Team Summary – continued

- Channeling police reports to the department's dedicated domestic violence unit in an expedited manner is of critical importance in providing victim safety.
- Police officers should be trained to look at the underlying scenario when responding to domestic disputes (request to remove someone from the home) to discern whether they are actually domestic violence-related.
- Police officers should be trained to contact the abuse hotline in accordance with Florida law when children are present at the scene of a domestic violence-related homicide or suicide, whether or not the child is placed in temporary custody of other family members.
- Violation of an injunction particularly immediate in time of issuance is indicative of high risk and warrants increased bond status considerations.
- Recognition and communication by the prosecution of risk factors is important in providing victim safety, especially for purposes of being related to the court in considering pretrial release and setting bond.
- Agencies should develop and maintain an appropriate forum for networking and communications. Additionally, when referring victims from one agency to another, appropriate managing of the case should include long-term follow-up.
- On a technological level, failure of automated systems to provide complete and accurate criminal histories may impact the capacity for relevant decision-makers with the criminal justice system to effectively access and manage offenders. Therefore, it is necessary to use the technology available and develop an innovative system that allows the exchange of relevant information between appropriate agencies.
- Referral of victims back and forth between law enforcement and prosecution may be a contributing factor to lethality. Another method of creating a "seamless system" is to develop mechanisms for appropriate referral of victims once critical issues have been responded to by the referring agency.

What changes in policy or procedure (if any) were made as a result of your reviews?

a) **Where did they occur?** See below.
b) **How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?** See below.

- Advocate Training and Treatment's (ACTT) domestic violence awareness campaign: "Silence isn't Golden Anymore," was inspired by the DV Review Team's most prevalent findings that in most cases, family and/or friends were aware of domestic violence existing in the relationship.
- Instituting lethality training within the justice system and associated community social service agency providers.

- Awareness regarding lethality indicators developed by the DV Review Team has motivated law enforcement to develop initiatives that call for the assessment of lethality in domestic violence offenses.
- The review process encouraged the local DCF department to increase training to Child Protective Investigators in the area of domestic violence.
- Team members are now vested in the fatality review process and provide input to their respective agencies on intervention strategies.

What changes in law, policy or procedure (if any) do your team recommend for consideration at the state level?

- Domestic violence-specific referrals should be contemplated and made by Florida Department of Children and Families where appropriate, with an expedited response, as opposed to general familial referral sources.
- Applicants applying for state financial assistance, whether cash assistance or food stamp assistance, should be screened for domestic violence and/or child abuse to determine eligibility for special services.
- Law enforcement agencies should prioritize investigation of misdemeanor domestic violence-related offenses.
- Law enforcement agencies should include dating relationships, where the parties are not living together, within the purview of cases handled by their specialized domestic violence units, in accordance with the new injunction statute, effective January 1, 2003, which recognizes dating relationships as qualifying for an order of protection with the same criteria as regular domestic violence cases.
- It is believed that when there is domestic violence in families, children are aware of the violence, in addition, it is believed that children may be most effective in encouraging victims to leave the abuse relationship. Therefore, a major finding is that domestic violence awareness and prevention should be implemented in all schools at all grade levels.
- School personnel should be trained to screen for domestic violence and child abuse and should be trained to call the child abuse hotline when abuse is found.
- Certain factors are seen in children belonging to abusive families (acting out, withdrawal, excessive school absences). Once these behaviors are seen in certain children, further investigation by teachers and administrators should be initiated.
- Those children that witness one parent kill the other, either visually or by earshot, or become orphaned as a result of domestic homicide, should be followed by the school to ensure proper attention is given to the child.
- Children under the age of 2 years are at greatest risk for death due to abuse or neglect. As such, perhaps the abandoned baby law would best be amended to include all infants.

Additional comments or concerns.

It has been our experience since undertaking the establishment of a multi-disciplinary child death review process, considering the comprehensiveness of our operating protocols, that this is extremely labor-intensive work, and that adequate funding is essential to accomplishing our work at maximum effectiveness and in totality. Currently, although we are the only team statewide which has received funding from our local government to support the death review process, a large part of our resources are also devoted to the operations of our domestic violence fatality review process.

MIAMI-DADE COUNTY – History

N/A

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

DUVAL COUNTY FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

Duval County has had a significant decrease in the number of domestic violence homicides in the past three years due to improved community collaboration. The committee noted several mental health issues involving batterers without significant intervention. The committee found batterers were not always mandated to attend state certified batterer's intervention programs, and ninety percent of the children who witnessed domestic violence received no intervention.

What changes in policy or procedure (if any) were made as a result of your reviews?

It is too soon for changes from this review. As a result of previous reviews, there has been increased collaboration by agencies and other community partners who provide specialized services to victims of domestic violence and who have required increased accountability for batterers.

a) **Where did they occur?**
   The criminal and civil justice system
b) **How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?**
   Through collaborative committees, interagency agreements, memorandums of understanding, and changes to written policy and procedures.

What changes in law, policy or procedure (if any) do your team recommend for consideration at the state level?

Increased funding for domestic violence issues. Mandated judicial training,
stricter laws requiring batters to be sentenced to a certified batterer's intervention program.

Additional comments or concerns.

Funding should be provided for the domestic violence fatality review teams. The state level submission form should be simplified.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM HISTORY

DUVAL COUNTY FATALITY REVIEW TEAM

Agency representation (type of agencies)

State Attorney's Office, Hubbard House, INVEST, Jacksonville Sheriff's Office and the Salvation Army.

Number of members:

Team consists of six members.

How long has team been meeting?

The team has been meeting for seven years.

Open or closed meeting (why)?

Closed meetings are held because of confidential information from case files.

Where are the meetings held and what time?

The meetings are held on the second Wednesday of each month at 10:00 am.

Types of cases reviewed (why)?

Domestic Violence Homicides of victims over the age of 18 years old. There is a child death review team in Duval County.

Greatest benefits derived from reviews?

Efforts to prevent domestic violence homicides.

Are you funded and if not why keep going?

No funding but will keep going because committee is dedicated.

Would team be interested in writing up a composition of team for annual report?

If requested.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

ESCAMBIA COUNTY FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

The team continues to find that, in many cases, the victim never received or requested services from the courts, law enforcement or victims' advocate centers. This was the case, even though there may have been relatives, friends, and/or neighbors who were aware of problems between the victim and their assailant. In other cases there seems to be no prior history or indication that there was a problem of domestic violence within a relationship and it is surprising that no one realized problems existed that would escalate to a point that a fatality would occur.

What changes in policy or procedure (if any) were made as a result of your reviews?

None. Because this team reviews only closed files, we have found that many of the practices and policies that the team would recommend have already been adopted by law enforcement agencies due to an increased awareness on their part and changes in the laws that affect victims of domestic violence.

a) **Where did they occur?**
N/A

b) **How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?**
There has been informal communication between some members of the team concerning the gathering of information and importance of getting that information in cases where domestic violence is a factor.

What changes in law, policy or procedure (if any) do your team recommend for consideration at the state level?

At both the state and local level, greater publicity and advertising would increase awareness of services that are available to victims of domestic violence.

DOMESTIC VIOLENCE FATALITY REVIEW
TEAM HISTORY

ESCAMBIA COUNTY FATALITY REVIEW TEAM

Agency representation (types of agencies)

State Attorney, Victim's Advocate (Favor House), Court Administration, Clerk of the Circuit Court, Community Corrections, Law Enforcement (Sheriff) and Department of Children and Families. While the Medical Examiner continues to provide information when needed, his schedule prevents him from attending the meetings.

Number of members:

Team consists of seven members.

How long has team been meeting?

Team has been meeting since January 2000.

Open or closed meeting (why)?

Open

Where are the meetings held and what time?

Every first and third Tuesday of the month @8:30 a.m. in a conference room within the M.C. Blanchard Judicial Building, usually at the Court Administrator's offices.

Types of cases reviewed (why)?

All types of domestic violence situations on closed cases. Closed cases are reviewed in order to avoid any ramifications to pending actions on open court files.

Greatest benefits derived from reviews?

Liaison between the agencies involved.

Are you funded and if not why keep going?

No. To provide answers on the review form that will lead to a greater understanding in the prevention of deaths from domestic violence.

Escambia County Team History – continued

Would team be interested in writing up a composition of team for annual report?

N/A

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

LEE COUNTY FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

In almost all of our cases, family and friends were very aware of the violence. And in almost all of the cases the victims did not reach out to community services or the legal system.
Our team has also found that Lee County lacks in Mental Health facilities and after care.
There is still great need for community education on the issue of domestic violence.
For our cases alcohol was not always a factor in the deaths.

What changes in policy or procedure (if any) were made as a result of your reviews? None

> **a) Where did they occur?** None
> **b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?** None

What changes in law, policy or procedure (if any) does your team recommend for consideration at the state level?

More funding for Mental Health Programs and Domestic Violence.

Additional comments or concerns.

Lee County has also reviewed Near Fatalities. With these cases we have been able to obtain more information of what needs to be changed or improved.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM HISTORY

LEE COUNTY FATALITY REVIEW TEAM

Agency representation (types of agencies)

Abuse Counseling and Treatment (DV Shelter), Cape Coral Police Department, State Attorney's Office, Ft. Myers Police Department, Medical Examiner's Office, Hope Hospice, Department of Health, AIM Target (Batterer's Program), Lee Memorial Hospital, Court Administration, Office of Attorney General – Lee Representative (DV Division)

Number of members:

Team consists of 22 members.

How long has team been meeting?

Team has been meeting since 1999.

Open or closed meeting (why)?

Open meetings.

Where are the meetings held and what time?

Third Thursday of the month at 9:00 am – 11:00 am, at the Old Lee County Courthouse.

Types of cases reviewed (why)?

Lee County has chosen to review homicides – manslaughter and homicide/suicides of adults and some children. Case must be of a domestic relationship. We have also reviewed near fatalities.

Greatest benefits derived from reviews?

Community involvement on wanting to educate about Domestic Violence.

Are you funded and if not why keep going?

No funding. Community involvement is very strong. The willingness to want to see what can be done so that there are no more fatalities.

Lee County Team History – continued

Would team be interested in writing up a composition of team for annual report?

N/A

Additional miscellaneous information.

Lee County has found a lot of benefit of reviewing near fatalities. With these cases they have more information, especially victim input of what kinds of services and types of domestic violence incident are reported and unreported. And what may have been of help to the victim.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

PALM BEACH FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

All cases had relationships in some state of separation. Family and friends knew of the 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 one case of assistance in applying for restraining orders, according to the documentation obtained by the Team. Two cases involved child witnesses to the fatality.
There were various methods used to commit the fatalities. One case involved strangulation, three cases involved stabbings, four cases involved guns, and one case involved a blunt instrument. The majority of the cases involved the use of a gun to commit the fatality.
One case involved problems with obtaining and enforcing orders of protection.
All of the cases reviewed had different ethnic backgrounds and consisted of culturally different perspectives. In the majority of the cases law enforcement had responded to the residence for a domestic incident prior to the fatality and most had occurred within 48.

What changes in policy or procedure (if any) were made as a result of your reviews?

The Palm Beach County Health Department has declared domestic violence a public health issue, in which agencies around Palm Beach County have signed a Resolution in which community entities acknowledge their support for the Resolution and will work together collaboratively to prevent future domestic violence fatalities.

a) **Where did they occur?**
The Team has provided in-depth domestic violence training to the Behavior Health Specialist of the Palm Beach County Health Care District. This training is provided to the elementary school social workers that work in the school district of Palm Beach County.

b) **How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?**
N/A

All participating agencies of the Team do agency internal and external trainings to various organizations and agencies to provide information on the Team's findings.
The Team has responded to local newspapers in response to insensitive articles written on domestic violence cases. These responses are written to educate the editors and readers on the dynamics of domestic violence that contribute to domestic violence fatalities.
Surviving family members have been linked with needed services as a result of the work of the Team.

Palm Beach Team Summary – continued

What changes in law, policy or procedure (if any) do your team recommend for consideration at the state level?

Recognizing the habitualization of convicted domestic violence perpetrators. This is taking into account any pre-trial diversion programs for domestic violence. Increase funding so the domestic violence fatality review teams can have support staff in this important endeavor. Increase funding to mandate local law enforcement to employ a victim advocate in every law enforcement agency.

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.
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.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM HISTORY

PALM BEACH COUNTY FATALITY REVIEW TEAM

Agency representation (types of agencies)

Local law enforcement agencies, State Attorney's Office, Health Department, Medical Examiner's Office, Victim Services, Department of Children and Families (DCF), Shelters, Public Defender's Office, Batterer's Intervention Program, Attorney General's Office, Clerk of the Court, Court Administration.

Number of members:

Team consists of 27 members.

How long has team been meeting?

The team has been meeting since October 1998 and reviewed its first case in January 1999.

Open or closed meeting (why)?

The team meetings are closed to ensure the confidentiality of the cases being reviewed.

Where are the meetings held and what time?

We meet the third Tuesday of each month from 1:00 pm to 4:00 pm at the Department of Children and Families (DCF).

Types of cases reviewed (why)?

The team reviews only closed cases for confidentiality. These cases may be homicide/suicide or homicides. These cases have exhausted all judicial review including appellate review.

Greatest benefits derived from reviews?

To be able to present to the local community the Team's findings in order to prevent future deaths.

Palm Beach Team History – continued

Are you funded and if not why keep going?

Currently, the Team does not have funding, but we have applied for two grants to obtain a part-time staff person. The Team is all in agreement of the importance of these case reviews. We have all decided to continue reviewing fatalities whether funding is obtained or not.

Would team be interested in writing up a composition of team for annual report?

N/A

Additional miscellaneous information.

The Team will contact surviving family members/friends when doing so would assist or benefit the review process on a case-by-case basis. Before the Team reviews the case, the Team will send a letter notifying the family members that the case will be reviewed and provide a contact name and phone number for the family member to contact with any additional information they wish to provide the Team for the review process.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

PINELLAS COUNTY FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

Trends: Firearm involvement, substance involvement, separation issues, age difference and family and friends knowing about abuse. Need for continued education in community regarding how to help someone in an abusive relationship.

What changes in policy or procedure (if any) were made as a result of your reviews?

All of the changes are informal in that specific people in our community made decisions to operate differently based upon the Fatality Review Team findings and discussions.
A homicide detective in a local police department shared that she asks more questions about domestic violence history when doing any homicide investigation. This change in practice came about from discussions and questions raised during our reviews. Domestic violence center staff/volunteers who staff the courthouse where injunctions for protection are filed are making extra efforts to discuss danger and lethality issues with petitioners who file for repeat violence or dating violence injunctions. As the victim advocate unit supervisor at our local Sheriff's Department reviews reports and sees red flags identified in our reviews, she directs one of her staff to call the victim immediately to assess safety. Local outreach education programs incorporating comments about red flags as they discuss relationships. Also encouraging people to consider new partner's past (domestic, criminal, violent) before committing to that individual.

a) Where did they occur?
Various agencies
b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
Informally

What changes in law, policy or procedure (if any) does your team recommend for consideration at the state level?

Creation and continuation of funds to provide outreach to general public about what to do if a friend or family member is in an abusive relationship.

Additional comments or concerns.

Examining near fatality cases has provided a wealth of information, which may not be present in fatality cases. We encourage teams to consider reviewing near fatalities in addition to fatalities.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM HISTORY

PINELLAS COUNTY FATALITY REVIEW TEAM

Agency representation (types of agencies)

Our Team consists of members from Law Enforcement, Domestic Violence centers, Probation, Clerk's Office, Medical Examiner's Office, Child Protection, Department of Children and Families, Health Department, Batterer's Intervention Provider, Veteran's Affairs, Elder/Aging, State Attorney's Office, Administrative Office of Courts/Judges, Guardian Ad Litem, Social Service Agency.

Number of members:

Team consists of 24 members.

How long has team been meeting?

Team began meeting in May of 2000.

Open or closed meeting (why)?

Our meetings are closed to protect confidentiality, and to create ease for members to discuss anything related to the case.

Where are the meetings held and what time?

We meet every other month (February, April, June, August, October and December) on the first Thursday between 9:00 am and 11:00 am.

Types of cases reviewed (why)?

We review homicides, homicide/suicides and near fatalities. Each gives us valuable information and insight into the relationship – hope to prevent through reviews.

Greatest benefits derived from reviews?

Relationship building among agencies, identification/validation of already identified red flags

Pinellas County Team History – continued

Are you funded and if not why keep going?

We do not have funding but will continue to function because we feel it is valuable to the community and enables us to recommend actions to save lives.

Would team be interested in writing up a composition of team for annual report?

N/A

Additional miscellaneous information.

Contemplating reviewing domestic related suicides but find them difficult to identify.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

POLK COUNTY FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

N/A

What changes in policy or procedure (if any) was made as a result of your reviews?

We found that the homicides we reviewed were not preventable. However, in some of the cases a person or persons knew of the threats and did not report them to anyone.

a) **Where did they occur?**
N/A

b) **How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?**
N/A

What changes in law, policy or procedure (if any) does your team recommend for consideration at the state level?

N/A

DOMESTIC VIOLENCE FATALITY REVIEW TEAM HISTORY

POLK COUNTY FATALITY REVIEW TEAM

Agency representation (types of agencies)

Court Administration, Clerk of Courts, County Probation, State Attorney's Office, Medical Examiner's Office, Department of Juvenile Justice, Domestic Violence Shelter, Department of Children and Families, Polk County Sheriff's Office, Polk County School Board, Winter Haven Police Department.

Number of members:

Team consists of 14 members.

How long has team been meeting?

Team has been meeting for three years

Open or closed meeting (why)?

Closed. Our meetings are closed in order to maintain confidentiality.

Where are the meetings held and what time?

Meetings are usually held in the Polk County Courthouse in Bartow, Florida, on the 3rd Thursday of each month.

Types of cases reviewed (why)?

See below

Greatest benefits derived from reviews?

Reviews provide an on-going dialogue regarding current processes and recommendation for improving issues relating to domestic violence incidents.

Are you funded and if not why keep going? No funding is available. To keep lines of communications open among agencies.

Polk County Team History – continued

Would team be interested in writing up a composition of team for annual report?

The Polk County Fatality Review Team met for the first time on March 15, 2000. The committee adopted a protocol for conducting fatality reviews, established some important guidelines, and created a mission statement. The team elected a chairperson and a recording secretary but no formal laws were written. Team members agreed to handle cases in the following manner: 1) Once a fatality has been identified to be appropriate for review, each member of the multi disciplinary team gathers information available to them. Each member brings pertinent information from their specific area of expertise to the next meeting of the Fatality Review Team. 2) All members of the team participate in answering the questions included on the Florida Department of Law Enforcement's Florida Domestic Violence Fatality Review Team Data Submission Form. 3) In addition to submitting information to FDLE, the team discusses and evaluates the data with the objective of reinforcing best practices, identifying possible gaps in the system and generating ideas for improving the communities' response to domestic violence incidents. Information is disseminated to others through reports at the Domestic Violence Task Force meetings. 4) The committee agreed to follow the definition of "family or household member" contained within the Florida statutes in determining which cases could be investigated. 5) It was determined that no investigations would be done on fatalities that have open investigations. 6) The team investigates the fatality using a team approach. Information is brought before the team, discussed, adopted by the committee in whole before dissemination of any report. 7) The team reviews cases pursuant to Florida Statute 741.316, and uses the standard form developed by the Florida Department of Law Enforcement. 8) Any report made by the fatality committee is presented to the Domestic Violence Task Force for dissemination. The Fatality Review Committee (Team) was institutionalized by resolution of then Chief Judge, the Honorable Charles B. Curry. During the past three years Polk County's Fatality Review Team has reviewed ten fatalities that occurred in Polk County. These fatalities were selected by consensus of Fatality Team members from a list provided by the Tenth Circuit's State Attorney's Office.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

SARASOTA COUNTY FATALITY REVIEW TEAM

What are the most significant findings from your review(s)?

Therapy and couples counseling is contradictory. Certified Batterers Intervention Programs are the only appropriate sentence. In some cases victims had contact with systems many times but variables such as alcoholism, drug abuse, and mental illness prevented effective assistance.

What changes in policy or procedure (if any) were made as a result of your reviews?

Changes have not been made yet, SPARCC met with Assistant State Attorney to review cases to ensure compliance with Governors Task Force Minimum Standards

a) **Where did they occur?**
N/A

b) **How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?**
N/A

What changes in law, policy or procedure (if any) do your team recommend for consideration at the state level?

While on Probation, Defendants must remain continuously enrolled in Certified Batterer's Intervention Programs. If they fail to comply it should be an immediate Violation of Parole.

Additional comments or concerns.

Our recommendations are not happening yet.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM HISTORY

SARASOTA COUNTY FATALITY REVIEW TEAM

Agency representation (types of agencies)

The team is composed of representatives from Sarasota, Manatee and DeSoto County Sheriffs' Departments, Sarasota Police Department, Sarasota County Examiner's Office, Department of Children and Families, Sarasota County Government, the State Attorney's Office, the Public Defender's Office, Manatee and Sarasota County Domestic Violence Agencies.

Number of members:

Team consists of 13 members.

How long has team been meeting?

The team has been meeting since January 2000.

Open or closed meeting (why)?

The meetings are closed. We do not want media/others to change our focus. This input from agency representatives could be misinterpreted as blaming. We also want to protect the confidentiality of client records.

Where are the meetings held and what time?

The meetings are held at SPARCC (Safe Place and Rape Crisis Center), 2139 Main Street, Sarasota, Florida. Meetings are quarterly on Wednesdays at 3:00 PM.

Types of cases reviewed (why)?

The team reviews closed domestic violence related homicide cases because we are able to access all records when the case is closed. Important team members such as the prosecuting attorney cannot be involved in the review if the case is open.

Greatest benefits derived from reviews?

The greatest benefits of the reviews are identification of problem areas and enhanced coordination of systems.

Sarasota County Team History – continued

Are you funded and if not why keep going?

The team is not funded. Meeting costs are born by Domestic Violence Center. Costs are minimal. Identification of problem areas and enhanced coordination of systems is critical.

Would team be interested in writing up a composition of team for annual report?

N/A

Appendix B

Profile of Data from 60 Domestic Violence Fatality Team Reviews Submitted to FDLE for 2002

Profile of Data

Date of Fatality	Decedent(s)	Perpetrator(s)	Decedent's Relationship to Perpetrator	Cause of Death	DV History
10/30/2000	White Female age 46	White Male age 52	Ex-Girlfriend	Gunshot	No
01/20/2001	Black Female age 23	Black Male age 25	Ex-Girlfriend	Gunshot	Yes
12/28/2000	White Female age 56	White Male age 50	Ex-Girlfriend	Gunshot	Yes
12/22/2000	Black Female age 24	Black Male age 21	Girlfriend	Stabbing	Yes
05/15/2000	White Female age 71	White Male age 72	Spouse	Stabbing	Unk
10/15/2000	White Female age 48	White Male age 41	Co-habitant	Stabbing	Yes
11/06/2000	Black Female age 26	Black Male age 43	Spouse	Strangulation	Unk
05/22/2001	White Female age 49	White Male age 53	Co-habitant	Gunshot	No
03/10/2000	White Female age 80	White Male age 39	Parent	Stabbing	Unk
05/22/1997	White Female age 48	White Female age 17	Parent	Stabbing	No
08/30/1997	White Male age 53	Asian/ Male age 32 Pacific Islander	Parent	Stabbing	No
10/24/1995	White Male age 20	White Male age 58	Child	Gunshot	Yes
03/24/1996	White Female age 37	White Male age 39	Spouse	Gunshot	Yes
07/11/1994	White Male age 71	White Male age 33	Parent	Blunt Trauma to head	No
07/11/1994	White Female age 72	Same perpetrator as above	Parent	Blunt Trauma to head	No
06/04/1996	White Female age 32	White Male age 34	Spouse	Gunshot	Yes
02/15/2002	White Female age 36	White Male age 26	Spouse	Strangulation	No
10/07/2001	White Female age 43	White Male age 39	Co-habitant	Gunshot	No
06/06/2000	Black Female age 37	Black Male age 40	Ex-spouse	Gunshot	Unk
10/08/2000	White Female age 42	White Male age 44	Ex-spouse	Gunshot	Yes
10/08/2001	White Female age 35	Unknown Male age 56	Spouse	Gunshot	Yes
05/04/2001	Black Female age 48	Black Male age 50	Spouse	Gunshot	No
10/21/2001	White Female age 75	White Male age 78	Spouse	Gunshot	Yes
01/02/2001	White Female age 61	White Male age 60	Spouse	Gunshot	No
01/02/2001	White Female age 81	Same perpetrator as above	Parent	Gunshot	No
07/22/2002	White Female age 23	White Male age 21	Sister	Gunshot	No
07/22/2002	White Female age 44	Same perpetrator as above	Parent	Gunshot	No
07/22/2002	White Female age 16	Same perpetrator as above	Girlfriend	Gunshot	No
09/08/1995	White Female age 29	White Male age 33	Spouse	Blunt Trauma to head	Unk
09/19/1994	White Female age 34	White Male age 48	Ex-spouse	Gunshot	Unk
09/30/1998	White Male age 41	White Female age 39	Ex-spouse	Gunshot	No
04/18/1992	White Female age 56	White Male age 58	Spouse	Gunshot	No
01/23/1991	White Female age 29	White Female age 36	Co-habitant	Stabbing	No
04/12/1995	White Female age 38	White Male age 44	Spouse	Gunshot	Yes
10/26/1999	Black Female age 50	Black Male age 42	Spouse	Stabbing	Yes
03/05/1997	Black Male age 37	Black Female age 30	Co-habitant	Stabbing	No
09/07/1998	Black Female age 23	Black Male age 33	Girlfriend	Gunshot	Yes
01/10/1998	White Female age 26	White Male age 37	Spouse	Strangulation	Yes
07/29/1994	White Female age 23	White Male age 23	Girlfriend	Stabbing	Unk
08/07/2002	White Female age 33	White Male age 37	Co-habitant	Gunshot	No
01/18/2002	Black Female age 28	Black Male age 29	Ex-girlfriend	Gunshot	No

07/24/2002	White Female age 35	White Male age 48	Ex-girlfriend	Gunshot	Yes
07/24/2002	White Female age 16	Same perpetrator as above	Other known(child of girlfriend)	Gunshot	No
07/24/2002	White Male age 49	Same perpetrator as above	Other known (boyfriend of ex-girlfriend)	Gunshot	No
08/30/2002	White Female age 42	White Male age 51	Co-habitant	Stabbing	Yes
04/16/2002	White Male age 79	White Male age 55	Parent (step-parent)	Gunshot	Unk
08/12/1999	White Female age 38	White Male age 39	Spouse	Stabbing	Yes
07/16/1998	Black Male age 23	Black Female age 37	Boyfriend	Stabbing	Yes
09/27/2002	White Female age 43	White Male age 54	Spouse	Gunshot	No
09/17/2002	White Female age 35	White Male age 36	Spouse	Gunshot	No
11/25/1997	White Female age 9 months	White Female age 58	Other known(child of son's girlfriend)	Blunt trauma to head	No
11/09/1997	White Male age 72	White Male age 36	Parent	Stabbing	No
03/26/2001	White Female age 78	White Male age 85	Spouse	Gunshot	No
04/10/2002	White Female age 49	White Male age 47	Girlfriend	Gunshot	No
11/02/2002	White Female age 40	White Male age 38	Spouse	Gunshot	Unk
12/31/1998	Black Female age 19	Black Male age 27	Ex-girlfriend	Gunshot	Unk
10/07/1998	White Female age 52	White Male age 45	Girlfriend	Gunshot	No
11/21/1998	Black Male age 51	Black Female age 37	Boyfriend	Stabbing	Yes
03/08/1999	White Female age 42	White Female age 68	Child	Gunshot	Unk
11/07/1996	White Female age 2	White Male age 29	Child	Gunshot	Unk
07/26/2002	White Female age 34	White Male age 37	Girlfriend	Stabbing	Yes
11/04/2002	White Female age 37	White Male 40	Spouse	Strangulation	No
06/23/2000	Black Female age 21	Black Male age 24	Girlfriend	Gunshot	Yes
06/23/2000	Black Female age 2	Same perpetrator as above	Child	Gunshot	Yes
11/13/2000	White Female age 49	White Male age 53	Spouse	Blunt trauma to head	Yes
08/20/2000	White Male age 32	White Female age 30	Spouse	Gunshot	No
07/24/2000	White Female age 52	White Male age 40	Ex-spouse	Blunt trauma to head	Yes

Appendix C

Raw Data From 60 Domestic Violence Fatality Team Reviews Submitted to FDLE for 2002

RAW DATA

The following data is from the cases that were provided to the DVDRC by participating teams. Because the data is from 12 teams covering only 14 counties the reader is cautioned about drawing conclusions from this data.

COMPLAINT INFORMATION

Time Received:

Morning	0053	0151	0211	0237	0242	0318	0404	0529	0545
	0615	0620	0634	0700	0748	0824	0901	1003	1053
	1057	1139	1156						
Evening	1216	1238	1333	1435	1445	1456	1519	1544	1549
	1552	1609	1645	1709	1717	1724	1730	1738	1750
	1800	1826	1845	1917	1930	2015	2115	2134	2138
	2145	2200	2200	2203	2258	2315	2331	2400	

Time Frames:

12:01 A.M. to 06:00 A.M.	9
06:01 A.M. to 12:00 P.M.	12
12:01 P.M. to 06:00 P.M.	19
06:01 P.M. to 12:00 A.M.	16
Unknown	2
No Information	2

Day of Week:

Monday	11
Tuesday	8
Wednesday	8
Thursday	6
Friday	10
Saturday	6
Sunday	5
Unknown	6

Complainant:

Decedent	2
Perpetrator	8
Family member of the decedent	14
Family member of the perpetrator	8
Neighbor	16
Co-worker	6
Acquaintance of decedent	4
Acquaintance of perpetrator	2
Medical Professional	2
Other	8
Unknown	3

Note: There were a total of 73 calls, this was due to multiple complainants.
Other: 1 employer, 1 friend of sister, 1 attorney, 1 building manager, 1 intimate partner, 1 not specified and 2 strangers.

COMPLAINT – continued

Call Received in Relation to Event:

During fatality	13
After fatality	45
No information	2

EVENT INFORMATION

Offense Type:

Homicide	30
Homicide/Suicide	24
Multiple Homicides	5
Multiple Homicides/Suicide	1
Hostage/Homicide	0
Hostage/Homicide/Suicide	0
Hostage/Multiple Homicides	0
Hostage/Multiple Homicides/Suicide	0

Event Type:

Intimate Partner	49
Familicide	0
Parricide	9
Killing the Competition	1
Killing of Children by Parent(s)	6
Suicide Pact	0
Mercy Killing	0
Fratricide and/or Sororicide	1
Perpetrator Kills Batterer	1
Other	0

The category of killing of children by parent(s) includes one event in which the perpetrator killed the child of his ex-girlfriend and one event in which the perpetrator killed the child of her son's girlfriend.

Certified Cause of Death:

Gun Shot Wound	41
Stabbing	16
Strangulation	4
Blunt Trauma to Head	6

Note: Some fatality review reports contained multiple decedents.

Location Type:

Residence of decedent and perpetrator	34
Residence of decedent	12
Residence of perpetrator	4
Residence of other family members	1
Workplace of decedent	3
Other	6

Other: 1 convenience store, 1 rehabilitative center, 1 wildlife refuge, 1 not specified and 2 streets.

EVENT INFORMATION – continued

Children at Scene of Fatality: YES 11 NO 49

Children heard fatal occurrence	7	Children may have heard fatal occurrence	1
Children observed fatal occurrence	6	Children may have observed fatal occurrence	0

Weapon Type:

Handgun	35
Rifle	5
Shotgun	2
Firearm (other/unknown)	2
Knife/cutting instrument	19
Blunt object	5
Fist/feet/hands (beating)	8
Drugs	1
Other	4

Other: Rope, shower curtain tie backs, T-shirt as a rope and concrete stairs.

Multiple weapons by perpetrator: 1) Knife caused death, hands/fists/feet were also used. 2) Handgun caused death, knife was also used, 3) Blunt object caused death, knife, hands/fist/feet and drugs were also used. 4) Hands/fists/feet caused death, Other (T-shirt) was also used, 5) Firearm caused death, knife was also used, 6) Knife caused death, hands/fists/feet also used, 7) Handgun and rifle caused death,
8) Blunt object caused death, hands/fists/feet were also used, 9) Handgun, rifle and shotgun caused death, 10) Handgun caused death, blunt object also used.

Status of Perpetrator:

Arrested	28
At-large	2
Killed by Law Enforcement Officer during arrest	1
Committed Suicide	28
Other	1

Other: Perpetrator killed batterer (perpetrator killed decedent in self defense)

ENVIRONMENT PRIOR TO FATALITY

Custody of Children:

Both had physical and legal custody	2
Unknown as to who had physical and/or legal custody	1
Decedent had physical and legal custody	6
Both had physical and unknown as to who had legal custody	2
Decedent had physical and unknown as to who had legal custody	1
Decedent had physical and both had legal custody	2
Decedent had physical and no information provided as to who had legal custody	1
Perpetrator had physical and both had legal custody	1
Not Applicable	40
No information provided	4

Injunction History of Perpetrator:

Active Injunction	7
Previous Injunction	13
Not Applicable	38
Injunction Denied	1
Unknown	1
No Information	2

Injunction History of Decedent:

Active Injunction	2
Previous Injunction	3
Not Applicable/None	48
Unknown	1
No Information	13

DECEDENT INFORMATION

Sex:

Male	11
Female	56

Marital Status:

Not Applicable (children)	5
Never Married	12
Widowed	4
Married to perpetrator	17
Married to other	7
Separated from perpetrator	6
Divorced from perpetrator	5
Divorced from other	7
Unknown	4

DECEDENT INFORMATION – continued

Race:

Black	14
White	53

Ethnicity:

Hispanic	4
Non-Hispanic	53
Unknown	3
Non-classified	7

Employment:

Employed	36
Unemployed	8
Retired	7
Unknown	12
Not Applicable	4

Criminal History:

Non Violent Crime Arrests	8
Domestic Violent Arrests	4
Other Violent Arrests	4
Not Applicable	51
Unknown	6

Other Related History:

Documented police response to residence	22
Decedent victim of other offenses	11
Previous incidents of domestic violence with different partner(s)	8
History of domestic violence known to other(s)	36

PERPETRATOR INFORMATION

Sex:

Male	51
Female	9

PERPETRATOR INFORMATION – continued

Martial Status:

Never Married	14
Widowed	2
Married to decedent	17
Married to other	1
Separated from decedent	5
Separated from other	0
Divorced from decedent	6
Divorced from other	6
Not Applicable (child)	1
Unknown	8

Race:

Black	13
White	45
Asian or Pacific Islander	1
Unknown	1

Ethnicity:

Hispanic	6
Non-Hispanic	42
Unknown	5
Non-classified	7

Employment:

Employed	26
Unemployed	13
Retired	8
Unknown	13

Criminal History:

Non Violent Crime Arrests	23
Domestic Violent Arrests	17
Other Violent Arrests	13
Not Applicable	23
Unknown	4

PERPETRATOR INFORMATION – continued

Other Related History:

Previous incident of domestic violence with different partners	14
Previous history of suicide attempt	4
Known allegations of stalking	9
Previous participation in batterer's intervention program	1
Previous abuse of drugs	16
Previous use of alcohol	25
Under medication	12
Previous incident(s) of animal abuse	2
Appeared in court for domestic violence offense	12
Domestic violence related charges dismissed against perpetrator	8
History of domestic violence known to other entities	37
Known incidents of prior child abuse	6

PERPETRATOR AS BATTERED VICTIM

Threat to kill perpetrator	5
Threat to commit suicide	1
Other	1

Other: Decedent stalked and harassed perpetrator

PERPETRATOR SUICIDE

Cause of Death:

Gunshot wound	21
Other	7

Other: one strangulation, one carbon monoxide, two stabbings, and three hangings

Suicide Note Left 12
Suicide appear part of homicide 15

RELATIONSHIP ISSUES

Relationship of Decedent to Perpetrator:

Spouse	22	Brother/Sister	1
Parent	9	Co-habitant	7
Girlfriend	8	Ex-girlfriend	6
Child	4	Other known	3
Boyfriend	2		
Ex-spouse	5		

Other known – child of son's girlfriend, competition and child of ex-girlfriend
Parent – one step-parent is listed under parent

RELATIONSHIP ISSUES – continued

Reported Prior Threats Made to Decedent by Perpetrator:

Threat to kill decedent	25
Threat to kill children or family member	7
Threat to commit suicide	9
Other	1

Other: threat to send decedent back to Haiti

Circumstance That Apply to Decedent and Perpetrator's Relationship:

They lived together at some point	42
They lived together at the time of the fatality	31
They were intimate prior to the fatal incident	12
They had a child/children in common	19
They had children in household, but not in common	12
They had previous report incidents of domestic violence	24
They had a significant change in relationship	36
Always maintained separate dwellings	2

CONTRIBUTING FACTORS TO INCIDENT

Priority Rating: (with 1 being the highest and 3 the lowest)

Relationship Factors	**Priority**		
	1	**2**	**3**
Signs of recent sexual intercourse with decedent by other	1	0	0
Signs of recent sexual intercourse with decedent by perpetrator	1	0	0
Decedent and perpetrator in process of separation at time of fatality	5	7	5
Decedent and perpetrator had separated	3	5	2
Perpetrator served with divorce papers	1	1	0
Decedent and perpetrator had divorce finalized	0	1	1
Decedent pregnant by perpetrator	0	1	0
Decedent had started a new relationship	2	2	1
Perpetrator had started a new relationship	0	1	0

Employment/Monetary Factors	**Priority**		
	1	**2**	**3**
Perpetrator had loss of employment, blames decedent	0	1	0

Employment/Monetary Factors	**Priority**		
	1	**2**	**3**
Perpetrator had loss of income blames decedent	1	4	3

CONTRIBUTING FACTORS TO INCIDENT – continued

Criminal Justice Interaction Factors	**Priority 1**	**2**	**3**
Decedent had filed an injunction on the perpetrator	1	0	0
Perpetrator had been served with an injunction	0	1	0
Perpetrator was arrested for domestic violence on decedent	1	0	0
Perpetrator was arrested for domestic violence on another partner	0	0	0

Substance Abuse Factors	**Priority 1**	**2**	**3**
Perpetrator has/had abused drugs	0	0	0
Decedent had/has abused drugs	0	0	1

Perpetrator had/has used alcohol	**Priority 1**	**2**	**3**
Alcohol abuse contributed to fatality	6	2	1

Decedent had/has used alcohol	**Priority 1**	**2**	**3**
Alcohol abuse contributed to fatality	1	4	0

Health/Mental Health Factors	**Priority 1**	**2**	**3**
Perpetrator taking a non prescription medication at time of fatality	0	0	0
Decedent taking a non prescription medication at time of fatality	0	0	0
Medication prescribed for perpetrator at time of fatality	0	1	3
Medication prescribed for decedent at time of fatality	0	0	0
Perpetrator taking prescribed medication at time of fatality	0	0	1
Decedent taking prescribed medication at time of fatality	0	0	0
Perpetrator taking psychiatric medication at time of fatality	0	1	0
Decedent taking psychiatric medication at time of fatality	0	0	0
Perpetrator had/has mental health problems	5	2	2
Decedent had/has mental health problems	0	1	0
Perpetrator attempted to commit suicide prior to fatality	0	1	2
Decedent attempted to commit suicide prior to fatality	0	0	0

Other Factors	**Priority 1**	**2**	**3**
Perpetrator alleged to have committed act to avenge a perceived wrongdoing:			
By decedent	11	5	4
By decedent family member	3	0	1
By other	0	1	0
Immigration status in question pertaining to decedent	0	0	0
Immigration status in question pertaining to perpetrator	0	0	0

CONTRIBUTING FACTORS TO INCIDENT – continued

Other (specify)	**Priority**		
	1	**2**	**3**
Wife (perp) having affair	1	0	0
Decedent intervened in parents DV	0	1	0
Lost status/position in family, church & community	1	0	0
Fear of losing control of life/possibility of going to assisted living/both in bad health	1	0	0
Perpetrator was tired of the abuse and did not want to get beat again	1	0	0
Controlling, abusive, stalking, seemed to have planned shortly after marriage	1	0	0
Perpetrator recent prostitution arrest and decedents reaction to prostitution arrest	1	0	0

ESCALATING CIRCUMSTANCES

The Decedent:

Expressed fear of physical danger to themselves or children	29
Express fear of losing children	2
Isolate themselves from family and friends	8
Had evidence of physical injury	19
Showed frequent signs of	
Depression	4
Anger	11
Low self-esteem	6
Suicidal thoughts	3
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	6
Showed or expressed history of family abuse	9
Expressed fear of being alone	3
Expressed fear of making a great life change	5
Expressed belief that partner would change their behavior	5

The Perpetrator:

Abused the decedent in public	6
Kept tabs on or stalk decedent	19
Put down the decedent's friends and family	13
Told decedent, jealousy is a sign of love	3
Made all decisions in the relationship (including finances)	7
Blamed decedent for abuse	10
Used intimidation	13
Smashed objects, destroyed property	11
Tell decedent their fears about relationship not important	1

SERVICES REQUESTED, ORDERED OR OBTAINED

Domestic Violence Services:

Domestic Violence counseling services	Requested	Received
Decedent	6	6
Perpetrator	0	0

Domestic Violence center	Requested	Received
Decedent	3	3
Perpetrator	0	0

Religious	Requested	Received
Decedent	1	1
Perpetrator	0	0

Children Services	Requested	Received
Decedent	2	2
Perpetrator	0	0

Other

Decedent	0	0
Perpetrator	0	1

Total Domestic Violence Services:

Decedent:	**Requested:**	**12**	**Received:**	**12**
Perpetrator:	**Requested:**	**0**	**Received:**	**1**

Criminal Justice/Legal Assistance:

Law Enforcement:	Requested	Received
Decedent	20	20
Perpetrator	8	10

Legal Assistance/attorney	Requested	Received
Decedent	7	7
Perpetrator	3	4

State Attorney/Prosecutor:	Requested	Received
Decedent	6	6
Perpetrator	1	4

Court/Judges	Requested	Received
Decedent	12	11
Perpetrator	2	7

Family Court	Requested	Received
Decedent	11	9
Perpetrator	7	5

Probation/Parole	Requested	Received
Decedent	2	3
Perpetrator	5	9

SERVICES REQUESTED, ORDERED OR OBTAINED – continued

Other (specify)

	Requested	Received
Decedent	1	1
Perpetrator	0	0

Note: In one case law enforcement was used 5 times, in one case legal assistance/attorney were used 2 and in one case court/judges were used 2 times.

Total Criminal Justice/Legal Assistance
Decedent: **Requested: 59 Received: 57**
Perpetrator: **Requested: 26 Received: 39**

Health Care Provider:

EMT/Paramedics:

	Requested	Received
Decedent	3	2
Perpetrator	3	2

Ambulance service

	Requested	Received
Decedent	3	2
Perpetrator	2	1

Emergency room

	Requested	Received
Decedent	2	2
Perpetrator	1	1

Physician

	Requested	Received
Decedent	3	2
Perpetrator	3	3

Mental Health Clinic

	Requested	Received
Decedent	3	1
Perpetrator	3	2

Mental Health program

	Requested	Received
Decedent	2	1
Perpetrator	3	2

Other:

	Requested	Received
Decedent	0	0
Perpetrator	2	1

Other: Priest

Total Health Care Provider:
Decedent: **Requested: 16 Received: 10**
Perpetrator: **Requested: 17 Received: 12**

SERVICES REQUESTED, ORDERED OR OBTAINED – continued

Children Services:

DCF	Requested	Received
Decedent	3	2
Perpetrator	4	2
Child of decedent	2	1
Child of perpetrator	1	1

Total Children Services: **Requested 10 Received 6**

LETHALITY INDICATORS

Emotional/Mental Deterioration:	Decedent	Perpetrator
Suicidal	3	24
Homicidal	1	34
Loss of function (i.e. not eating, sleeping, working)	2	8
History of psychiatric problems	3	8
Poor compliance with taking medication	2	4
Depression	5	15
Economic loss	3	16
Loss of family support	2	7
No Information provided	52	14

Antisocial Behavior:	Decedent	Perpetrator
History of domestic violence	8	35
History of assaults on other	7	20
History of criminal activity	7	22
History of stalking	1	14
History of substance	10	22
Possession of weapons	3	33
History of abusing children (physically or sexually)	2	4
History of childhood abuse or witnessing violence	2	3
No information provided	43	9

Failure of Community Control:	Decedent	Perpetrator
Violation(s) of restraining order	3	5
Violation(s) of probation	2	4
Arrest(s) for domestic violence	4	8
Fail complete Batterer's Intervention Program	2	0
Failure to complete Substance Abuse treatment	2	0
Failure to complete anger management program	1	1
No information provided	57	44

LETHALITY INDICATORS – continued

Severity of Violence:	Decedent	Perpetrator
Used a weapon	3	41
Death threat	2	26
Unwanted sexual contact	0	1
Strangulation	0	6
Hurt pet	0	1
Severe injury	4	16
Sadistic/Threatening act	0	8
Expressed concerns that she/he would be killed	17	1
No information provided	41	8

Ownership/Centrality of Victim to Perpetrator:	Decedent	Perpetrator
Obsessive about partner or family	2	23
Extreme jealousy	3	24
Access to victim and/or family members	4	29
Rage and/or depression over separation	2	24
Perceived betrayal	7	28
Perceived rejection after attempt to reconcile	1	9
No information provided	56	19

SUMMARY OF REPORTS

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

Yes	36
No	10
Unknown	2
No information provided	12

Entities that had knowledge of the domestic violence:

Law Enforcement	15
Family	31
Acquaintances/Neighbors	11
Friends	18
State/County Agencies	16
Employers	1
Co-workers	5
Military	1
Abuse Centers/Shelters	2
No information provided	14

Appendix D
Section 741.316, Florida Statutes

741.316, Florida Statutes 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.