**REPORT TO THE GOVERNOR, SUPREME COURT,
ATTORNEY GENERAL, AND GENERAL ASSEMBLY**

IOWA DOMESTIC ABUSE DEATH REVIEW TEAM

Annual Report

Calendar Year 2001

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Forward

The Iowa Domestic Abuse Death Review Team was created in 2000 to review domesticabuse-related homicides and suicides in the state. Legislative authorization is given in the *Code of Iowa* Chapter 135.108 and in the *Iowa Administrative Code* 641-91. The specific purpose of the team is "...to aid in the reduction of the incidence of domestic abuse deaths by accurately identifying the cause and manner of deaths occurring from domestic violence and by making recommendations for changes in policy and practice to improve community interventions for preventing domestic abuse deaths." A domestic abuse death means a homicide or suicide that involves or is a result of an assault as defined in section 708.1 *(Iowa Code*) and the parties involved were:

- current, separated, or former spouses,
- current or former co-habiting partners,
- parents of the same minor children,
- current or former dating partners,
- related by blood or affinity to someone in the same household or workplace, or
- subject to an order of protection between the perpetrator and victim.

The team meets six times per year, and members are appointed by the director of the Department of Public Health in consultation with the Attorney General. Two team members are appointed by the Chief Justice of the Iowa Supreme Court. There are nine government agency liaisons assigned to the team, who also serve as full team members. Appointed members receive mileage and related expenses for team meetings. Administrative support is provided by the Department of Public Health.

The team responsibilities include:

1. Preparing an annual report for the governor, supreme court, attorney general, and the general assembly concerning:
   - The causes and manner of domestic abuse deaths, including an analysis of factual information obtained through review of domestic death certificates and domestic abuse death data,
   - The contributing factors of domestic abuse deaths, and
   - Recommendations regarding the prevention of future domestic abuse deaths, including actions to be taken by communities.
2. Advising and consulting the agencies represented on the team regarding program and regulatory changes that may prevent domestic abuse deaths.
3. Developing protocols for domestic abuse death investigations and team review.

The team is specifically charged with reviewing the relationship between the decedent victim and the identified perpetrator from the point where the abuse reportedly began, until the domestic abuse death occurred to ascertain whether a correlation exists between certain events in the relationship and any escalation of abuse, and whether patterns and risk factors can be established regarding such events in relation to domestic abuse deaths in general.

The type of records requested for each case include: newspaper articles, birth and death certificates, autopsy reports, law enforcement investigative reports, 911 call logs, arrest histories, court records, crime victim assistance applications, corrections files, medical records, and victim service records. The findings are based on the information that is documented in the records received for each case. Not all records are available for every case.

Executive Summary

The Iowa Domestic Abuse Death Review Team met six times during 2001 to review domestic abuse deaths that occurred in Iowa from 1997 - 2000. This was the first full year of case review for the team, since members did not begin to review records until July 2000. There were four cases reviewed during the latter half of 2000 and 17 cases reviewed during 2001. The deaths in two of the 21 cases were determined not to be domestic violence related, so they were excluded from the data analysis.

The findings include data from 19 of the 36 cases of domestic abuse homicide that occurred between January 1997 and December 2000. They were identified by Crime Victim Compensation applications received by the Iowa Department of Justice. The team was unable to review every domestic violence death during those years due to time limitations and insufficient records. The team intends to obtain sufficient records to allow review of the remaining cases from 2000 and all deaths from 2001 during the next calendar year. In addition, team members believe that there may be additional domestic abuse deaths that are improperly classified as suicides or accidents. Within the next few years, the scope of cases reviewed will include those as well.

Summary of Findings

Domestic abuse homicides in Iowa are crimes of gender violence; in the cases reviewed this year, 95 percent of the perpetrators were men and 92 percent of the victims were women. In half of the cases, perpetrators also took their own lives. Six of the cases (32 percent) involved multiple victims—primarily children or other family members. The most common relationship between victim and perpetrator was a current spouse or current live-in partner. In 68 percent of the cases reviewed, the victim was planning to divorce or end the relationship with the perpetrator. The first month of separation proved to be the most dangerous time for victims. Almost one-third (31.5 percent) of the deaths occurred within the first month of separation. This finding is consistent with national studies that conclude women are at greater risk of homicide when they file for divorce, go to a shelter, or obtain a protection order.

The most common means of death was by firearm. Sixty-five percent of the deaths and all of the perpetrator suicides were committed with a firearm. Hand guns and shotguns were used most often.

In 53 percent of the cases reviewed, there was a documented history of domestic abuse. The team discovered that family and friends often had more "informal" knowledge of prior domestic abuse than was known to law enforcement in the community. In less than 40 percent of the cases, there were prior calls to police. In a quarter of the cases, there were prior domestic abuse arrests or prior protection orders filed. Only one case showed evidence of prior contact with a domestic abuse shelter. These findings suggest that people do not know about or use community options for safety in domestic abuse situations.

The most common circumstance preceding the homicide was an impending divorce or separation. The other factors that were present included:

- an argument between the couple,
- prior homicide threat by perpetrator,
- alcohol or drug use by the perpetrator,
- prior suicide threat by perpetrator,
- perpetrator discovered victim had other boyfriend.

The team was unable to identify all circumstances preceding the homicide in every case, but concluded that all homicide threats need to be taken seriously whenever there is a history of domestic violence. Friends, family, and community public safety officials should use whatever means are possible to insure safety for victims.

Recommendations to Communities for the Prevention of Future Domestic Abuse Deaths

1. Family, friends, and others should take threats of homicide or suicide seriously, and should contact local law enforcement, Clerk of Court's office, or the local domestic violence program for help and information. The statewide domestic violence hotline number is 1-800-942-0333.
2. Attorneys should screen for domestic violence in all family law cases, make referrals to community resources knowledgeable in domestic violence, and encourage use of Protective Orders.
3. Community professionals who may come in contact with domestic abuse victims and perpetrators (such as health care providers, clerks of court, religious leaders, substance abuse counselors, mental health providers, social workers, and teachers) should be adequately trained to identify domestic abuse, appropriately intervene, and provide referral to resources knowledgeable about domestic violence in their community.

Recommendations to State Agencies for Program and Regulatory Changes

Iowa Legislature

1. Persons convicted of domestic abuse should be required by the court to turn over firearms in their possession upon conviction of the domestic abuse. (Support language in HSB 78.)
2. All women in Iowa experiencing domestic abuse must have adequate, accessible services available to them. As a result, services should be no more than a 30-minute drive and existing domestic violence programs need the resources to meet the demand in the communities they serve.
3. There should be resources (financial, training, and technical assistance) available to communities to establish Domestic Abuse Response Teams. These multi-disciplinary teams are equipped to respond immediately to domestic abuse situations and enhance investigation, prosecution, and safety to victims and their children.

State Court Administrator

1. Judges should be alert to the dynamics of domestic abuse and treat them as a higher priority of the court. When domestic abuse is present in cases of divorce, they should:
   - refrain from ordering mediation,
   - utilize neutral exchange sites, and
   - refrain from routinely awarding joint custody as allowed in *Iowa Code* 598.41.

Iowa Department of Corrections

1. Correctional officers should be trained to identify high-risk situations with clients who have a history of domestic abuse, and be able to recognize when the use of more aggressive monitoring and supervision practices may be indicated.
2. All convicted domestic abuse perpetrators should be screened for substance abuse and mental health. If the evaluation indicates a need for treatment, they should receive treatment from substance abuse and mental health providers knowledgeable about domestic violence.
3. Batterer's Education coalitions should be developed in areas of the state where they don't exist to promote stronger linkages between community agencies who serve victims and perpetrators of domestic abuse.

Iowa Department of Human Services

1. The department should continue to provide joint training for child abuse protection staff and domestic abuse advocates so that all child protective workers are able to identify the presence of domestic abuse and make appropriate interventions and referrals.
2. The department should continue to allow the family violence option for applicants to the Family Investment Program (FIP). FIP participants who are victims of domestic violence also need adequate services and support to be able to maintain safer choices for themselves and their families.

Iowa Department of Justice

1. All county attorneys should be encouraged to implement "evidence-based " prosecution policies in domestic abuse cases, even without the victim's testimony where other admissible evidence is available to convict (use of 911 tapes where hearsay exceptions allow, victim's statements to third parties, medical reports, etc.).
2. There should be counseling and crisis intervention services available to children who witness domestic violence and especially those who witness and survive a parent's death by domestic violence. Child survivors may have unique needs that may not develop until years after the death, and services and resources should be available to them throughout the remainder of their childhood.
3. Violent crime victim advocacy programs offer supportive services and crisis intervention with family members following a domestic abuse homicide/suicide. They should develop a reporting mechanism for family members who have information about the circumstances preceding the death and wish to share that information with the Domestic Abuse Death Review Team.

Iowa Department of Public Health

1. All individuals seeking a substance abuse assessment should be assessed for a history of intimate partner violence.

2. Substance abuse programs and domestic violence projects should be jointly trained in the crossover between domestic violence and substance abuse, and collaborate on appropriate intervention strategies.
3. The department should continue to provide training and resources to health care providers and facilities across the state regarding identification, intervention, and documentation of domestic abuse.

Iowa Department of Public Safety

1. In every domestic abuse case seen by law enforcement, domestic violence service information and referral should be given to victims. Whenever an arrest is made, the information should be provided immediately, as stated in *Iowa Code* 236.12. If possible, contact with the victim by a domestic violence advocate should occur at the time of the arrest, in collaboration with the law enforcement agency.
2. All perpetrators of suspected domestic abuse homicides should be tested for blood alcohol content and other mood-altering substances after they are apprehended.
3. Law enforcement officials should enforce federal law and seize firearms from persons convicted of domestic abuse.

Iowa Law Enforcement Academy

1. Every 5 years, all law enforcement officers in Iowa should receive a minimum of 4 hours training on domestic abuse and stalking.
2. In every domestic abuse case seen by law enforcement, domestic violence service information and referral should be given to victims. Whenever an arrest is made, the information should be provided immediately, as stated in *Iowa Code* 236.12. If possible, contact with the victim by a domestic violence advocate should occur at the time of the arrest, in collaboration with the law enforcement agency.
3. Law enforcement officials should enforce federal law and seize firearms from persons convicted of domestic abuse.

Findings

The number of deaths resulting from the 19 cases reviewed are listed by year of death in Table 1.

Table 1. Domestic abuse deaths by year

	1997	1998	1999	2000	Total
Victims	3	12	5	6	**26**
Perpetrators*	1	4	3	1	**9**
Total	**4**	**16**	**8**	**7**	**35**

* Represents perpetrators who committed suicide following the homicide

Thirty-five people died as a result of domestic violence in the 19 cases reviewed. Twenty-six were killed by the identified perpetrator and nine of the 19 perpetrators (47 percent) committed suicide following the homicide.

The relationship of the victim to the perpetrator was noted in all of the cases (Table 2).

Table 2. Relationship of victim to perpetrator by year of death

	1997	1998	1999	2000	Total
Current spouse	1	4	3	1	**9**
Current live-in	0	2	0	3	**5**
Current dating partner	1	1	0	0	**2**
Former spouse	0	1	0	0	**1**
Former live-in	1	0	0	0	**1**
Former dating partner	0	0	0	1	**1**
Child	0	2	1	0	**3**
Other family	0	2	1	0	**3**
Not related	0	0	0	1	**1**

There were 19 "primary" victims, or persons involved in an intimate relationship with the perpetrator. The remaining seven victims were either children, other family members, or were not related to the perpetrator. The majority of primary victims (84 percent) were a current spouse, live-in partner, or dating partner of the perpetrator. Spouses comprised the most common relationship (52.5 percent) of the primary victims.

Demographic Information

Demographic information on the victims and perpetrators is presented in Tables 3, 4 and 5.

Table 3. Gender of victims and perpetrators

	Female	Male
Victims	24	2
Perpetrators	1	18

Table 4. Race/ethnicity of victims and perpetrators

	Caucasian	African/Am.	Hispanic	Asian/Am.	Native Am.
Victims	23	0	0	3	0
Perpetrators	16	1	0	2	0

Table 5. Ages of victims and perpetrators

	0-17	18-25	26-35	36-45	46-55	56-65	> 65
Victims	3	7	5	6	3	1	1
Perpetrators	0	2	7	6	2	1	1

Ninety-two percent of the victims were female, and 95 percent of the perpetrators were male. Eighty-eight percent of the victims and 84 percent of the perpetrators were Caucasian (Table 4). All of the cases except one involved a relationship between people who were of the same race.

The most common age range of victims was between 18 – 45 years. The most common age range of perpetrators was 26 – 45 years. There were three children under the age of 18 killed at the same time as their mothers, and two fetuses died following the homicide of the pregnant woman.

Information on the population area distribution of the location in which the death occurred is contained in Table 6.

Table 6. Population area where deaths occurred

	1997	1998	1999	2000	Total
< 10,000	0	0	0	0	**0**
10,000 – 20,000	1	1	1	1	**4**
> 20,000	1	1	0	1	**3**
Urban (MSA* counties)	1	6	2	3	**12**

*Metropolitan Statistical Area

The population areas where the deaths occurred were primarily urban. Of the cases reviewed, there were none that occurred in counties with a population less than 10,000.

Cause and Manner of Deaths

Information on cause of death is included in Table 7.

Table 7. Cause of death

	1997	1998	1999	2000	Total
Gunshot wound to head	1	7	5	1	**14**
Multiple gunshot wounds	0	1	0	2	**3**
Asphyxia (suffocation)	1	2	0	1	**4**
Blunt trauma to head	1	2	0	0	**3**
Stab wound	0	0	0	2	**2**

The majority were caused by gunshot wounds to the head. In 1998 and 1999 gunshot wounds were the cause of death in sixty-six percent of the cases; in 1997 and 2000, guns were used in 50 percent or less of the deaths.

Method of death or weapon used to commit the homicide is listed in Table 8.

Table 8. Weapon/Method of victim death by year

	1997	1998	1999	2000	Total
Hand Gun	1	5	0	1	**7**
Shotgun	0	0	5	2	**7**
22 Caliber Rifle	0	3	0	0	**3**
Hands/Manual	1	1	0	1	**3**
Blunt instrument	1	2	0	0	**3**
Knife	0	0	0	2	**2**
Other	0	1	0	0	**1**

Perpetrators used firearms to commit the homicide in 17 (65 percent) of the victim deaths. Hand guns were used in seven cases, shotguns in seven cases, and a rifle was used in the remaining three cases. All of the perpetrator suicides were committed with a firearm. Although there was incomplete data to track how all of the perpetrators acquired firearms, none of the perpetrators was required to surrender weapons under current law.

Information on the location of the death is included in Table 9.

Table 9. Location of death by year

	1997	1998	1999	2000	Total
Victim residence	2	5	5	2	**14**
Joint residence	0	3	0	4	**7**
Perpetrator residence	1	4	0	0	**5**

More than half of the deaths (54 percent) occurred at the victim's residence. Just over one-fourth (27 percent) occurred in the couple's joint residence.

Circumstances Prior to Death

It was difficult to accurately identify causal factors in all deaths, due to lack of thorough records and documentation in each of the cases reviewed. This was especially true in cases where the perpetrator committed suicide and there was no specific information available about the situation prior to the homicide. Most of the immediate circumstances surrounding domestic abuse deaths were gleaned from law enforcement interviews with family or friends following the death. Table 10 summarizes the factors that team members identified as present within a few hours to a few days prior to the homicide. These factors are not mutually exclusive—several factors may be present for each death.

Table 10. Circumstances immediate to death

	1997	1998	1999	2000	Total
Divorce/threat of divorce or victim ending relationship	3	5	3	2	**13**
Argument	2	3	0	3	**8**
Perpetrator alcohol use	2	1	0	3	**6**
Perpetrator discovered victim had other boyfriend	2	2	0	1	**5**
Custody conflict	0	0	0	2	**2**
Perpetrator upset by victim pregnancy	0	1	0	1	**2**
Perpetrator had financial problems	0	0	1	0	**1**
Perpetrator drug use	0	0	0	1	**1**

The only circumstance that was known to be present more than 50 percent of the time was an impending divorce/separation or threat of divorce/separation. In 42 percent of the cases, there had been an argument preceding the homicide and in 32 percent of cases, the perpetrator had consumed alcohol prior to the homicide.

National studies support the finding that women are most at risk when they choose to separate from an abusive partner. To look at this further, the team members tried to identify the length of the relationship between victim and perpetrator (Table 11) and the length of time between the separation and the domestic abuse death (Table 12).

Table 11. Length of relationship between primary victim and perpetrator by year of death

	1997	1998	1999	2000	Total
< 6 mos.	0	2	0	0	**2**
6 mo. – 1 yr.	1	1	0	0	**2**
1 - 2 yr.	0	0	0	0	**0**
2 - 5 yr.	1	1	1	2	**5**
6 - 10 yr.	0	2	1	0	**3**
10 - 20 yr.	0	2	1	2	**5**
Unknown	1	0	0	1	**2**

Table 12. Length of separation

	1997	1998	1999	2000	Total
Never lived together	1	1	0	0	**2**
Not separated	0	3	0	3	**6**
< 1 week	0	1	0	1	**2**
1 week – 1 month	1	1	2	0	**4**
1 – 6 months	0	1	0	1	**2**
6 – 12 months	0	1	0	0	**1**
> 1 year	1	0	1	0	**2**

In fifteen of the cases (79 percent), the relationship was more than two years old. When separation status was analyzed, 58 percent of the cases involved a separation between the parties. Of those cases, slightly more than half of the deaths occurred within one month of the separation.

Out of the six cases where the partners were living together at the time of the homicide, two of the victims had recently notified the perpetrator that the relationship was ending. The most common factor present in the six cases where partners were living together was an argument prior to the homicide. In two of those, perpetrators had been drinking.

Requirements under 135.110 (2)

Enabling legislation requires the Domestic Abuse Death Review Team to "...review the relationship between the decedent victim and the alleged perpetrator from the point where the abuse allegedly began, until the domestic abuse death occurred...". It was difficult to find enough information documenting the history of abuse or significant events that may have occurred. This was due to a number of factors, including the small number of cases having prior domestic abuse arrests by law enforcement and the lack of prior contact with shelter services or other community agencies. Team members accommodated for insufficient data by obtaining historical information from interviews contained in the law enforcement record or court records, where available.

Table 13 lists the type of information team members identified as evidence that there was prior domestic violence. (Information is not mutually exclusive, since several factors may be present in any one case.)

Table 13. Evidence of prior domestic violence

	1997	1998	1999	2000	Total
Prior police calls	1	2	1	3	**7**
Prior homicide threat	1	3	1	2	**7**
Prior domestic abuse arrests	1	2	1	1	**5**
Prior suicide threat	2	2	1	0	**5**
Prior injury	0	1	0	2	**3**
Prior shelter use	1	0	0	0	**1**
Known history of domestic abuse (as reported by friends/family)	1	5	1	3	**10**

A known history of domestic abuse was found in 53 percent of the cases. This information was generally obtained from friends or family and was documented in the law enforcement investigations following the homicide. In the remaining nine cases where a history could not be documented, team members classified the cases as domestic abuse homicides due to key features that preceded the deaths. The next two most common types of evidence were a record of prior police calls and/or a history of homicide threat (37 percent of cases). It is interesting to note that in every case where there was a prior homicide threat, there was also a history of abuse known by friends or family. There was only one case in which contact with a domestic abuse shelter or service was confirmed prior to the homicide. This information, as well as evidence of prior injury, was difficult to confirm due to lack of records. (Only records from shelters in the county of death were requested, and not all medical records could be obtained.)

Team members looked for evidence of prior community contact in an attempt to understand if there were opportunities for intervention when there was a known history of domestic violence. This data is presented in Table 14.

Table 14. Prior community contact in cases with a known history of domestic violence

	1997	1998	1999	2000	Total
Prior domestic abuse arrests	0	2	1	1	**4**
Prior police calls	0	2	1	2	**5**
Prior homicide threat	1	3	1	2	**7**
Prior suicide threat	1	2	1	0	**4**
Total cases (out of 10)	**1**	**5**	**1**	**3**	

In seven of the ten cases (70 percent), there was evidence of prior homicide threat. All but two of those had been made to family or friends in addition to the victim. In 50 percent of the cases with a known history of domestic violence, there were prior domestic calls to police and in 40 percent there was a prior domestic abuse arrest.

Information on the presence of stalking is illustrated in Table 15.

Table 15. Presence of stalking prior to homicide

	1997	1998	1999	2000	Total
Order of protection (current)	0	0	2	2	**4**
Order of protection (expired)	0	0	0	1	**1**
Other documentation	2	3	1	2	**8**

In cases where there was a separation just prior to the homicide, only five had an order of protection (under Chapters 236, 598, or 811 of the *Iowa Code*). The team identified other evidence of stalking in eight of the cases, including evidence that the perpetrator had been following the victim or otherwise monitoring her activities. Law enforcement experts on the team believe that stalking is a behavior that is usually present in domestic abuse cases but is often not well recognized by law enforcement agencies.

Perpetrator Outcome & History

The team could not obtain complete histories on all identified perpetrators. In future reports, the team expects to gather additional information on perpetrator and victim history from sources such as medical and mental health records. Information on the convicted perpetrators was obtained from corrections records and information on perpetrators who committed suicide was obtained from law enforcement investigation reports.

The criminal outcomes for convicted perpetrators are listed in Table 16.

Table 16. Perpetrator criminal outcome by year

	1997	1998	1999	2000	Total
Murder 1	1	2	0	2	**5**
Murder 2	0	1	0	1	**2**
Manslaughter	1	0	0	1	**2**
Attempted Murder	0	1	0	0	**1**

All perpetrators were convicted of a crime, and the majority (78 percent) were convicted of murder in the 1st or 2nd degree.

Criminal arrest histories were obtained for all perpetrators (see Table 17).

Table 17. Perpetrator arrest history

	1997	1998	1999	2000	Total
No previous arrests documented	1	5	1	3	**10**
Domestic abuse	1	2	1	1	**5**
Juvenile crime	2	1	0	2	**5**
Burglary	2	1	0	1	**4**
Alcohol/drug related	1	1	0	2	**4**
Assault	1	1	0	1	**3**
Prior incarceration	1	1	0	1	**3**
Sexual crime	0	1	1	0	**2**
Other	1	1	0	0	**2**

The majority (53 percent) had no documented previous arrests. Of the nine who had an arrest history, five had a history of multiple arrests. Sixty percent of perpetrators who were convicted and 40 percent of perpetrator's who committed suicide had an arrest history. The most common criminal histories were for domestic abuse, juvenile crime, burglary, and alcohol/drug related activities. None of the perpetrators were on probation or parole at the time of the homicide.

In addition, team members looked for other information on perpetrator behaviors or involvement with community agencies that might have been a point of intervention. Table 18 summarizes those findings.

Table 18. Perpetrator history (other)

	1997	1998	1999	2000	Total
Prior founded child abuse	0	1	1	0	**2**
Weapons seizure order	0	0	0	0	**0**
Prior BEP* involvement	0	0	0	0	**0**
History of substance abuse	2	3	1	4	**10**
Prior substance abuse treatment	2	2	0	0	**4**
Prior mental health treatment	0	2	1	1	**4**

* Batterer's Education Program

The factor that seemed most significant was a history of substance abuse (53 percent of perpetrators). Four (21 percent) had prior substance abuse treatment and four had prior mental health treatment.

Education level of the perpetrators was documented, when available (see Table 19).

Table 19. Perpetrator education level

	1997	1998	1999	2000	Total
No history documented	0	2	3	2	**7**
Less than 8th grade	1	0	0	0	**1**
9-12th grade	0	1	0	1	**2**
High school diploma	2	4	0	1	**5**
G.E.D.	0	0	0	1	**1**
Post H.S. education	0	2	0	0	**2**
B.A./B.S. degree	0	1	0	0	**1**
Post-graduate	0	0	0	0	**0**

There was a range of education experience, from less than 8th grade through college level. A high school diploma was the education level found most often, but that comprised only 25 percent of the total.

Further information about the Iowa Domestic Abuse Death Review Team may be obtained by writing or calling. The contact information is as follows:

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