Domestic Violence Deaths in Georgia

County	# of Primary Victims 2006	# of Secondary Victims 2006	# of Alleged Perpetrators 2006	2003 Total Deaths	2004 Total Deaths	2005 Total Deaths	2006 Total Deaths
Appling	1	2	1				4
Baldwin	2		1			3	3
Barrow				1	1	1	
Bartow				4		2	
Ben Hill				1	2		
Bibb	1		1	1	4	6	2
Bleckley						2	
Brantley					1		
Bulloch			1				1
Burke				2	1		
Butts				1			
Calhoun				2			
Camden				1	1	1	
Carroll	1			1	1		1
Chatham	2	1		6	2	8	3
Cherokee				2	1	4	
Clarke	2		1	3		2	3
Clayton	5	2	4	3	3	10	11
Cobb	5	1	4	7	3	8	10
Coffee						1	
Colquitt				3		3	
Cook	1		1				2
Coweta					1		
Columbia				1		2	
Crisp				2		1	
Dawson						1	
Dekalb	5	2	1	17	5	3	8
Dodge	1						1
Dooly					1		
Dougherty	2			1	2		2
Douglas				1	1		
Elbert				1		1	
Effingham	1						1
Fannin				1		1	
Fayette	1				4		1
Floyd	1			1	2	1	1
Forsyth	1		1	4			2
Franklin					1		
Fulton	2	1		9	15	7	3
Gilmer						1	
Glascock						1	
Glynn	1						1
Gordon	1				4		1
Grady				1	1		
Gwinnett	7	1	5	6	12	11	13
Habersham				1			
Hall		1	1		2		2
Hancock					1		
Haralson				4			
Harris					1	2	
Henry		3	1	4	1	3	4
Houston	1		1	1		2	2
Jackson	2	3			2	1	5
Jefferson	1	1		2			2
Jenkins	1						1
Lamar						2	
Laurens	1			2	2	1	1
Liberty	3		2	4			5
Lowndes						9	
Lumpkin					1		
Macon						1	
Madison				2			
McDuffie				1	2		
Monroe	1						1
Montgomery				1			
Muscogee	1			4		9	1
Newton	2		1	3	1		3
Oconee					1		
Oglethorpe				2			
Paulding				1	2		
Pickens						1	
Polk				1	2		
Rabun			1				1
Richmond	1			4	6	2	1
Rockdale					4	3	
Screven	1						1
Seminole	1						1
Tattnall				1	2		
Telfair	1					3	1
Tift						1	
Thomas					1		
Towns					2		
Troup				1		1	
Twiggs					1		
Upson				2	1		
Walker						2	
Walton					2		
Ware						1	
Washington				1		1	
Wayne				3			
Webster				1			
Wheeler				1			
White				2	1		
Whitfield				3	3	1	
Total Deaths	60	20	29	135	110	127	106

Acknowledgements

The Georgia Commission on Family Violence (GCFV) and the Georgia Coalition Against Domestic Violence (GCADV) owe a great amount of gratitude to the many individuals and systems that continue to make Georgia's Fatality Review Project possible. With strong Fatality Review Committees, high participation from a variety of systems, and clear direction from the Project Coordinators, this fourth year has been a success.

Fatality Review Project Staff

Jasmine Williams-Miller, Co-Coordinator, Fatality Review Project, GCFV
Taylor Thompson, Co-Coordinator, Fatality Review Project, GCADV
Kirsten Rambo, Executive Director, GCFV
Beck Dunn, Interim Executive Director, GCADV

For part of the current project year, ***Nancy Grigsby,*** Former Executive Director, GCADV

The Georgia Coalition Against Domestic Violence is a state coalition of about 60 organizations responding to domestic violence in Georgia. GCADV operates Georgia's 24-hour toll free domestic violence hotline (800-33-HAVEN) and provides education, consultation, training, technical assistance, and dissemination of research and information. GCADV also promotes best practices and resources for victims and their children through a number of initiatives including the Fatality Review project, a Transitional Housing project, a Victim Liaison project, and a Legal Assistance project. Finally, GCADV advocates for improvements in systems responding to victims and offenders through public policy and legislative advocacy. Please visit www.gcadv.org for more information.

The Georgia Commission on Family Violence is a Commission under the Governor's Office, administratively attached to the Department of Corrections. The Commission was legislatively formed to assist in the development of domestic violence task forces in judicial circuits and to monitor legislation impacting families experiencing domestic violence. GCFV is the certifying body for Family Violence Intervention Programs (FVIPs) in Georgia and provides training and technical assistance to FVIPs and task forces, and hosts an annual statewide conference on domestic violence. Please visit www.gcfv.org for more information.

Special Thanks

A special acknowledgement goes to the **family members and friends** of homicide victims who were willing to share with us the struggles their loved ones faced.

Our special thanks to the **survivor of the near fatality** who allowed us to learn from her experience.

Shelley Senterfitt, Attorney at Law provided legal research and counsel for the project.

We are especially grateful to **Allison Smith, GCADV**, who again conducted data analysis for the project, allowing us to provide aggregate data for this report.

We are also grateful for technical assistance from the **National Domestic Violence Fatality Review Initiative**. We are particularly grateful for their support in allowing us to receive strategic planning assistance from **Robin H. Thompson**.

Our special appreciation goes to the **Washington State Coalition Against Domestic Violence** for their ongoing guidance and technical assistance. Our efforts have benefited greatly from the groundbreaking work done by Washington review teams, under the leadership of the Coalition staff.

Our special thanks to **Debbie, Lillard, L.C.S.W.**, Mosaic Counseling, Inc., who assisted with the near fatality review.

Financial Support

The Georgia Fatality Review Project was funded by the ***Criminal Justice Coordinating Council*** through ***Violence Against Women Act*** funds. We are grateful for the grant which allowed our state to join many others around the country in conducting fatality reviews.

The following companies provided in-kind donations of time and skill in the design and printing of this annual report: ***Grace Design, LLC***, Lawrenceville, GA and ***Printing Partners***, Marietta, GA.

Acknowledgements

Fatality Review Project Advisory Committee

Many thanks are due to our Fatality Review Project Advisory Committee, whose leadership and time dedication have helped to provide ongoing direction for this project. The members of the Advisory Committee include:

Ms. Jamie Apple-Anderson
State Probation

Mr. Dick Bathrick
Men Stopping Violence

Ms. Judy Byrnes
Division of Public Health

Lt. Col. Maureen Carter
Retired, USAR

Ms. Cynthia Hinrichs Clanton
Administrative Office of the Courts

Ms. Brenda Cook
Gateway House, Inc.

Ms. Lisa Dawson
Division of Public Health

Ms. Erin Derrick
Gateway Domestic Violence Center

Ms. Karen Geiger
Georgia Legal Services Program

Ms. Misty Giles
Governor's Office

Dr. Sheryl L. Heron
Department of Emergency Medicine
Emory University

Ms. Patricia Holloway
DHR, Family Violence Unit

Mr. Garland R. Hunt
State Board of Pardons and Paroles

Ms. Kris Jones
Georgia Legal Services Program

Mr. Steve Page
Georgia Probation Management

Mr. Brad Shear
Atlanta Humane Society

Ms. Carmen D. Smith
Fulton County Solicitor General

Ms. Paula P. Smith
Prosecuting Attorney's Council of Georgia

Deputy Sheriff Chris Storey
Clayton County Sheriff's Department

Review Teams

We acknowledge the commitment of the Fatality Review participants from around the state who devoted their time, energy and expertise to work towards creating safer communities.

Atlanta Judicial Circuit

Laura Barton, Partnership Against Domestic Violence
Becky Bennett, Judicial Correction Services, Inc.
Nikki Berger, District Attorney's Office
Errol Boyland, City of Roswell Police Department
Det. Silvia Browning, City of Roswell Police Department
Beverly Cole, New Birth South Church
Cameron Daniel III, Fulton County DFCS
Lyndall Doxey, State Board of Pardons and Paroles
Sharolyn Griffin, District Attorney's Office
Becky Gorlin, Judicial Correction Services, Inc.
Lisa Geer, Families First
Juree Hall, Solicitor-General's Office
Jeanette Handy, Partnership Against Domestic Violence
Minister William B. Hill, New Birth South Church
Emerson Jones, Atlanta Public Schools
Wendy Lipshutz, Jewish Family and Career Services
Sheri Miller, Odyssey Family Counseling Center
Jodi Mount, Atlanta Legal Aid Society
Danna Philmon, Judicial Correction Services, Inc.
Amanda Planchard, Solicitor-General's Office
Jennie Riski, Partnership Against Domestic Violence
Genevieve Schmidt, Fulton County Superior Court
Karria Simmons, Partnership Against Domestic Violence
Michelle Small, New Birth South Metropolitan Church
Jenni Stolarski, Atlanta Volunteer Lawyers Foundation
Renata Turner, Atlanta Volunteer Lawyers Foundation
Chastity Sims-Rogers, Partnership Against Domestic Violence
Vince Williams, New Birth South Metropolitan Church

Blue Ridge Judicial Circuit

Detective David Barone, Cherokee County Sheriff's Office
Gregory Douds, Flint and Connolly, LLP
Investigator Beth Furman, Cherokee County Sheriff's Office
Melissa Garner, Indigent Defense
Kay Kreft, Solicitor General's Office
Niki Lemeshka, Cherokee Family Violence Center
Meg Rogers, Cherokee Family Violence Center

Clayton Judicial Circuit

Pat Altemus, Securus House
Jennifer Bivins, Southern Crescent Sexual Assault Center
Capt. Chris Butler, Clayton County Police Department
Charles Fisher, Clayton County DFCS
Capt. Richard Gandee, Clayton County Police Department
Jenitha Gouch, Solicitor-General's Office
Investigator Michael Harris, Clayton County Police Department
Katie Hart, Clayton County Public Schools
Kia Johnson, Clayton County Magistrate Court
Sheila Love, New Birth South Metropolitan Church
Mario Orizabal, Multi-Cultural Counseling and Services, Inc.
Stephanie Owen, Delta Airlines
Michelle Small, New Birth South Metropolitan Church
Deputy Sheriff Chris Storey, Clayton County Sheriff's Department
Elizabeth Toledo, Angels Recovery and Spirituality
Rose Gibbs Torres, Clayton Center for Behavioral Health Services
Judge Daphne Walker, Clayton County Magistrate Court
Phyllis Walker, Esperanza! A Woman's Hope, Inc.

Acknowledgements

Chattahoochee Judicial Circuit
(Muscogee County)

Kyle Bair, Sexual Assault Support Center
Linda Bass, Muscogee County School Department
LaShern Colbert, District Attorney's Office
Valencia Evan, Hope Harbour
Sally Haskins, Georgia Legal Services Program
Hattie Jones, Judicial Alternative of Georgia
Pam Maney, Judicial Alternatives of Georgia
Jane Prest, Victim/Survivor
Angela Rozar, Atlanta Resources
Ruthie Shelton, Georgia Department of Corrections
Rachel Snipes, The Family Center

Eastern Judicial Circuit

Wanda Andrews, Georgia Legal Services Program
Judge James Bass, Superior Court, Chatham County
Pastor Matthew S. Brown Jr., First Union Baptist Church
Sharon Carson, Chatham County DFCS
Marta Greenhoe Kaufman, Latin American Services Organization
David Lock, District Attorney's Office
Frank Pennington II, District Attorney's Office
Tere Rivera, Hunter Army Airfield
Sara Rudolph-Pollard, Hunter Army Airfield
Rose Grant-Robinson, S.A.F.E Shelter Outreach
Kevin Scarlett, Parent and Child
Laura Singleton, Georgia Legal Services Program
Regina Smith, PCDS/Union Mission Inc.
Marcus Tucker, District Attorney's Office
Yukeyveaya Wright, District Attorney's Office

Mountain Judicial Circuit

Vickie Ansley, Stephens County Hospital
Wendi Bailey, Chamber of Commerce
Vicki Bourne, Circle of Hope
Dorothy Brown, St. Matthias Episcopal Church
Scott Chitwood, State Probation
Michael Crawford, District Attorney's Office
Suzanne Dow, Circle of Hope
Chief Don Ford, Habersham County Board of Education, P.D.
Tina Gonzalez, Power House for Kids
Mylene Hallaran, LifeWorks Counseling
Tim M. Housley, State Probation
Kris Jones, Georgia Legal Services Program
Sharon Moore, District Attorney's Office
Leah Norton, Ninth District Opportunity
Dan T. Pressley, Solicitor General's Office
Barbara Stevens, Stephens County Schools
Edith Swarthout, Stephens County DFCS

Northeastern Judicial Circuit

Larry Baldwin, Solicitor-General's Office
Officer Chris Banks, Flowery Branch Police Department
Brenda Cook, Gateway Domestic Violence Center
Erin Derrick, Gateway Domestic Violence Center
Rosa de-Kelly, Catholic Charities Atlanta, Inc.
Inv. Dan Franklin, Hall County Sheriff's Department
Rochelle Galletti, Family Recovery
Juan F. Garcia, Judicial Alternatives of Georgia
Kris Jones, Georgia Legal Services Program
Nancy Martin, Gainesville State Probation Office
Pari-Ann McDuffie, Avita Community Partners
Karen Neff, Hall County Health Department
Sgt. Johnny Ray, Gainesville Police Department
Captain Andy Smith, Oakwood Police Department
Leigh Stallings-Jarrell, Hall County 911
Renee Parrish Strickland, Hall County Schools

Stone Mountain Judicial Circuit

Lt. Billi Akins, DeKalb County Sheriff's Department
Judge Berryl A. Anderson, Magistrate Court
Erica Barnes, DeKalb County DFCS
Dick Bathrick, Men Stopping Violence
Kevin Batye, State Court Probation
Jean Douglas, Women's Resource Center
Natalie N. Dunn, State Court Probation
Sgt. Jay Eisner, DeKalb County Police Department
Gwen Keyes Fleming, District Attorney's Office
Kim Frndak, Women's Resource Center
Glenda Giddens, Public Defender's Office
Christina Kasper, Solicitor-General's Office
Betsy Ramsey, Solicitor-General's Office
LaDonna R. Varner, State Court Probation
Sandra Williams, Atlanta Intervention Network
Ramona Wilson, District Attorney's Office

"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has."

– Margaret Mead

Executive Summary

2007 was the fourth year of Georgia's Domestic Violence Fatality Review Project. This project was created in response to the terrible tragedy of domestic violence, which continues to be a leading cause of injuries for girls and women between the ages of 15 and 44 in the state of Georgia.[1] Domestic violence has taken the lives of almost 500 Georgians in the last four years.[2] Through this project, multi-disciplinary teams in 12 communities across Georgia meet to review domestic violence deaths in their area and, from these tragedies, learn how to improve their response to domestic violence.

The process of convening community teams to study domestic violence deaths in Georgia has deepened our understanding of these deaths in numerous ways. The reviews themselves have yielded countless insights and have enabled communities to examine the strengths and weaknesses in the way they respond to domestic violence. Project staff have worked to gather the data from these case reviews, and the resulting findings have highlighted some significant patterns.

While some findings are specific to particular communities, others are common to several different communities, and still others reflect gaps in response at the statewide level. Through the Annual Report, the project issues recommendations that correspond with the findings. These recommendations are directed at specific systems that interact with victims and perpetrators of these homicides, with the goal of preventing future loss of life.

After four years of reviewing deaths and strategizing about how to prevent them, the project is at a crucial point in its development. Fatality review teams, as well as project staff members, are eager to turn their findings and recommendations into action steps to prevent future homicides.

Some communities have already begun this process of implementing their recommendations to make their communities safer, while others are just preparing to begin.

This year's Annual Report reflects this pivotal moment in which we are taking stock of what we have learned so far and using those findings to progress toward future change. This report thus represents a bridge from our initial work (reviewing fatalities, gathering findings, and issuing recommendations) to the next phase: implementing those findings for meaningful change at both the community and the state levels.

Reviewed Cases: 2004-2007

Of the 61 cases reviewed in four years, there were a total of *85* fatalities. These included:

- 59 intimate partner victims
- 19 alleged perpetrators
- 3 children of the intimate partner victim
- 2 sisters of the intimate partner victim
- 1 new partner of the intimate partner victim
- 1 aunt of the intimate partner victim.

There were also 5 unsuccessful murder attempts on:

- 1 intimate partner victim
- 1 new partner of the intimate partner victim
- 1 sister of the intimate partner victim
- 1 brother of the intimate partner victim
- 1 mother of the intimate partner victim.

There were also 2 bystanders wounded, including:

- 1 child of the intimate partner victim
- 1 family member of the intimate partner victim.

Of the 59 intimate partner fatalities:

- 33 were caused by firearms
- 15 were caused by stabbing or laceration
- 5 were caused by strangulation
- 5 were caused by blunt force trauma
- 1 was caused by asphyxiation due to smoke inhalation.

---

[1] Georgia Department of Public Health, Injury Prevention, Violence Prevention Project: http://health.state.ga.us/programs/injuryprevention/vaw.asp.

[2] Statistics compiled by the Georgia Coalition Against Domestic Violence from its clipping service and from reporting domestic violence programs statewide show that 480 Georgians lost their lives to domestic violence from 2003-2006. This count represents all the homicides known to us for that time period at the time of this report.

Executive Summary

How to Read this Report

In this year's report, you will find details about the new fatalities reviewed this year, as well as aggregate data on the fatalities that have been reviewed over the past four years. In addition, the report contains a narrative description of the near fatality studied this year and some of the lessons that might be learned from that survivor's experience. The report also includes detailed analysis of four "Spotlight Issues"—topics that have emerged through case reviews and that warranted a more in-depth analysis. Last, this report provides a review of the findings and recommendations made through the project over the past four years. This year's "Findings and Recommendations" section is separated by discipline and includes observations from the past four years. This format has been chosen in order to provide a reminder of what we have learned, and a roadmap for each system about how to make changes going forward.

Spotlight Issues

The subjects detailed in the "Spotlight Issues" section include the following:

- **Firearms**
  Firearms continue to be the leading cause of death for domestic violence victims in Georgia. This section examines the lethal combination of domestic violence and firearms and describes a variety of strategies that some communities in Georgia are using to combat this problem.

- **Information Sharing**
  Systems that respond to victims and/or perpetrators of domestic violence include shelters, courts, probation, law enforcement, Family Violence Intervention Programs, and many others. Too often, one system has information about a case that would be useful to another system, but that information is not transmitted. This section explains the danger of allowing victims and perpetrators to fall through these cracks and provides suggestions for sharing information across systems.

- **Employers**
  In the cases reviewed by this project, most victims and perpetrators of domestic violence were employed. Domestic violence often reaches into the workplace, and employers must be prepared to respond in a way that supports the safety of the victim and all employees. This section provides information on numerous ways that employers can responsibly support victims and protect their employees and clients.

- **Faith Communities**
  Reviews of both fatalities and near fatalities have shown that faith communities are often a primary place where victims seek safety and support. This section provides a range of practical strategies for faith communities to support victims while holding abusers accountable.

The Fatality Review Project is federally funded by the Violence Against Women Act (VAWA) through Georgia's Criminal Justice Coordinating Council. It is conducted jointly by the Georgia Coalition Against Domestic Violence (GCADV) and the Georgia Commission on Family Violence (GCFV). Two full-time Fatality Review Project Coordinators lead and assist Fatality Review Committees across the state in conducting homicide reviews and implementing the resulting findings and recommendations. The Fatality Review Advisory Committee, consisting of leaders from various systems across the state, meets quarterly to provide support and direction to the project.

Mission Statement

The Georgia Fatality Review Project seeks to enhance the safety of victims and the accountability of batterers. The project does this by conducting detailed reviews of fatalities and by preparing, publishing, and disseminating objective information gained from these reviews. The resulting information is used as a tool for identifying gaps in system response, improving statewide data collection, enhancing efforts to train systems on better responses, identifying critical points for intervention and prevention, and providing a forum for increasing communication and collaboration among those involved in a coordinated community response to domestic violence.

Committee Formation

The Family Violence Task Force in each participating community was asked to form a multi-disciplinary Fatality Review Committee to function as a sub-committee of the local family violence Task Force. Representatives from the following systems comprise the committees: community and prosecution-based advocates, corrections, prosecution, judicial, law enforcement, Family Violence Intervention Programs, Department of Family and Children Services, faith, mental health, alcohol and drug counseling, and schools.

Case Selection

The committees selected domestic violence-related homicide cases for review with three criteria in mind:

- All civil and criminal proceedings related to the victim and the perpetrator have been closed with no pending appeals.
- The perpetrator has been identified by the criminal justice system.
- No more than 3 to 5 years has passed since the date of the homicide.

One community chose a near fatality case. See the Near Fatality section of this report for details about their methodology.

Homicides were defined as domestic violence-related if the victim and perpetrator were current or former intimate partners. Cases involving the homicide of a secondary victim such as a friend, current partner, child, or family member of the domestic violence victim were also considered domestic violence-related.

Case Information Collection

Once the cases were selected, the committee members gathered all public records pertaining to the case. The majority of the information was located in the prosecutor's file and/or the homicide file. Only information that could be obtained pursuant to the Open Records Act was collected.

Family & Friend Interviews

When applicable and appropriate, the Project Coordinators sought out interviews with surviving family and friends of the victim, who, in turn, provided incredible insight not gleaned from the public documents. The discussions were open-ended, with family members and friends being invited to share what they wanted the committee to know about their loved one, the steps the victim took to try to be safe, and the victim's perceptions of the options available in the community.

Case Chronology Development

A chronology for each case was developed by the Project Coordinator with a focus on all prior significant events leading up to the death. These included prior acts of violence perpetrated by the person who committed the homicide, whether against this victim or another, previous attempts by the victim to seek help, previous criminal and civil history, etc. A completed chronology was distributed to each committee.

Fatality Reviews

The committees, after signing a confidentiality statement, having a moment of silence for the victim(s), and an out-loud reading of the chronology, went item by item through the chronology to see where the community could have stepped in and how the system response could have been stronger. With a strong trust in each other and a commitment not to blame one another, each committee identified gaps in local response, areas where practice didn't follow protocol, and innovative ideas to make the system response more effective in increasing victim safety and offender accountability.

Development and Implementation of Findings and Recommendations

The committees then made findings about the factors in each case which appeared to contribute to the death, or conversely, actions which, if taken, might have prevented the death. Review committees were always focused on reviewing the system's response: what was available in that system for victims and offenders, what was the protocol for response, was it followed or not, and what monitoring, training and accountability existed in that system for workers who responded to families. From the findings, each committee made recommendations about changes to systems that would improve victim safety and offender accountability.

Data Analysis

Data was entered into an electronic database designed for this project and adapted from the work of data collection tools used around the country. The data was then aggregated and comprises the data findings in this report.

For more detailed information regarding the methodology of the Georgia Fatality Review Project, please see pages 10-11 in our 2005 Annual Report.

Near Fatality

For the second year, the Fatality Review Project has reviewed a near fatality in the pursuit of enhancing the safety of victims and the accountability of batterers.

This process provides a safe forum for a survivor to offer feedback to a community or system about her near-fatal experience. It is a process in which we, as a community, can hear from survivors and learn ways of better serving domestic violence victims through the lens of the victim herself.

Case selection is based on specific criteria and utilizes a system of interviewing which includes a licensed therapist, a support person chosen by the survivor, a note taker, and an interviewer. At all times, the safety and security of the victim are priority. Detailed information about the case selection process can be found in the Near Fatality section of the 2006 Georgia Domestic Violence Fatality Review Annual Report.

History

Erika is a 27-year-old mother of two. Erika and the perpetrator, Tom, were together for eight years; for five of those years, they lived together. They both grew up in the same town and worked together at a local restaurant. They are parents of a 7-year-old girl, and Erika also has a 10-year-old son from a previous relationship.

Erika felt that they had a pretty good relationship for the most part until the last two years that they were together, at which time he became increasingly possessive and controlling. He timed where she went and was verbally, mentally, and physically abusive. For example, she described an incident of him standing over her with a knife while she was sleeping. She also described a previous incident in which he pulled a gun and threatened suicide in the car while she was driving.

A few months before the near-fatal incident, Erika separated from Tom and moved back to her hometown. They remained in contact because they still worked together and Erika often gave him a ride to work. During the time they were apart, he consistently begged her to come back to him.

The Thursday prior to the incident, Erika explained that she went to pick Tom up for work and something just did not seem right. She felt jittery and her stomach was nervous. She usually did not go into his house when she picked him up, but this day she did. She waited on the couch by the door, but she was so nervous, she had to go to the bathroom. She went to the bathroom, which was located inside the bedroom. When she came out of the bathroom, he had shut the bedroom door and barricaded it with large stereo speakers. He pulled out a gun and would not allow her to leave. All she could think about were her kids not having a mother. She was crying and fell to her knees and began to pray. He was yelling at her, accusing her of cheating, and calling her names. He took her cell phone and smashed it against the wall. She was in his second floor apartment and looked at the window, wondering how she could escape. She saw someone outside and thought about how to get his or her attention. Tom sensed what she was thinking and made her move away from the window.

Erika says she remained calm. She described that he put the gun to her back and forced her to have anal sex against her will. Then he seemed to calm down. He finally opened the bedroom door and walked out. She followed him into the living room, all the while wondering about an escape. He was still pacing with the gun in his hand. After about fifteen minutes, he took the bullets from the gun, handed her the gun, and said that he could not do anything to her because he loved her. She told him, "I hate you," and she left. Erika went to work, and her boss recognized that something was wrong because she was never late. She confided in her boss what had happened but first made him swear that he would not tell. The next day her boss fired Tom. Tom continually attempted to contact Erika by calling her mother and her job, because she could not be reached on the cell phone he destroyed.

The Incident

On the day of the incident, Erika and her co-worker walked to their cars just after working the lunch shift at the restaurant. She had gotten in her car and was preparing to leave when she heard her co-worker start to scream, and then the shooting started. Erika recalls slumping down in her seat and pretending to be dead. By this time she had been shot several times. She remembered her co-worker screaming at him, and she said, "I remember him walking behind the car, so I cranked up. When I went to put the car in gear, he came back around and shot again." It was at this point that it became clear to her that he intended to take her life. She did not realize she had been shot until she saw blood, nor did she realize where she had been hit. Erika remembered thinking that, if she died, there would be no one to pick up her kids from school,

and she couldn't let that happen. The thought of her children alone gave her the will and strength to put the car in drive. Fortunately, no car was parked in front of her, so she was then able to pull away. She could not yet feel pain, although she had been shot in the shoulder, chest, abdomen, forearm, and both hands. She drove herself to a medical center which she chose because she did not think that he would follow her there. She had to talk herself through it. She got her strength because she knew her kids would be waiting at school. Later that day, he turned himself in to the police. He was subsequently convicted and sentenced to eighteen years in prison for aggravated assault, possession of a firearm during the commission of a crime, and possession of a firearm by a convicted felon (he had previously been convicted on assault and firearms charges.)

What We Learned

Again this year, as with the near fatality detailed in the 2006 Annual Report, Erika did not access traditional systems, such as the judicial systems or shelters. Erika explained that she didn't even know how or where to reach out. She said she did not know how or if she wanted to leave. Erika had two children, and like so many other women, she wanted Tom to be there for the children. He was a male figure for the children, especially for her ten-year-old son. Even though Erika did not directly tell any of her family members what was going on, she gave them bits and pieces. Her mother played a significant role in her decision to leave the relationship. Erika explained that, previously, she had been afraid to leave the relationship, but her mother's words gave her the confidence that she needed. Her mother knew that something was wrong and said, "If you don't want to be here, we can go," and it was that day that Erika decided to leave. This is a clear example of the importance of having supportive family and friends around.

Another lesson that emerged from Erika's story pertains to the role of employers. On the Thursday prior to the shooting, Erika confided in her boss. He responded by terminating Tom's employment. While he did take immediate action in responding to the situation, he appeared to have a lack of understanding about how this action could potentially heighten the risk of lethality for Erika, other employees and even himself. There were multiple missed opportunities here, both for criminal intervention and for training and education for the employees.

Additionally, six months before she left Tom, Erika reached out to her church for spiritual guidance and relationship counseling. Although she did not disclose the abuse there, it seems that she did not have the opportunity, because the sessions were conducted jointly, and she feared Tom's response. She felt that if the church had probed her more, or separated them for individual sessions, she might have opened up more.

Last, throughout the interview with Erika, factors emerged that indicated her increased risk for homicide, including the following:

- Suicidal ideation and depression on the part of the abuser
- Recent separation
- History of abuse in the relationship (verbal, physical, sexual, and mental)
- Stalking and constant monitoring
- Prior use of a weapon against her
- Previous felony conviction for a violent offense.

Words From a Survivor

Several times as Erika shared her story, she talked about her feelings of uncertainty and nervousness prior to the incidents discussed earlier. Just prior to the sexual assault, and again just before the near-homicide, she said that she knew something was not right because she felt jittery and her stomach felt nervous. In fact, before the shooting, she even mentioned her feelings to her co-worker. Erika teaches all of us who are advocates and service providers how important it is to listen to our intuition and encourage women to pay attention to their instincts when assessing for danger.

Another thing that emerged very strongly from Erika's story was how much the love for her children gave her the desire to live. Each time she was close to giving up, her fortitude and desire to fight came from knowing that she needed to be around for her children. Erika was shot and drove herself to get medical attention because she kept thinking that, if she didn't, there wouldn't be anyone to pick up her children from school. Erika is a young woman who not only fought for her life but for the lives of her children as well.

After the near-fatal attempt on her life, Erika felt that her family and the system did a great job in helping her to get through this. She expressed much gratitude to her mother who was by her side all the way. Although she was not satisfied with the sentence that Tom got for almost taking her life, she felt that the

judge validated her experience with the seriousness with which he addressed the perpetrator. She also felt that the law enforcement team did a great job of keeping her informed throughout the process.

Emerging Themes

The process of interviewing survivors of domestic violence that have nearly lost their lives at the hands of their intimate partners is both powerful and informative. What we learn from their experiences truly has the potential to change outcomes for other victims. There are several noteworthy commonalities that arose from both the near-fatality case reviewed in 2006 and the one reviewed in 2007. Neither of the survivors we interviewed accessed traditional systems. Neither of them called the police or contacted their local domestic violence program. In this sense, these women were untouched by the way we are doing much of our work.

Second, both women were involved in a faith community. One was quite active in her church, yet in her own words, she "was too ashamed" to admit that she was experiencing violence at the hands of her intimate partner. The second survivor actively sought counseling from her church, yet admitted their response left much to be desired in terms of making it safe for her to disclose abuse to them.

Also, both women sought support from their employers. When one woman asked her employer to call the police if they saw her abuser on the property, she was told to keep her private problems at home. The other woman confided in her employer regarding an assault that happened less than a week before the near-fatal attack. This employer responded by firing the abuser, who was also employed there. While this willingness to take action is to be applauded, employers clearly need training and response protocols that address the safety needs of the victim and the workplace. It is notable that the near-fatal attacks on both of these women took place in front of their workplace and in the presence of others.

Lastly, as in prior cases involving fatalities, these two cases contain a set of factors commonly believed to be indicators of increased risk for homicide. Both women had experienced violence in their relationships and were recently separated from their partners. Both women indicated that their partners had a history of suicidal ideation and depression. It is of note that neither woman appeared to recognize this factor as being significantly tied to her safety. And both women experienced stalking, which included calling and coming by their places of employment and escalation of this behavior after separation.

Recommendations

- Domestic violence programs and task forces should work with employers in their counties to provide training and to assist in developing policies and procedures that promote victim safety in the workplace.
- Domestic violence programs should reach out to victims in non-traditional venues (for example, providing information and education programs for parents in day care settings).
- Domestic violence programs and task forces should reach out to churches to provide training specifically to ministers, lay ministers, and clergy personnel who provide marriage counseling.

We honor Erika for her courage, and we are grateful to her for sharing her story of survival.

The following data, while stripped of any identifying information as to what fatality or county it came from, was directly collected from the fatality reviews conducted from 2004 through 2007. Data from some of the reviews is unknown and is indicated as such on the charts below.

The data is organized into the following sections:

Section 1: Gender, Employment, and Income 2004-2007

Section 2: Domestic Violence Fatality Data

Section 3: Domestic Violence Perpetrator's History of Abuse and Other Lethality Indicators

Section 4: Civil and Criminal History: Law Enforcement, Prosecution, and Sanctions

Section 5: Agencies Involved in the Five Years Prior to the Homicide

Section 1: Gender, Employment, and Income 2004-2007

Characteristic	Victim		Perpetrator	
	Number	%	Number	%
Gender				
Female*	59	97%	2	3%
Male	2	3%	59	97%
Employment Status				
Employed	45	74%	38	62%
Employed full-time	32	52%	28	46%
Employed part-time	4	7%	4	7%
Employed, unsure if full-time or part-time	5	8%	2	3%
Self-employed	3	5%	4	7%
Employed part-time and student	1	2%	0	0%
Unemployed	7	11%	8	13%
Retired	2	3%	1	2%
Disabled	1	2%	1	2%
Unemployed student	1	2%	1	2%
Unknown	5	8%	12	20%
Sources of Financial Support				
Personal wages	44	72%	37	61%
No personal income, reliant on perpetrator for financial support	3	5%	0	0%
Personal wages and family support	2	3%	0	0%
Family support	1	2%	1	2%
Family support, WIC, and Food Stamps	1	2%	1	2%
No income, unknown source of support	1	2%	2	3%
Personal wages and alimony	1	2%	0	0%
SSI/SSDI	1	2%	0	0%
Widow's pay	1	2%	0	0%
Drug dealing	0	0%	2	3%
No personal income, reliant on victim for financial support	0	0%	7	11%
Retirement pension	0	0%	1	2%
Unknown	6	10%	10	16%

*Note: One female perpetrator killed a male partner; one killed a female partner.

Section 2: Domestic Violence Fatality Data

Who Was Killed in 2007 Reviewed Cases

Of the 7 cases reviewed in 2007, there were a total of 12 fatalities.

These included:

- 7 intimate partner victims
- 5 alleged perpetrators

Homicide Narratives

The following table briefly describes each homicide reviewed in 2007. Sentencing data sources are prosecutor's files, Georgia Department of Corrections, and Fatality Review Committees. Sentences may reflect the fact that many of the perpetrators in reviewed cases had prior contact with the police and courts.

Data Findings

Section 2: **Domestic Violence Fatality Data** – continued

Brief Narratives of Each Fatality		Sentence Imposed for this Homicide
Case 1:	A week after the DV victim asked DV perpetrator to move out, he stabbed her in the presence of her children. He also stabbed her adult brother multiple times when he attempted to intervene. He later hanged himself in jail. DV perpetrator had a criminal history of DUI, violence, drugs, and robbery with a weapon.	**Deceased perpetrator.**
Case 2:	DV perpetrator waited outside DV victim's residence before gunning her down with an AK-47 assault rifle. After a long separation, DV victim had downloaded a petition for divorce on the internet and filed it ten days before her death.	**Perpetrator was found guilty of Malice Murder, four counts of Aggravated Battery and Possession of a firearm during the commission of a felony. He was sentenced to life without parole.**
Case 3:	DV victim and her new partner were shot in the presence of her youngest child. DV perpetrator later killed himself. DV perpetrator and DV victim were separated and going through a divorce. He was arrested for domestic violence five months prior to the homicide. This case was still pending at the time of the homicide. He was also attending a Family Violence Intervention Program.	**Deceased perpetrator.**
Case 4:	After a history of violence, DV perpetrator shot DV victim in the neck prior to shooting himself in the head. The couple's four children were home, and one of them was shot in the arm. One of the children called the police to the home earlier that same day after witnessing a verbal altercation and becoming frightened. No arrest was made at that time because DV perpetrator had fled the scene. The shootings occurred upon his return to the home.	**Deceased perpetrator.**
Case 5:	After being separated from DV victim for five months, DV perpetrator rented a hotel room where he shot DV victim and then shot himself in the head.	**Deceased perpetrator.**
Case 6:	After a history of verbal and psychological abuse, DV perpetrator pushed DV victim down the stairs. DV perpetrator placed a pillow over DV victim's face and suffocated her. To conceal the homicide, DV perpetrator buried his wife's body in a 3-foot grave and disposed of her property in another location.	**Perpetrator was found guilty of Malice Murder and Felony Murder. He was sentenced to life in prison.**
Case 7:	When DV perpetrator returned to DV victim's residence to drop off the couple's 12-year-old daughter, an argument ensued. That night, DV perpetrator shot DV victim in the abdomen and the head and later shot himself. The couple's daughter was sleeping in the adjoining room and woke to her mother yelling for her to call 911.	**Deceased perpetrator.**

Types of Incidents 2004-2007	Aggregate % for 2004-2007
Single victim	54%
Homicide/Suicide	20%
Homicide/Attempted Suicide	7%
Homicide/Attempted Homicide of Others	5%
Homicide/Attempted Suicide/Attempted Homicide of Others	5%
Multiple Homicide/Suicide	3%
Homicide/Suicide/Attempted Homicide of Others	2%
Multiple Homicide	2%
Incidents involving suicide/attempted suicide	38%
Incidents involving homicide of others/attempted homicide of others	18%

This chart summarizes the types of incidents that occurred in the fatalities reviewed. Although 54% of the cases were single-victim homicides, it is noteworthy that in 38% of the cases the perpetrator not only killed one or more persons but also attempted or completed suicide. This information is significant for several reasons. In the 61 cases reviewed from 2004 through 2007:

- 38% (23) of domestic violence homicide perpetrators were known to have either threatened or attempted suicide **prior to the homicide**, indicating a possible opportunity for intervention before the homicide.
- 36% (22) of perpetrators either attempted or completed suicide **at the homicide scene or soon thereafter**, indicating that intervention in these cases would have also benefited perpetrators.
- Perpetrators in 25% of the reviewed cases were known to have had a history of or current problems with depression.

In the 36 cases reviewed from 2005, 2006 and 2007,

- **53% (19) of all perpetrators at some point either threatened, attempted, or successfully completed suicide**, indicating a significant correlation between suicide and danger.

Cause of Death: 2004-2007	Aggregate % for 2004-2007
Gunshot	54%
Stab wounds/Stab wounds and lacerations	25%
Strangulation	11%
Blunt or sharp force trauma	7%
Asphyxiation due to smoke inhalation	2%
Multiple traumatic injuries	2%

Data Findings

Who Was Present, a Witness to, or Killed at the Fatality: 2004-2007

	Present			Witnessed			Killed		
	Number of cases	% of total '04-'07 cases	Actual number of people	Number of cases	% of total '04-'07 cases	Actual number of people	Number of cases	% of total '04-'07 cases	Actual number of people
Children	29	48%	55	11	18%	39	3	5%	3
Family members	12	20%	19	3	5%	11	0	0%	2
Friends	3	5%	3	2	3%	2	0	0%	0
New intimate partners	2	3%	2	1	2%	1	1	2%	1
Co-workers	1	2%	1	0	0%	0	0	0%	0
Acquaintances or neighbors	4	7%	6	4	7%	5	0	0%	0
Strangers	4	7%	19	4	7%	19	0	0%	0

This chart describes who was present, a witness to, or killed at the fatality. For the purpose of this chart, individuals labeled as "present" are those who were in the same area where the homicide occurred but did not have any sort of sensory experience of the homicide (e.g. hearing or seeing the homicide occur.) Those individuals who did have a sensory experience of the homicide have been determined to have "witnessed" the homicide

2004-2007 data indicate that in 59% of reviewed cases, someone was present at the scene of the fatality. 43% of the time, someone witnessed the homicide; in 18% of the cases, those witnesses were children. In 10% of the cases, someone else was killed.

Section 3: Domestic Violence Perpetrator's History of Abuse and Other Lethality Indicators

Perpetrator's History as Known by the Community: 2004-2007

This chart details the information we gathered about how often certain lethality factors were present in reviewed cases, as well as who was aware of these factors. The data reveals that family and friends of the victim generally know the most information about the relationship. For example, the chart explains that in 87% of the reviewed cases, the perpetrator had a history of domestic violence against the victim. In those cases, family and friends of the victim knew about this history 66% of the time, while criminal courts knew of this history only 17% of the time.

Perpetrators' History as Known by the Community		Who Was Aware?					
		Frequency	Law enforcement	Criminal courts	Civil courts	Service providers	Family & friends
Controlling behavior	Monitoring and controlling	52%	13%	0%	6%	16%	69%
	Isolation of victim*	34%	0%	0%	8%	8%	83%
	Ownership of victim*	23%	0%	0%	0%	13%	88%
Violent or criminal behavior	History of DV against victim	87%	58%	17%	21%	28%	66%
	Threats to kill primary victim	57%	43%	17%	26%	20%	51%
	Violent criminal history	56%	85%	26%	9%	21%	38%
	Threats to harm victim with weapon	44%	41%	19%	7%	19%	52%
	Stalking	41%	36%	12%	0%	16%	48%
	Inflicted serious injury on victim*	26%	50%	38%	0%	13%	100%
	Sexual abuse perpetrator	25%	33%	0%	27%	7%	33%
	Child abuse perpetrator*	18%	36%	9%	45%	18%	18%
	Strangulation	18%	36%	18%	0%	9%	36%
	History of DV against others*	16%	50%	30%	10%	10%	70%
	Threats to kill children, family &/or friends	16%	57%	29%	29%	14%	57%
	Hostage taking*	16%	50%	50%	25%	50%	75%
	Harmed victim with weapon*	13%	80%	60%	0%	40%	60%
Mental health issues and substance abuse	Depression*	25%	30%	20%	10%	60%	60%
	Suicide threats and attempts	38%	26%	9%	4%	35%	48%
	Alcohol and drug abuse	51%	55%	13%	13%	29%	61%

*Includes cases reviewed in 2005, 2006, and 2007 only

Section 4: **Civil and Criminal History: Law Enforcement, Prosecution, and Sanctions**

Prior Violence and Injuries as Known in Reviewed Cases as Noted in Police Reports: 2004-2007

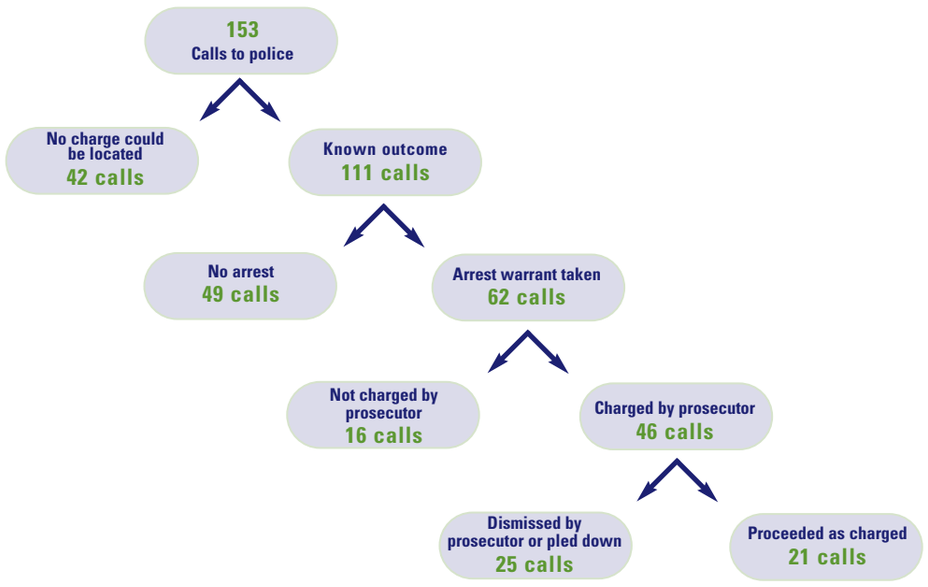
Police reports prior to these homicides revealed a wide range of perpetrators' abusive behaviors and injuries they inflicted on their victims. Documented abusive behaviors as noted in police reports include the following: hit in face or body, pulled a gun or held it to her head, grabbed by the neck, handcuffed to bed, kicked, pinned down, pulled hair, slapped in face, pushed down stairs, pushed into a wall, spit on her, knocked out tooth. Documented injuries to victims as noted in police reports include the following: bruises, cuts and contusions, head injuries, busted lips, bloodied noses, broken bones, neck injuries due to strangulation, red marks on shoulders, eyes burned by substance, stab wounds.

It is significant to note that in the cases studied over the last four years, 87% of calls to the police prior to the homicide had no major injury documented in law enforcement reports. In 64% of prior calls, no visible injuries to victims were documented. This means that most victims who were later killed were either not injured or did not have major injuries documented in calls to the police prior to their deaths. This suggests that while serious and visible injury is a predictor of future, and possibly lethal violence, it will not always be present in cases where victims are later killed.

Investigation and Prosecution Breakdown: 2004-2007

A review of the case histories reveals that victims' attempts to access the criminal justice system do not often result in increased safety, justice, or perpetrator accountability. In those cases where the outcome is known, only 41% were charged by the prosecutor, and more than half of those were subsequently either dismissed or pled down. This chart details several junctures at which cases slip through the cracks of the criminal justice system. For a more complete discussion of this problem, see the 2006 Annual Report of Georgia's Fatality Review Project at http://www.gcfv.org/Fatalityreview2007.pdf.

Detail of Investigation & Prosecution Breakdown



*Note: The dismissed and pled down category includes cases that were dismissed because the victim was killed prior to the case proceeding to prosecution.

Data Findings

Section 5: Agencies Involved in the Five Years Prior to the Homicide

The Fatality Review Committees identified agencies and community entities or systems with which the domestic violence victim and/or perpetrator were involved in the five years prior to the homicide, as detailed below.

Agencies and Services Involved with Victim or Perpetrator in the Five Years Leading Up to the Homicide: 2004-2007 Reviewed Cases

Agency/Service/Program		Victims		Perpetrators	
		Number	% of total cases	Number	% of total cases
Justice System Agencies	Law enforcement	47	77%	51	84%
	County prosecutor	22	36%	29	48%
	Superior court	19	31%	23	38%
	Magistrate court	18	30%	22	36%
	State court	13	21%	9	15%
	Civil divorce court	12	20%	12	20%
	Protection order advocacy program	10	16%	1	2%
	Court-based legal advocacy	10	16%	2	3%
	Probation	5	8%	22	36%
	Municipal court	3	5%	8	13%
	Legal aid	3	5%	0	0%
	Parole	1	2%	6	10%
	City prosecutor	1	2%	5	8%
Social Service Agencies	Child protective services (DFCS)	4	7%	4	7%
	Child care services	4	7%	2	3%
	TANF or Food Stamps	2	3%	1	2%
	WIC	2	3%	0	0%
	Homeless shelter	1	2%	0	0%
Health Care Agencies	Hospital care	10	16%	11	18%
	Emergency medical service (EMS)	9	15%	4	7%
	Emergency medical care	8	13%	2	3%
	Private physician	8	13%	9	15%
	Mental health provider	7	11%	12	20%
	Medicaid	3	5%	0	0%
	Substance abuse program	2	3%	2	3%
	PeachCare	1	2%	0	0%
Family Violence Agencies	Community-based advocacy	12	20%	4	7%
	Domestic violence shelter or safe house	11	18%	0	0%
	Sexual assault program	1	2%	0	0%
	Family violence intervention program (FVIP)	1	2%	9	15%
Miscellaneous Agencies	Religious community, church, or temple	14	23%	10	16%
	Immigrant resettlement	2	3%	1	2%
	English as a Second Language (ESL) program	1	2%	0	0%
	Anger management	0	0%	3	5%

Steps Toward Independence

In most of the cases reviewed over the past four years, victims had taken steps toward independence from their batterer shortly before they were killed. In some cases, these were formal steps, such as filing for divorce or for a protective order. In other cases, the steps toward independence were of a more informal nature, ranging from changing locks or moving out, to calling a domestic violence hotline, to interviewing for a job in a different city, to telling friends and family about a plan to separate from the abusive partner. Regardless of the steps taken, all of these moves toward independence demonstrate a victim's desire to separate that was expressed not long before the homicide. Taken together, these steps have significant implications for all those who work to help victims as they seek safety and independence. In particular, all safety plans should consider the safety implications of any move toward independence, no matter how seemingly subtle or small. Some of the steps taken in the cases reviewed this year are described on this page.

Following his arrest for an assault against her, she convinced her husband to seek mental health assistance.

Police had already been out to the house on a domestic violence call on the day she was murdered. While they were there, she told the police officers that she was planning to file a TPO.

She asked him to move out one week before her death.

Three months before the homicide, she contacted a domestic violence hotline.

She filed for divorce ten days before her death.

She filed a TPO five months prior to the homicide.

Three months before the homicide, she separated from her husband and relocated to another county.

She filed for divorce less than two months before she was killed. She had also moved out of their house and was moving some of her furniture to her new apartment the day she was killed.

Spotlight Issues

Firearms: The Leading Cause of Domestic Violence Deaths

Over the course of thirteen years, the perpetrator was arrested three times for committing acts of violence against his wife. She also obtained a protective order against him because of his abuse. Yet the first documented attempt to limit his access to firearms only occurred in year thirteen, when she filed for divorce. The temporary order in that case stated that he could retrieve personal items, except firearms, from their home. When she moved to Florida the next month to flee his abuse, he moved back into their home. Their mediated divorce agreement granted him possession of the marital residence, presumably where his guns remained. A few days later, he received a message at the home phone number from the dentist's office, confirming that she had a dental appointment. He stalked her at the appointment, where he located her in the treatment room with the dentist and a dental assistant. He shot his wife once in the face and three times in the chest, killing her. He then turned the .38 on himself, killing himself.

Of the 61 homicide cases studied by this project, 54% have been caused by abusers with guns. In addition, both of the survivors of near-fatal domestic violence attacks studied in this project almost lost their lives by the use of a gun. Because firearms are consistently the leading cause of death for battered women in the state of Georgia, removing guns from the hands of abusers is essential to decreasing domestic violence homicides. Fortunately, federal law already exists making it a crime to possess a firearm or ammunition under the following circumstances (punishable by a maximum prison term of ten years):

- while subject to a Temporary Protective Order (18 U.S.C. Section 922(g)(8)), or
- after a conviction of a qualifying misdemeanor crime of domestic violence (18 U.S.C. Section 922(g)(9)).

Enforcement of the federal statutes at the local level, however, has been challenging for a variety of reasons. Judges sometimes contend that they lack jurisdiction to impose federal law. Law enforcement officers report that they cannot enforce federal law without some local authority to do so, such as a judge's order. Prosecutors of domestic violence cases sometimes fail to document the relationship between the defendant and the victim. This is necessary to determine whether a misdemeanor qualifies under the federal "domestic violence misdemeanor" restriction. In these ways, many misdemeanants who qualify for this restriction fall through the cracks and are able to purchase or retain firearms.

Such enforcement problems are not unique to Georgia, nor are they insurmountable. As a result, the 2006 version of the federal Violence Against Women Act (VAWA) requires states to certify, as a condition of their continued eligibility to receive this federal funding, that they notify abusers of the federal firearms restrictions that apply to them.

While Georgia considers statewide solutions to this problem, several communities have already taken steps locally to reduce the incidence of domestic violence committed with firearms. None of these programs represents a comprehensive or fail-proof solution, yet each is a model that takes significant steps toward addressing the problem of firearms in domestic violence cases.

Strategies for Change

All Georgia communities should consider replicating these programs, or establishing new models, to reduce domestic violence deaths by firearm in their areas.

Criminal Cases

Example: Shelter Advocate in Sheriff's Office

One Georgia county sought and received federal funding to focus on the removal of weapons at the scenes of Family Violence Act (FVA) arrests. As a key component of this effort, an advocate from the local DHR-certified shelter is housed in the sheriff's office. In addition, responding officers use a different, more detailed report form to document these arrests. When the special FVA arrest form is completed, it is forwarded to this advocate and to the DV Investigator. Magistrates in the county give strong consideration to risk assessments by the advocate and investigator, and they ensure that FVA offenders may not bond out of jail without first seeing a judge. Weapons are stored in the sheriff's evidence room. In addition, law enforcement officers are trained yearly on domestic violence. Finally, judges use a variety of accountability methods when sentencing these offenders, including increased probation supervision.

As a result of this close collaboration, information sharing between systems is greatly enhanced, and gaps in response are less likely to occur.

Firearms – continued

Example: Firearms Language in Bond Conditions Magistrates in another Georgia county use a form for special bond conditions that notifies the defendant of firearms restrictions. Specifically, the form states, in part, that

> *Defendant shall not possess any firearms while free on bail and shall surrender any and all firearms now in Defendant's domicile or possession, to the arresting agency within twenty-four hours from time of release on bond (original emphasis) and*
>
> *Defendant shall not exercise the privileges afforded by a Georgia Firearms License (concealed weapons carry permit) at any time while free on bail.*

Civil Cases

Example: Removal of Specific Firearms in TPO Documents
Standard language added to temporary protective order (TPO) forms, as used in one Georgia county, can specify the removal of firearms known to be possessed by the respondent. Such language, containing a description of the firearms themselves as well as their location, is added in the petition in the section that begins, "order additional relief as follows." In addition, the *ex parte* order further states that law enforcement shall maintain possession of the named weapons until the order, or any extended order, expires.

Example: Removal of Any Firearms in TPO Documents, with Explanation of Sanctions Another Georgia county includes language in its *ex parte* TPO orders directing respondents to surrender immediately any weapons in their possession, regardless of ownership. The order also authorizes law enforcement to search for weapons and arrest and incarcerate the respondent without bond upon failure to surrender. Last, this language specifies where the seized weapons shall be stored until further order of the court.

Example: Special Notice to Parties to a TPO In TPO cases where the seizure of firearms is ordered, one judicial circuit details the procedures for seizure and return of the firearms. This information is provided to both parties via a separate document and states clearly that it is the obligation of the respondent—not the court or law enforcement—to pursue the retrieval of weapons upon expiration of the order. The document specifies the process and timeframe required for respondents to request the return of firearms, and the potential forfeiture of these weapons if these procedures are not followed.

Statistical information on the success rates of these programs is not yet available. Nonetheless, measures such as these that limit batterers' access to guns via the enforcement of federal law can reasonably be presumed to strongly enhance the safety of victims of domestic violence and their children.

Recommendations

Judges

- Judges should give domestic violence offenders notice of federal firearms prohibitions upon issuance of a protection order and at the time of sentencing in criminal cases.
- Judges should ensure that protection orders include language explicitly requiring the removal of firearms and/or ammunition from the perpetrator.
- In TPO cases where weapons are seized, judges should notify offenders of the process for retrieving them upon expiration of the order.
- In protective order proceedings, judges should sign the provision confirming that the case meets federal firearm prohibition requirements.
- Magistrate judges should consider a perpetrator's possession of firearms at the bond stage and consider ordering surrender of weapons and/or ammunition as a condition of release.
- Judges should set compliance hearings automatically to ensure that perpetrators have surrendered firearms and/or ammunition.

Law Enforcement

- Officers should remove all known firearms and/or ammunition from perpetrators upon issuance of a protective order.
- Officers should arrest any person found with a firearm who is subject to a temporary protective order or who has been convicted of a misdemeanor against a family member.

Prosecutors

- Prosecutors should collaborate with probation to initiate contempt of court proceedings upon an offender's refusal or failure to surrender firearms and/or ammunition.

Private Attorneys

- Private attorneys should inform their clients about the possibility of filing a contempt action if the abuser fails to surrender firearms and/or ammunition as ordered in a TPO.

Spotlight Issues

Firearms – continued

Private Attorneys – continued

- Private attorneys should request that judges specifically address the respondent's possession or use of firearms or ammunition and should ask judges to set compliance hearing dates to follow up with any order they issue concerning firearms.

Probation

- Probation departments and officers should ensure that firearms restrictions and surrender are specifically incorporated into the terms of probation and enforced.
- Probation officers should file a petition to revoke probation when an offender refuses or fails to surrender firearms or ammunition.
- Probation officers should file a petition to revoke probation when an offender is found with a firearm or ammunition in his possession.
- Probation officers and departments should collaborate with prosecutors to initiate contempt of court proceedings upon an offender's refusal or failure to surrender firearms and/or ammunition.

Court Clerks

- Clerks of court should ensure that criminal judgments are entered into the state and national registry and that protection orders are entered into the state protective order registry within 24 hours of entry.

Advocates

- Both shelter-based and prosecution-based advocates should always ask victims about their partner's use of firearms and should inform them regarding the court's ability to restrict access to firearms.
- Both shelter-based and prosecution-based advocates should incorporate the additional risks associated with firearms into their safety planning with victims.

Community

- Communities should support efforts to pass state legislation in Georgia that would assist with implementation of federal firearms law.

Information Sharing: Bridging the Gap

The victim and perpetrator were high school sweethearts and had been married for ten years. Following a violent assault that led to the perpetrator's arrest and a TPO, the victim and their daughter moved to another county. There were several signs of escalating danger that occurred after the arrest: the perpetrator forced the victim to strip at gunpoint while they were riding down the highway, the perpetrator spent two weeks in a mental health facility, and the perpetrator was stalking the victim at her new residence. In addition to a history of violence, the perpetrator had threatened several times to kill himself if the victim ever left him. The system contacts that the victim had were in her prior county of residence. Law enforcement, the court system, advocates, and family and friends were all aware of the domestic violence. She was not connected to resources in her new county, nor had the two counties shared any information they had on the case.

Effective systemic response to domestic violence cases requires a working partnership among many systems, including, but not limited to, law enforcement, judicial, advocacy, corrections, DFCS, Family Violence Intervention Programs, faith communities, medical, schools and the general public. Each of these systems, and the individuals therein, have specific knowledge and desired outcomes. It can be a challenge to create policies, procedures, and practices that promote service coordination and information-sharing across systems or jurisdictions. However, it is crucial that these systems find ways to collaborate and share pertinent information with each other, because the collective action of these systems is imperative to ending domestic violence and its subsequent loss of life.

In the last four years in Georgia, fatality reviews have revealed several ways in which the lack of coordination of information among systems promotes the escalation of the perpetrator's violence. Frequently, systems do not communicate with each other when they have real concerns and valuable information about the escalation of violence. Additionally, we have found several points of disconnection between those people who have crucial information about danger and those who have the power to intervene.

Information Sharing – continued

A chart on page 14 lists several factors that have emerged from research that can be considered significant in contributing to increased risk of homicide. Additionally, this chart details who knew about these factors in the relationship of the parties prior to the homicide. These are broken down into law enforcement, criminal courts, civil courts, service providers, and family and friends. In cases where the data is only available for three years, it is noted on the chart.

Comparing homicide case files with interviews with family and friends of the homicide victims reveals consistently that family and friends have the most information about the nature, history, and escalation of violence in the intimate partner relationship prior to the homicide. However, these same people generally have the least amount of information regarding the dynamics of domestic violence, safety and lethality, and available resources. While the family and friends of a domestic violence victim can play a valuable role in supporting her and connecting her to helping services, they are typically provided the least resources to intervene.

Second to family and friends, law enforcement knew the most about the factors that indicated danger prior to the homicide. This finding suggests that while law enforcement is collecting evidence and information, there still remains a breakdown in the way in which that information is shared with courts and other systems.

The court system appears to have the least amount of information regarding perpetrators' dangerous behavior, although courts have the most tools at their disposal to impose sanctions. This lack of information hinders the criminal justice system's ability to effectively prosecute cases and sanction the perpetrator's behavior. The subsequent low rate of prosecution of domestic violence cases, detailed at length in prior reports, sends a harmful message to victims and perpetrators of domestic violence about the system's willingness to intervene.

Strategies for Change

One way to increase the flow of information is to develop information-sharing protocols for agencies involved in responding to domestic violence. While some agencies are bound by confidentiality, simple protocols can be implemented that allow an agency to share information without compromising confidentiality. For example, one community has formed a committee that is currently working on drafting a protocol to facilitate communication between probation officers, Family Violence Intervention Programs, and victim liaisons. This would allow for victim liaisons to have better contact information for victims, thereby increasing liaisons' chances of contacting victims and assisting them with ongoing safety planning. This process would also allow Family Violence Intervention Program providers to have more accurate information regarding the perpetrator's history of violence, thereby increasing their ability to hold him accountable.

Some communities have found that counting the total number of domestic violence cases entering the system via 911 calls and tracking them as they move through the criminal justice system can be informative on many levels. This kind of analysis sheds light on systemic response by highlighting the steps in the process in which cases fall through the cracks. This case tracking requires buy-in and a willingness to share information from the key players involved in responding to domestic violence.

One community has accomplished this by compiling statistics related to the total number of domestic violence cases in their circuit. In some instances they were able to rely on statistics already collected by law enforcement and 911 agencies, such as total number of domestic violence calls, number of dispatches, and incident reports. For all other systems, a data-tracking program had to be developed. The sheriff's and police departments forward all incident reports coded as family violence, rape, violation of a TPO, harassing phone calls, and stalking to the Chair of the Family Violence Task Force. Additionally, 911 and EMS, the prosecutor's offices, the probation department and the Family Violence Intervention Programs share with the task force their statistics related to the total number of domestic violence cases they are handling. The task force also looks at civil court records to see the total number of Temporary Protective Orders filed and granted, and how many victims had the assistance of community based legal advocacy when filing their order.

Another way that the fatality review process lends itself to relationship-building and increased collaboration is in the networking of members. One of the main objectives of the Fatality Review Project is to

Spotlight Issues

Information Sharing – continued

provide a forum for increased coordination and collaboration between agencies providing services to families experiencing domestic violence. The networking that occurs in Fatality Review meetings is a valuable, informal process that has occurred since the inception of the Project. Simply stated, the fatality review process brings individuals and agencies to the table and engages them in conversations that otherwise might not take place. Fatality Review Committee members also gain an increased understanding of the policies, procedures, and practices of other agencies. When individuals share their knowledge and expertise of their own system's inner workings, it can ease tensions that may have existed between agencies due to a lack of understanding about what a service provider or system can and cannot do.

Recommendations

- Communities should develop protocols for information sharing about abusers across all systems that come into contact with domestic violence cases.
- In communities where the case load is of a sufficient size to warrant it, specialized units and dockets should be created, following national models for detectives, prosecutors and judges, to create focused expertise, better coordination, and a system better prepared to hold offenders accountable.
- Family Violence Task Forces should track domestic violence cases as they move through the system to see points at which cases might fall through the cracks of the criminal justice system.

Domestic Violence: A Workplace Issue

One morning on the way to work, the perpetrator approached the victim on the grounds of the school where she was employed. She described this day as "the day I was fighting for my life." They argued, he pulled a gun, and she ran away. He chased her and pulled her to the ground by her hair. He held the gun to her head and fired and it jammed, and then to her chest where it jammed again. He then proceeded to beat her with the butt of the gun. Her coworkers came out of the school building, screaming for him to stop.

With one in three women reporting domestic violence at sometime during their lives,[3] it should be no surprise that our workplaces are affected by domestic violence. Overwhelmingly, employers are not doing enough to protect themselves and their employees from domestic violence.

Domestic violence in the workplace includes behaviors ranging from harassing or repeated calls, emails, or text messages, to unwelcome visits, to homicide. It also includes intimate partner violence that occurs outside of the workplace but that impacts an individual's ability to perform her or his job (for example, due to physical injury).[4] The consequences of domestic violence at work can be fatal not only to the victim, but to coworkers and anyone else present at the workplace, including customers.

In Georgia, most victims and offenders involved in the reviewed deaths from 2004-2007 were employed. 52% of the victims were employed full-time and 46% of the perpetrators were also employed full-time. In many cases, co-workers and supervisors knew about the abuse.

Workplace violence is a health and safety issue that affects the bottom line for all employers. Employers should be concerned about domestic violence not only for humanitarian reasons, but also for its effects on productivity and absenteeism. A study by the National Alliance to End Partner Violence found that 21% of adults employed full-time were victims of domestic violence and 64% of them indicated that their work performance was impacted by the violence.[5] The U.S. Centers for Disease Control and Prevention (CDC) reported over $8 million in lost productivity as a result of employee domestic violence.[6]

---

[3] Heise, L., Ellsberg, M. and Gottemoeller, M., *Ending Violence Against Women. Population Reports, Series L, No. 11.,* December 1999.

[4] Ganley, Anne, PhD. and Carole Warshaw M.D., *Improving the Healthcare Response to Domestic Violence: A Resource Manual for Healthcare Providers, San Francisco:* Family Violence Prevention Fund, 1995.

[5] www.caepv.org. Information retrieved from the website November 9, 2007.

[6] Ganley, Anne, PhD. and Carole Warshaw M.D., *Improving the Healthcare Response to Domestic Violence: A Resource Manual for Heathcare Providers, San Francisco:* Family Violence Prevention Fund, 1995.

Workplace – continued

Employers are responsible for creating and maintaining a safe and secure work environment. If an abusive partner creates a hostile work environment and the employer fails to take reasonable action to protect the victim, this can create liability concerns. In order for employers to protect themselves, policies and procedures must be in place.

Over 70% of United States workplaces have no formal program or policy that addresses workplace violence.[7] Of the 30% of workplaces in the US that have some sort of formal workplace violence policy, only 44% have a policy to address domestic violence in the workplace. Only 4% of all establishments train employees on domestic violence and its impact on the workplace.[8]

Strategies for Change

Examples from Around the Nation

Around the country, employers are initiating programs and policies that respond to workplace violence. Listed below are just a sample of corporations around the country that have taken on the challenge of integrating domestic violence prevention programs, many of which include policies and procedures for workplace violence. Several of these are considered model programs around the nation.

- Allstate Insurance Company
- American Express Company
- Avon Products, Inc./The Avon Foundation
- CIGNA Corporation
- Kaiser Permanente
- Verizon Wireless
- Liz Claiborne, Inc.
- Mary Kay, Inc.
- State Farm

Many states have passed laws and adopted executive orders creating model policies and procedures on workplace domestic violence. One such state, Florida, has enacted a domestic violence leave act, which went into effect on July 1, 2007. The act requires employers with fifty or more employees to provide up to three days' leave for a variety of activities connected with domestic violence. Information on this legislation can be obtained at http://tinyurl.com/37v67k. More information on which states currently have policies or executive orders can be obtained from www.legalmomentum.org.

Examples from Georgia

Georgia does not have statewide policies, legislation, or executive orders that mandate domestic violence workplace policies. Nonetheless, local Fatality Review Committees are working with employers around the state to develop policies and procedures. In fact, one community is working with a major airline to develop a plan of action for implementing training, policies, and procedures on domestice violence in the workplace. This same community is working with its local county government to implement a specific domestic violence policy and procedure, using a model policy from Louisiana as a guide.[9] The purpose of the policy is to heighten awareness of domestic violence and to guide employees and management on ways to address the occurrence of domestic violence and its impact on the workplace. The policy looks at leave options, safety and security issues, intervention and prevention strategies, and guidelines for assisting survivors.

Recommendations

Employers should:

- Participate in training from domestic violence organizations about creating a work environment that allows victims to disclose the abuse and one that accommodates the safety needs of all employees.
- Create a workplace where victims or offenders learn how and where to ask for help (e.g. visibly display posters, place brochures in paycheck envelopes, and conduct lunchtime programs on domestic violence.)
- Ensure that the workplace is a supportive environment so that victims are not at risk for losing their jobs due to abuse. (e.g. include supervisory training and ensure workplace policies on domestic violence.)
- Understand their liability when the organization fails to respond to employees who disclose family violence concerns.
- Encourage supervisors and co-workers to ask about abuse if they suspect abuse of their co-worker. (Silence only supports the violence.)

---

[7] *The Survey of Workplace Violence Prevention*, Bureau of Labor Statistics, October 2006.
[8] *The Survey of Workplace Violence Prevention*, Bureau of Labor Statistics, October 2006.
[9] *Louisiana Department of Justice Domestic Violence in the Workplace Task Force Guidelines for Providing Assistance in Managing Domestic Violence in the Workplace.*

Spotlight Issues

Faith-Based Community: Unique Role in Prevention of Homicide

For a family who had recently immigrated to the US, their rabbi was their closest advisor. He helped the family buy a car and helped the victim obtain a driver's license. Two months before the murder, the victim told the rabbi that her husband had been abusing her for years, that she had left him twice before, and that she could no longer live with him. She admitted being afraid of her husband, and the rabbi encouraged her to leave him.

After the separation, the rabbi spent significant time with the perpetrator. The rabbi observed several factors that caused him concern, including the perpetrator's depression and suicidal ideation, but did not seek outside assistance in addressing those factors. On the day of the murder, the couple and children went to worship services together. In the car afterwards, the perpetrator fatally stabbed the victim, then himself.

A significant finding in Georgia's domestic violence fatality cases is the presence of faith communities within the lives of victims, abusers and/or their families. In some instances, victims sought guidance and counseling prior to their homicide. In other cases, faith communities were aware of violence due to community histories and concerns voiced by extended families. There were also cases in which victims were connected with their faith communities but were unwilling or unable to disclose the abuse there.

It is difficult to know how education and response protocols within the faith community would have made a difference in the Georgia fatality cases. It is established, however, that the faith community was important to victims and, in some cases, to batterers. Faith communities may represent the following:

- a spiritual and emotional sanctuary
- a familiar and comfortable place to seek help and validation
- a sense of community, family, and belonging
- a place to reveal secrets without judgment.

Clergy members provide spiritual guidance and support to their congregations. They also counsel and directly assist persons in need. Unfortunately, too few clergy members are trained about the dynamics of domestic violence. Without a comprehensive understanding and application of common domestic violence intervention principles, the safety of all parties can be compromised.

Clergy Need Training On

- Common dynamics of battering
- Ways that batterers use faith and religion as techniques against their victims
- Intervention techniques
- Safety for victims and congregations
- Resources available for victims
- Common protocols for faith-based response
- Methods of incorporating religious teachings to hold abusers accountable, work with abusers to change their behavior, and maintain safety for victims and congregants.

In addition to leading congregations, clergy members are often active in their communities in other roles, such as volunteer chaplains in hospitals, law enforcement agencies, and first responder units. They may also participate in their local Family Violence Task Force. These active community members are well-positioned to gain increased understanding of domestic violence and to assist in training other clergy and congregations.

Historically, faith communities have supported the physical, emotional, and spiritual needs of the community. For victims of domestic violence, these needs include safety and support. Faith communities may hold important keys to providing these essential needs. For example, when responding to domestic violence, faith communities are often inclined to treat the family as a unit, rather than addressing the separate issues of individual family members. Yet treating all family members the same and working with all family members together when abuse may have occurred ignores the fundamental dynamics of domestic violence: power and control. The role of clergy with victims and with abusers are very different. The victim and the abuser should be assisted by separate clergy members and, ideally, within different congregations, with safety for the victim as the guiding principal. Clergy's work with victims should focus on safety and confidentiality, while their work with batterers should focus on accountability.

Furthermore, clergy should be aware of common tactics batterers use to gain support from the faith community, justify their behavior, and avoid punishment. Without this awareness, clergy can inadvertently contribute to increased danger for victims. Collaborating with domestic violence programs is crucial for gaining this awareness and strategizing about safety and appropriate responses to victims and perpetrators.

Faith-Based Community – continued

Creating safety and justice for victims requires that faith communities be trained to understand the dynamics of domestic violence. Comprehensive training of clergy members, clergy associations, and entire congregations leads to the enhancement of protocols and strategies for responding to domestic violence. This increased understanding will open the way for the expansion of victim safety nets.

Recommendations

Clergy should:

- Receive comprehensive training on the dynamics of domestic violence, including how batterers use faith as a tool of victimization.
- Present sermons, messages, and informative documents about domestic violence.
- Take a public stand against domestic violence. This will also make congregants feel comfortable in approaching you about domestic violence.
- Adapt prevention, intervention, accountability, and counseling policies consistent with standard domestic violence intervention practices.
- Invite other clergy to unite in efforts to support victims and hold batterers accountable.
- Provide leadership to the community at large on domestic violence issues.

Congregations and individuals of faith should:

- Seek intensive training on domestic violence dynamics, including how it involves the faith community and how to stay safe while helping others.
- After completing training, offer to be a support advocate to friends and family members of victims.
- Offer their special skills by volunteering in a manner that supports victims, such as at a local shelter, within a faith-community domestic violence effort, or at a special event.
- Support clergy initiatives to create a sanctuary for victims.
- Support clergy initiatives that hold batterers accountable while encouraging their spiritual connection.
- Support efforts by local shelters or domestic violence programs to create practical resources for victims.
- Take a public stand against domestic violence by pressuring public officials to support funding for shelters and other victim services. Speak out against injustice in domestic violence cases.
- Support local, state and federal legislative and policy efforts that benefit victims and their children.
- Take up a special collection/offering for the local shelter or domestic violence program during Victims' Rights Week and/or Domestic Violence Awareness Month.
- Participate in domestic violence awareness month events by advertising local domestic violence program events in bulletins, newsletters, or fliers.
- Become a member of or otherwise support a local domestic violence task force, or start one if none exists.
- Start or participate in a peer advocacy program, collaborate with the local shelter to provide services to victims of faith, and offer meeting space for support groups.

Clergy Associations should:

- Provide practical support and funding for clergy to be trained on domestic violence.
- Create and support model policies and protocols to address domestic violence in local congregations.
- Create and support model policies and protocols regarding domestic violence among clergy members.
- Produce and/or distribute educational materials for use in local congregations.
- Produce and/or distribute devotional and faith-related materials for use with victims.
- Produce and/or distribute spiritual and faith-related materials for use with perpetrators.
- Sponsor and fund special programs for faith communities, informing them about domestic violence and faith issues.
- Take a public stand against domestic violence by sponsoring public service announcements.
- Develop resource materials (including sample sermons) for clergy to use.
- Collaborate with the local shelter or domestic violence program to train and continually educate the clergy.

Findings and Recommendations

Issues identified as findings and recommendations are not limited to individual cases from this year. Instead, they are the product of Fatality Review Committees identifying practices over the last four years that not only impacted a specific homicide, but were common problems throughout their community. For this report, we have further narrowed findings and recommendations to those that were replicated among several communities.

Findings	Recommendations
DFCS	
Surviving children of domestic violence homicides are not receiving adequate follow-up services once placement has been made.	Georgia's Office of the Child Advocate should convene representatives from DFCS, Georgia Center for Children, local Child Advocacy Centers and other appropriate agencies to develop a model for responding to children who are present at, or witness to, a domestic violence homicide or who lose one or both parents to domestic violence homicide. This model response should include providing and/or referring these children to professional counselors or therapists who specialize in grief and trauma.
Department of Family and Children Services (DFCS) case plans in domestic violence cases are often made for both the victim and the perpetrator rather than making separate plans. They often include a requirement that the perpetrator attend a Family Violence Intervention Program (FVIP). While requiring batterers to attend FVIPs is appropriate, putting this requirement in a case plan designed for both parties makes the victim responsible for the perpetrator's actions.	In cases where domestic violence exists, DFCS should collaborate with domestic violence advocates and ensure that offenders have individual case plans so that victims are not held accountable for perpetrators' actions. Safety of both adult and child victims should be central to all domestic violence case plans. DHR should ensure that each newly hired DFCS caseworker receives comprehensive training on the dynamics of domestic violence, including the dangers of separating from an abusive partner.
DFCS caseworkers are placed in harm's way daily, especially when dealing with a family where there is domestic violence.	DFCS should provide pre-service training for all of its caseworkers on the indicators of danger and lethality in domestic violence cases, as well as strategies for enlisting law enforcement assistance with these cases.
Law Enforcement	
Safety for all parties and officers responding to domestic violence calls depends upon law enforcement officers having access to the TPO registry and criminal history information such as active parole or probation, arrests, warrants, 911 calls, violent offenses or use of weapons, and bond conditions. Currently, access to this information is inconsistent, even for those officers with car computers, because of security protocols at GCIC and/or high call volume at 911.	GCIC should provide all Georgia law enforcement officers with access to its crime database via vehicle computers so as to better prepare officers for their encounters with perpetrators as they respond to calls.

Sabrina Thompson, 28, mother of two: stabbed by her daughter's father in the presence of her children. He later hanged himself in jail.

Findings	Recommendations
911 operators are not consistently trained regarding domestic violence, nor do many participate on local domestic violence task forces.	911 operators should receive annual, required training on domestic violence, safety planning with victims, and lethality indicators. 911 operators and supervisors should participate regularly on their local domestic violence task forces as well as the Fatality Review committees. Task forces and Fatality Review committees should make it a priority to invite 911 operators to the table.
911 tapes are periodically recycled, often making it impossible for law enforcement or prosecutors to pull tapes as evidence.	911 should develop procedures regarding 911 calls that report violent crimes to ensure that those tapes be made accessible until cases are completely resolved or litigated.
Officers do not consistently record minors' names on police reports or incident reports due to concerns about breaking the minors' confidentiality.	Municipal police departments, sheriff's departments, and the Georgia Bureau of Investigation should revise incident report forms to ensure that the names of children in domestic violence cases are included. Accurate and efficient reports can mean the difference between a weak or strong case in prosecution. Officers should be required to attach an extra page marked "for law enforcement only" if this information is considered confidential. Because children are often present on domestic violence calls, responding officers should take five minutes at every scene to tell any children that the violence is not their fault, that they should never try to directly intervene in the violence, that they should get to a safe place if the violence occurs again, and that it is OK to call police in the future.
There is often a gap between written policy and actual practice in law enforcement agencies.	Law enforcement agencies should institute offense report reviews on an ongoing basis to monitor adherence to policy and to reduce liability and danger to officers and victims.
When a responding officer directs a victim to the court to take his or her own warrant, this unnecessarily places the burden of prosecution on the victim.	Municipal police departments, sheriff's departments and the Georgia Bureau of Investigation should revise policies and protocols to ensure that responding officers, upon finding probable cause for domestic violence, immediately prepare warrants for the perpetrator. Revised policies should compel officers to complete warrants rather than directing victims to take their own warrants.
In many instances, an offense report is not created after a dispatch for a domestic violence incident.	Law enforcement agencies should revise their protocols to ensure regular monitoring of any discrepancies between the number of dispatched calls and the number of offense reports written. Policies should require officers to get approval from a supervisor in order to reclassify a call and deviate from domestic violence protocols. A report of such reclassifications should be written by the responding officer.
Some communities are experiencing a dangerous lag time between the issuance of a TPO and personal service upon the respondent.	Law enforcement agencies should revise their policies to ensure that service of process and execution of warrants happen expeditiously. Where possible, law enforcement agencies should create specialized domestic violence units staffed with officers and advocates trained in domestic violence response. Police departments should formalize their operational oversight by conducting internal audits of their responses to domestic violence

Findings and Recommendations

Findings	Recommendations
	calls. One way to conduct a simple audit is to take a random sample of the previous day's calls for service (approximately 10%), contact victims to assess their experience with the call, and determine the process followed when no arrest or dual arrest was made or no report was written. Processes followed should be compared against protocols. The audit should include a report of the results be presented to the chief and supervisors.
Law enforcement first responders are often a victim's initial contact with the justice system. It is crucial for law enforcement officers to make effective referrals and appropriate arrests. This will have an impact on the victim's willingness to call the police or involve another system in the future.	Printed materials in a variety of languages should be kept in police vehicles and contain, at minimum, these core statements: 1. Violence is not your (a victim's) fault. 2. No one deserves to be abused. 3. There is help available through the domestic violence hotline (1-800-33-HAVEN). You may qualify for shelter or non-shelter services. 4. You may get a copy of the police report by going to _____ or calling_____. 5. You have the right to request that charges be filed if a crime has been committed. 6. You have the right to request a temporary protection order.
Responding officers have, at times, told domestic violence victims that her kids will be taken away or that both parties will go to jail if she calls the police one more time. These tactics are not effective in reducing domestic violence, as victims who have received these threats may be reluctant to call law enforcement for help again.	Officers should refrain from threatening arrest and removal of children by DFCS. Officers should follow protocol when responding to domestic violence calls, and supervising officers should regularly monitor for compliance with protocol and policy. Law enforcement agencies should train officers on the danger of using such tactics and, where possible, should revise policies to prohibit their use.
Law enforcement officers don't always separate the two parties to conduct private, individual interviews with each party when responding to a domestic violence call.	Law enforcement agencies should create policies and protocols so that all parties involved will have a private interview. Responding officers should separate suspects and victims for questioning to ensure that neither party can see or hear the other.
Dual arrests remain a regular practice in domestic violence cases in some jurisdictions.	Law enforcement agencies should monitor the level of dual arrests in their jurisdiction and consider implementing training and accountability mechanisms. General or standing orders should be written to ensure that a primary aggressor investigation takes place in domestic violence cases and that only the primary aggressor is arrested. The orders should also discourage dual arrest.
Arrests of battered women continue to occur at questionably high rates. In the reviewed cases, some of the women who were murdered had called the police for help and had instead been arrested, through what appeared to be flawed primary aggressor assessments.	Law enforcement agencies should monitor the level of female arrests in domestic violence cases and implement corrective action any time the rate of female arrests exceeds 5%.

Findings	Recommendations
Law enforcement may be reluctant to investigate or arrest if they perceive that either the victim or perpetrator is experiencing mental health problems.	All municipal police departments, sheriff's departments and the Georgia Bureau of Investigation should mandate pre-certification and re-certification training on domestic violence dynamics, including suicide and lethality indicators.
In cases studied by the Fatality Review Project from 2005 to 2007, 53% (19) of all perpetrators at some point either threatened, attempted, or successfully completed suicide, indicating a significant correlation between suicide and danger.	

Medical Personnel/Healthcare Professionals

Often, survivors of domestic violence do not disclose the abuse to medical personnel without being asked, for a variety of reasons. First, injuries associated with the abuse may not be the primary cause for this visit to the health care facility. In addition, the shame and stigma still associated with domestic violence prevent many victims from self-identifying as such.	Healthcare professionals (HCPs), including physicians, physician assistants, dentists, psychologists, nurses, and social workers, should consider domestic violence to be a possibility in all cases and screen all patients as possible victims of domestic violence. It is suggested that this screening be given by a trained, sensitive interviewer in the context of obtaining a social history from the patient.
Additional reasons survivors may be reluctant to disclose the abuse include legitimate fears of the consequences of disclosing the abuse, such as retribution by the abuser or mandated involvement of the criminal justice or child protective system.	HCPs should assure confidentiality and obtain appropriate consent for evaluation and treatment per the standard policy of the hospital, clinic, or physician's office. HCPs should interview the patient in private. If a demanding or solicitous partner is in the room, they should ask the person to leave the room until the exam and interview are completed. HCPs should help the patient feel comfortable in discussing the abuse by encouraging the patient to describe the incident or incidents, and question the patient in a direct manner. Specific examples include: "Have you been hit, punched, slapped, forced to have sex? Or "Are you afraid of your partner?" Responses to any of these questions provide the HCP with information for exploring with the patient the risk of future violence.
Documenting injuries related to domestic violence is an important aspect of safety, both for the purposes of medical treatment and for the survivor's future interaction with the court system, which often requires "proof" of abuse.	HCPs should obtain a thorough history and physical, including appropriate lab and radiographs. Documentation should include name, address, phone number(s), and address of where injuries occurred. HCPs should include a statement of what happened in the patient's own words, and a description of all bruises and abrasions when documenting the patient's history. HCPs should also document untreated old injuries, use body maps and, with the victim's permission, obtain photographs.

Cristina Santana, 35, mother of four: shot in the neck by her husband, who then killed himself. Their teenaged daughter was also wounded during the attack.

Findings and Recommendations

Findings	Recommendations
	If law enforcement is currently involved or may become involved, HCPs should preserve physical evidence (e.g. torn or blood-stained clothing) in a sealed bag with date, patient's name, and the name of the individual who placed the items in the bag. These items (including relevant photos) should be kept in a locked area until they are relinquished to appropriate law enforcement personnel. At that point, they should ask the law enforcement officer to sign the appropriate papers to maintain a proper chain of custody.
Healthcare professionals play a critical role in helping survivors plan for safety. In some cases, medical treatment may be the only outside help a survivor is willing or able to seek.	HCPs should assess the patient's safety as well as the safety of involved minors. They should assure the patient of their safety concerns and reiterate the availability of resources, including the 1-800-33-HAVEN hotline, and offer access to a telephone. HCPs should discuss safety planning as a priority and provide appropriate referrals for shelter, legal assistance, and support groups. If social services are available through the medical facility, they should utilize them. For additional resource information, they should consult *Life Preservers - A Guidebook: How to Recognize & Treat Victims of Domestic Violence*, available through the Medical Association of Georgia, 404-876-7535.
Media	
News reporters sometimes inadvertently misinform the public about domestic violence through their coverage of this crime. Headlines about domestic violence often minimize the violence as a "dispute," or portray the death as the fault of the victim or of both parties.	Reporters covering domestic violence crimes, including homicides, should seek out information from domestic violence experts (such as a Director from the local domestic violence shelter, the Georgia Coalition Against Domestic Violence, or the Georgia Commission on Family Violence) to ensure that they are covering the issue responsibly, accurately, and appropriately. Reporters covering domestic violence crimes should ask local domestic violence experts to help them contact survivors of domestic violence in order to seek out survivors' experience and expertise in this area. Reporters should incorporate the perspective of survivors into every domestic violence story, if recommended by the experts. Domestic violence task forces should assign a person or subcommittee to monitor local media reporting on domestic violence cases. Task forces should respond directly to the reporter responsible for the story by phone or email to offer feedback (both positive and negative, as warranted) on these stories. Task forces should seek to make these contacts part of an ongoing relationship with their local media.
News stories about domestic violence rarely call this crime by name. Headlines, articles, and television segments may describe a series of violent acts committed against an intimate partner without ever naming domestic violence or abuse. Failing to name the crime in each story gives the reader a greatly diminished sense of the prevalence of domestic violence.	Reporters should identify domestic violence as such when reporting on violence between intimate partners, particularly when there is a pattern or history of one partner abusing the other.

Findings	Recommendations
News stories often focus on the extraordinary aspects of domestic violence cases (such as an unusual means of death, or a high-profile victim or perpetrator), without mentioning what all of these cases have in common (e.g. violence by an intimate partner; histories of abuse). Emphasizing the uniqueness of each case without identifying its similarities to other domestic violence cases impedes the public's ability to connect these dots and identify the magnitude of this problem.	When creating headlines, lead-ins, and graphics for stories that involve domestic violence, producers and editors should ensure domestic violence is labeled so the public clearly understands the type of crime committed.
News outlets have a wide audience and are thus uniquely positioned to disseminate appropriate information about domestic violence. News stories can be a key way for victims to learn about help and resources.	Producers, reporters, and editors should ensure that the statewide domestic violence hotline, (1-800-33-HAVEN), accompanies every story about domestic violence.
Private Attorneys	
Private attorneys representing victims of domestic violence in civil cases such as a divorce, TPO, or custody cases do not always have enough information about the dynamics of domestic violence and lethality factors to advise victims in a way that does not compromise their safety. They are also sometimes reluctant to address the issue of domestic violence.	The State Bar Association should include domestic violence considerations in every Continuing Legal Education Course it offers in family law. The State Bar should also contract with agencies with expertise in domestic violence and family law to provide specific Continuing Legal Education courses. These courses should address identifying domestic violence, resources for support, lethality factors, and indicators of escalating violence.
When parties have two pending civil cases, such as a Temporary Protection Order (TPO) and a divorce, too often the cases are combined rather than being handled separately. Omitting the protective order language of the TPO from the temporary or permanent divorce decree can create serious safety issues for the survivor. Law enforcement may be reluctant to enforce the safety provisions of the divorce decree because it is not identified as a Temporary Protective Order. In these cases, the victim loses the ability to engage the criminal justice system when the TPO is violated, since breaking the	Private attorneys should actively resist allowing the Temporary Protection Order to be absorbed into the divorce decree. Private attorneys should also familiarize themselves with the special protections afforded to their client through the TPO process.

continued on next page

DeeDee Marie Golden, 35, mother of one, employed as an assistant to a local attorney: died from trauma to the head and neck by her husband, who buried her body to conceal the homicide. Their fifteen-year-old son was in the house when the homicide occurred.

Findings and Recommendations

Findings	Recommendations
conditions of a divorce remains a civil matter. The order is also not filed in the TPO registry. The victim is not afforded the "full faith and credit" protections that allow her to expect protection from other states. She also risks forfeiting any federal firearms restrictions that would have applied to her if she had obtained a TPO. Finally, it appears from court records as though the victim has dismissed the TPO.	
Prosecutors	
Domestic violence victims are often reluctant to participate in the prosecution process for a variety of reasons, including concerns about their future physical safety.	Prosecutors should not rely on the participation of victims in order to prosecute domestic violence cases. Prosecutors should work with local law enforcement agencies to ensure that enough evidence is gathered at the crime scene to allow for victimless prosecution.
The definition of family violence is broad in the law so as to encompass a variety of relationships. However, the power and control dynamics known to exist in intimate partner violence may be different than those reflected in non-intimate partner violence (ie., two brothers fighting.)	Prosecutors should prioritize cases that demonstrate ongoing dynamics of power and control.
There are prosecutor's offices in Georgia that do not have a specialized domestic violence unit.	Prosecutors should develop specialized units to handle domestic violence cases in jurisdictions where there is a substantial caseload.
Prosecutors may find it easier to get a conviction on a non-FVA charge (such as simple battery), than on a charge under the FVA (such as family violence simple battery.) Proving the relationship necessary for an FVA charge may seem burdensome and unnecessary, yet prosecuting domestic violence cases without identifying them as such has multiple negative implications. First, in terms of accurate information-gathering and record-keeping, this practice effectively skews the number of DV cases, suggesting that rates of DV are lower than they actually are. In addition, convictions that would otherwise qualify for federal firearms restrictions may be disqualified when not charged under the FVA. Last, it is harder for other	Prosecutors should include language defining the relationship of the parties as one that falls under the Family Violence Act when drawing accusations and indictments for domestic violence cases.

Stacy Boddie, 35, mother of one, employed as an operator for Bell South: shot in the abdomen and head by her husband, who then killed himself. Their twelve-year-old daughter in the adjoining room was awakened by her mother's cries for help.

Findings	Recommendations
members of the criminal justice system (such as law enforcement and judges) to see the history that is such an important aspect of domestic violence cases when previous prosecutions were not charged under the FVA despite meeting statutory criteria.	
Cases studied through the project revealed several junctures at which offenses that occurred prior to the homicide were not prosecuted.	Law enforcement, prosecutors, and judges should treat seriously that which appears to be low-level violence as a means of potentially limiting the future escalation of the violence. Whenever possible, prosecutors should avoid pre-trial diversion for domestic violence cases. In cases where diversion is unavoidable, it should be used as a tool to enhance perpetrator accountability and victim safety.
Prosecution-based advocates are frequently the first service providers with whom domestic violence victims come into contact.	Prosecutors should employ advocates trained in domestic violence to conduct lethality assessments, provide individualized safety planning and connect victims to additional resources. If resources are limited, prosecutors should work closely with a community-based domestic violence program to provide advocacy for victims.
In some communities, there is a lack of communication between shelter-based advocates, prosecution-based advocates, and law enforcement-based advocates.	Prosecution-based advocates, shelter-based advocates, and law enforcement-based advocates should form a collaborative group to assist with information sharing, cross-training, and transitioning of cases through the justice system.
Judges	
Some judges continue to send domestic violence offenders to anger management programs, although Georgia statute requires that offenders be sent to certified Family Violence Intervention Programs (FVIPs) (O.C.G.A. 19-13-16). In addition to contradicting the law, this practice allows abusers to avoid addressing their core problems, none of which relate to the management of anger.	Judges should order domestic violence offenders to state-certified FVIPs, pursuant to state law. Judges should recognize the expertise of these programs and the benefits of state regulation of these programs, including that they are evaluated for knowledge, training, and experience; receive oversight and technical assistance from the Georgia Commission on Family Violence; and require continuing education to maintain certification.
Many domestic violence offenders who are ordered to attend FVIPs are never brought back to the court to report to the judge about their compliance with this requirement.	Judges should hold compliance hearings or otherwise require proof that abusers are complying with court orders and should impose sanctions when their orders are ignored.
Many domestic violence offenders, even when prosecuted, leave court with minimal sanctions, thereby increasing their sense of license to re-offend and decreasing the likelihood that the victim will seek help from the criminal justice system in the future.	When sentencing or otherwise sanctioning offenders, judges should take into consideration the repetitive and escalating nature of domestic violence.

Findings and Recommendations

Findings	Recommendations
Some judges will not hold batterers accountable for violating a Temporary Protection Order (TPO) if there is an allegation that the victim had what appears to be voluntary contact with the batterer.	When considering TPO violations, judges should recognize the following and impose sanctions accordingly: · Victims may sometimes appear conciliatory in these cases because of economic dependency or because they believe that doing so will help avert another assault. · Offenders commonly try this "invitation" defense. Successfully avoiding sanctions in this way makes abusers believe that they can avoid following court orders if they can get the victim to agree to have contact with them. Judges should expect offenders to follow orders, regardless of directives or invitations from non-court personnel, and should notify batterers that they alone will be held accountable for violating orders.
Offenders subject to protection orders are prohibited from possessing firearms or ammunition by federal law, but this federal law is sometimes not enforced, posing great danger to victims.	Judges should sign the provision on protective order forms confirming that the case meets federal firearm prohibition requirements. Judges should give domestic violence offenders notice of federal firearms prohibitions upon issuance of a protection order and at the time of sentencing in criminal cases. Judges should ensure that protection orders include language explicitly requiring the removal of firearms and/or ammunition from the perpetrator. In TPO cases where weapons are seized, judges should notify offenders of the process for retrieving them upon expiration of the order. Magistrate judges should consider a perpetrator's possession of firearms at the bond stage and consider ordering surrender of weapons and/or ammunition as a condition of release. Judges should set compliance hearings automatically to ensure that perpetrators have surrendered firearms and/or ammunition.
Military	
Consistent with what we have seen across disciplines, there is often a gap between written policy and actual practice in domestic violence cases. Victims of domestic violence who are married to military personnel have limited privacy and confidentiality.	All branches of the military should adopt policies to assist in addressing domestic violence among officers, enlisted personnel, and civilians, in compliance with the Department of Defense administrative directive DD6400.1, including ordering offenders into FVIP programs.
Victims who are military personnel face specific barriers when they seek help from other military personnel, who may issue orders for the victims to follow. These orders may ironically result in negative consequences to the victim seeking help from the military.	All branches of the military should utilize national protocols developed for military response. Specifically, protocols should ensure that victims are not ordered to take specific actions related to their victimization when violation of such orders could produce harmful consequences and reluctance to report future abuse.

Findings	Recommendations
Shelters	
Many domestic violence advocates are not prepared to provide support to family and friends of the domestic violence victim. Often, they will insist that the victim herself call the hotline rather than speaking with others about her. There is a lack of community support and resources for family and friends of domestic violence victims, even though they are an important part of the victim's resources and the community's response.	Domestic violence shelters and outreach programs should revise protocols to permit domestic violence advocacy and provision of assistance to family and friends of victims. The Georgia Coalition Against Domestic Violence (GCADV) should provide technical assistance to local programs about ways to provide these services without breaching the confidentiality and trust of victims. GCADV and local programs should provide training to domestic violence advocates on responding to phone calls from family and friends. This training should include information about how to support a loved one, safety planning with family and friends, ways in which family and friends can assist in the victim's safety, and warning signs of escalating danger, especially the risk during separation and the dangerousness of suicidal abusers. When working with victims, domestic violence advocates should ask about the safety of their immediate family, and, if risk is identified, they should offer safety planning. GCADV should develop printed materials to educate family and friends about danger and how to help a loved one who is either being abused or being abusive. This material should contain information on the statewide domestic violence hotline (1-800-33-HAVEN.)
Some shelters continue to be unprepared to accommodate victims with active substance abuse issues or mental illnesses.	GCADV should provide training for domestic violence advocates on the intersection of domestic violence, substance abuse, and mental illness, including education about local and statewide referral resources. This training should include specific strategies for providing ongoing advocacy to victims with active substance abuse issues or mental illnesses. Domestic violence shelters and outreach programs should revise admission policies to ensure that victims with disabilities, addiction, and mental illness are proactively screened-in for shelter and other services.
Some shelters require domestic violence victims to be in immediate physical danger to be eligible for shelter.	Domestic violence shelters should enhance or develop eligibility policies and screening procedures to make sure that victims with previous and/or current concerns of domestic violence are offered refuge rather than being required to demonstrate immediate danger as a requirement for admission. Local domestic violence programs, GCADV, and the Department of Human Resources should convene a committee to devise a strategy or policy to address this issue.
Some domestic violence hotlines focus exclusively on the needs presented by callers but do not proactively ask about or plan for safety unless the victim raises the issue.	Protocols should require that cases be screened for danger factors, even when victims call regarding other aspects of their situation. These protocols should incorporate the use of lethality assessment tools that capture historical information, reflect the totality of the victim's experience, and seek to identify factors that are viewed as high risk. One high risk factor that should be included is the presence or eventuality of a separation or significant changes in the relationship. Protocols should provide examples of separation-specific cues that may indicate increased risk.

Debra Thomason, 40, mother of two, bus driver: shot multiple times with an AK-47 assault rifle by her estranged husband.

Findings and Recommendations

Findings

In only 18% (11) of all cases reviewed through this project, domestic violence victims had known contact with a domestic violence shelter or safe house in the five years leading up to the homicide. Some communities felt that, because these programs are called "shelters" and they focus most of their resources on shelter, victims do not know what other services are available to them. Additionally, some victims who are not seeking shelter or have concerns due to their beliefs about the desirability of living in a shelter environment may also be reluctant to seek help from these programs.

Recommendations

Domestic violence shelters should seek funding to increase their ability to provide non-residential services to victims.

Domestic violence community outreach and education efforts should include myth-dispelling information about shelter life.

Domestic violence shelters should consider referring to themselves as Domestic Violence Centers or Programs. This more appropriately identifies the comprehensive nature of the agencies services. Brochures and other informational materials should identify the non-shelter services provided.

In some communities, there is a lack of communication between advocates based in prosecutor's offices, law enforcement agencies and shelters. This lack of communication can interfere with the victim's ability to receive the services and support she needs.

Prosecution-based advocates, shelter-based advocates, and law enforcement-based advocates should form a collaborative group to assist with information sharing, cross-training, and transitioning of cases through the justice system.

Eliete Barcelos, 33, mother of one, editor of a popular Brazilian publication: shot by her former boyfriend who then killed himself.

Legislators

Domestic violence exists in many Georgia homes, as evidenced by GCADV's media clipping service report indicates that almost 500 Georgia citizens lost their lives due to domestic violence from 2003-2006. As a result, any legislation that affects families, marriages, or children will affect victims of domestic violence. Lawmakers often introduce legislation, particularly in the arena of family law, without considering its potential impact on domestic violence victims or their children.

People who have first-hand and/or professional knowledge about domestic violence can be valuable assets to legislators as they consider pieces of legislation that may impact victims of domestic violence or their children. When introducing, supporting, or opposing legislation, legislators should consult with domestic violence experts (such as directors of domestic violence shelters, the Georgia Commission on Family Violence, or the Georgia Coalition Against Domestic Violence) regarding its potential impact.

Bill sponsors and committee chairs should incorporate input from domestic violence experts when drafting, amending, or evaluating legislation that may impact victims of family violence.

Domestic violence shelter staff and other task force members should develop relationships with their legislators and provide them with information about domestic violence on an ongoing basis.

Family Violence Intervention Programs

Family Violence Intervention Programs (FVIPs) do not consistently communicate with victim liaisons regarding the initial screening of the perpetrator.

The Georgia Commission on Family Violence (GCFV) should require FVIPs to communicate with victim liaisons regarding perpetrators' initial screening outcomes, including any potential indicators of lethality, such as depression and suicidal ideation. GCFV should update the Victim Contact Request Form to include a checklist of major lethality indicators. This information should be faxed by the FVIPs to liaisons within 24 hours of each participant's enrollment.

Findings	Recommendations
In the 36 cases reviewed in 2005, 2006, and 2007, 53% (19) of all perpetrators at some point either threatened, attempted, or successfully completed suicide.	GCFV should continue training FVIP providers on understanding the significant connection between depression, suicide, and homicide. FVIPs should implement the protocol disseminated by GCFV for responding to suicidal batterers.
FVIPs sometimes rely solely on batterers for information during their enrollment without referencing other collateral sources regarding any past or present violent behavior.	GCFV, County and Municipal Probation Advisory Counsel (CMPAC) and Georgia Department of Corrections (GDC) should develop policies to facilitate sharing information between probation departments and FVIPs. FVIPs should require, as a condition of enrollment, that all court-ordered participants provide a copy of the arrest report or TPO petition related to the precipitating incident. FVIPs should inform participants as to where and how this information can be obtained.
Schools	
The cases reviewed in 2005, 2006, and 2007 involved 37 children between the ages of 5-18 years old.	Task forces and domestic violence programs should collaborate with local schools to train and provide resources to teachers and other school professionals. Trainings should include forms of abuse, warning signs, and changes in behavior such as truancy, bad grades, and absenteeism. School boards, with the assistance of their local domestic violence task forces, should develop protocols to assist teachers, administrators, counselors, and school resource officers in addressing the following: · identifying and reaching out to children who are living with ongoing domestic violence, · making appropriate personnel aware of cases where there is a TPO and any specific restrictions imposed by the court regarding the children, and · maintaining safety and confidentiality in domestic violence cases. School administrators should incorporate information about domestic violence into all of their current prevention programs such as D.A.R.E., anti-bullying, and anti-gang initiatives.
School districts lack the funding to have social workers or counselors readily available for students. Students do not have a specific source of support for personal and family problems.	Georgia Department of Education should pursue funding to hire a part-time social worker for every school to assist students who are experiencing domestic violence at home.
Family Violence Task Forces	
Often, domestic violence perpetrators and the danger they pose are well-known: they may have multiple victims; they may have interacted with various criminal justice or other systems, or they may be known as a danger in the	In order to increase collaboration and information sharing, domestic violence task forces should actively recruit participants who represent all levels of law enforcement and the judicial system, advocacy community, corrections, animal control, and other systems in a position to affect support for victims and accountability for perpetrators.

continued on next page

Findings and Recommendations

Findings	Recommendations
community. The individuals and systems with this information, however, are often disconnected from each other, leaving each with only isolated snapshots of the big picture. In addition, while individual people may know the potential danger victims are in, they are unaware of who else knows, and they feel unprepared to marshal a coordinated response among all of those who know about the violence.	Task Forces that already evaluated their systems' response using the fatality review model should consider applying for federal funding to engage in formal safety audits or to implement a Court Watch Project. Task Forces should ensure that agencies, whether justice system, advocacy, law enforcement or other, have a brochure that includes a list of victims' rights and legal remedies in brochures informing victims about domestic violence.
Local and state governing agencies often do not provide services in a culturally-competent manner.	Task Forces should provide technical assistance to local and state governing agencies to revise policies and procedures related to the agencies under their jurisdictions to ensure that response, outreach and education efforts include content that is culturally sensitive, culturally relevant, and language accessible.

State, County and Private Probation

Rebecca Lamastro, 36, mother of three, employed by the school system: shot to death by her estranged husband in the presence of their child. He later killed himself.

There is inconsistent practice in revocation of probation in Georgia. Many offenders on probation re-offend or commit technical violations (ie. violation of no contact orders, failure to attend mandated programs) but the standard required to revoke probation varies.	Probation departments should have clear policies that revocation should be sought as soon as the probation officer learns of the violation. Where evidence supports the likelihood that a violation has clearly occurred, probation officers should enforce that policy immediately. Probation departments should consult with judges to explore the court's preferences and directives relative to domestic violence cases. Probation departments should use this opportunity to educate the judiciary regarding the importance of acting with expediency in dealing with violations, swift and sure consequences for violations as it relates to victim safety, offender empowerment, and community perception of the justice system. Judges should also be encouraged to take immediate and appropriate action when advised of any domestic violence case violation; this can be done by formulating suitable recommendations for the immediate issuance of warrants, consulting with and requesting the assistance of the prosecuting attorney and recommending consequences to be imposed at the revocation hearing. Probation Officers should also consult with prosecutors to solicit their assistance in educating the judiciary, formulating suitable recommendations, and to assist with the presentation of evidence or prosecution of the case.

Findings	Recommendations
Probation officers have a unique opportunity to impact the safety of the community by monitoring domestic violence offenders who frequently have multiple contacts with the criminal courts. However, high caseloads prevent close and specialized monitoring of dangerous probationers. 36% of domestic violence homicide perpetrators in the reviewed cases were known to have been in contact with state, county or private probation in the five years leading up to the homicide.	All domestic violence cases should be considered High Risk, as no known assessment tool is totally reliable. Probation departments should establish supervision standards that maximize the supervision and monitoring of these offenders. Careful consideration should be given relative to conducting home visits in domestic violence cases. Officers should be specially trained regarding victim safety issues as they relate to conducting home or field visits. Officers should obtain copies of the incident report leading to the conviction in order to obtain a better understanding of the context of the offense(s), officers should review criminal history information paying special attention to any violent offenses or drug/alcohol related offenses and they should check the Temporary Protective Order Registry for prior or existing orders. The information contained in these sources provides additional information about the offender's behavior patterns and serves to supplement any formal assessment instrument that may be utilized in these cases. When making a determination regarding the frequency and intensity of monitoring, probation departments should examine the entire criminal history of the perpetrator as well as Protection Orders filed against him or her, rather than solely focusing on the incident leading to the conviction. Monitoring domestic violence cases should be a priority for community corrections, given the repetitive and escalating nature of domestic violence. Because the majority of domestic violence cases are prosecuted as misdemeanors, any additional funding directed towards the criminal justice system for improving response to domestic violence should be focused on probation and post-sentence supervision for misdemeanor domestic violence cases.
Victims, Victim Liaisons, and FVIP providers are frequently not made aware of sentencing requirements, (ie. stay away conditions or no violent contact conditions.)	The sentence or order of probation is public record and should be forwarded along with a copy of the incident report by probation to the Family Violence Intervention Program provider, who in turn should forward the information to the Victim Liaison.

What You Can Do

What You Can Do About Domestic Violence

Throughout this report, we have talked specifically about the system's response to domestic violence cases. We have made specific recommendations for change to agencies and institutions involved in the response to domestic violence.

However, what has become clear is that we all have a role to play in ending domestic violence in our communities whether or not we work in the field of domestic violence. Although the criminal justice system and other social service agencies have a crucial role to play in ending domestic violence, any one person can take steps to support a loved one and create awareness in their community. ***It is the responsibility of the community as a whole to take action against this crime.***

The closest support system to domestic violence victims is often made up of family members, friends, and co-workers. These individuals generally have extensive information about the level and detail of physical abuse and threats. Also, by the nature of their relationship to the victim, they understand the larger context of the relationship and history between the victim and perpetrator. These are all very valuable insights. However, what we have learned from our interviews with those who have lost a loved one to domestic violence homicide is that they often lack information as to how to best support their loved one. Below are some suggested actions.

If you are a family member, friend or co-worker of a victim of domestic violence, you can:

1. Link the victim to 1-800-33-HAVEN, the statewide, toll-free domestic violence hotline.
2. Contact a victim advocate yourself via 1-800-33-HAVEN to get support.
3. Talk openly and often with your friend or family member.
4. Educate the victim about indicators that the situation is getting more dangerous.
5. Let the victim know that you care and that you are worried about her safety.
6. Remain non-judgmental. Let the victim know that you will support her even if you do not understand her decisions.

If you are a concerned community member, you can:

1. Raise awareness about domestic violence in community groups to which you belong or places you frequent, including your place of employment, where you worship, and your hair salon or barber shop.
2. Raise money or take collections for domestic violence programs.
3. Volunteer at a domestic violence program.
4. Develop a Court Watch program in your community to monitor court response to domestic violence.
5. Before voting, find out how candidates stand on family violence by sponsoring a candidate forum or some other means.
6. Write letters to the editor about domestic violence issues or to address how the media covers domestic violence cases.
7. Visit GCADV's website (www.gcadv.org) and GCFV's website (www.gcfv.org) often from January through April each year to monitor the legislative session and respond to policy alerts to call your legislators.
8. Write, call, or visit your elected officials and tell them that domestic violence is an important issue to you as a voter.
9. Attend Stop Violence Against Women Day at the Capitol to show legislators how important this issue is to voters (usually January of each year.) Check GCADV's website (www.gcadv.org) and GCFV's website (www.gcfv.org) for exact date.
10. Join your local domestic violence task force.

Silence and a lack of information perpetuate the pain of those living with domestic violence. Raising community awareness about the issue of domestic violence can go a long way toward creating safer homes and safer communities.