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

# IOWA DOMESTIC ABUSE DEATH REVIEW TEAM

## Annual Report

## Calendar Year 2002

**JUNE 2003**

*Administrative Support Provided by the Iowa Department of Public Health*

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## *Forward*

The Iowa Domestic Abuse Death Review Team was created in 2000 to review domestic abuse- 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 four to six times per year, and members are appointed by the director of the Department of Public Health in consultation with the Attorney General. The Chief Justice of the Iowa Supreme Court appoints two team members. There are nine government agency liaisons assigned to the team, who also serve as full team members. Appointed members are eligible to receive mileage and related expenses for team meetings. Since July 1, 2002, however, there has been no appropriation for team expenses. 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 or received for each case.

## Status of Prior Year Recommendations

The statuses of recommendations made during the prior year were tracked for completion. Not all could be tracked, due to lack of data or follow-up, but those with significant activity are summarized here.

### *Recommendation to Communities*

- *Family & friends should take domestic violence seriously and report it to police or contact the statewide hotline* – During FY 2002; there were 1,561 calls to the Iowa Domestic Abuse Hotline, a decrease of 65 percent over the prior year. Planning is in progress for a public service campaign to get more information out to the public on the impact of domestic violence and who to call for help.
- *Community professionals should be adequately trained to identify domestic violence and what resources are available to serve victims and perpetrators* – Designated state trainers from the Iowa Attorney General's office, Iowa Coalition Against Domestic Violence, Iowa Department of Public Health, Iowa Law Enforcement Academy, and Supreme Court Administrator's Office conducted training sessions on domestic violence to over 5,000 community professionals during FY 2002. Thirty-five local domestic violence service programs also conduct training in their communities upon request.

### *Recommendations to State Agencies*

**Iowa Legislature**

- *Support passage of HSB 78, requiring persons convicted of domestic violence to turn over firearms to police* – This bill did not pass during the 2002 legislative session.
- *There should be adequate resources for domestic violence services and shelters* – In the face of declining federal funds and severe state budget shortfalls, the Legislature eliminated the line item for funding to support local domestic abuse and sexual assault service programs during the 2002 Legislative session. The Attorney General temporarily used funds to cover 85% of that amount with funds from the Crime Victim Compensation fund reserves. The net effect has been to decrease the level of service available to victims; in the past year one shelter and several rural outreach offices were closed.

**Iowa Department of Human Services**

- *Continued joint training for child abuse protection staff and domestic abuse advocates* – The IDHS received continued private funding to offer training and technical assistance to five communities working to improve their response to joint cases where domestic violence and child abuse coexist.

**Iowa Department of Justice**

- *There should be a mechanism for homicide survivors in domestic abuse deaths to offer information to the Domestic Abuse Death Review Team in cases where there has been no prior community contact* – The team completed work on a survivor questionnaire and will offer it for use by victim service programs during 2003.
- The IDOJ received a federal grant to develop family violence response teams; this two-year project is a six-agency collaboration offering training and technical assistance to

sites around the state to improve investigation and intervention with domestic abuse/child abuse cases. The project's goal is to improve safety for victims and their children through use of multi-disciplinary community protocols in these complex cases.

**Iowa Department of Public Health**

- *There should be joint training between substance abuse and domestic violence service personnel* – The University of Northern Iowa initiated a joint training project for substance abuse and domestic violence service personnel during 2002-2003. There will be five sites receiving training.
- *The IDPH should continue providing training and technical assistance for health care providers on identifying and responding to domestic violence* – With the assistance of a private grant and some federal program funding, the department will be expanding training of all public health clinics and many rural hospitals on domestic violence response during 2003. They are also distributing new national consensus guidelines on how to respond to domestic violence in health care settings.

## *Executive Summary*

The Iowa Domestic Abuse Death Review Team met four times during 2002 to review domestic abuse deaths. The number of meetings was decreased to minimize expenses when the department of public health eliminated the appropriation for FY2003. There were eight cases carried forward from 1999 and 2000 because the criminal disposition was pending in prior years. The team reviewed a total of 17 cases. Three cases were eliminated from data analysis because they were determined *not* to be domestic abuse related. In these cases, there was no evidence that domestic abuse had been part of the intimate relationship and/or there was clear indication of other circumstances primary to the homicide that were not related to a history of abuse.

The cases were identified by the State Medical Examiner and by Crime Victim Compensation applications received by the Iowa Department of Justice. During 2002, cases of suicide and undetermined death that were known to have a domestic violence history were also reviewed by referral to the team. These were added because fatality review literature indicates there may be a strong link between female suicides and accidental deaths with a history of domestic abuse. In the future, the team expects to review more of these cases.

### Summary of Findings

Domestic abuse homicides in Iowa are largely crimes of gender violence. In the cases reviewed this year, 85.7 percent of the perpetrators were men and 85.7 percent of the victims were women. This figure is lower than last year, but the average remains at around 91 percent for both years. In 35.7 percent of cases, perpetrators also took their own lives. Only one of the cases reviewed during 2002 involved multiple victims, who were children of the victim. The most common relationship between victim and perpetrator was a current spouse or current live-in partner (50% of cases). In 78.5 percent of the cases reviewed, the victim was planning to divorce or end the relationship with the perpetrator. The most dangerous time for victims was either before separation (50 percent) or within the first month of separation (28.5 percent). 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, and in some way have made an effort to leave.

The most common means of death was by firearm, however it comprised only 38.8 percent of deaths. The majority of deaths were committed with a blunt instrument or knife. All of the perpetrator suicides were committed with a firearm. Handguns were the predominant firearms used.

In 78.5 percent of the cases reviewed, there was a known 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 42.8 percent of the cases, there had been prior calls to police, yet only 28.6 percent had prior domestic abuse arrests. A quarter of the cases had used an order of protection. When use of these community options for safety are compared over time, it appears that people are increasing the number of calls made to police and that arrests and use of protection orders are increasing. In almost one-fifth of cases reviewed for the past three years, the victim had a current protection order in place at the time of the murder.

There are also few cases in which contact with a domestic violence shelter prior to the homicide can be documented. This may be due to a number of factors, including victims need to maintain confidentiality, which still indicates the need to provide better outreach and services to victims following arrests and service of protection orders. In some cases, women will not reveal identity out of need for confidentiality

The most common circumstance preceding the homicide was an impending divorce or separation. That occurred in over three-fourths of cases. The other factors that were present in more than one case that were known to the team included:

- an argument between the couple (64.3 percent),
- prior homicide threat by perpetrator (57.1 percent),
- financial problems (42.9 percent),
- jealousy or discovery of other boyfriend/girlfriend (35.7 percent),
- prior suicide threat by perpetrator (28.6 percent),
- alcohol or drug use by the perpetrator (28.6 percent), and
- custody conflict over children (21.4 percent).

The team was unable to identify all circumstances preceding the homicide in every case, but concluded that **the most dangerous time for victims was when the victim is preparing or has left the relationship.** Victims of domestic abuse leaving a relationship are at 75 percent greater risk of death than non-abused individuals. All homicide or suicide threats need to be taken seriously, especially when there is a history of domestic violence. Iowa law offers public safety officials clear options for intervening in these cases, and whenever there are threats, family, friends, and community public safety officials should use whatever means are possible to insure safety for potential victims.

## *RECOMMENDATIONS*

### 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. There should be private and public partnerships to promote greater public awareness of domestic abuse and the community resources available for responding to it.
3. 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.
4. 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.
2. All women in Iowa experiencing domestic abuse must have adequate, accessible services available to them. The Legislature should reinstate the line item in the Attorney General's budget funding services to victims of domestic abuse and sexual assault.
3. The Iowa Legislature should reinstate a minimal level of funding for the Iowa Domestic Abuse Death Review Team to allow the team to fulfill its mandate ($3,000).
4. 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 and magistrates should use the most current set of uniform orders recommended by the Iowa Supreme Court, and not deviate from the language on the form.
2. Judges and magistrates should be adequately trained in the dynamics of domestic abuse and treat cases 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. There should be budgetary support to insure good quality, available intervention services for domestic abuse perpetrators. 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 in the state 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, thorough law enforcement investigative 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. Some of the challenges arise out of the definition of the problem and the philosophy of treatment, however because of the overlap between the two, we need to push for more effort in this area.

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. If possible, add mental health providers.

### *Iowa Department of Public Safety and local law enforcement agencies*

1. In every domestic abuse case seen by law enforcement, domestic violence service information and referral should be given to victims. As stated in *Iowa Code* 236.1 the information should be provided immediately whenever an arrest is made. , 2. When 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.
4. Stalking behavior is usually present in domestic abuse cases but is often not well recognized by law enforcement agencies. Local law enforcement needs to pay attention to the type of stalking that domestic abuse perpetrators typically engage in and document it, so escalating abuse and dangerousness can be more fully identified and intervened.
5. Every 5 years, all law enforcement officers in Iowa should receive a minimum of 4 hours training on domestic abuse and stalking in consultation with Coalition Against 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 in consultation with Coalition Against Domestic Abuse.

### *Office of the State Medical Examiner*

1. Sexual assault examinations should be routinely conducted on every female homicide victim, whether autopsied by the state office or local coroners.

## *Findings*

The Iowa Domestic Abuse Death Review Team met four times during 2002 to review domestic abuse deaths. The number of meetings was decreased to minimize expenses when the appropriation for FY2003 was eliminated. There were eight cases carried forward from 1999 and 2000 because the criminal disposition was pending in prior years. The team reviewed a total of 17 cases. Three cases were eliminated from the final data analysis because they were determined *not* to be domestic abuse related. In the tables that follow, the deaths are listed by the year they occurred. As mentioned above, they do not reflect all of the domestic abuse related deaths occurring in that calendar year, just the number of deaths reviewed by the team during 2002.

The number of deaths by manner of death is listed in Table 1 (by year they occurred).

**Table 1. Manner of domestic abuse deaths by year of death**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Homicides** | 1 | 6 | 9 | **16** |
| **Suicides** | - | 4 | 2 | **6** |
| **Undetermined** | - | 1 | 0 | **1** |
| **Total** | **1** | **11** | **11** | **23** |

Twenty-three people died as a result of domestic violence in the fourteen cases that were reviewed and analyzed by the team during 2002. Sixteen were homicides, and six individuals committed suicide. Five of the perpetrators (36 %) committed suicide. One victim of domestic abuse committed suicide, and one death was undetermined for homicide or suicide.

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

**Table 2. Relationship of decedent to perpetrator***

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Current spouse** | 1 | 4 | 2 | **7** |
| **Current live-in** | 0 | 0 | 2 | **2** |
| **Former spouse** | 0 | 2 | 0 | **2** |
| **Former live-in** | 0 | 0 | 0 | **0** |
| **Dating partner** | 0 | 1 | 0 | **1** |
| **Former dating partner** | 0 | 0 | 0 | **0** |
| **Child of P and V** | 0 | 0 | 0 | **0** |
| **Other family** | 0 | 0 | 0 | **0** |
| ***Not related*** | | | | |
| **Child of victim** | 0 | 0 | 5 | **5** |
| **Dating partner of V** | 0 | 0 | 1 | **1** |

*Excludes perpetrator suicides

There were 12 "primary" victims, or persons involved in a current or former intimate relationship with the perpetrator. The majority of primary victims (75 percent) were current or former spouses of the perpetrator. The other 25% were current or former live-in partners or

dating partners of the perpetrator. The remaining six victims were not related to the perpetrator, but were either children or a dating partner of the primary victim.

### *Demographic Information – All Deaths*

Gender and age of decedents are presented in Tables 3 and 4.

**Table 3. Gender of decedents by victim/perpetrator status**

| | Female | Male |
|---|---|---|
| **Primary victim** | 10 | 2 |
| **Other victim** | 2 | 4 |
| **Perpetrator** | 0 | 5 |
| **Total** | **12** | **11** |

**Table 4. Age of decedents by victim/perpetrator status**

| | 0-17 | 18-25 | 26-35 | 36-45 | 46-55 | 56-65 | > 65 |
|---|---|---|---|---|---|---|---|
| **Primary victim** | 0 | 1 | 4 | 3 | 0 | 3 | 1 |
| **Other victim** | 5 | 0 | 1 | 0 | 0 | 0 | 0 |
| **Perpetrator** | 0 | 0 | 0 | 3 | 0 | 1 | 1 |
| **Total** | **5** | **1** | **5** | **6** | **0** | **4** | **2** |

The gender of decedents was almost equal male and female. All of the perpetrators who committed suicide were male.

Almost half of all decedents were between 26 – 45 years of age. There were five children under the age of 18 killed at the scene of their mothers' homicide.

### *Demographic Information – Primary Victim/Perpetrator Relationship only (14 cases)*

Demographic information on the primary victim and perpetrator in the fourteen determined domestic abuse cases will be presented in the tables that follow. These include information on parties who may still be living (either because it was a failed murder attempt, the perpetrator was convicted, or it was a suicide only) in order to give a broader picture of the relationship.

Gender, age, racial/ethnic background and educational background of the primary victims and perpetrators are presented in Tables 5, 6, 7, and 8.

**Table 5. Gender of primary victims and perpetrators**

| | Female | Male |
|---|---|---|
| **Primary victim** | 12 | 2 |
| **Perpetrator** | 2 | 12 |

In 92.9 percent of cases, the primary victim of the domestic abuse was female and the perpetrator was male. (In one of the cases involving a female homicide perpetrator, there was a documented history of domestic violence by the male homicide victim against the female perpetrator.)

**Table 6. Age of primary victim/perpetrator**

| | 0-17 | 18-25 | 26-35 | 36-45 | 46-55 | 56-65 | > 65 |
|---|---|---|---|---|---|---|---|
| **Primary victim** | 0 | 1 | 5 | 4 | 0 | 3 | 1 |
| **Perpetrator** | 0 | 1 | 4 | 5 | 1 | 2 | 1 |

The majority of victims and perpetrators were in the age range of 26-45 years, with the youngest person being 20 and the oldest 73.

**Table 7. Race/ethnicity of primary victim/perpetrator**

| | Caucasian | African/Am. | Hispanic | Asian/Am. | Native Am. |
|---|---|---|---|---|---|
| **Primary victim** | 9 | 1 | 2 | 2 | 0 |
| **Perpetrator** | 10 | 2 | 1 | 1 | 0 |

The majority (67.9%) of primary victims/perpetrators were Caucasian. Racial/ethnic background was reflective of the distribution in Iowa's population, except for the proportion of Asian/Americans, which was higher. In 85.7% of the cases, the primary victim/perpetrator had the same racial/ethnic background. The perpetrators who committed suicide were either Caucasian or Asian/American.

**Table 8. Educational background of primary victim/perpetrator**

| | < 8th | 9 – 12 | HS Diploma | GED | College | BA/BS | > BA/BS |
|---|---|---|---|---|---|---|---|
| **Primary victim** | 3 | 2 | 6 | 0 | 1 | 1 | 0 |
| **Perpetrator** | 2 | 2 | 4 | 2 | 1 | 0 | 0 |

Note: Information not available in all cases.

Educational background was distributed across all levels, with majority receiving a high school diploma. None of the primary victims and perpetrators had a post-graduate education.

### *Cause and Manner of Deaths*

Information on cause of death is included in Table 9.

**Table 9. Cause of death (all decedents except perpetrators)**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Gunshot wound to head** | 0 | 2 | 2 | **4** |
| **Gunshot wound to chest** | 1 | 1 | 0 | **2** |
| **Multiple gunshot wounds** | 0 | 1 | 0 | **1** |
| **Asphyxia (suffocation)** | 0 | 0 | 1 | **1** |
| **Cranial/cerebral trauma** | 0 | 1 | 5 | **6** |
| **Traumatic stab wound** | 0 | 2 | 2 | **4** |

The majority (one-third) of all victim deaths were caused by cranial/cerebral trauma. However, when all deaths resulting from gunshot wounds were combined, they comprised 38.9 percent of the total. This figure is lower than last year, when death by gunshot wound occurred in at least half of the cases.

The primary method or weapon used to commit the death is listed in Table 10.

**Table 10. Weapon/Method of victim death by year**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Hand gun** | 1 | 3 | 2 | **6** |
| **Shotgun** | 0 | 1 | 0 | **1** |
| **22 Caliber rifle** | 0 | 0 | 0 | **0** |
| **Hands/manual** | 0 | 0 | 0 | **0** |
| **Blunt instrument** | 0 | 0 | 5 | **5** |
| **Knife** | 0 | 2 | 2 | **4** |
| **Other** | 0 | 1 | 1 | **2** |

Perpetrators used a weapon other than a firearm in 61.1 percent of the deaths. Of firearms used, handguns were the most common. Although not included in the table, all of the perpetrator suicides were committed with a firearm and cause of death was gunshot wound to chest or head. In the one case that could be tracked, the firearm was acquired the month before the homicide/suicide. None of the perpetrators was under any current order to surrender weapons at the time the death(s) occurred.

Information on the location of the death is included in Table 11.

**Table 11. Location of death by year**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Victim residence** | 0 | 4 | 1 | **5** |
| **Joint residence** | 1 | 1 | 4 | **6** |
| **Perpetrator residence** | 0 | 0 | 1 | **1** |
| **Other** | 0 | 2 | 0 | **2** |

The majority of deaths occurred at the joint residence of the couple (if they were not separated) or at the victim's residence.

Information on the population area distribution of the location in which the death occurred is contained in Table 12.

**Table 12. Population area of county of death**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Rural (< 10,000)** | 0 | 0 | 0 | **0** |
| **10,000 – 20,000** | 0 | 1 | 3 | **4** |
| **> 20,000** | 0 | 3 | 0 | **3** |
| **Urban (MSA* counties)** | 1 | 3 | 3 | **7** |

* Metropolitan Statistical Area

Fifty percent of the deaths occurred in the largest urban areas of the state. None occurred in counties with a population less than 10,000.

### *Circumstances Prior to Death*

During prior year case reviews, team members have identified and tracked a number of common factors occurring prior to the death. These are often documented in the police investigation report or in court records. However, there may be other sources of information overlooked when formal documentation only is reviewed. In cases of suicide or homicide/suicide, a full investigation may not be conducted and there is minimal information available. Table 13 rank orders the factors that team members were able to identify from the information given as being present within a few hours to a few days prior to the homicide. These factors are not mutually exclusive, and several may be present for each death.

**Table 13. Circumstances immediate to death**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Divorce/threat of divorce or victim ending relationship** | 1 | 6 | 4 | **11** |
| **Argument** | 0 | 5 | 4 | **9** |
| **Financial problems** | 0 | 3 | 3 | **6** |
| **Jealousy or other boyfriend/girlfriend** | 0 | 2 | 3 | **5** |
| **Perpetrator alcohol use** | 0 | 2 | 1 | **3** |
| **Custody conflict** | 0 | 2 | 1 | **3** |
| **Perpetrator drug use** | 0 | 0 | 1 | **1** |
| **Perpetrator legal problems/ arrest** | 0 | 0 | 1 | **1** |
| **Perpetrator depression** | 0 | 0 | 1 | **1** |
| **Other** | 1 | 1 | 0 | **2** |

In 78.6 percent of the cases, there was documentation of a recent divorce/separation or threat of divorce/separation by the primary victim. An argument preceded the death in 64.3 percent of cases. The other circumstances that occurred less than half of the time but in more than two cases included recent financial problems (perpetrator), jealousy/discovery of other girlfriend or boyfriend, alcohol use (by perpetrator), and custody conflict. In cases where there was evidence of depression, it was difficult to find adequate documentation.

Prior year data and other national studies support the finding that women are most at risk when they choose to separate from an abusive partner. In Table 14, the length of the relationship is summarized and in Table 15, the length of separation between the separation and the domestic abuse death is presented.

**Table 14. Length of relationship between primary victim and perpetrator by year of death**

| | 1999 | 2000 | 2001 | Totals |
|---|---|---|---|---|
| **< 6 mos.** | 0 | 0 | 0 | **0** |
| **6 mo. – 1 yr.** | 0 | 1 | 1 | **2** |
| **1 - 2 yr.** | 0 | 1 | 0 | **1** |
| **2 - 5 yr.** | 1 | 0 | 0 | **1** |
| **6 - 10 yr.** | 0 | 1 | 1 | **2** |
| **10 - 20 yr.** | 0 | 1 | 2 | **3** |
| **20 + yr.** | 0 | 0 | 0 | **0** |
| **Unknown** | 0 | 3 | 2 | **5** |

Because of the number of cases in which there was no information on length of relationship available, it is difficult to draw conclusions. In 35.7 percent of the cases, the relationship was more than 6 years old. On an average, the length of relationship for cases reviewed during 2002 were longer than those reviewed during 2001.

**Table 15. Length of separation**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Never lived together** | | 1 | | **1** |
| **Not separated** | 1 | 1 | 3 | **5** |
| **1 day – 1 month** | | 2 | 2 | **4** |
| **1 – 6 months** | | 0 | 1 | **1** |
| **6 – 12 months** | | 1 | 0 | **1** |
| **> 1 year** | | 2 | 0 | **2** |

In more than one-third (35.7 percent) of cases there was not a separation. There was evidence, however of a recent threat or discussion of impending separation. In 28.5 percent of the cases, the separation had occurred within the past month. Since such a large majority of the circumstances involved a separation (or threat of the relationship ending), it would appear that a recent separation or impending threat would be the highest risk factor for domestic abuse homicide or suicide. **This is when the victim asserts their desire for safety, which is often viewed by the perpetrator as a threat to his control.** In the cases where the separation occurred over a year before the deaths, there had been a custody or divorce hearing around the time of the homicide.

Table 16 describes the number of cases where children were present at the scene of the homicide or suicide.

**Table 16.Child witnesses to death**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Present at scene** | 0 | 5 | 12 | **17** |
| **Surviving loss of parent/s** | 0 | 5 | 7 | **12** |

Twelve of the 17 children present survived the death of one or more parents. Studies on the effects of witnessing domestic violence reveal that children who live in homes where domestic

abuse is present face future emotional, developmental, and social disruptions. These challenges are multiplied if the child witnesses a parent being murdered.

### *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...". Information documenting the history of abuse or significant events that may have occurred is difficult to obtain without an adequate law enforcement history. In cases of homicide/suicides, this may be difficult if there is no prior law enforcement history. Usually there is a limited investigation of these cases. Team members obtained additional information from court records, where available.

Table 16 lists the type of information 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 17. Evidence of prior domestic violence**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Prior police calls** | 1 | 2 | 3 | **6** |
| **Prior homicide threat** | 1 | 2 | 5 | **8** |
| **Prior domestic abuse arrests** | 0 | 0 | 4 | **4** |
| **Prior suicide threat** | 0 | 2 | 2 | **4** |
| **Prior injury** | 0 | 0 | 1 | **1** |
| **Prior shelter use** | 0 | 0 | 1 | **1** |
| **Known history of domestic abuse (as reported by friends/family)** | 1 | 4 | 6 | **11** |

There were three cases in which documentation of prior domestic violence was not found, but team members classified the cases as domestic abuse homicides due to key features that preceded the deaths (notes found at the scene, conversations with other family or friends).

A known history of domestic abuse was found in 78.6 percent of the cases, as reported by family or friends and documented in the law enforcement report following the homicide. In 57.1 percent of cases there had been a history of homicide threat made by the perpetrator against the victim prior to the death circumstances. In 42.9 percent of cases, there was evidence of prior police calls to the residence for domestic dispute.

There was only one case in which contact with a domestic abuse shelter or service was confirmed prior to the homicide. This information is difficult to obtain if the victim seeks services in a community other than her own. There was little evidence of prior injury noted from the autopsies, and medical records of the victims were not obtained if they could not be tracked.

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 information is incomplete for the 11 cases identified, since it wasn't always documented in records. Refer to Table 17.

**Table 18. Prior community contact in cases with a known history of domestic violence**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Prior domestic arrests** | 0 | 0 | 4 | **4** |
| **Prior police calls** | 1 | 2 | 3 | **6** |
| **Prior shelter contact** | 0 | 0 | 1 | **1** |
| **Prior hospital contact** | 0 | 1 | 1 | **2** |
| **Prior homicide threat** | 1 | 2 | 5 | **8** |
| **Prior suicide threat** | 0 | 2 | 2 | **4** |

In eight of the 11 cases (72.7 percent) where there was a known history of domestic abuse, there was evidence of prior homicide threat. In all but two cases, there had been a prior homicide or suicide threat involving the victim made to friends or family. In 54.5 percent of the cases with a known history of domestic violence, there were prior domestic calls to police and in 36.3 percent there was a prior domestic abuse arrest.

Information on the presence of stalking is illustrated in Table 18.

**Table 19. Evidence of stalking prior to homicide**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Order of protection (current)** | 0 | 0 | 2 | **2** |
| **Order of protection (expired/dropped)** | 0 | 1 | 1 | **2** |
| **Other documentation** | 0 | 1 | 0 | **1** |

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*). All protection orders had been filed on behalf of the victim. 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, especially in cases of suicide (five cases). Information on the convicted perpetrators was obtained from corrections records.

The criminal outcomes for perpetrators who did not commit suicide are listed in Table 19.

**Table 20. Perpetrator criminal outcome by year**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Murder 1** | 1 | 0 | 2 | **3** |
| **Murder 2** | 0 | 0 | 1 | **1** |
| **Manslaughter** | 0 | 2 | 0 | **2** |
| **No charges** | 0 | 1 | 2 | **3** |

There were three cases with no charges filed, based on the manner of death or lack of criminal evidence. The other charges ranged from Murder in the first degree to manslaughter.

Criminal arrest histories for all perpetrators are listed in Table 20. This information may be duplicative in cases where the perpetrator had prior arrests for more than one crime.

**Table 21. Perpetrator arrest history**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **No previous arrests documented** | 0 | 1 | 2 | **3** |
| **Burglary** | 0 | 1 | 2 | **3** |
| **Alcohol/drug related** | 1 | 1 | 3 | **5** |
| **Domestic abuse** | 0 | 0 | 4 | **4** |
| **Assault** | 0 | 1 | 4 | **5** |
| **Sexual crime** | 0 | 0 | 0 | **0** |
| **Juvenile crime** | 0 | 0 | 2 | **2** |
| **Other** | 0 | 2 | 4 | **6** |
| **Prior incarceration** | 0 | 1 | 3 | **4** |
| **On probation/parole** (at time of homicide) | 0 | 0 | 2 | **2** |

There was a history of arrest in 78.6 percent of cases. Five of the perpetrators had multiple arrests (more than one arrest). Juvenile crime history was only available if it was documented in the adult record. The most common criminal histories were for assault, alcohol/drug related crimes, or domestic abuse. Four of the perpetrators had prior incarcerations and two were on probation or parole at the time of the homicide. Team members noted other information on perpetrator behaviors or involvement with community agencies that might have been a point of intervention. This information is incomplete for all cases, when documentation was not available. This is generally available in cases where a conviction occurs, because a more detailed history is conducted. Unless community providers are identified, the team has no way of obtaining records for substance abuse or mental treatment without specific consent. Table 21 summarizes those findings.

**Table 22. Perpetrator history (other)**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Prior founded child abuse** | 0 | 0 | 0 | **0** |
| **Weapons seizure order** | 0 | 0 | 0 | **0** |
| **Prior BEP* involvement** | 0 | 0 | 0 | **0** |
| **History of substance abuse** | 1 | 1 | 4 | **6** |
| **Prior substance abuse treatment** | 0 | 1 | 0 | **1** |
| **Prior mental health treatment** | 0 | 2 | 3 | **5** |

* Batterer's Education Program

Although a history of substance abuse was the most common factor present, only one of the perpetrators had received prior substance abuse treatment. Mental health treatment was the other community contact where there might have been an opportunity for intervention. None of the perpetrators had been ordered to batterer's education in spite of having domestic abuse arrests.

### *Victim History*

Criminal history and community contact were also obtained for the victim, where possible. This data is also incomplete for all cases. Table 22 presents the findings.

**Table 23. Victim history**

| | 1999 | 2000 | 2001 | Total |
|---|---|---|---|---|
| **Prior founded child abuse** | 0 | 0 | 0 | **0** |
| **Prior arrest** | 0 | 1 | 1 | **2** |
| **History of substance abuse** | 0 | 1 | 1 | **2** |
| **History of mental health problems** | 0 | 0 | 1 | **1** |
| **History of suicide threat/attempts** | 0 | 1 | 1 | **2** |

Two victims had a criminal arrest history. There was a history of substance abuse or mental health problems in three of the cases, and a history of suicide attempt or threat in two cases.

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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