FLORIDA DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL REPORT 2004

FOREWORD

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 composed of representatives from local law enforcement agencies, State Attorney's Office, Clerk of the Court, Court Administrator's Office, Medical Examiner's Office, Domestic Violence Centers, victim services, batterer's intervention program providers, Department of Children and Families (DCF), shelters, other state agencies, business entities, county probation and corrections, local animal shelter, local clergy, child death review teams and/or other involved parties. The composition varies from team to team.

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, and to publish an annual state-level report.

In 2001, the legislature approved, and Governor Bush signed into law, the "Family Protection Act" which requires a 5-day mandatory jail term for any crime of domestic battery in which the perpetrator deliberately injures 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 requires persons convicted of violent crimes to pay a $201 surcharge to offset the costs of local incarceration and support domestic violence shelters.

In 2002, the legislature approved, and Governor Bush signed into law, Senate Bill 716 (s. 741.28, F.S.) which clarifies 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 eliminates the filing fee for protective orders (s. 741.30, F.S.) and allows certified domestic violence advocates, prosecution, or law enforcement advocates to be present during injunction hearings.

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.

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. Since Fiscal Year 1998-99 funding for domestic violence shelters and their services has increased by nearly eighty percent.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM
2004 ANNUAL REPORT EXECUTIVE SUMMARY

The 2004 annual report contains information from the case reviews of 53 domestic violence incidents which resulted in the death of 60 victims. This report is not meant to statistically represent all domestic violence deaths in Florida. The cases reviewed for this annual report were independently selected by the fatality review team members and occurred during different years. For the reasons noted above, caution should be taken before attempting to generalize or draw conclusions about state policy based on this limited and unscientific sample.

This year the report contains information from the past three years. Due to differing methods of selecting incidents for review and the changing number of fatality review teams the data are not provided as a year-to-year comparison. However, the reader may discern consistencies of patterns when reviewing the data for the three year period.

The data in this report are based on the reviews of 53 cases involving 60 decedents (six of which were children) and 53 perpetrators. Four of the 53 cases reported involved multiple victims (five in one case and two in three cases). Seven of the 53 cases reported involved the use of multiple weapons (three in one case and two in six cases). Firearms accounted for 58% of the weapon types used. Twenty-seven (45%) of the 60 deaths occurred in/at the residence of the decedent and perpetrator. In 28 (53%) of the 53 cases, the parties lived together at time of death. In 23 (43%) of the 53 cases, prior incidents of domestic violence had been reported. Profiles of the perpetrator and decedent are listed below.

Perpetrator

- 46 (87%) were male
- 7 (13%) were female
- 36 (68%) were white
- 17 (32%) were black
- 38 was the average age

Decedent

- 42 (70%) were female
- 18 (30%) were male
- 45 (75%) were white
- 15 (25%) were black
- 37 was the average age

The following data were gathered from the Annual Summary Evaluation Forms that were provided to the FDLE's Domestic Violence Data Resource Center (DVDRC) by the participating Domestic Violence Fatality Review Teams. Other findings, changes and recommendations can be found in Appendix A, where the Fatality Review Teams' individual case reviews are provided. Many of these issues are currently addressed by Florida law.

The following changes were implemented locally by the Domestic Violence Fatality Review Teams based on the cases reviewed for the 2004 reporting period.

- Many of the Fatality Review Teams report continued lethality training with the justice system and associated community social service agency providers throughout the year. Also internal and external training is provided to various organizations and agencies. Another important implementation is that surviving family members are being linked with needed services.
- A Domestic Violence University (DVU) was designed by the Miami-Dade Fatality Review Team. The DVU was implemented to train court personnel in domestic violence issues.
- In Broward County an ad hoc committee created a model policy for first responders.
- A follow-up hearing at 30 and 75 days following the final judgment of the injunction was implemented by Duval County.
- The Orange County Team will start reviewing near fatal cases to enable them to collect more information.
- The Lee County Team will re-establish the Domestic Violence and Sexual Assault Council.
- In Palm Beach County responses are made to newspapers in regard to insensitive articles written on domestic violence cases. This helps educate editors and readers on the dynamics of domestic violence that contribute to domestic violence fatalities.

The following findings were identified by the Domestic Violence Fatality Review Teams based on the cases reviewed for the 2004 reporting period.

- Victims underestimated their risk of injury or death.
- Family members, friends and neighbors knew of the fighting and threats but did not intervene.
- Drugs and alcohol abuse of the decedent and/or perpetrator appear to be the most significant factors directly related to the death occurring in many cases.
- Gunshot wounds were the leading cause of death for domestic violence-related homicide cases.
- The perpetrator often had a history of substance abuse, prior domestic violence, criminal history and/or antisocial behaviors that played a role in the fatal incident.
- The decedent and perpetrator were separated, divorced or in the process of separating at the time of the fatal incident.
- Mental health was a key factor in many cases.
- Over half of the cases had escalating circumstances.

The following recommendations were made by the Domestic Violence Fatality Review Teams based on the cases reviewed for the 2004 reporting period.

- Extend Florida Statute 741.3165 that governs the protection of confidentiality for Fatality Review Teams. This statute will be repealed on October 2, 2005.
- Increase funding for domestic violence issues; e.g., batterer intervention programs in jails and technology for better information sharing.
- Educate doctors on adult/elder abuse and substance abuse of ALL medications.
- Amend Florida law and agency policies to require that all persons assigned to family and domestic violence courts receive annual mandatory specialized training in domestic violence provided by a certified domestic violence trainer.
- Mandate domestic violence education beginning in public schools.
- Mandate judicial training on the dynamics of domestic violence.
- Recommend Statutory sentencing on violations of probation.
- Establish domestic violence courts in each circuit.
- Increase funding to mandate local law enforcement to employ victim advocates in every law enforcement agency.
- Require screening and referral for domestic violence in alcohol/substance abuse treatment programs.
- Focus intervention efforts on repeat families or cases.
- Create a policy for gun accessibility.

The following comments and concerns were expressed by the Domestic Violence Fatality Review Teams based on the cases reviewed for the 2004 reporting period.

- Throughout the years the review process has revealed several system gaps and procedural and/or policy issues that need improvement to provide victim and family safety.
- Community education efforts must include reaching out with tips on how to help victims and/or perpetrators to the friends and families of individuals involved in domestic violence incidents.
- Although there have been many improvements in the response to domestic violence, the budget cuts have affected the court system, school system, mental health and other service providers. These cutbacks will undoubtedly put families at greater risk of harm and eventually lead to greater costs.
- Domestic violence should be considered a public safety concern, and resources should be allocated to ensure proper response in an attempt to be proactive in preventing these incidents, rather than reactive to them.
- Annual training on domestic violence for judges, attorneys, and law enforcement needs to be mandatory for all.
- Begin domestic violence education in public schools.
- Feedback regarding recommendations and allocation of funding to support domestic violence teams would be helpful and encouraging.

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

The 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.

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DOMESTIC VIOLENCE FATALITY REVIEW TEAM
2004 ANNUAL REPORT

This year the report contains information collected from the past three years. FDLE's goal is to accurately report the information provided by the local teams. Due to the differing methods of selecting incidents for review, and the changing number of participating Fatality Review Teams (FRT), the data are not provided as a year-to-year comparison. However, the reader may discern consistencies of patterns when reviewing the data for the three years.

DOMESTIC VIOLENCE IN FLORIDA

According to the Uniform Crime Reports Annual Report, Crime in Florida, a total of 120,697 domestic violence incidents were reported in 2003. Domestic violence accounted for 40% of all comparably reported violent offenses.

Domestic violence accounted for 179 (19%) of the State's 924 murders during the same reporting period. The spouse or live-in partner was the victim in 59% of these offenses. Children accounted for 13% of the victims.

As of May 6, 2004, there were 128,193 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 last six months of 2003, the FDLE's DVDRC staff revised the Florida Domestic Violence Fatality Review Team Data Submission Form based on input and suggestions from the local teams. During the first months of 2004, the DVDRC traveled throughout the state, visiting 13 of the 16 Domestic Violence Fatality Review Teams, including one newly established team in Seminole County. During these visits the DVDRC staff presented the new and revised Florida Domestic Violence Fatality Review Team Data Submission Forms. The original form was reduced from 14 pages to 11, capturing the most pertinent information. Additional forms were created for multiple victims, multiple perpetrators and bystander victims. Teams will begin submitting data on the new forms for cases reviewed in 2004. Yearly visits are planned in order to maintain a close working relationship with the various team members and to provide assistance to newly formed teams.

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 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.

Domestic Violence Fatality Review Team Members

Domestic Violence Fatality Review Teams currently consist of members representing the local law enforcement agencies, State Attorney's Office, Clerk of the Court, Court Administrator's Office, Medical Examiner's Office, Domestic Violence Centers, victim services, batterer's intervention program providers, Department of Children and Families (DCF), shelters, other state agencies, business entities, county probation and corrections, local animal 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 2003, the following counties had active Domestic Violence Fatality Review Teams: Bay County, Brevard County, Broward County, Columbia County (also reporting for Madison, Taylor, Lafayette, Dixie, Hamilton and Suwannee counties), Dade County, Duval County, Escambia County, Lee County, Orange County, Palm Beach County, Pinellas County, Polk County and Sarasota County (also reporting for Manatee and Desoto Counties).

The following 10 teams submitted Domestic Violence Fatality Review Team Data Submission Forms in compliance with Florida Statute s. 741.316 for inclusion in the 2004 annual report. Additionally, these teams provided individual case review information and an overview of the critical findings resulting from the reviews conducted for this reporting period. The team and the number of reviews conducted and submitted are reflected below.

TEAM	REVIEWS
BAY	3
BREVARD	2
BROWARD	5
DUVAL	11
ESCAMBIA	2
LEE	5
ORANGE	6
PALM BEACH	4
PINELLAS	7
POLK	8

The Putnam/Volusia County Review Team and the Collier County Review Team are currently inactive. Due to staffing difficulties, the Sarasota County Review Team was unable to submit data. The Columbia County Review Team is newly established and is still in the process of organizing their team and procedures. Seminole County has begun establishing a Domestic Violence Fatality Review Team as of 2004 and will participate in the 2005 reporting period. The Miami-Dade County Review Team provides only summary information for inclusion in the statewide report.

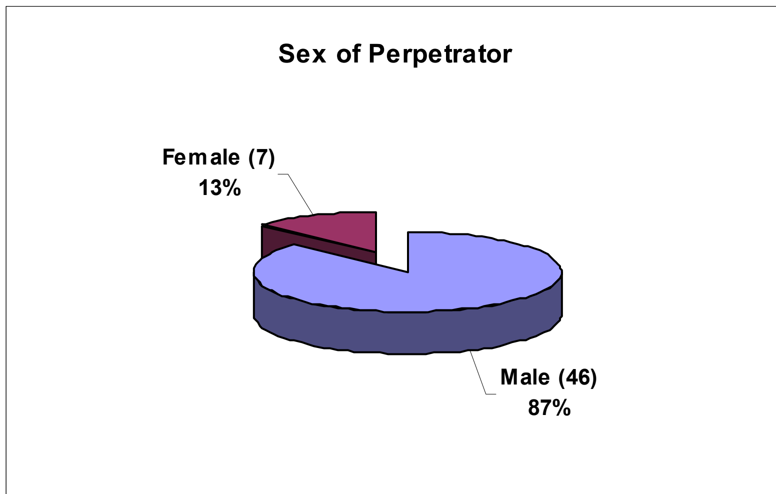
Highlights of the 2004 Domestic Violence Fatality Report

DOMESTIC VIOLENCE DATA REVIEW

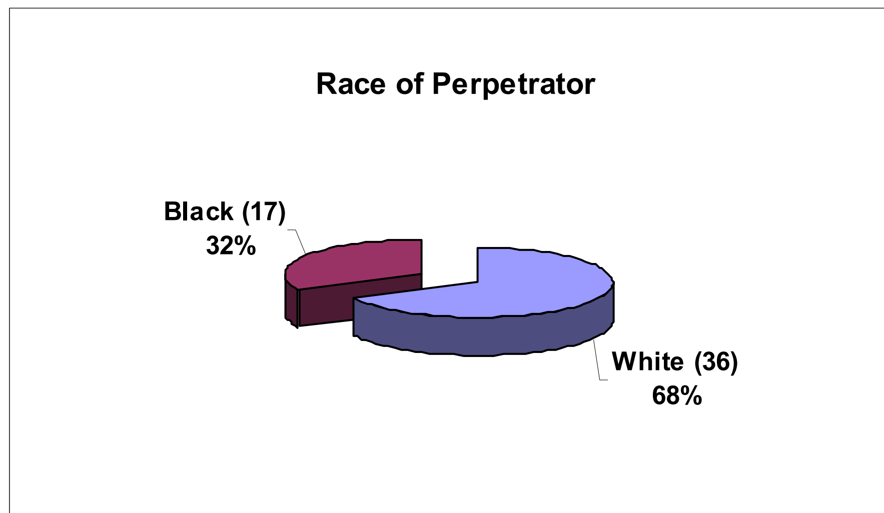
The following data are from 53 cases provided to the FDLE's DVDRC by the participating Domestic Violence Fatality Review Teams. **The cases were not selected based on any specific date, time frame or circumstance. The data are from 10 teams covering only 10 counties, and the number of reviews completed by each team varies. Therefore, the reader is cautioned about drawing conclusions from this data.**

HIGHLIGHTS OF THE 2004 DOMESTIC VIOLENCE FATALITY REPORT

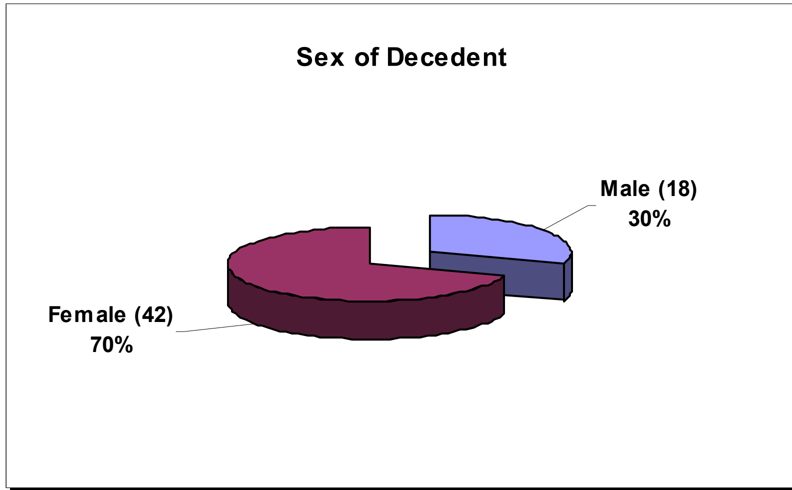
Perpetrator Profile



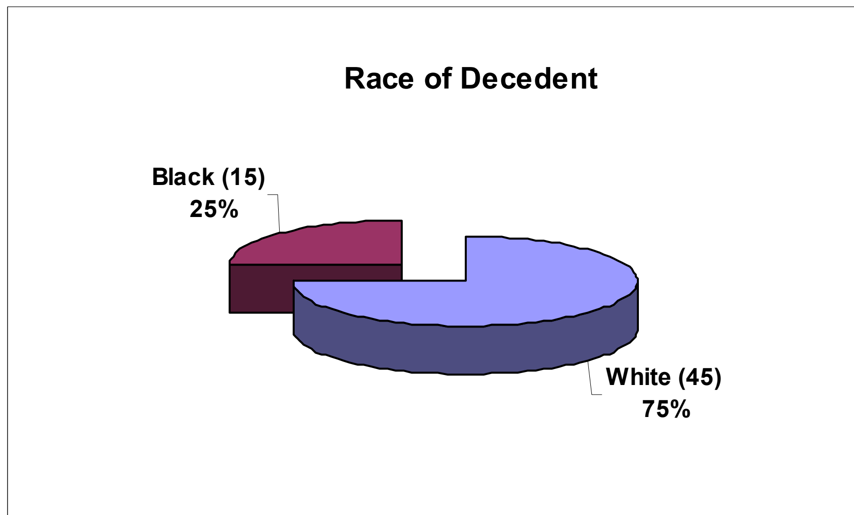
Perpetrator Age	
1-10 years of age	0
11-20 years of age	3
21-30 years of age	13
31-40 years of age	18
41-50 years of age	10
51-60 years of age	5
61-70 years of age	1
71-80 years of age	2
81-90 years of age	1
Average Age	**38**



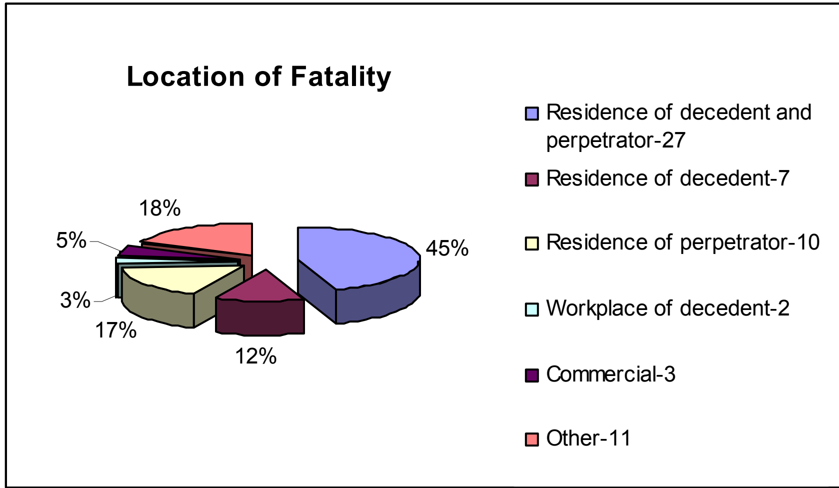
Decedent Profile



Decedent Age	
1-10 years of age	4
11-20 years of age	5
21-30 years of age	13
31-40 years of age	15
41-50 years of age	9
51-60 years of age	8
61-70 years of age	4
71-80 years of age	2
81-90 years of age	0
Average Age	**37**



Location of Fatality

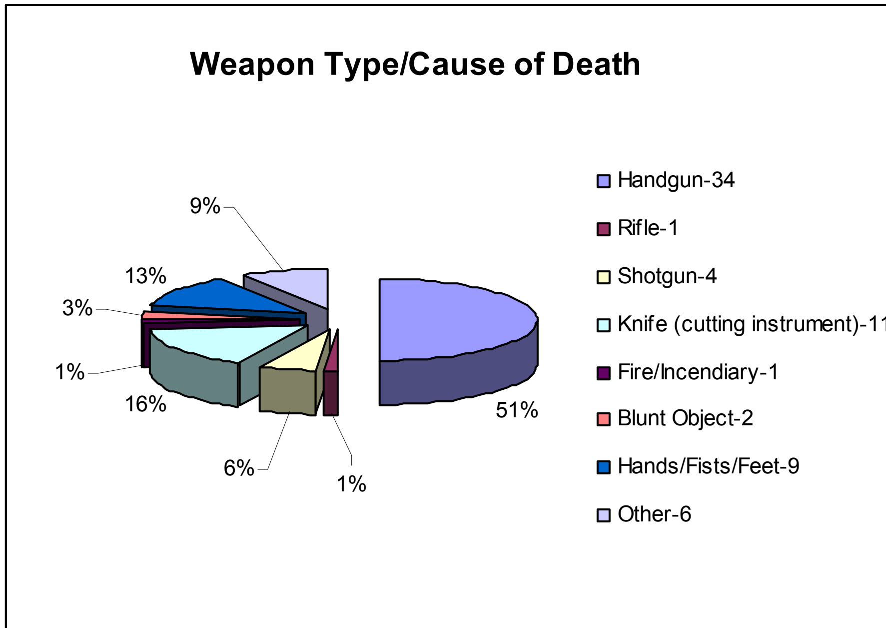


This chart depicts the location of the fatality of each of the **60** victims.

Four of the 53 cases reported involved multiple victims (five in one case and two in three cases) totaling **60** fatalities.

Twenty-seven (51%) of the 53 cases, involving 27 (45%) of the 60 victims, occurred in/at the residence of the decedent and the perpetrator.

Weapon Types

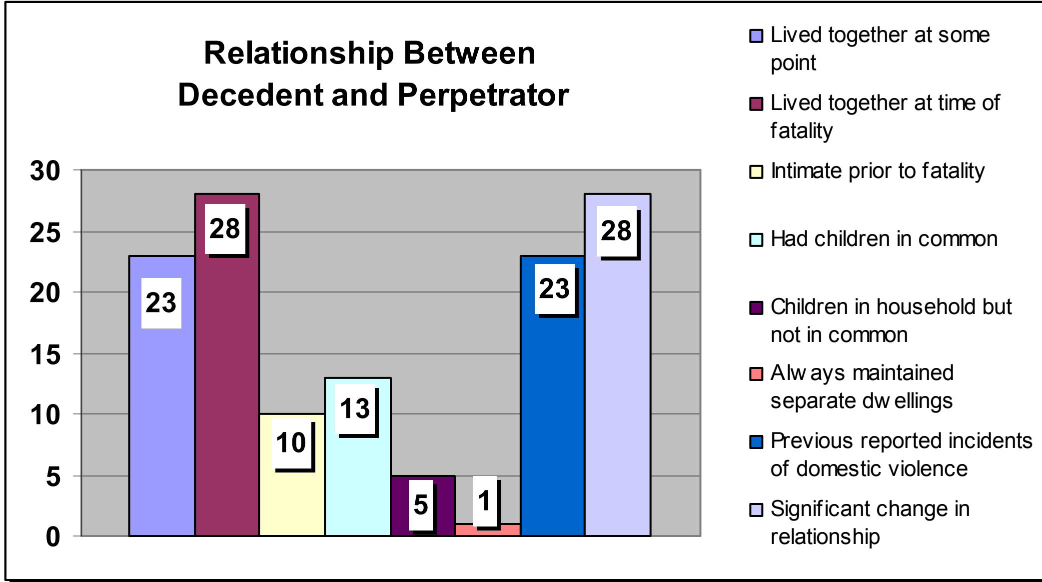


This chart depicts the type of weapon used to carry out the fatality of the 60 victims. Firearms accounted for 58% of the **68** weapon types.

Seven (13%) of the 53 cases reported involved the use of multiple weapons (three in one case and two in six cases) totaling **68** weapons.

"Other" consists of the following items being used as a weapon to carry out the fatality: rope, chain, bed post, statue, glass object. Additionally, one death was a direct result of neglect (habitual lack of care).

Relationship Between Decedent and Perpetrator



****Note: The Relationship Between Decedent and Perpetrator category contains multiple selection fields and the review forms may contain more than one response for this category.***

Highlights of the Domestic Violence Fatality Reports for Years 2002-2004

Highlights of the domestic violence fatality reports reviewed for the years 2002 -2004

The tabulations contained in this table are based on the number of cases submitted for each reporting period.

Due to the use of differing sampling methods the data reflected in the following table are not provided as a year-to-year comparison. However, the reader may discern consistencies of patterns when reviewing the data for the three years.

	2002	**2003**	**2004**
Average Age of Perpetrator	48	42	38
Average Age of Decedent	46	41	37
Sex of Perpetrators	41 (89%) male 5 (11%) female *(there were two perpetrators in one case)*	51 (85%) male 9 (15%) female	46 (87%) male 7 (13%) female
Sex of Decedents	11 (23%) male 36 (77%) female *(there were multiple victims 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)*	18 (30%) male 42 (70%) female *(there were multiple victims in four cases: five in one case and two in three cases)*
Location	35 (78%) of the 45 cases occurred in/at the decedent's residence	34 (57%) of the 60 cases occurred in/at the residence of the decedent and perpetrator	27 (51%) of the 53 cases 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	In 32 (60%) of the 53 cases a firearm was involved in the fatality
Relationship	In 29 (64%) of the 45 cases, the parties lived together at the time of fatality	In 31 (52%) of the 60 cases, the parties lived together at time of fatality	In 28 (53%) of the 53 cases, the parties lived together at the time of fatality
History	In 18 (40%) of the 45 cases, prior incidents of domestic violence had been reported	In 24 (40%) of the 60 cases, prior incidents of domestic violence had been reported	In 23 (43%) of the 53 cases, prior incidents of domestic violence had been reported

Fatality Review Incident Information for Years 2002-2004

THE FOLLOWING SECTIONS CONTAIN SUMMARIES OF DATA SUBMITTED BY THE TEAMS ON THE STATEWIDE FATALITY REVIEW DATA SUBMISSION FORM.

Due to the use of differing sampling methods the summary data in the following sections are not provided as a year to year comparison. However, the reader may discern consistencies of patterns when reviewing the data for the three years.

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

Regarding the **53** domestic violence fatality reports reviewed for the 2004 reporting period, **14 (26%)** of the incidents occurred on Monday, making this the most predominant day. **Over half** of the calls were received during the time frames of **12:01 AM - 06:00 AM** and **12:01 PM – 06:00PM. Thirty-two percent** of the calls were received from a family member of either the perpetrator or the decedent, and **15%** of the calls were received from a neighbor. An acquaintance of the decedent made **14%** of the calls, and the perpetrator of the fatality made **12%** of the calls. **Over half** of the calls were received after the event.

TIME FRAME	2002	2003	2004
12:01 AM to 06:00 AM	3	9	15
06:01 AM to 12:00 PM	8	12	7
12:01 PM to 06:00 PM	12	19	15
06:01 PM to 12:00AM	10	16	13
Unknown	12	4	3
Total	**45**	**60**	**53**

CALL RECEIVED	2002	2003	2004
After Fatality	43	45	36
During Fatality	3	13	17
No information provided	0	2	0

CALL RECEIVED FROM*	2002	2003	2004
Decedent	1	2	1
Perpetrator	11	8	8
Family member of decedent	11	14	12
Family member of perpetrator	6	8	9
Neighbor	0	16	10
Co-worker	0	6	1
Acquaintance of decedent	19**	4	9
Acquaintance of perpetrator	**	2	2
Medical professional	0	2	1
Unknown	0	3	3
Other	11	8	9
Total	**59**	**73**	**65**

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

****Due to data collection methods in 2002 Acquaintance of decedent and Acquaintance of perpetrator were collapsed to the category of Acquaintance for a combined total of 19. For the purposes of this report the 2002 combined total noted above is reflected in the Acquaintance of decedent category.**

Sixty-five telephone calls were received regarding the 53 domestic violence fatality reports reviewed for the 2004 reporting period. This was due to multiple complainants. The category of “Other” consists of: one stranger, one ex-spouse, one landlord, one student, one maintenance worker, one girlfriend of perpetrator, one deputy sheriff, one fire department and one friend.

EVENT INFORMATION - This information is a general overview of the fatality itself from the type of offense, activities, parties involved, weapon, injury types sustained during fatality (both to the decedent and the perpetrator) and the current status of the perpetrator of the offense. This information is available from the law enforcement initial offense or case report.

Of the **53** domestic violence fatality reports reviewed for the 2004 reporting period, there were four cases with multiple victims, resulting in a total of **60** fatalities. Firearms **(39)** accounted for **65%** of the **60** deaths. Over half of the decedents, **57%**, were killed in their own residences.

OFFENSE TYPE	**2002**	**2003**	**2004**
Homicide	27	30	31
Homicide / Suicide	15	24	18
Multiple Homicides	1	5	0
Multiple Homicides / Suicide	1	1	3
Hostage Homicide / Suicide	1	0	0
Hostage Multiple Homicides	0	0	1
Total	**45**	**60**	**53**

There were a total of 60 victims in the 53 incidents reviewed for the 2004 reporting period. For this offense category four fatality review reports reflected that the perpetrator killed multiple victims. The review forms reflected five victims in one report and two victims in three reports.

EVENT TYPE *(OF FATALITIES)*	**2002**	**2003**	**2004**
Intimate partner	40	49	41
Ex-intimate partner	*	*	1
Parricide	1	9	2
Fratricide and/or Sororicide	1	1	0
Killing the competition	2	1	3
Killing of children by parents	3	6	5
Perpetrator kills batterer	0	1	3
Other	0	0	5
Total	**47**	**67**	**60**

***Ex- intimate Partner was captured in the Intimate Partner category in both the 2002 and 2003 reporting periods.**

"Other" comprises the perpetrator killing the following: child of intimate partner, ex-boyfriend, neighbor, and two in-laws.

WEAPON TYPES	2002	2003	2004
Handgun	21	35	34
Rifle	1	5	1
Shotgun	3	2	4
Firearm *(other/unknown)*	0	2	0
Knife /Cutting Instrument	9	19	11
Fire/Incendiary	1	0	1
Blunt Object	1	5	2
Hands/Fists/Feet	8	8	9
Drugs	0	1	0
Other	2	4	6
Total	**46**	**81**	**68**

This category depicts the 68 weapon types used to carry out the fatality of the 60 victims reflected in the 53 reports reviewed for the 2004 reporting period. Seven reports contained multiple weapons (six reflected two weapons and one reflected three weapons) for a total of 68 weapons.

"Other" consists of the following items being used as a weapon to carry out the fatality: statue, glass object, bedpost, rope, chain. Additionally, one death was a direct result of neglect (habitual lack of care).

LOCATION OF FATALITY	2002	2003	2004
Residence of decedent and perpetrator	15	34	27
Residence of decedent	20	12	7
Residence of perpetrator	1	4	10
Residence of other family members	3	1	0
Workplace of decedent	1	3	2
Commercial	0	0	3
Other	5	6	11

Regarding the 53 domestic violence fatality reports reviewed for the 2004 reporting period, "Other" comprises the following locations: three hotel/motel, two residence of friend, one residence of competition, one street, one motor home, one construction site, one hospital and one park.

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 is available from an investigative follow-up report done by the law enforcement agency.

Of the **53** domestic violence fatality reports reviewed for the 2004 reporting period, an active injunction was filed on the perpetrator in **15%** of the cases; previous injunctions had been present in **9%** of the cases and in one case the perpetrator died before injunction could be served. The decedents had **one** active and **one** previous injunction filed at the time of the fatality.

INJUNCTION HISTORY OF PERPETRATOR	2002	2003	2004
Active injunction	5	7	8
Previous injunction	6	13	5
Injunction denied	1	1	0
Expired injunction	1	0	0
Unknown	0	0	1

INJUNCTION HISTORY OF DECEDENT	2002	2003	2004
Active injunction	1	2	1
Previous injunction	0	3	1
Unknown	0	0	3

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

Of the **60** domestic violence fatalities reviewed for the 2004 reporting period, **70%** of the victims were female. The marital status indicated that **14** of the victims were married to the perpetrator. The racial breakdown of the cases reflected that **75%** of the victims were white. A total of **38%** of the decedents were employed at the time of their death. The decedents had **16** non-violent arrests, **8** domestic violence arrests and **four** arrests for other violent crimes. Police had responded to the residence for some reason in **25** cases. The decedent was the victim of another crime **eight** times and had been the victim of previous domestic violence with a different partner **seven** times. In **30** cases, others knew of a history of domestic violence between the decedent and the perpetrator.

Sex
Of the 53 cases reviewed for the 2004 reporting period four had multiple victims resulting in a total of 60 decedents. Of the 60 decedents, 42 were female (70%) and 18 male (30%).

Race
Of the 60 decedents, 45 were white (75%) and 15 were black (25%).

DECEDENT MARITAL STATUS	2002	2003	2004
Never married	9	12	17
Widowed	0	4	2
Not applicable *(child)*	2	5	6
Married to perpetrator	20	17	14
Married to other	0	7	5
Separated from perpetrator	3	6	5
Divorced from perpetrator	2	5	3
Divorced from other	10	7	5
Unknown	1	4	1

DECEDENT EMPLOYMENT STATUS	2002	2003	2004
Employed	28	36	23
Unemployed	8	8	12
Retired	5	7	4
Not applicable (decedent is a child)	3	4	6
Unknown	3	12	13

DECEDENT CRIMINAL HISTORY*	2002	2003	2004
Non-violent crime arrest(s)	10	8	16
Domestic violence crime arrest(s)	8	4	8
Other violent crime arrest(s)	6	4	4
Not applicable (decedent is a child)	0	0	6
Unknown	0	0	1

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

DECEDENT OTHER RELATED HISTORY*	2002	2003	2004
Documented police response(s) to residence	12	22	25
Victim of other offense(s)	12	11	8
Previous incidents of domestic violence with different partner(s)	8	8	7
History of domestic violence known to other(s)	24	36	30

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

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

Of the **53** domestic violence fatality reports reviewed for the 2004 reporting period, **87%** of the perpetrators were male. The marital status indicated that **26%** of the perpetrators were married to the decedent at the time of the fatality. The racial breakdown of the cases reviewed reflected **68%** of the perpetrators were white. A total of **53%** of the perpetrators were employed at the time of the fatality. The perpetrators had **31** non-violent arrests, **21** domestic violence arrests and **19** arrests for other violent crimes. The perpetrator had a previous domestic violence incident with a different partner in **six** cases; in **seven** cases, previous domestic violence charges against the perpetrator were dismissed. Known incidents of prior child abuse were reported in **six** cases. Drugs, alcohol and/or medication were present in **53** of the cases. In **30** of the cases reviewed, other entities had knowledge of domestic violence in the life of the perpetrator.

Sex

There were a total of 53 perpetrators contained in the 53 domestic fatality reports reviewed for the 2004 reporting period. Of the 53 perpetrators 7 were female (13%) and 46 male (87%).

Race

Of the 53 perpetrators, 36 were white (68%) and 17 were black (32%).

PERPETRATOR MARITAL STATUS	2002	2003	2004
Never married	5	14	21
Widowed	2	2	0
Not applicable *(child)*	0	1	0
Married to decedent	20	17	14
Married to other	2	1	1
Separated from decedent	4	5	5
Separated from other	0	0	2
Divorced from decedent	2	6	3
Divorced from other	9	6	7
Unknown	2	8	0

PERPETRATOR EMPLOYMENT	2002	2003	2004
Employed	18	26	28
Unemployed	15	13	10
Retired	7	8	2
Unknown	6	13	13

PERPETRATOR CRIMINAL HISTORY*	2002	2003	2004
Non-violent crime arrest(s)	22	23	31
Domestic violence crime arrest(s)	16	17	21
Other violent crime arrest(s)	13	13	19
Unknown	0	0	2

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

PERPETRATOR OTHER RELATED HISTORY*	2002	2003	2004
Previous incidents of domestic violence with different partner	15	14	6
Previous history of suicide attempt	0	0	5
Known allegations of stalking	9	9	11
Previous participation in batterer's intervention program	0	0	2
Previous abuse of drugs	14	16	18
Previous abuse of alcohol	24	25	28
Under medication	13	12	7
Appeared in court for domestic violence offense	15	12	14
Domestic violence related charges were dismissed against the perpetrator	10	8	7
History of domestic violence known to other entities	25	37	30
Known incidents of prior child abuse	8	6	6
Other	12	7	0

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

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 available from the law enforcement agency's investigative report. There were **three** cases in which the perpetrator killed the batterer.

PERPETRATOR KILLED BATTERER	**2002**	**2003**	**2004**
	0	1	3

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	**2002**	**2003**	**2004**
Gunshot	14	21	18
Hanging	0	0	3
Other	5	7	0
Total	**19**	**28**	**21**

SUICIDE NOTE	**2002**	**2003**	**2004**
Suicide note left	3	12	8
Suicide appeared to be part of the homicide	11	15	15

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

Of the **60** domestic fatalities reviewed for the 2004 reporting period, the victim in **37%** of the fatalities was the spouse or ex-spouse of the perpetrator and in **38%** of the fatalities the victim was either the boyfriend, co-habitant or ex-co-habitant of the perpetrator. Prior threats to kill the decedent occurred in **20%** of the fatalities. Previous incidents of domestic violence had been reported in **38%** of the fatalities. A significant change in the relationship between the decedent and perpetrator had occurred in **47%** of the fatalities.

DECEDENT RELATIONSHIP TO PERPETRATOR	2002	2003	2004
Spouse	23	22	19
Ex-spouse	2	5	3
Parent	1	9	2
Step parent	0	0	0
Child	2	4	5
Step child	1	0	0
Boyfriend	0	2	1
Ex-boyfriend	0	0	0
Child of boyfriend	0	0	0
Brother/Sister	0	1	0
In-law	0	0	2
Co-habitant	9	7	10
Ex-cohabitant	0	0	12
Girlfriend	6	8	0
Ex-girlfriend	0	6	0
Child of girlfriend	0	0	0
Other *(known)*	3	3	6
Total	**47**	**67**	**60**

Regarding the 60 domestic violence fatalities reviewed for the 2004 reporting period, the categories of spouse, ex-spouse, boyfriend, co-habitant and ex-co-habitant made up 75% of the relationships involved in the fatalities.

"Other Known" consists of the following relationships between the decedent and the perpetrator: two competitions, one friend of perpetrator's girlfriend, one neighbor, one ex-boyfriend of wife and one child of girlfriend.

PRIOR THREATS TO DECEDENT BY PERPETRATOR*	2002	2003	2004
Threat to kill decedent	12	25	12
Threat to kill children or family member	2	7	3
Threat to commit suicide	8	9	8
Other	0	1	3

***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.**

Regarding the 53 domestic violence fatality reports reviewed for the 2004 reporting period, the category of "Other" consists of one unknown, one threat to take decedent away from mother and one report reflected threats to wife.

RELATIONSHIP ISSUES*	2002	2003	2004
They lived together at some point	41	42	23
They lived together at the time of the fatality	29	31	28
They were intimate prior to the fatality	10	12	10
They had a child(ren) in common	11	19	13
They had a child(ren) in the household, but not in common	6	12	5
They always maintained separate dwellings	2	2	1
They had previous reported incidents of domestic violence	18	24	23
They had a significant change in the relationship	21	36	28

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

CONTRIBUTING FACTORS TO THE INCIDENT - This information concerns the factors that may have contributed to the violence escalating to the point where a homicide occurred. 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 is 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.

The two major contributing factors to the fatalities identified by the Domestic Violence Fatality Review Teams were: **1)** Decedent and Perpetrator had separated **2)** Perpetrator had/has abused alcohol. In **42%** of the reviewed fatalities, a separation was taking place or had already taken place in the relationship.

Major Contributing Factors To The Fatalities were:

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

1) Decedent and perpetrator had separated – **15** times.
2) Perpetrator had/has abused alcohol - **14** times.
3) Perpetrator alleged to have committed act to avenge a perceived wrongdoing by decedent - **12** times.
4) The category of Other* was reported **11** times.
5) Decedent and perpetrator in process of separation at time of fatality - **ten** times.
6) Perpetrator had/has abused drugs – **nine** times
7) Decedent had started a new relationship and Perpetrator had attempted suicide were each reported **seven** times.

***** Other: Decedent moving to Columbia, South America, thought of abandonment, depressed/suicidal, self-defense, decedent helped perpetrator's girlfriend, terminal cancer, perpetrator angry with decedent, missing debit card, decedent difficult/no support from family, ongoing domestic violence, pending going to jail

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 is 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/or decedent.

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 depression, anger, low self esteem, suicidal thoughts and **3)** have evidence of physical injury.

The three escalating circumstances that occurred most for the perpetrator were: 1) keep tabs on or stalk the decedent**, 2)** abuse the decedent in public **3)** make all the decisions in the relationship *(including finances*).

ESCALATING CIRCUMSTANCES (DECEDENT)*	2002	2003	2004
Express fear of physical danger to themselves and/or children	13	29	22
Express fear of losing custody of children	1	2	3
Isolate themselves from family and friends	10	8	4
Have evidence of physical injury	14	19	10
Exhibit signs of: depression, anger, low self esteem, suicidal thoughts	16	24	21
Express fear of involvement in the criminal justice system process	5	5	0
Show or express signs of sleeping difficulties	1	1	0
Express guilty feelings about the failed relationship	2	6	1
Show or express history of familial abuse	7	9	4
Express fear of being alone	1	3	1
Express fear of making a great life change	4	5	0
Express belief that perpetrator would change and/or stop abusive behavior	6	5	2

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

ESCALATING CIRCUMSTANCES (PERPETRATOR)*	2002	2003	2004
Abuse the decedent in public	7	6	8
Keep tabs on or stalk the decedent	20	19	12
Put down the decedent's friends and family	8	13	6
Tell the decedent, jealousy is a sign of love	6	3	1
Make all decisions in the relationship (including finances)	6	7	8
Blame decedent for abuse	10	10	2
Use intimidation by instilling fear through looks and gestures	13	13	7
Smash objects and destroy property	9	11	7
Tell the decedent their fears about the relationship were not important	0	1	0

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

SERVICES REQUESTED, ORDERED OR OBTAINED - This information relates to the decedents' and perpetrators' interactions with services, legal aid and medical organizations as they 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 **six** prior requests/orders for domestic violence services for decedents and **four** for perpetrators. The review revealed that domestic violence services were provided on **six** occasions for decedents and **two** occasions for perpetrators.

DOMESTIC VIOLENCE SERVICES INCLUDE THE FOLLOWING:

- **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 **45** prior requests/orders for criminal justice/legal services for decedents and **46** for perpetrators. The review revealed that criminal justice/legal assistance was provided on **51** occasions for decedents and **60** occasions for perpetrators. The findings revealed that criminal justice/legal assistance services were provided on more occasions than requested for both the decedent and the perpetrator. *Note: This can occur when services are offered/provided in accordance with a statutory requirement or court order.*

CRIMINAL JUSTICE/LEGAL ASSISTANCE SERVICES INCLUDE THE FOLLOWING:

- **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.

HEALTH CARE PROVIDER FINDING:

Of the cases reviewed, there were **10** prior requests/orders for health care services for decedents and **13** for perpetrators. The review revealed that health care services were provided on **11** occasions for decedents and **13** occasions for perpetrators. The findings revealed that health care services were provided on more occasions than requested for the decedent. *Note: This can occur when services are offered/provided in accordance with a statutory requirement or court order.*

HEALTH CARE PROVIDER SERVICES INCLUDE THE FOLLOWING:

- **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.

CHILDREN AND/OR FAMILY SERVICES FINDING:

Of the cases reviewed, there were **seven** prior requests/orders for children and/or family services for decedents, **three** for perpetrators and **seven** for children of the decedent and/or perpetrator. The review revealed that children and/or family services were provided on **six** occasions for decedents, **three** occasions for perpetrators and **seven** occasions for the children of the decedent and/or perpetrator.

CHILDREN AND/OR FAMILY SERVICES INCLUDE THE FOLLOWING:

- **Department of Children and Family (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 is available through law enforcement investigative reports, possible service agency reports, medical examiner reports, newspaper accounts and personal interviews with persons that knew the perpetrator and decedent.

Decedents' Emotional / Mental Deterioration*	2002	2003	2004
Suicidal	1	3	1
Homicidal	1	1	3
Loss of day to day function	1	2	0
History of psychiatric problems	2	3	2
Poor compliance with taking medication	2	2	1
Depression	4	5	7
Economic loss	2	3	2
Loss of family support	3	2	1

Perpetrators' Emotional / Mental Deterioration*	2002	2003	2004
Suicidal	14	24	24
Homicidal	20	34	26
Loss of day to day function	5	8	2
History of psychiatric problems	10	8	2
Poor compliance with taking medication	4	4	1
Depression	13	15	13
Economic loss	11	16	4
Loss of family support	6	7	3

Decedents' Antisocial Behavior*	2002	2003	2004
History of domestic violence	9	8	9
History of assaults on others	4	7	5
History of criminal activity	4	7	8
History of stalking	0	1	2
History of substance abuse	14	10	15
Possession of weapons	2	3	3
History of abusing children*(physically and/or sexually)*	1	2	2
History of childhood abuse or witnessing violence	1	2	5

Perpetrators' Antisocial Behavior*	2002	2003	2004
History of domestic violence	25	35	30
History of assaults on others	16	20	18
History of criminal activity	18	22	22
History of stalking	11	14	14
History of substance abuse	22	22	31
Possession of weapons	21	33	28
History of abusing children*(physically and/or sexually)*	5	4	6
History of childhood abuse or witnessing violence	2	3	1

Decedents' Failure in Community Control*	2002	2003	2004
Violation(s) of restraining order	0	3	1
Violation(s) of probation	1	2	2
Arrest(s) for domestic violence	6	4	6
Failure to complete batterer's intervention program	0	2	1
Failure to complete substance abuse treatment	1	2	0
Failure to complete anger management program	0	1	1

Perpetrators' Failure in Community Control*	2002	2003	2004
Violation(s) of restraining order	5	5	4
Violation(s) of probation	9	4	6
Arrest(s) for domestic violence	9	8	10
Failure to complete batterer's intervention program	1	0	3
Failure to complete substance abuse treatment	2	0	0
Failure to complete anger management program	0	1	0

Decedents' Severity Of Violence*	2002	2003	2004
Used a Weapon	1	3	2
Death threat	2	2	3
Unwanted sexual contact	1	0	0
Strangulation	1	0	0
Hurt pet	1	0	0
Severe injury	4	4	0
Sadistic / Threatening act	0	0	2
Expressed concerns that she / he would be killed	11	17	11

Perpetrators' Severity of Violence*	2002	2003	2004
Used a weapon	25	41	21
Death threat	9	26	12
Unwanted sexual contact	1	1	2
Strangulation	5	6	4
Hurt pet	0	1	0
Severe injury	6	16	8
Sadistic / Threatening act	3	8	5
Expressed concerns that she / he would be killed	2	1	2

Decedents' Ownership / Centrality of Decedent to Perpetrator*	2002	2003	2004
Obsessiveness about partner or family	**	2	2
Extreme jealousy	**	3	1
Access to victim and/or family members	**	4	2
Rage and/or depression over separation	**	2	0
Perceived betrayal	**	7	2
Perceived rejection after attempt to reconcile	**	1	0

**2002 data not available

Perpetrators' Ownership / Centrality of Decedent to Perpetrator*	2002	2003	2004
Obsessiveness about partner or family	21	23	18
Extreme jealousy	20	24	14
Access to victim and/or family members	20	29	21
Rage and/or depression over separation	14	24	19
Perceived betrayal	21	28	17
Perceived rejection after attempt to reconcile	10	9	11

***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 TEAMS SUMMARY - This portion of the data collection process allows the Domestic Violence Fatality Review Team to summarize their overall findings and recommendations that relate to the specifically reviewed domestic violence fatality. This information is derived from a careful analysis of the information available during the review.

INDICATIONS THAT ABUSE WAS INCREASING	**2002**		**2003**		**2004**	
	VOLUME	**%**	**VOLUME**	**%**	**VOLUME**	**%**
Yes	18	40%	36	60%	29	55%
No	21	47%	10	17%	18	34%
Unknown	6	13%	2	3%	1	2%
No information provided			12	20%	5	9%

ENTITIES WITH KNOWLEDGE OF ABUSE*	**2002**	**2003**	**2004**
Law Enforcement	14	15	26
Family	15	31	28
Acquaintance/Neighbor	14	11	11
State/County	15	16	20
Employer/Co-worker	5	6	2
Abuse center/Shelter	8	2	2
Military	0	1	0
Friends	0	18	18
Medical	0	0	1
No known entities had knowledge of abuse	19	14	0
No information provided	0	0	12

*** Entities With Knowledge of Abuse 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 Submitted to FDLE for 2003

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

BAY COUNTY FATALITY REVIEW TEAM

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

- Alcohol and Substance Abuse continues to be the significant factor involved in most of the fatality cases.

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

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

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

4) Additional comments or concerns.

No comments

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

BREVARD COUNTY FATALITY REVIEW TEAM

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

- Mental Health Issues: Not enough local resources in the community that are affordable to clients. After the 72 hour stay clients are not case managed, thus a high rate of recidivism. If there is lack of funds, more often than not the client ends up in the local ER, jail or they have nothing at all to turn to.
- After Diagnosis: Often lack treatment, if they can get any treatment the wait is 3 months or more. Clients must fall under certain criteria to receive services at all.
- Substance Abuse: Clients lack the willingness to go for help and when they do there are very limited resources to get the help they need. In misdemeanor/felony cases regarding crack, the police must catch them, families can not turn their loved ones in to get them help.
- In the area of medication abuse, lack of follow up by doctors, we are seeing a lot of "shopping" different doctors and drug stores. To this end, there is nothing in place such as a large database that can track prescriptions by name, doctor, drug, etc.

2) 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)? No answer provided.

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

- Education for doctors on Adult/Elder abuse and substance abuse for ALL medications. Ask doctors to do blood tests to screen for what drugs are in the blood stream. Make insurances cover this test.
- Mandatory education beginning in public schools.

BREVARD COUNTY – continued

4) Additional comments or concerns:

- General lack of resources at the community/grass roots level.
- Since we never receive feedback from reports, there is an overall feeling that information stops and there is a lack of follow through back to the local community.
- Information needed to tell the Team that policy changes and policy reviews have happened as a result of the Review Teams in the state.
- Training on domestic violence for judges, attorneys, law enforcement mandatory YEARLY for all. It appears training is lacking and being reduced rather than accelerated.
- Begin DV education in the public schools.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

BROWARD COUNTY FATALITY REVIEW TEAM

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

- Medical professionals should notify law enforcement when they suspect domestic violence due to the presence of stabbing/cutting, serious bodily harm, or endangerment of life injuries.
- Officers investigating domestic violence fatalities should utilize a short data collection form to facilitate the domestic violence fatality review process.
- Victim safety would benefit from the improved ability of law enforcement to trace the location of a cell phone call.
- Service providers should make face-to-face follow-up contact with each party involved when a call to a residence is identified as a domestic related incident. A direct referral to either internal or external service providers should be made by law enforcement within 24 hours.
- All persons assigned to family and domestic violence courts should receive annual mandatory specialized training in domestic violence provided by a certified domestic violence trainer.

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

- An ad hoc committee created a model policy for first responders.

  a) Where did they occur?
  - This policy has been submitted to the Broward Domestic Violence Council for approval.

  b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
  - Once approved, this model policy will be delivered to the Broward Chiefs of Police Association for endorsement and implementation.

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

- Florida law should be amended to require that medical professionals notify law enforcement when they suspect domestic violence due to the presence of stabbing/cutting, serious bodily harm, or endangerment of life injuries.
- Florida law and agency policies should be amended to require that all persons assigned to family and domestic violence courts should receive annual mandatory specialized training in domestic violence provided by a certified domestic violence trainer.

BROWARD COUNTY – continued

4) Additional comments or concerns.

- Volunteers have committed considerable time, talent and resources to the Fatality review initiative. No feedback or response has been received regarding the recommendations made over the last four years. **We respectfully request that teams receive annual feedback/follow-up responses from the Governor's Office.**
- Due to the lack of funding for administrative support, the Broward team has temporarily suspended active reviews to direct its limited resources toward the implementation of its four years of recommendations. The team hopes to conclude this process in the next few months so that it may resume active reviews of domestic violence deaths. **We respectfully request the allocation of appropriate funding to support this life saving initiative.**
- Additionally, the last statewide meeting of Florida teams was in 2000. **We respectfully request that consideration be given to convening another meeting of existing Florida teams.** Such a meeting would facilitate the exchange of ideas regarding best practices, implementation issues, and funding initiatives.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

MIAMI-DADE COUNTY FATALITY REVIEW TEAM

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

Quantitative findings

The Miami-Dade County Domestic Violence Fatality Review Team reviewed a total of 21 cases in the year 2003. One case was declared a justifiable homicide, and for the purposes of statistical analysis has not been included in this data set.

- The review found that gunshot wounds were the leading cause of death for the majority of domestic violence related homicide cases that were reviewed (55%).
- In 70% of the cases reviewed, the Decedent had been a victim of domestic violence by the Perpetrator prior to the fatal incident.
- In 60% of the cases reviewed, records indicated that the Perpetrator had a history of substance abuse.
- The review found that in 50% of the cases reviewed, the Decedent and Perpetrator were separated at the time of the fatal incident.
- In 50% of the cases reviewed, the Perpetrator was found to have a history of criminal activity.
- In 45% of the cases reviewed, records indicated that the Perpetrator engaged in prior death threats towards the Decedent.
- In 45% of the cases reviewed, the Perpetrator committed suicide at the time of the fatal incident, and in two cases reviewed, the Perpetrator attempted suicide, but survived.
- In 20% of the cases reviewed, children witnessed the fatal incident, either visually or by earshot.

Lethality Indicators

The review revealed that in the majority of the cases reviewed, lethality indicators were present. In 75% of the cases reviewed, ownership/centrality of the victim to Perpetrator were major factors leading up to the fatal incident.

- In 70% of the cases reviewed, the Perpetrator's decomposition prior to the fatal incident was a factor in the fatal incident.
- In 70% of the cases reviewed, the Perpetrator was found to have engaged in prior antisocial behaviors that played a role in the fatal incident.
- In 50% of the cases reviewed, the Perpetrator had previously displayed actions of severe violence.
- In 45% of the cases reviewed, the Perpetrator either had an individual history or family history of mental illness.
- In 15% of the cases reviewed, the Perpetrator had previously been the perpetrator of child abuse, either physical or sexual.

Quantitative Findings

- The review revealed that public awareness on elder abuse is needed.
- The review revealed that community awareness regarding lethality indicators is needed. Additionally, specific attention should be given to obsessive and jealous behaviors displayed by Perpetrators as major risk factors. Further, educational awareness of death threats should be a training topic to focus upon throughout the community, as well as by service providers.
- The review revealed that currently there is no Batterers' Intervention Treatment Program in place in the jails for domestic violence offenders. A mandatory Batterers' Intervention Program while in custody is an important public safety intervention.
- The review revealed that public awareness regarding the Victims Compensation Program, which arranges financial and other assistance to survivors, may be beneficial to the community. Additionally, treatment providers and law enforcement should also be given information regarding this program.
- The review revealed that public awareness which targets cultural differences and the dynamics of domestic violence would be beneficial to the community and victims of domestic violence.
- The review revealed that the mental health system is in need of continued training in lethality indicators and risk assessment. Additionally, there is a need for resources to intensively treat high risk cases, and effectively follow up on patients after their release from a crisis center or hospital for continued treatment and medication management.
- The review revealed that the electronic monitoring officers (house arrest officers) and probation officers should improve their communication with the State Attorney's Office and forward any relevant information obtained regarding defendants in a timely manner.
- The review revealed that agencies servicing offenders that are under community supervision should be in regular contact with the supervising officers, in order to corroborate and verify information given by offenders.
- The review revealed that the majority of the law enforcement agencies do not have victim advocates assigned to their homicide units. Additionally, many agencies do not have advocates assigned to domestic violence because of lack of funding. However, the review found that the services provided by these advocates are essential to victims and surviving family members.
- The review revealed that, due to budget constraints, the Miami-Dade Medical Examiner's Department does not have a bereavement counselor on site to provide support and referral services to surviving family members of domestic fatalities and all other types of cases. The reviewing found that funding this position would greatly benefit the community.
- The review revealed that the surviving family members of homicide perpetrators who commit suicide should also be viewed as victims of these tragic incidents, and be offered services accordingly.

- The review revealed that there should be educational awareness to family members of patients diagnosed with organic brain syndrome or other similar diseases, regarding the possibility of violent and paranoid symptomology. Additionally, family members should be given resources and taught coping skills to help them respond to violent incidents in these patients.
- The review revealed that it would be beneficial to have community advocates present at injunction hearings to provide support and information to victims, in order to ensure that victims do not voluntarily dismiss petitions out of fear and/or coercion from the respondents.
- The review revealed that all city and county workers should be trained regarding domestic violence in the workplace and their obligation to assist victims by calling law enforcement when witnessing a domestic violence incident.
- The review revealed that it is essential for advocates and law enforcement to provide victims with information as to the limitations of interagency communication, in order for victims to understand their responsibility in giving information to law enforcement, when there is an ongoing domestic violence criminal investigation.

2) What changes in policy or procedure (if any) were made as a result of your reviews?
   a) Where did they occur? .
   b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?

- Continued lethality training within the justice system and associated community social service agency providers throughout the year.
- The DV Review Team was involved in the design and implementation of the Domestic Violence University (DVU). This is an in-house training institute designed to train court personnel in domestic violence issues and is the first of its kind nationally.
- The DV Review Team implemented a procedure whereby all related agencies are immediately notified of all domestic violence-related fatality incidents. This allows for an expedited response to surviving family members, as well as an immediate internal review of policies and procedures by each respective agency.
- The review process has encouraged the local Department of Children and Families office and different law enforcement agencies to work together and set up formal policies and procedures when both agencies are investigating the same family.
- The review process has prompted systematic change through the intensive review of each domestic violence fatality case within a multi-disciplinary setting. Examples of these changes include several policies and procedures which have been instituted by multiple justice systems and community agencies. One such example is the implementation of lethality assessment by local law enforcement responding to domestic violence incidents. In these cases, the presence of a death threat is viewed as a risk factor and police respond accordingly.

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

- The DV Review Team recommends a statewide educational awareness campaign on lethality indicators and the cycle of violence. Additionally, all state certified Batterers' Intervention Program treatment providers should receive continued culturally competent training on these issues.
- The DV Team recommends that a Batterers' Intervention Program be implemented in the jail/prison system and become mandatory for all domestic violence offenders while in custody.
- The DV Review Team recommends that Florida Statutes 741.36 & 741.365 be re-enacted and saved from repeal prior to October 2, 2005. This critical legislation provides the review team proceedings and meetings exemption from the "Sunshine Law" and keeps records obtained by the review team confidential.

4) Additional comments or concerns.

- Throughout the years, the review process has revealed system gaps and procedural and/or policy issues that need improvement to provide the victim and family safety. A continuing issue has been the lack of coordinated community resources to carry out recommendations set forth by the DV Review Team. Although there have been many improvements in the response to domestic violence we have been discouraged by the recent budget cuts that have affected the court system, school system, mental health and other service providers in the community. We feel that these "cutbacks" will undoubtedly put families at great risk from harm and eventually lead to great costs. For example, in Miami-Dade County, there was a **24% reduction** in the domestic violence *homicide* rate in 2003. This was the first significant reduction seen since the inception of the review process. Research indicated that in Medical Examiner costs alone, this reduction saved government an excess of **$8,000,000.** This figure does not include the greater costs saved for law enforcement investigations and court/prosecutorial procedures. We feel that domestic violence should be considered a public safety concern, and resources should be allocated to ensure proper response in an attempt to be proactive in preventing these incidents, rather than reactive to them.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

DUVAL COUNTY FATALITY REVIEW TEAM

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

- The committee noted that in a number of cases in which the batterer was required to attend a state certified Batterer's Intervention Program, there were no consequences when they failed to complete the program.
- Family and friends of domestic violence victims do not always take acts of violence seriously and fail to seek intervention.
- Substance abuse continued to be a problem with perpetrators. Often treatment is not ordered.
- The judiciary does not always have information on civil actions during criminal proceedings and criminal histories during civil proceedings.

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

- In Duval County we have added a follow-up hearing at 30 and 75 days following the final judgment of the injunction. The purpose of the hearing is to ensure compliance with all conditions of the injunction, particularly orders to complete Batterer's Intervention Programs.

  a) Where did they occur?
    - In civil court.

  b) How were they implemented (e.g., formal written policy, memo of understanding or by formal agreement)?
    - Policy change was implemented by the civil court.

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

- Increased funding for domestic violence issues: e.g., Batterer's Intervention Programs in jails and technology for better information sharing
- Mandated judicial training on the dynamics of domestic violence
- Statutory recommendations concerning sentencing on violations of probation
- Domestic violence courts in each circuit

4) Additional comments or concerns.

- Increase in hot-line calls following press conference about homicides.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

ESCAMBIA COUNTY FATALITY REVIEW TEAM

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

- In most of the cases there was little or no contact with any service provider.
- Law enforcement, the courts and domestic violence providers had not been contacted by the victim prior to the homicide.

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

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

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

- Stronger enforcement of the current laws
- Greater education

4) Additional comments or concerns.

- The need for funding to assist fatality review committees in their review of cases

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

LEE COUNTY FATALITY REVIEW TEAM

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

- In almost all cases that were reviewed there was prior knowledge of domestic violence in the home.
- Need for more mental health care facilities and providers.
- We have for the second year found how important community education is and to expand that to awareness of mental health issues also.

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

- Lee County will be starting back up the Lee County Domestic Violence and Sexual Assault Council within the next few months.

  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

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

- More funding for domestic violence issues.
- More training of law enforcement, judges, health care providers on the issues of domestic violence.

4) Additional comments or concerns.

- Lee County has also found it helpful in reviewing near fatalities. With these cases there is more information available and victim input.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

ORANGE COUNTY FATALITY REVIEW TEAM

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

- Victims get lost in the system. Not enough manpower to update potential volatile situations.
- Guns continue to play a major role in domestic violence fatalities.

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

- Our team will begin reviewing near fatal domestic violence cases. More information can be obtained from these cases which will be beneficial in assessing the factors that cause domestic violence fatalities to occur.

  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

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

- A policy that addresses the gun accessibility problem needs to be developed.
- We would like to see a policy to improve better communications between law enforcement agencies.

4) Additional comments or concerns.

- The lack of communication between agencies/entities continues to be an ongoing problem that needs to be addressed.
- Accessibility of guns is a major problem that should be dealt with.
- We suggest that near fatalities be included in the review and collection process.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

PALM BEACH FATALITY REVIEW TEAM

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

- Two of the cases had relationships in some state of separation.
- Three of the cases had prior law enforcement involvement, which resulted in a domestic violence arrest.
- Two of the cases involved decedents who were previously arrested for domestic violence.
- Two cases involved the perpetrator committing suicide.
- Two of the cases, the perpetrator was ordered to Batterer's Intervention by the Court System.
- One victim had an active restraining order against him due to violence in a previous relationship.
- One case involved child witnesses to the fatality.
- There were various methods used to commit the fatalities. One case involved a stabbing and three cases involved guns.
- All of the cases reviewed had different ethnic backgrounds and consisted of culturally different perspectives.
- All of the cases reviewed had a myriad of age ranges, which spanned 18 years old to 78.
- One case involved the death of a police officer that was under investigation for battery on his wife and had an active restraining order against him from his former wife.
- Probation violations were not implemented within a timely manner.
- There is a lack of domestic violence education within the school system.
- One victim was a habitual runaway with chronic mental health problems. There appeared to be a lack of appropriate services and interventions to assist this population resulting in a child being placed in an inappropriate Baker Act facility.
- Professionals adhering to the Florida State Statutes that addressed elder issues appeared to be remiss.

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

- 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.

- 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 fatalities.
- Surviving family members have been linked with needed services as a result of the work of the Team.
-

  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

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

- 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.
- A standard for Probation that will ensure timely violations of probation.
- An improved standard for interdepartmental law enforcement communications especially when Police Officers are under investigation for domestic violence.
- Increase funding to mandate local law enforcement to employ victim advocates in every law enforcement agency.

4) 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 supportive outreach network created by the team members while working in the community encourages community members to reach out for assistance when they suspect cases of domestic violence within their own caseload.
- 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 ANNUAL SUMMARY EVALUATION

PINELLAS COUNTY FATALITY REVIEW TEAM

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

- Substance use/abuse involved in 80% of our cases.
- Age differences of seven years or more in 50% of cases.
- Separation issues in 60% of cases.
- Friends/family/neighbors/coworkers aware in 70% of cases.
- Most families have no contact with the system prior to homicide in 80% of cases.

2) 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

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

Policy Change Suggestion:

- Screening and referral for domestic violence in alcohol/substance abuse treatment programs.
- Police Departments focus intervention efforts on repeat families or cases.
- When probationer violates probation with violent behavior, give jail time or extend probation term.

4) Additional comments or concerns.

- Our reviews support the philosophy that leaving the decision to arrest or prosecute to the victim is not successful.
- It is imperative that community education efforts include reaching out to friends and families with tips on how to help a victim and/or a perpetrator.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM ANNUAL SUMMARY EVALUATION

POLK COUNTY FATALITY REVIEW TEAM

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

- Victims underestimated their risk of injury or death.
- Family members, friends and neighbors knew of the fighting and threats but did not intervene.
- Agencies had no established procedure for sharing information.
- Drugs and alcohol abuse of the decedent and/or the perpetrator appears to be the most significant factor directly related to the death occurring.
- Murder/suicide contemplated by perpetrator but did not always carry out.

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

- Increased interagency communication through domestic violence task force meetings held monthly.
- Workshop on domestic violence was presented at our Family Court Summit at which attendance was over 400 people.
- Other appropriate changes where need was apparent.

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

- Extend Florida Statute 741.316 that governs the operation and protection of confidentiality for fatality review teams. (Currently set to expire as of 10/2/2005).

4) Additional comments or concerns. None

Appendix B

Profile of Data from 53 Domestic Violence Fatality Team Reviews Submitted to FDLE for 2003

2004 Annual Domestic Violence Fatality Review Profile of Data

Date of Fatality	Decedent Race Sex & Age	Perpetrator Race Sex & Age	Decedent's Relationship to Perpetrator	Cause of Death	Domestic Violence History
09/05/1992	White male; 65	White female; 39	Spouse	Stabbing	Yes
12/27/2002	White female; 39	White male; 40	Spouse	Gunshot	No
06/28/1998	White female; 35	White male; 36	Co-habitant	Stabbing	No
12/26/1998	White female; 68	White male; 43	Parent	Neglect	No
05/27/2000	White Female; 24	White male; 36	Co-habitant	Stabbing	No
10/16/2002	Black female; 38	Black male; 46	Ex-cohabitant	Gunshot	Yes
01/13/2003	White female; 23	White male; 28	Ex-cohabitant	Gunshot	No
07/18/2002	White female; 21	White male; 26	Ex-spouse	Gunshot	No
10/28/2003	Black female; 38	Black male; 29	Co-habitant	Gunshot	No
08/25/2003	Black male; 12	Black male; 41	Child	Gunshot	Yes
03/13/2003	Black male; 45	Black female; 35	Co-habitant	Stabbing	Yes
11/25/2003	Black female; 26	Black male; 31	Ex-cohabitant	Gunshot	Yes
12/28/2003	White female; 41	White male; 42	Co-habitant	Blunt trauma	Yes
01/25/2003	White female; 55	White male; 62	Spouse	Gunshot	No
05/06/2003	Black male; 1	Black male; 20	Child	Blunt Trauma	Yes
05/14/2003	White female; 30	White male; 27	Spouse	Gunshot	Yes
	White male; 39	Same as above	Wife's ex-boyfriend	Gunshot	By-stander
	White male; 20	Same as above	Neighbor	Gunshot	By-stander
	White male; 32	Same as above	In-law	Gunshot	No
	White male; 60	Same as above	In-law	Gunshot	No
06/15/2003	Black female; 47	Black male; 48	Spouse	Blunt Trauma	Yes
06/23/2003	White male; 54	White female; 53	Spouse	Gunshot	No
06/25/2003	White male; 34	White female; 32	Ex-cohabitant	Gunshot	Yes
07/16/2003	Black female; 21	Black male; 26	Spouse	Gunshot	Yes
10/18/2003	White female; 34	White male; 25	Ex-cohabitant	Stabbing	No
03/05/1999	Black female; 26	Black male; 34	Spouse	Gunshot	No
04/28/2000	White female; 11	White male; 30	Child	Gunshot	No
06/13/1999	White male; 38	White male; 31	Other Known	Gunshot	No
	White male; 1	Same as above	Child	Gunshot	No
07/26/1999	White female; 80	White male; 83	Spouse	Gunshot	No
02/25/1996	White female; 38	White male; 33	Co-habitant	Strangulation	No
07/05/2002	White female; 44	White male; 41	Spouse	Gunshot	No
03/12/1998	White female; 47	White male; 15	Parent	Gunshot	No
11/04/2002	White female; 37	White male; 40	Spouse	Strangulation	No
04/24/2000	White female; 20	White male; 21	Spouse	Gunshot	No
12/20/2001	White female;51	White male; 51	Spouse	Gunshot	Yes
	White male;55	Same as above	Other Known	Gunshot	Unknown
12/24/2001	Black female; 3	Black male; 31	Child	Hanging	No
04/18/2001	White female; 55	White male; 38	Co-habitant	Blunt Trauma	Yes
02/03/2003	White female; 28	Black male; 35	Ex-spouse	Gunshot	Yes
10/07/2001	White female; 21	White male; 21	Ex-cohabitant	Gunshot	Yes
09/29/2001	White female; 70	White male; 78	Spouse	Gunshot	No
04/16/2002	Black male; 22	Black female; 18	Boyfriend	Stabbing	Yes
03/17/2002	Black male; 34	Black male; 22	Competition	Gunshot	No
11/30/2002	White female; 73	White male; 74	Spouse	Gunshot	No
09/05/2000	White female; 48	Black Male; 33	Ex-cohabitant	Strangulation	Yes
04/13/2002	Black male; 51	Black female; 50	Spouse	Stabbing	Yes

2004 Annual Domestic Violence Fatality Profile of Data

Date of Fatality	Decedent Race Sex & Age	Perpetrator Race Sex & Age	Decedent's Relationship to Perpetrator	Cause of Death	Domestic Violence History
04/15/2001	White female; 31	White male; 38	Co-habitant	Stabbing	Yes
04/25/2002	Black female; 44	Black male; 54	Ex-cohabitant	Gunshot	No
10/15/2000	Black female; 39	Black male; 24	Ex-cohabitant	Gunshot	No
05/14/2000	White female; 45	White male; 51	Ex-cohabitant	Strangulation	No
01/04/2000	White female; 44	White male; 45	Spouse	Gunshot	Yes
09/11/2000	White female; 53	White male; 43	Ex-cohabitant	Gunshot	Yes
11/18/1990	White female; 26	White male; 30	Ex-spouse	Stabbing	Unknown
07/26/1999	White female; 24	White male; 36	Spouse	Stabbing	Unknown
04/07/1997	White female; 22	White male; 26	Ex-cohabitant	Gunshot	Yes
	White male; 4	Same as above	Other Known	Gunshot	Yes
11/03/1998	White female; 32	White male; 41	Co-habitant	Burns	No
02/25/1997	White female; 20	White male; 37	Co-habitant	Gunshot	No
06/28/1999	White male; 62	White female; 55	Spouse	Gunshot	No

Appendix C

Raw Data from 53 Domestic Violence Fatality Team Reviews Submitted to FDLE for 2003

2004 RAW DATA

The following data is from the cases that were provided to the DVDRC by participating teams. Because the data is from 10 teams covering only 10 counties the reader is cautioned about drawing conclusions from this data.

COMPLAINT INFORMATION

Time Received:

Morning	0002	0013	0039	0044	0115	0140	0211	0221	0245
	0300	0400	0402	0430	0517	0600	0730	0820	0941
	1054	1130	1142	1200					
Evening	1207	1237	1238	1345	1400	1445	1457	1500	1600
	1612	1635	1656	1700	1800	1800	1817	1900	1913
	1923	2054	2104	2117	2157	2219	2300	2319	2339
	2348	Unk	Unk	Unk					

Time Frames:

12:01 A.M. to 06:00 A.M.	15
06:01 A.M. to 12:00 P.M.	7
12:01 P.M. to 06:00 P.M.	15
06:01 P.M. to 12:00 A.M.	13
Unknown	3

Day of Week:

Monday	14
Tuesday	8
Wednesday	3
Thursday	5
Friday	5
Saturday	7
Sunday	9
Unknown	2

Complainant:

Decedent	1
Perpetrator	8
Family member of the decedent	12
Family member of the perpetrator	9
Neighbor	10
Co-worker	1
Acquaintance of decedent	9
Acquaintance of perpetrator	2
Medical professional	1
Other	9
Unknown	3

Note: There were a total of 65 calls, this was due to multiple complainants and multiple calls by the same complainant.
Other: 1 stranger, 1 landlord, 1 ex-husband, 1 student, 1 maintenance worker
1 friend, 1 girlfriend of perpetrator, 1 deputy sheriff(friend), 1 fire department.

COMPLAINT – continued

Call Received in Relation to Event:

During fatality	17
After fatality	36

EVENT INFORMATION

Offense Type:

Homicide	31
Homicide/Suicide	18
Multiple Homicides	0
Multiple Homicides/Suicide	3
Hostage/Homicide	0
Hostage/Homicide/Suicide	0
Hostage/Multiple Homicides	1
Hostage/Multiple Homicides/Suicide	0

Event Type:

Intimate partner	41
Familicide	0
Parricide	2
Killing the competition	3
Killing of children by parent(s)	5
Suicide pact	0
Mercy killing	0
Fratricide and/or Sororicide	0
Perpetrator kills batterer	3
Ex-intimate partner	1
Other	5

Other: 2 in law, 1 neighbor, 1 ex-boyfriend, 1 child of intimate partner.

Certified Cause of Death:

Gun shot wound	39	Neglect	1
Stabbing	10	Hanging	1
Strangulation	4	Burn	1
Blunt trauma	4		

Note: Some fatality review reports contained multiple decedents.

Location Type:

Residence of decedent and perpetrator	27
Residence of decedent	7
Residence of perpetrator	10
Commercial	3
Workplace of decedent	2
Other	11

Other: 1 Park, 1 Hospital, 1 Construction Site, 1 Motor Home, 1 Street, 1 Residence of Competition, 2 Residence of Friends, 3 Hotel/Motel

Children at Scene of Fatality: YES 15 NO 36 N/A 2

Note: N/A – child is decedent

Children heard fatal occurrence	14
Children observed fatal occurrence	8

Weapon Type:

Handgun	34
Rifle	1
Shotgun	4
Knife/Cutting instrument	11
Blunt object	2
Hands/Fists/Feet (beating)	9
Fire/Incendiary	1
Other	6

Other: Statue. Glass object, bedpost, rope, chain, neglect.

Multiple weapons by perpetrator: 1) Handgun caused death, knife and statue were also used. 2) Handgun caused death, glass object was also used, 3) Two cases where the Knife caused death, hands/fists/feet were also used. 4) Two cases where a Blunt object caused death, hands/fists/feet were also used, 5) Handgun caused death, hands/fists/feet were also used.

Status of Perpetrator:

Arrested	22
At-large	0
Killed by law enforcement officer during arrest	0
Committed suicide during the fatality	18
Committed suicide after the fatality	3
Other	10

Other: 3 Perpetrator killed batterer (perpetrator killed decedent in self defense),
5 Convicted, 1 fifteen year probation, 1 died from injuries one week later.

ENVIRONMENT PRIOR TO FATALITY

Injunction History of Perpetrator:

Active injunction	8
Previous injunction	5
Not applicable	39
Unknown	1
No information	0

Injunction History of Decedent:

Active injunction	1
Previous injunction	1
Not applicable/None	53
Unknown	3
No information	0

2 – Decedents were By -Standers

DECEDENT INFORMATION

Sex:

Male	18
Female	42

Marital Status:

Not Applicable (children)	6
Never Married	17
Widowed	2
Married to perpetrator	14
Married to other	5
Separated from perpetrator	5
Divorced from perpetrator	3
Divorced from other	5
Unknown	1

2 – Decedents were By -standers

Race:

Black	15
White	45

Ethnicity:

Hispanic	5
Non-hispanic	43
Unknown	12
Non-classified	0

DECEDENT INFORMATON – Continued

Employment:

Employed	23
Unemployed	12
Retired	4
Unknown	13
Not applicable	6

Criminal History:

Non violent crime arrests	16
Domestic violence arrests	8
Other violent arrests	4
Not Applicable	6
Unknown	1

Other Related History:

Documented police response to residence	25
Decedent victim of other offenses	8
Previous incidents of domestic violence with different partner(s)	7
History of domestic violence known to other(s)	30

PERPETRATOR INFORMATION

Sex:

Male	46
Female	7

Martial Status:

Never Married	21
Widowed	0
Married to decedent	14
Married to other	1
Separated from decedent	5
Separated from other	2
Divorced from decedent	3
Divorced from other	7
Not Applicable (child)	0
Unknown	0

Race:

Black	17
White	36
Asian or Pacific Islander	0
Unknown	0

PERPETRATOR INFORMATION – continued

Ethnicity:

Hispanic	6
Non-Hispanic	36
Unknown	11
Non-classified	0

Employment:

Employed	28
Unemployed	10
Retired	2
Unknown	13

Criminal History:

Non violent crime arrests	31
Domestic violence arrests	21
Other violent arrests	19
Unknown	2

Other Related History:

Previous incident of domestic violence with different partners	6
Previous history of suicide attempt	5
Known allegations of stalking	11
Previous participation in batterer's intervention program	2
Previous abuse of drugs	18
Previous use of alcohol	28
Under medication	7
Previous incident(s) of animal abuse	0
Appeared in court for domestic violence offense	14
Domestic violence related charges dismissed against perpetrator	7
History of domestic violence known to other entities	30
Known incidents of prior child abuse	6

PERPETRATOR AS BATTERED VICTIM

Threat to kill perpetrator	3

PERPETRATOR SUICIDE

Cause of Death:

Gunshot wound	18
Hangings	3

Suicide Note Left 8
Suicide appear part of homicide 15

RELATIONSHIP ISSUES

Relationship of Decedent to Perpetrator:

Spouse	19	In-Law	2
Parent	2	Co-habitant	10
Girlfriend	0	Ex-co-habitant	12
Child	5	Other *(known)*	6
Boyfriend	1		
Ex-spouse	3		

Other known – 2 Competition, 1 friend of perpetrator's girlfriend, 1 neighbor, 1 ex-boyfriend of wife, 1 child of girlfriend.

Reported Prior Threats Made to Decedent by Perpetrator:

Threat to kill decedent	12
Threat to kill children or family member	3
Threat to commit suicide	8
Other	3

Other:1 Threat to Wife, 1 Threat to take Decedent from mother, 1 Unknown

Circumstance That Apply to Decedent and Perpetrator's Relationship:

They lived together at some point	23
They lived together at the time of the fatality	28
They were intimate prior to the fatal incident	10
They had a child/children in common	13
They had children in household, but not in common	5
Always maintained separate dwellings	1
They had previous report incidents of domestic violence	23
They had a significant change in relationship	28

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	0	1	0
Signs of recent sexual intercourse with decedent by perpetrator	0	0	1
Decedent and perpetrator in process of separation at time of fatality	6	3	1
Decedent and perpetrator had separated	6	6	3
Perpetrator served with divorce papers	1	1	1
Decedent and perpetrator had divorce finalized	0	0	1
Decedent pregnant by perpetrator	1	0	0
Decedent had started a new relationship	5	0	2
Perpetrator had started a new relationship	1	1	0

CONTRIBUTING FACTORS TO INCIDENT- continued

Employment/Monetary Factors	**Priority**		
	1	**2**	**3**
Perpetrator had loss of employment, blames decedent	0	0	1
Perpetrator had loss of employment due to domestic violence arrest	0	0	0

Employment/Monetary Factors	**Priority**		
	1	**2**	**3**
Perpetrator had loss of income blames decedent	0	1	1
Perpetrator had loss of income due to domestic violence arrest	0	1	0

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

Substance Abuse Factors	**Priority**		
	1	**2**	**3**
Perpetrator has/had abused drugs	2	3	4
Decedent had/has abused drugs	1	1	1
Perpetrator had/has used alcohol	2	9	3
Decedent had/has used alcohol	2	1	3

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

CONTRIBUTING FACTORS TO INCIDENT- continued

Other Factors	**Priority** **1 2 3**
Perpetrator alleged to have committed act to avenge a perceived wrongdoing:	
By decedent	3 4 5
By decedent family member	3 0 0
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

Other (specify)	**Priority** **1 2 3**
Decedent moving to Columbia	1 0 0
Thoughts of abandonment	0 1 0
Depressed/suicidal	0 0 1
Self-defense	1 0 0
Decedent helped perpetrator's girlfriend	1 0 0
Terminal Cancer	1 0 0
Perpetrator angry with decedent	0 1 0
Missing debit card	1 0 0
Decedent difficult/no support from family	1 0 0
Ongoing domestic violence	1 0 0
Pending going to jail	0 1 0

ESCALATING CIRCUMSTANCES

The Decedent:

Expressed fear of physical danger to themselves or children	22
Express fear of losing children	3
Isolate themselves from family and friends	4
Had evidence of physical injury	10
Showed frequent signs of	
depression	5
anger	6
low self-esteem	6
suicidal thoughts	4
Expressed fear of involvement in the criminal justice system process	0
Showed or expressed signs of sleeping difficulties	0
Expressed guilty feelings about the failed relationship	1
Showed or expressed history of family abuse	4
Expressed fear of being alone	1
Expressed fear of making a great life change	0
Expressed belief that partner would change and/or stopped abusive behavior	2

ESCALATING CIRCUMSTANCES – continued

The Perpetrator:

Abused the decedent in public	8
Kept tabs on or stalk decedent	12
Put down the decedent's friends and family	6
Told decedent, jealousy is a sign of love	1
Made all decisions in the relationship (including finances)	8
Blamed decedent for abuse	2
Used intimidation by instilling fear through looks and gestures	7
Smashed objects, destroyed property	7
Told decedent their fears about relationship not important	0

SERVICES REQUESTED, ORDERED OR OBTAINED

Domestic Violence Services:

Domestic violence counseling services	**Requested**	**Received**
Decedent	3	3
Perpetrator	1	0

Domestic violence center	**Requested**	**Received**
Decedent	0	0
Perpetrator	1	0

Religious	**Requested**	**Received**
Decedent	1	1
Perpetrator	0	0

Children Services	**Requested**	**Received**
Decedent	2	2
Perpetrator	1	1

Other		
Decedent	0	0
Perpetrator	1	1

Total Domestic Violence Services:

Decedent: **Requested: 6 Received: 6**

Perpetrator: **Requested: 4 Received: 2**

Criminal Justice/Legal Assistance:

Law enforcement:	**Requested**	**Received**
Decedent	18	18
Perpetrator	14	17

Legal Assistance/attorney	**Requested**	**Received**
Decedent	3	3
Perpetrator	5	5

SERVICES REQUESTED, ORDERED OR OBTAINED- continued

State Attorney/Prosecutor:	**Requested**	**Received**
Decedent	4	6
Perpetrator	5	9

Court/Judges	**Requested**	**Received**
Decedent	11	14
Perpetrator	10	14

Family Court	**Requested**	**Received**
Decedent	3	3
Perpetrator	1	2

Probation/Parole	**Requested**	**Received**
Decedent	6	6
Perpetrator	11	12

Other (specify)	**Requested**	**Received**
Decedent	0	1
Perpetrator	0	1

Total Criminal Justice/Legal Assistance
Decedent: **Requested: 45 Received: 51**
Perpetrator: **Requested: 46 Received: 60**

Health Care Provider:

EMT/Paramedics:	**Requested**	**Received**
Decedent	2	3
Perpetrator	1	1

Ambulance service	**Requested**	**Received**
Decedent	0	0
Perpetrator	1	1

Emergency room	**Requested**	**Received**
Decedent	1	1
Perpetrator	2	2

Physician	**Requested**	**Received**
Decedent	4	4
Perpetrator	2	2

Mental Health Clinic	**Requested**	**Received**
Decedent	1	1
Perpetrator	1	1

SERVICES REQUESTED, ORDERED OR OBTAINED – continued

Mental Health program

	Requested	**Received**
Decedent	1	1
Perpetrator	3	3

Other:

	Requested	**Received**
Decedent	1	1
Perpetrator	3	3

Total Health Care Provider:
Decedent: **Requested: 10 Received: 11**
Perpetrator: **Requested: 13 Received: 13**

Children Services:

DCF

	Requested	**Received**
Decedent	6	6
Perpetrator	3	3
Child of decedent	4	5
Child of perpetrator	2	2

School Involvement

	Requested	**Received**
Decedent	1	0
Perpetrator	0	0
Child of decedent	1	0
Child of perpetrator	0	0

Other(children services)

	Requested	**Received**
Decedent	0	0
Perpetrator	0	0
Child of decedent	0	0
Child of perpetrator	0	0

Decedent: **Requested: 7 Received: 6**
Perpetrator: **Requested: 3 Received: 3**
Child of Decedent: **Requested: 5 Received: 5**
Child of Perpetrator: **Requested: 2 Received: 2**

LETHALITY INDICATORS

Emotional/Mental Deterioration:

	Decedent	**Perpetrator**
Suicidal	1	24
Homicidal	3	26
Loss of function (i.e. not eating, sleeping, working)	0	2
History of psychiatric problems	2	2
Poor compliance with taking medication	1	1
Depression	7	13
Economic loss	2	4
Loss of family support	1	3
No Information provided	47	18

LETHALITY INDICATORS – continued

Antisocial Behavior:	**Decedent**	**Perpetrator**
History of domestic violence	9	30
History of assaults on other	5	18
History of criminal activity	8	22
History of stalking	2	14
History of substance	15	31
Possession of weapons	3	28
History of abusing children (physically or sexually)	2	6
History of childhood abuse or witnessing violence	5	1
No information provided	34	10

Failure of Community Control:	**Decedent**	**Perpetrator**
Violation(s) of restraining order	1	4
Violation(s) of probation	2	6
Arrest(s) for domestic violence	6	10
Failure to complete batterers intervention program	1	3
Failure to complete substance abuse treatment	0	0
Failure to complete anger management program	1	0
No information provided	50	37

Severity of Violence:	**Decedent**	**Perpetrator**
Used a weapon	2	21
Death threat	3	12
Unwanted sexual contact	0	2
Strangulation	0	4
Hurt pet	0	0
Severe injury	0	8
Sadistic/Threatening act	2	5
Expressed concerns that she/he would be killed	11	2
No information provided	45	24

Ownership/Centrality of Victim to Perpetrator:	**Decedent**	**Perpetrator**
Obsessive about partner or family	2	18
Extreme jealousy	1	14
Access to victim and/or family members	2	21
Rage and/or depression over separation	0	19
Perceived betrayal	2	17
Perceived rejection after attempt to reconcile	0	11
No information provided	52	19

SUMMARY OF REPORTS

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

Yes	29
No	18
Unknown	1
No information provided	5

Entities that had knowledge of the domestic violence:

Law enforcement	26
Family	28
Acquaintances/Neighbors	11
Friends	18
State/County agencies	20
Employers/Co-workers	2
Military	0
Medical	1
Abuse Centers/Shelters	2
No information provided	12