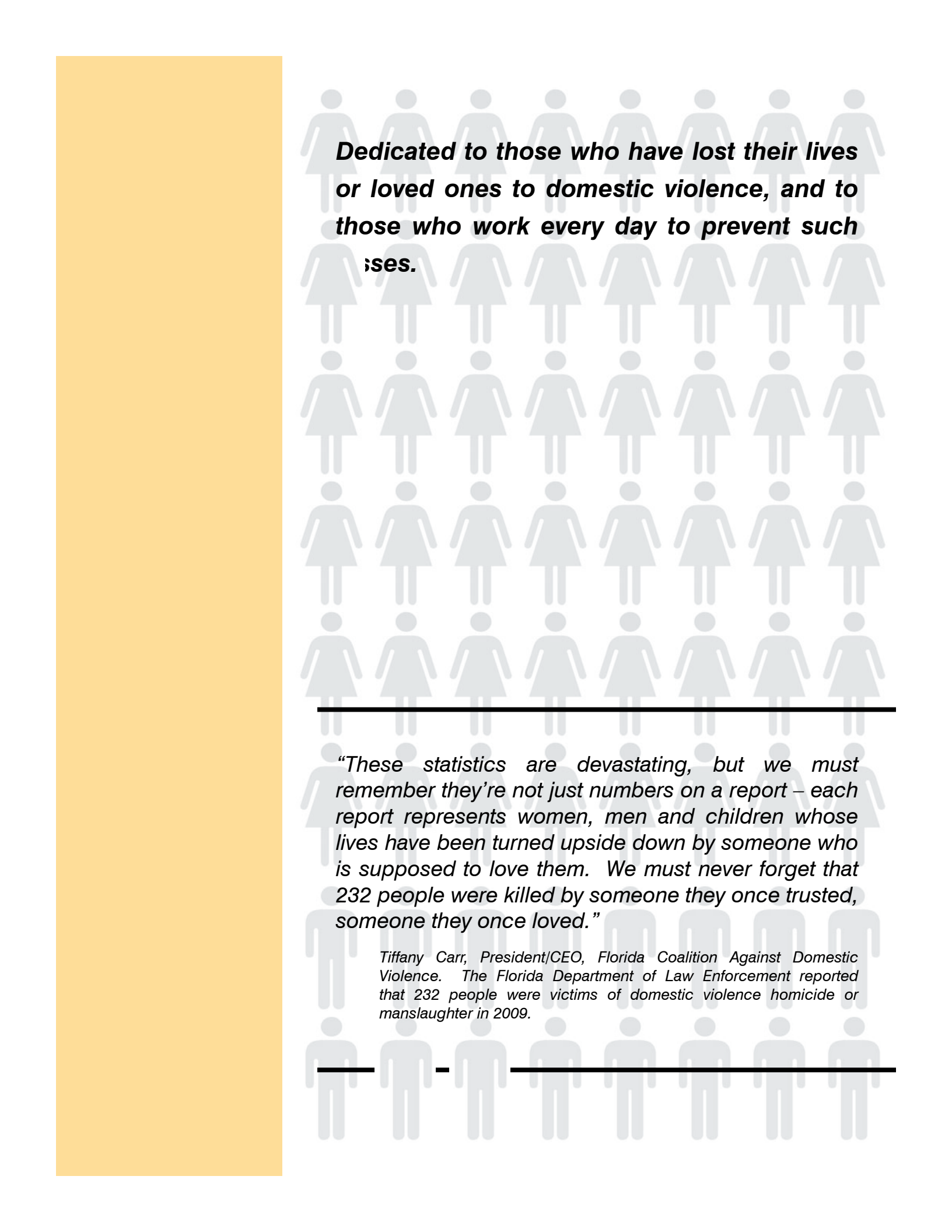


# The Faces of Fatality

January 2011



**Overview, Findings and  
Recommendations of The  
Florida Attorney General's  
Statewide Domestic Violence  
Fatality Review Team**



***Dedicated to those who have lost their lives  
or loved ones to domestic violence, and to  
those who work every day to prevent such  
cases.***

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*“These statistics are devastating, but we must remember they’re not just numbers on a report – each report represents women, men and children whose lives have been turned upside down by someone who is supposed to love them. We must never forget that 232 people were killed by someone they once trusted, someone they once loved.”*

*Tiffany Carr, President/CEO, Florida Coalition Against Domestic Violence. The Florida Department of Law Enforcement reported that 232 people were victims of domestic violence homicide or manslaughter in 2009.*

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## EXECUTIVE SUMMARY

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The Florida Department of Law Enforcement (FDLE) reported a 15.6% increase in domestic violence murders in 2009, while all other crime in Florida dropped by 6.7%. Then Attorney General Bill McCollum responded to this marked increase in domestic violence homicides by establishing, for the first time in Florida, a **statewide** domestic violence fatality review team. Led by the Florida Coalition Against Domestic Violence (FCADV), in collaboration with the Office of the Attorney General and the Department of Children and Families Domestic Violence Program Office (DCF DVPO), the statewide team includes representatives of domestic violence centers, legal and other direct service providers, government agencies, faith-based organizations, probation, parole, corrections, law enforcement, health care, the military, the court system, prosecutors, the defense bar, and a survivor. The diversity of the team reflects the complexity of the lives of victims and perpetrators and the different agencies they may encounter.

Domestic violence fatality review is a critical tool for identifying systemic gaps and strategies to improve and increase interventions to protect victims and children, hold batterers accountable and prevent domestic violence homicides. A key element of fatality review is the “no blame, no shame” philosophy, which means that no one system is responsible for the death(s). Ultimately the responsibility for the homicides rests with the perpetrator.

Over the course of 10 months, the statewide team conducted an in-depth review of a 2009 domestic violence murder-suicide, reviewed data relating to 43 domestic violence homicides collected by local fatality review teams, and conducted reviews of 20 additional intimate-partner homicides based on information available from public records. The team also reviewed national research and trends, and received input from local fatality review teams and other community partners throughout the state. The short time frame and the fact that this is the first report issued by the statewide team dictated a cautious approach to the team’s findings and recommendations, particularly because of the challenges described in this report regarding uniform data collection and analysis.

Those working in the domestic violence advocacy community may recognize that some of the recommendations in this report are not new. However, a key difference from the past is that a multidisciplinary statewide team of high ranking officials or their designees from almost every state agency in Florida, along with state and local civil and criminal justice agencies and other community partners, issued these recommendations as a unified team.

The issuance of this report by a unified, multidisciplinary, statewide team represents a remarkable step forward in collaborative efforts to eradicate domestic violence in our state. We hope to continue to build upon this collaboration, both statewide and locally, to increase and improve interventions to keep families safe at home.

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***...domestic violence is a pervasive societal problem in Florida...***

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## **FINDINGS**

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1. While all other criminal offenses in Florida decreased by 6.7% in 2009, domestic violence murders increased 15.6%, and aggravated stalking, often a precursor to homicide, increased 31.6%.
2. A significant number of domestic violence fatalities occurred in families in White, Black, and Hispanic communities. This fact demonstrates that domestic violence is a pervasive societal problem in Florida necessitating effective interventions from systems as well as community recognition that domestic violence adversely impacts the community as a whole, not just individual families.
3. 88% of perpetrators were male, and 79% of decedents were female.
4. In 37% of domestic violence fatalities, family members, friends, co-workers and others were aware domestic violence was occurring.
5. 50% of victims of domestic violence fatalities left behind surviving children. However, there currently exists no statewide method to link and provide specialized services to children who have lost a parent or parents to domestic homicide. Children exposed to domestic violence, particularly children who lose parents or family members as a result of domestic violence homicide suffer short- and long-term adverse consequences.
6. In 25% of the fatalities, either the decedent or the perpetrator contacted 911 during the course of the incident.
7. 63% of perpetrators had a prior criminal history, and 47% of perpetrators had a prior criminal history of domestic violence.
8. In 47% of the cases the victims died from gunshot wounds.
9. 47% of perpetrators of domestic violence homicide had a known history of substance abuse, and 23% had a known mental health diagnosis.
10. In 26% of the fatalities, the family had some known contact with DCF.
11. Local fatality review teams report that domestic violence fatality review is a critical tool to identify systemic gaps and ways to improve responses to prevent domestic violence homicides. However, the local teams need continued support and guidance from the statewide fatality review team.

## RECOMMENDATIONS

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1. Given the significant increase in domestic violence homicides, including high profile familicides, and a marked escalation in reports of aggravated stalking, the Florida Legislature should increase funding for certified domestic violence centers, law enforcement, state attorney's offices, civil legal services, civil and criminal court systems, child welfare providers and supervised visitation programs to improve and increase interventions to prevent future domestic violence homicides.
2. The statewide domestic violence fatality review team should identify funding sources for a comprehensive, statewide domestic violence public awareness campaign to increase awareness about the adverse effects of domestic violence on families and on the community as a whole. The campaign should consider the linguistic and cultural diversity of Florida's citizens, and employ a variety of media including billboards, training materials, public service announcements, and websites to communicate that domestic violence is a crime and that comprehensive services are available to assist families experiencing violence, including that domestic violence centers offer a wide-range of free outreach services to victims and their children in addition to shelter. FCADV should seek funding to hire a statewide coordinator who will serve as a multi-agency liaison to implement the public awareness campaign and implement the recommendations of the statewide fatality review team.
3. DCF should develop local agreements with law enforcement to ensure DCF is notified when children lose one or both parents to domestic violence homicide. If the surviving children become dependent in the child welfare system, DCF should ensure that they are provided with appropriate services while in foster or relative care to address their trauma. In addition, child protective investigators should be trained and required to provide service referrals for surviving children who do not enter the child welfare system but stay with family members or other caregivers.
4. Given that in 26% of fatalities the family had known contact with DCF, state and local domestic violence fatality review teams and child death review teams should meet together yearly at a minimum to discuss the overlap between domestic violence and child abuse, and share data collected and trends identified.
5. Training curricula for Emergency 911 operators should include specific training regarding domestic violence calls and the potential for lethality.
6. Judges, state attorneys, probation, parole, and other criminal court personnel should receive specialized training on the risk factors present in cases where domestic violence homicides have occurred. Such training will assist them in advocating for and ordering effective interventions to increase perpetrator accountability and victim safety, including certified Batterer's Intervention Programs, substance abuse and mental health treatment, and when appropriate, monitoring of perpetrators, including global position device monitoring.
7. When considering conditions of supervision, the courts and the Florida Parole Commission should consistently order perpetrators to certified Batterer Intervention Programs, and should institute sanctions when the perpetrator does not comply with ordered participation, including the issuance of a warrant. The supervising authorities should develop specialized domestic violence units to work with high risk domestic violence offenders on post-incarceration supervision or probation.



8. The courts and the Parole Commission should consistently order removal of firearms in domestic violence cases when authorized by applicable law.
9. Judges, service providers and other personnel involved with Drug and Dependency Courts should receive training on the unique correlation between substance abuse and domestic violence and consult with and include domestic violence advocates familiar with substance abuse issues in developing case plans.
10. The Office of the Attorney General in partnership with FCADV and DCF should seek funding to continue the work of the statewide domestic violence fatality review team. The DCF DVPO should continue to work with the local fatality review teams to standardize reporting formats, including creating uniform definitions of data elements, to compile meaningful statewide data for policy recommendations and for an annual report.

## MISSION AND FRAMEWORK

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During the period January to December 2009, FDLE reported<sup>1</sup> that more than 116,000 people were victims of domestic violence crimes.<sup>2</sup> The FDLE report for 2009 reflected a 15.6% increase in domestic violence-related murders, and an increase of almost 32% in stalking, which is a frequent precursor to homicide.<sup>3</sup> Significantly, while domestic violence crimes increased notably, all other crimes in Florida dropped by 6.7%.

In 2009, then Attorney General Bill McCollum, in collaboration with FCADV and the DCF DVPO, responded to the increase in domestic violence homicides by establishing a statewide domestic violence fatality review team. In 2000, the Florida Legislature passed laws governing the establishment of domestic violence fatality review teams.<sup>4</sup> For 10 years, local domestic violence fatality review teams have conducted reviews to strengthen community responses to domestic violence. The Attorney General's initiative is Florida's first statewide domestic violence fatality review team. Florida is the first state in the nation to implement both a local and statewide fatality review team structure.

The statewide team includes representatives of domestic violence centers, legal and other direct service providers, government agencies, faith-based organizations, probation, parole, corrections, law enforcement, health care, the military, the court system, prosecutors, the defense bar, and a survivor. The diversity of the team reflects the complexity of the lives of victims and perpetrators and the different agencies they may encounter. The Attorney General requested that FCADV lead the team, noting that, "While a statewide fatality review team has members from many different agencies and organizations, representatives of the domestic violence advocacy community should provide leadership to the team because it is critical to view systemic response to domestic violence through the eyes of victims of domestic violence. Domestic violence center advocates have the experience and expertise to provide insights into why a homicide victim may have made certain choices, or sought particular services."

The previous Attorney General held an organizational meeting in Tallahassee in December 2009, where he charged the team to both conduct reviews of domestic violence homicide cases and analyze data collected by local fatality review teams to identify statewide trends and make recommendations to prevent domestic violence fatalities. To accomplish these goals, the team formed two subcommittees to conduct a fatality review of a recent case and to collect and analyze data submitted by local fatality review teams.

National experts Dr. Neil Websdale and Matthew Dale provided the team with training, guidance and oversight.<sup>5</sup> Their extensive research and experience in the field of domestic violence fatality review on a national level guided Florida's team during a 10 month period. The team employed the "no blame, no shame" philosophy, a basic tenet of fatality review, in the conduct of its work. "No blame, no shame" means that no one system is responsible for the death(s). Ultimately the responsibility for the killing rests with the perpetrator. Additionally, in keeping with statutory mandates, the team complied with fatality review and victim confidentiality requirements.<sup>6</sup>

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<sup>1</sup>FDLE Report available at [http://www.fdle.state.fl.us/Content/getdoc/563b1fa3-3c7b-4787-ac6d-96c8fea73dcd/CIF\\_Annual09.aspx](http://www.fdle.state.fl.us/Content/getdoc/563b1fa3-3c7b-4787-ac6d-96c8fea73dcd/CIF_Annual09.aspx)

<sup>2</sup>Domestic violence crimes are any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member. "Family or household member" means spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a family, and persons who are parents of a child in common regardless of whether they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit. Section 741.28, Fla. Stat.

<sup>3</sup>Uniform Crime Reports (UCR) are collated at the state and national level based on reports submitted by local law enforcement agencies. Each law enforcement agency is to report any offense that meets the reporting requirements and definitions of the UCR program when it becomes knowledgeable that the offense has occurred. UCR captures data about each criminal incident using a Hierarchy Rule. In the event that multiple reportable offenses occur within a single incident, only the highest-ranking offense will be reported for UCR purposes. For example, if both threat/intimidation and aggravated assault occurred in the same incident, only the more serious offense of aggravated assault would be counted for UCR reporting purposes. Stalking in particular is a crime that is often underreported (McFarlane, Judith et al. 1999. Stalking and Intimate Partner Femicide. Homicide Studies November 1999 vol. 3 no. 4 300-316).

<sup>4</sup>Florida Statute Sections 741.316 and 741.3165.

<sup>5</sup> Dr. Websdale is Professor of Criminal Justice at Northern Arizona University and Principal Project Advisor to and Director of the National Domestic Violence Fatality Review Initiative. He has published extensively, including five books, on domestic violence homicides, the history of crime, policing, social change, and public policy. Matthew Dale is the director of the Montana Department of Justice's Office of Consumer Protection and Victim Services and oversees the Montana statewide domestic violence fatality review team. He serves as a senior consultant to the National Domestic Violence Fatality Review Initiative.

<sup>6</sup> Florida Statute Sections 741.316, 741.3165, and 39.908.



## **OVERVIEW OF TEAM ACTIVITIES**

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### ***TRAINING INSTITUTES***

FCADV coordinated a two-day training institute specifically for the statewide team in January 2010, conducted by national experts Websdale and Dale. The experts provided a general overview of domestic violence fatality review and national trends, as well as specific guidance to the team as it began review of a domestic violence murder-suicide that occurred in Florida in 2009. FCADV offered a second training institute in Tampa, open to the public, in June 2010. More than 50 attendees heard presentations from Websdale and Dale, as well as a facilitated discussion from a panel of family members of domestic violence homicide victims. The family members provided insights on interviewing techniques and family involvement in the fatality review process as well as their thoughts on preventative measures.

### ***ORLANDO COMMUNITY FORUM***

The statewide team held a forum in Orlando in June 2010 to provide an opportunity for the community to speak out about the significant rise in domestic violence homicides in their county. Citing a 12.5% increase in domestic violence calls to law enforcement from 2008 to 2009, at the same time other crimes in the county were decreasing, Orange County officials called domestic violence an “epidemic.”<sup>7</sup> More than 60 community members attended the meeting, representing domestic violence centers, law enforcement, the Department of Children and Families, mental health and substance abuse providers, probation, animal control, the print media, the Girl Scouts, the state attorney’s office and members of the recently reconvened local domestic violence fatality review team. The community identified potential gaps in services as well as promising collaborations implemented to prevent future homicides.

### ***TEAM AND SUBCOMMITTEE MEETINGS***

The full team met in-person four times, and the subcommittees held in-person and conference call meetings.

### ***FATALITY REVIEW SUBCOMMITTEE***

The Fatality Review Subcommittee reviewed police reports, court records and other information relating to a 2009 domestic violence murder-suicide in Florida, including interviewing persons familiar with the victim and the perpetrator.

The Subcommittee used the following techniques to gather key information:

- Constructed a timeline to visually capture changes in the case and the lives of the parties. The timeline provided a longitudinal sense of developments in an effort to convey the need for agencies and professionals to go beyond incidents and episodes of abuse/violence and to examine cases/lives in the longer term.
- Identified warning signs or red flags that might have formed the basis for more strident interventions.
- Assessed the degree of agency and community involvement in the case and specifically inquired about the degree of coordination, communication and collaboration between these entities. Of particular importance was the team’s outreach to gather information from the family, friends and co-workers of the perpetrator and victim.

- Completed and reported on in-depth interviews with five people who were familiar with the victim and the perpetrator.
- Reviewed other sources of information including the perpetrator's extensive criminal history, redacted dispatch transcripts, records from the courts, probation, law enforcement, parole, and the Department of Corrections, and a series of newspaper articles.

Based on information gathered, the team was able to gain insight into the relationship between the victim and the perpetrator and prepared a case study.

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<sup>7</sup> "A United Front Against Domestic Violence," Orlando Sentinel, March 29, 2010.

## CASE STUDY

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*In January 2009, C.M., age 35, was murdered by her boyfriend of six years, R.J., age 47, who then took his own life.<sup>8</sup> At the time of their deaths, R.J. was living with C.M., her young son, and her extended family.*

*R.J. had an extensive criminal record beginning in 1980 that included numerous arrests for burglary, grand theft, obstructing a law enforcement officer, uttering forged bills, marijuana possession, and battery. Notably, R.J. was convicted in 1990 of second-degree murder by gunshot of his girlfriend for which he served five and one-half years of his 17-year sentence and five years' probation. R.J. had his GED and was employed at the time of his death.*

*C.M. owned her own home and car, had a college degree, and a steady job. She was a single mother and a sought-after friend and confidant. Several observers who knew R.J. commented that he was a "charmer," but also noted his jealousy and his attempts to control C.M. They reported that C.M.'s demeanor would change when R.J. contacted her when she was away from him. While it is not clear when R.J.'s physical abuse of C.M. began, C.M. disclosed to friends that on different occasions R.J. "choked her", forced her to have sex, and threatened her with a machete. In hindsight, some observers realized that when C.M. asked for aspirin it may have been for pain from physical abuse.*

*Reports and accounts by friends and family reveal C.M. eventually learned about R.J.'s criminal history, and possibly about the second-degree murder. People interviewed believed C.M. thought she could handle the abusive relationship with R.J. One observer stated that she wasn't sure if C.M. stayed with R.J. out of love or fear.*

*In January 2009, C.M. told friends she had decided she wanted R.J. to move out by the end of the month. A person who was close to R.J. reported that during this time R.J. was upset because he suspected C.M. had started to date someone else, someone R.J. knew. She also stated that R.J. called her a few days prior to the murder/suicide to give her his bank account number and other information about his possessions, and that he seemed "too quiet" and "not himself." C.M.'s family members reported that the weekend prior to the murder/suicide, R.J. became intoxicated and threatened to kill everyone in the house.*

*On the day of C.M.'s murder, her co-workers called 911 because they feared R.J. had abducted her. C.M. had called in sick to work after she and R.J. dropped her son off at school, and a co-worker suspected, based on the tone of her voice and answers to yes and no questions, that R.J. was holding her against her will. There was also a call to 911 that morning from C.M.'s son's school, but law enforcement could not identify the person who made that call.*

*Friends, family members, co-workers and law enforcement engaged in a citywide search for C.M. They were able to reach her on her cell phone several times, and she repeatedly stated she was fine. However later that morning law enforcement found C.M. and R.J. in a hotel room where R.J. had apparently shot C.M. and then took his own life.*



Due to time constraints, the statewide team was only able to review in-depth one case. However, several key factors identified in this case are supported by Florida fatality review data reflected in this report as well as national data trends on domestic violence homicides.<sup>9</sup>

These factors, which often indicate increased risk, include:

- The perpetrator had a prior criminal history, and a prior history of domestic violence.
- There was a history of physical abuse and controlling behavior in the relationship.
- The perpetrator threatened the victim's family with physical abuse.
- The victim was in the process of separating from the perpetrator and may have started a new relationship.
- The perpetrator was obsessively possessive of the victim.
- The perpetrator had a history of drug and alcohol use.

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<sup>8</sup> Out of respect for the victim, the perpetrator and their families, and in compliance with Florida's confidentiality statutes, the initials of the victim and perpetrator have been changed.

<sup>9</sup> Websdale, Neil. 2010. *Familicidal Hearts: The Emotional Styles of 211 Killers*. New York. Oxford University Press; Campbell, J. et al. 2007. *Intimate Partner Homicide: Review and Implications of Research and Policy*. *Trauma, Violence and Abuse*. 8: 246-269.

## DATA SUBCOMMITTEE

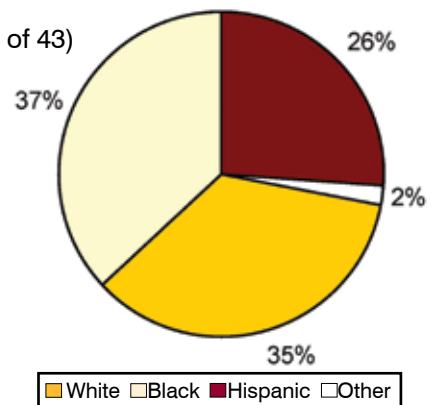
The Data Subcommittee worked closely with local fatality review chairpersons to develop a data instrument to collect and analyze information for this report. The Subcommittee also invited local fatality review team members to provide feedback on the challenges and issues they face in their communities.

The Miami-Dade team provided its data collection instrument to use as a starting point for developing a uniform review instrument. The new form contains 80 data elements and the Subcommittee is currently developing operational definitions for each element where appropriate. Local teams used the form to provide data on 43 domestic violence homicides reviewed between January 2009 and May 2010. The DCF DVPO reviewed the data submitted to identify statewide trends. The DCF DVPO also conducted a “desk review” of 20 domestic violence fatalities that occurred during the same time period, based on information available in public records and the media.

### FINDINGS BASED ON LOCAL FATALITY REVIEW TEAM DATA

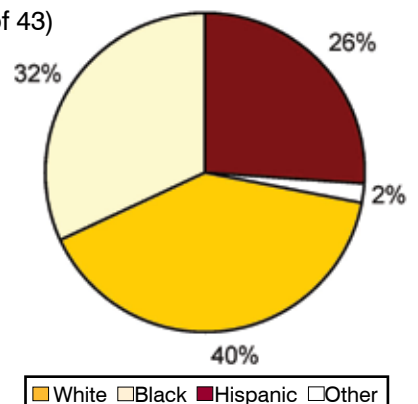
#### Perpetrator Characteristics

- Gender: 88% male (38 of 43), 12% female (5 of 43)
- Race/Ethnicity:
  - 35% White, non-Hispanic (15 of 43)
  - 37% Black, non-Hispanic ( 16 of 43)
  - 26% Hispanic (11 of 43)
  - 2% Other (1 of 43)
- Average age: 37



#### Decedent Characteristics

- Gender: 79% female (34 of 43), 21% male (9 of 43)
- Race/Ethnicity:
  - 40% White, non-Hispanic (17 of 43)
  - 32% Black, non-Hispanic (14 of 43)
  - 26% Hispanic (11 of 43)
  - 2% Other (1 of 43)
- Average age: 37



### Relationship Characteristics

- The mean length of the intimate partner relationship was approximately eight years.
- In 56% of cases (24 of 43) the couples were living together at the time of the incident.
- In 28% of cases (12 of 43) formerly married couples or couples who had previously lived together were separated<sup>10</sup> at the time of the incident.<sup>11</sup>
- 33% of perpetrators (14 of 43) were known to be employed and 42% (18 of 43) were known to be unemployed (remaining nine perpetrators' employment status was unknown).
- 47% of perpetrators (20 of 43) had a known substance abuse history.<sup>12</sup>
- In 44% of cases (19 of 43), perpetrators were known by the decedent or by other friends/family to carry a weapon.
- 23% of perpetrators (10 of 43) had a known mental health diagnosis.

### Criminal Records

- 63% of perpetrators (27 of 43) had a known criminal history.
- 47% of perpetrators (20 of 43) had a known domestic violence criminal history.<sup>13</sup> In 28% of cases (12 of 43), there were known prior reports to the police, by the decedent, alleging domestic violence by the perpetrator.
- In 37% of cases (16 of 43), friends/family/co-workers report knowing or suspecting domestic violence by the perpetrator.
- In 16% of cases (7 of 43) there was a known filing for a permanent injunction against the perpetrator on the part of the decedent.
- In 9% of cases (4 of 43) there was a known "do not contact" order issued against the perpetrator.
- In 13% of cases (1 of 8) with an injunction order, there was a known injunction violation.
- In 14% of cases (6 of 43), the decedent alleged stalking by the perpetrator.



### Domestic Violence Services

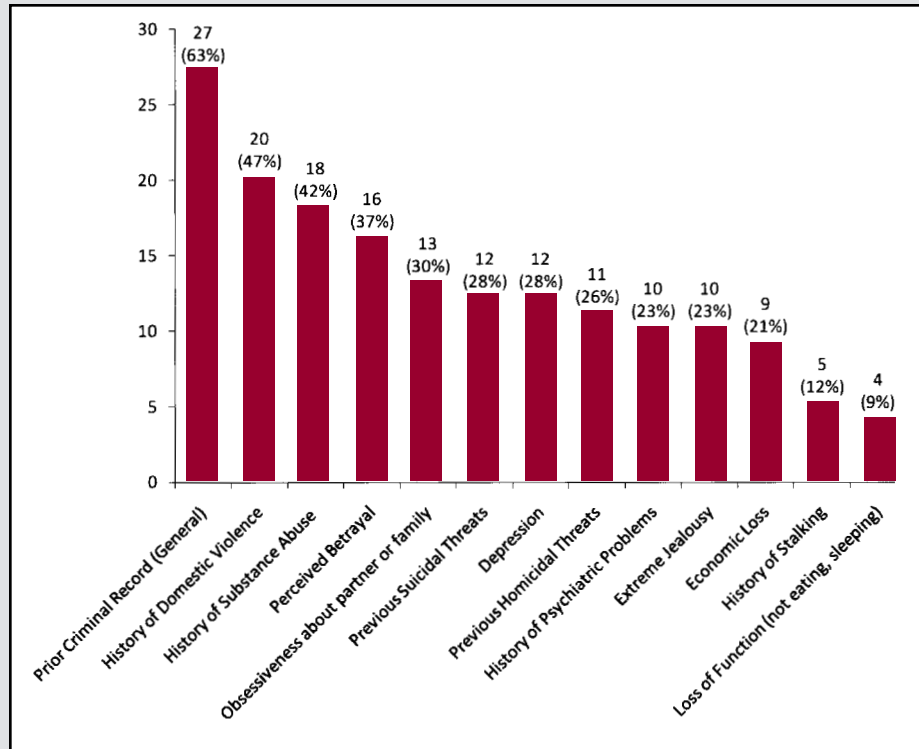
- In 26% of cases (11 of 43) there was known contact between DCF and the decedent or his/her family. However, the exact nature of the contact is unknown.
- In 7% of cases (3 of 43) there was known contact between decedents and a victim services shelter.<sup>14</sup>
- 5% of perpetrators with a domestic violence criminal history (1 of 20) was currently or had been previously enrolled in a Batterers' Intervention Program (BIP).

### ***Incident Characteristics***

- In 23% of cases (10 of 43) the perpetrator committed suicide.
- 16% of perpetrators (7 of 43) had been using drugs, alcohol or both at or before the time of the incident. <sup>15</sup>
- 16% of cases (7 of 43) suffered collateral victims.
- Manner of death:
  - 47% (20 of 43) - Gunshot
  - 28% (12 of 43) - Stabbing
  - 7% (3 of 43) - Beating
  - 7% (3 of 43) - Strangulation
  - 12% (5 of 43) - Other
- Place of incident:
  - 81% (35 of 43) Decedent's own residence
  - 7% (3 of 43) Other residence
  - 5% (2 of 43) Street or highway
  - 2% (1 of 43) Decedent's workplace
  - 2% (1 of 43) Vehicle
  - 2% (1 of 43) Unknown



### Breakdown of Known Risk Factors<sup>16</sup>



Note: As mentioned previously, findings related to the perpetrator and the perpetrator-decedent relationship stem from multiple sources that include official records and police reports, media accounts and interviews with friends and family of the victims. Consequently, histories of substance abuse, symptoms of depression and history of psychiatric problems are not confirmed by medical or other records that are confidential.

It is important to also note that anecdotal information reveals that stalking occurs at a much higher rate in domestic violence fatalities than indicated in the graph above. However, accurate data relating to incidents of stalking is difficult to obtain because stalking is a crime that is often not identified and/or underreported (McFarlane, Judith et al. 1999. Stalking and Intimate Partner Femicide. Homicide Studies November 1999 vol. 3 no. 4 300-316). Additionally, when stalking occurs along with higher ranking offenses, a perpetrator may be charged with the higher ranking offense.

<sup>10</sup> Separation in this instance refers to a physical separation. There were other known “separations” in which it appeared that the couples were separated but were still living together at the time of death (2 of 43). In one of these cases, the victim remained in the home while waiting for dissolution of marriage to be completed. The circumstances surrounding the other case are unclear.

<sup>11</sup> Of the nine known separations, six had been separated for two months or less, one couple was separated for four or five months, and one had been separated for eight months.

<sup>12</sup> Likely in the form of both/either objective and subjective indicators of substance abuse discovered by case reviewers.

<sup>13</sup> Domestic violence criminal history refers to any known arrests or convictions for domestic violence related offenses.

<sup>14</sup> This only includes known contact based on a report in a public record or other source as Florida Statutes protects the confidentiality of clients of certified domestic violence centers.

<sup>15</sup> Based on known toxicology reports.

<sup>16</sup> Some of these risk factors were previously described above, and shown again here for illustrative purposes.



## **FINDINGS BASED ON DESK REVIEW**

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The data and trends described below are based on a DCF DVPO desk review of 20 intimate partner homicide cases that occurred in Florida between January 2009 and May 2010. These cases were reviewed using information available from public sources, including but not limited to court records, police reports (when available), and media publications. The DCF DVPO selected these cases primarily because local fatality review teams had not reviewed them,<sup>17</sup> and there was sufficient information available from the aforementioned sources. Due to substantial differences in both the type and the depth of information available using this review method when compared to reviews by local fatality review teams, the data trends gathered from the desk review are presented separately from the local team data. Open and closed cases of homicide, homicide/suicide and attempted homicide were all included in the desk review.

### ***Individual Characteristics***

- The average perpetrator age was 39 and the average decedent age was 38.
- In all 20 of the cases reviewed, the perpetrator was male.
- 90% of decedents (18 of 20) were female.
- Perpetrator race/ethnicity:
  - 40% White, non-Hispanic (8 of 20)
  - 20% Black, non-Hispanic (4 of 20)
  - 35% Hispanic (7 of 20)
  - 5% Other (1 of 20)
- Decedent race/ethnicity:
  - 45% White, non-Hispanic (9 of 20)
  - 15% Black, non-Hispanic (3 of 20)
  - 35% Hispanic (7 of 20)
  - 5% Other (1 of 20)

### ***Perpetrator Prior Record<sup>18</sup>***

- For 50% of perpetrators (10 of 20), there was evidence of a prior domestic violence record, and 50% of those with domestic violence histories (5 of 10) had multiple arrests (average number of domestic violence arrests for those with record = 1.9).<sup>19</sup>
- Perpetrators were also likely to have prior criminal histories for other offenses, including 35% with substance-related offenses (7 of 20, e.g. DUIs, drug possession), and 25% with other, non-domestic violence related assaults (4 of 20).
- 30% of perpetrators (6 of 20) had known probation histories, and 25% of perpetrators (5 of 20) were known to be on probation at the time of the incident.
- Of the perpetrators with a prior domestic violence record, 10% (1 of 10) was currently or had been previously enrolled in a Batterers' Intervention Program (BIP).
- In 50% (10 of 20) of the cases there was evidence of a previous or current injunction against the perpetrator, either by the decedent or by a previous intimate partner.

### ***Relationship Characteristics***

- 50% of the couples (10 of 20) had children together, and 30% (6 of 20) had children from prior relationships.
- In 35% of the cases (7 of 20) there was evidence of some type of financial loss (e.g. foreclosure, bankruptcy, loss of job, business failing) on the part of one or both individuals.<sup>20</sup>

### ***Incident Characteristics***

- 80% of the incidents (16 of 20) occurred at a jointly- or decedent-owned residence.
- Manner of death:
  - 50% gunshot (10 of 20)
  - 40% stabbing (8 of 20)
  - 10% strangulation (2 of 20)
- 40% of cases (8 of 20) involved perpetrator suicide or attempted suicide.
- 30% of the incidents (6 of 20) suffered collateral victims, oftentimes children of either or both the decedent and the perpetrator.

### **Other Factors**

- 25% of the reviewed cases (5 of 20) involved either the decedent or the perpetrator contacting 911 during the course of the incident.
- In 45% of cases (9 of 20) there was evidence of substance abuse history on the part of the perpetrator.<sup>21</sup>
- In 25% of cases reviewed (5 of 20), there was evidence of the decedent amending an injunction request, failing to show for final injunction hearings, or requesting charges of abuse or assault against the perpetrator be dropped.<sup>22</sup>

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<sup>17</sup> Using identifying information included in the 43 reviews received by local fatality review teams, the DCF DVPO was able to determine whether or not selected cases were previously reviewed by local teams.

<sup>18</sup> It is important to note that information on prior criminal records are based on official court and arrest records, and are limited to those found in the county of incident, and, if different, the county of residence for the perpetrator and decedent. However, as in most cases, reported trends cannot speak to other unknown recorded and non-recorded incidents. Thus, the statistics presented here are likely underestimations of prevalence since they do not include self-reported criminal activity and victimization, and only report on discovered facts.

<sup>19</sup> Based on information gathered from arrest and court records inquiries in the county of incident and, if different, individuals' county of residence.

<sup>20</sup> Based on records searches and also subjective media accounts reporting on the incident.

<sup>21</sup> Substance abuse history as described here includes both objective and subjective measures (friends, neighbors or family members' reports as described in a record or media report), this information should be considered with caution.

<sup>22</sup> Again, this is a conservative estimate of these types of actions, and is sometimes based on media accounts, so findings should be considered with caution.

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*State and local collaborations increase safety of victims and children.*

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**INNOVATIVE COLLABORATIONS TO COMBAT DOMESTIC VIOLENCE**

The team identified several existing state and local collaborations intended to increase the safety of victims and children and hold batterers accountable that merit consideration by other communities. A few of these collaborations are highlighted below.

***The InVEST Program (Intimate Violence Enhancement Services Team)***

The InVEST program is a partnership between local law enforcement and domestic violence centers to provide enhanced services to domestic violence victims and monitor domestic violence perpetrators. Together, law enforcement and advocates review domestic violence police reports to identify high risk cases. Victims voluntarily enroll in the InVEST program to receive specialized services and enhanced law enforcement protection such as safety checks. The goals of InVEST are to develop partnerships between law enforcement and domestic violence advocates, bridge gaps, increase contact with victims in high risk situations and increase batterer accountability. There are InVEST programs in 12 Florida jurisdictions, funded primarily with temporary federal stimulus funding. The Office of the Attorney General has made a commitment to continue funding InVEST with Victims of Crime Act (VOCA) funding.

***Palm Beach County Sheriff's Office, Domestic Violence Unit***

***Domestic Abuse Internet Information Network (DAIIN)***

DAIIN maintains restricted access case information for domestic violence criminal cases with a goal of improving investigations and prosecutions of these cases. Investigating deputies are able to input information directly into the DAIIN system. This information includes the names of the individuals involved, children and witnesses, photographs of injuries, damage to property as a result of the altercation and 911 tapes. DAIIN is also able to upload scanned Abuse Indicator Assessments and written and/or taped statements. The information stored in DAIIN is linked with the State Attorney's Office, Domestic Violence Courts (to include First Appearance Court), Victim Services, Probation/Parole, Court Administration, domestic violence centers and the Palm Beach County School Board. Users may input case numbers, addresses, trial dates, or names into the system to search for a particular case. New case records are also input and photos can be uploaded into any case record.

## ***The Safe and Together Model***

### ***Intersection of Child Endangerment and Domestic Violence***



“Family Violence Threatens Child” (domestic violence) is the first or second most common maltreatment identified in the child welfare reporting system when child abuse/neglect is reported. Since 2006, the Department of Children and Families, Office of Family Safety, through the circuits and regions, has gradually implemented changes in child welfare practices to increase safety for children and adult victims in domestic violence cases. The agency is moving away from charging the non-offending victim parent in child welfare/domestic violence cases for the maltreatment of “failure to protect,” and instead employing an alternative approach, the Safe and Together Model developed by Connecticut-based David Mandel and Associates. The goal of Safe and Together is to keep children safe with the non-offending parent, rather than removing them. The model recognizes the most successful approach to protecting the children is by developing a successful partnership with the non-offending parent. The Northeast Region of Florida has implemented all aspects of the Safe and Together Model, including training domestic violence consultants and inviting advocates from the certified domestic violence centers to participate on their multi-disciplinary case advisory team. They have also co-located an advocate from their local domestic violence center with the Child Protective Investigators.

## ***Animal Services - PAWS***

### ***Harbor House of Central Florida, Inc. and Orange County Animal Shelter***

Approximately 71% of domestic violence victims entering shelters reported the perpetrator had threatened to harm or had killed their pets.<sup>23</sup> In some cases, victims have refused to leave home if they cannot find a safe place for their family pets. As a result, Harbor House of Central Florida, Inc., the certified domestic violence center serving Orange County, and Orange County Animal Services have developed a unique implementation of the American Humane Society’s PAWS Program. PAWS involves a first-responder transport program that enables Animal Services Officers to assist domestic violence victims by transporting their pets to Harbor House’s on-site kennel, vaccinating them and evaluating them for injuries. In cases where animal abuse is suspected, Animal Services will launch a cruelty investigation. As part of the program, Animal Services provides on-going best practices consultation for the on-site kennel including housing and care, animal handling and other safety standards. Animal Services Officers have received training on identifying domestic violence and connecting victims and their children with appropriate services when they respond to animal cruelty calls.



## ***The Intimate Partner Violence Assistance Clinic***

The Intimate Partner Violence Assistance Clinic (IPVAC) is a first-of-its-kind partnership between the University of Florida Levin College of Law, College of Medicine, Shands Teaching Hospital and certified domestic violence center Peaceful Paths. IPVAC runs The Source Program, a multi-disciplinary team providing indigent victims of intimate partner violence with legal, social, counseling and educational services. Located in the Levin College of Law, IPVAC consists of a lawyer, social worker and victim outreach counselor who supervise graduate student interns from law, social work, public health, and

counseling programs who attend the University of Florida and other major universities. This ‘team” approach provides a rich experience for students and invaluable “wrap around” services for victims. IPVAC also does regular training at Shands Teaching Hospital and the College of Medicine, providing medical personnel with the knowledge, tools and encouragement to screen patients for intimate partner violence. In response to the increasing rates of intimate partner violence during pregnancy, IPVAC spends two days every week at both the College of Medicine’s outpatient ob-gyn clinic and the pediatric clinic to counsel victim/patients. IPVAC also provides Shands Teaching Hospital and the Child Protection Team with on-call service, arriving bedside to counsel victim/patients. IPVAC accepts client referrals from the community and community agencies and has recently begun working with the large immigrant population and the homeless population in Gainesville and the surrounding areas. In addition to operating the clinic, IPVAC has also integrated domestic violence into the curriculum of the law and medical schools so these professionals graduate with a basic understanding of the dynamics of intimate partner violence, the effects it has on children and how both may affect their practices.

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<sup>23</sup> Ascione, F.R., Weber, C. V. & Wood, D. S. (1997). The abuse of animals and domestic violence: A national survey of shelters for women who are battered. *Society & Animals* 5(3), 205-218.

## Statewide Fatality Review Team Members

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### SPECIAL ACKNOWLEDGEMENTS

The Statewide Fatality Review Team expresses its appreciation to the following persons for their support and guidance during the past 10 months.

Former Attorney General Bill McCollum for establishing and providing leadership to the statewide team.

The individuals who agreed to interviews that allowed the team to gain greater insight into the homicide/suicide victims. We realize how difficult it was to revisit the loss of your family member, friend and co-worker.

Shirley and Larry Bostrom and Sally Sjaastad for providing testimony to our committee regarding the tragic deaths of their family members.

Dr. Neil Websdale and Matthew Dale, for sharing their knowledge, expertise and research to help the team learn more about the fatality review process and to craft recommendations to move Florida forward in the prevention of intimate partner homicides.

The local fatality review teams for sharing their ideas and years of experience in conducting fatality reviews and for assisting with data collection efforts.

Local fatality review team chairpersons Nancy Tanner (Broward); Ellen Siler (Duval); Nikki Daniels (Hillsborough) Terri O'Brien (Pasco); Frieda Widera (Pinellas); and John Feliu, Data Analyst for the Miami-Dade fatality review team, for presenting information to our team and data subcommittee.

Miami-Dade County's Domestic Violence Fatality Review Team for their data collection instrument that served as the basis for developing the statewide fatality review data collection instrument for the purposes of this report, and for the collection of statewide data in the future.



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*This project was supported by Grant No. 2007-WE-AX-0055 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women or the Florida Department of Children and Families.*