REPORT ON 1997 DOMESTIC VIOLENCE AND RELATED HOMICIDES

CUYAHOGA COUNTY DEATH REVIEW COMMITTEE of the
DOMESTIC VIOLENCE COORDINATING COUNCIL OF GREATER CLEVELAND

Presented by: Marcia K. Petchers, Ph.D., Chair
December 7, 1999

ACKNOWLEDGMENTS:

This report is being issued by the 1999 members of the Death Review Committee; a membership roster is attached. The Committee continues to operate as an all volunteer committee without benefit of staff support.

We wish to acknowledge the following people who have assisted in our efforts.

Pam Vacca of Witness Victim Service Center who has assisted the Committee Chair in keeping our membership mailing list updated and sends out our meeting notices.

Liz Tidwell of the Coroner's Office who assists in our search of the coroner's case records and data base in producing the homicide lists for our review.

Samantha Mishne who has assisted the Committee Chair in reviewing the case records, updating the homicide lists for our review, and analyzing the data for our final report.

Robert Staib who has assisted the Committee Chair in reviewing case records and analyzing data for our final report.

BACKGROUND:

Nationally, during the 1990s, there has been increased awareness of and concern about domestic violence offenses. There is a growing realization that legal and social control strategies are needed in order to reduce domestic violence. Nationally as well as locally, this decade has been a period of active efforts in detection, prevention and intervention. As one outgrowth of this growing vigilance, fatality review committees have been formed and are operating all around the country as an attempt to learn retrospectively from domestic violence and related lethal cases.

In 1996, the Domestic Violence Coordinating Council established a county Death Review Committee to begin the process of tracking domestic violence related homicides in the county.

The Committee charge is:

- *To review the situations surrounding and leading to the homicides.*
- *To review the characteristics of victims and perpetrators.*
- *To review the systems and agencies involvements in cases prior to the homicides.*

The goals are:

- *To detect service accessibility barriers, systems gaps, and needed systems linkages.*
- *To improve lethality assessment, differentiate from domestic violence risk assessment.*
- *To generate discussion and suggestions for reducing preventable homicides.*

The Cuyahoga County Death Review Committee has met monthly for the past several years to review records of domestic violence and related homicides in Cuyahoga County. The Committee membership, representative of diverse public and private agencies, offers broad interdisciplinary expertise. All Committee members have signed and adhere to confidentiality agreements.

The Committee continues to evolve in our review process. Through our gained experience, we are trying to improve the completeness and efficiency of the investigation. The Committee has identified the need for staff support to manage the research and investigation process. Fatality review is a challenging yet arduous process consuming much time.

The Committee has also invited agency representatives who could provide additional relevant information. The Department of Children and Family Services and the Juvenile Court are major additions to the committee membership. We invite relevant parties such as police detectives to report on specific cases as needed. We plan to extend our membership through by additional police, probation and prosecution staff in various suburban jurisdictions and health care professionals.

The review of the 1997 domestic violence related homicides has been completed and is contained herein. This is our second annual report.

The Committee is continuing its review process. We are now turning our attention to 1998 domestic violence and related homicides. All members agree that we have gained valuable experience that continues to inform and expedite our next year's work. Meetings are held the first Tuesday of the month at 1 p.m. at the County Coroner's Office except as otherwise noted.

FATALITY REVIEW PROCESS:

A screening subcommittee identified the 26 domestic violence and related homicide cases through reviewing all 120 homicides (as ruled by the Coroner) that occurred in the county during 1997. This represents 22% of all homicides occurring in Cuyahoga County during the year 1997. Cases from two years earlier were selected to obtain closed cases; all but one of the 26 reviewed cases had a final disposition.

Two related suicides associated with three of the homicide cases were also studied. These two suicides were 1.4% of all suicides in Cuyahoga County in 1997. The Committee did not review other suicides to determine domestic violence related cases.

Case screening of all homicides was necessary since homicides are not currently categorized as domestic violence related. Through this method, 25 cases met the legal definition of family or household member as defined in the domestic violence statute (2919.25) in the Ohio Revised Code. One other homicide was deemed closely associated with domestic violence (i.e., between intimate partners who did not reside together). Note we did not include additional homicides that involved intimate or dating partners who had more casual or short-term relationships.

Using data from multiple record sources, the Committee investigated all 26 domestic violence and related homicides that occurred in 1997. Results are presented in the aggregate with either the total numbers of cases and/or percentages given to reflect a particular condition found. Note, percentages have been rounded and thus, may not always add to 100%.

LIMITATIONS:

The greatest challenge to the Committee was the task of categorizing domestic violence and related homicides and then searching existing records. Homicide records were often very brief, incomplete, sketchy and even inconsistent in describing social circumstances and lethality indicators. The names of some perpetrators, victims, and family members were sometimes incorrectly recorded. Social security numbers or permanent addresses that would enable a definitive records search were not always known. Agency computerized management information systems were not always able to locate cases that may be filed under related or different surnames.

Both the victim and perpetrator may have or have had prior incidents of domestic violence but not necessarily with each other. Marital status was also difficult to obtain because of informal relationships as was employment. Residential mobility, within and between towns, counties and/or states, makes tracking more difficult as does the passage of time over the life span.

All case files were reviewed for any listed or reported agency or other service contacts. In addition, Committee members directly checked records kept by courts, probation, police, batterers' programs, and victim services. Three local domestic violence agencies shelter and counseling records were checked; other local shelters' records were not directly checked. Moreover, anonymous hotline records could not be checked, thus, all such contact is unknown.

Note, prior histories of domestic violence, substance use history and agency contacts were not verified. Victims were tested upon coroner's autopsy for alcohol and drug toxicology levels. Perpetrators/suspects are not routinely tested by law enforcement.

The Committee's efforts were also constrained due to record confidentiality in several sectors. Agencies that provide mental health treatment, drug abuse counseling or medical care are legally constrained from releasing individual client's records; though some have been able to provide aggregate information. Hospital records were not accessed.

A note of caution, all findings are based only on what is known through the case records. Missing

data in the file cannot be interpreted as meaning the issue wasn't present in the case. The absence of a recorded service or agency contact means only there is no verified contact; it does not mean there was no actual contact. Further, in secondary records, it is hard to determine escalation patterns of such problems as domestic violence, substance abuse, or mental illness. Hence, totals likely represent an undercount.

FINDINGS SUMMARY:

From the information obtained, a descriptive summary of major findings and trends are highlighted below. All data below is from the 26 cases analyzed to date which constitute all cases (i.e., not a sample) occurring in a single year, 1997. Thus far, the 1997 case review findings appear to parallel the 1996 findings in most respects; one noted difference is the larger number of suburban cases. Due to the small number of cases, it is not possible to determine if the homicides studied here are representative of all domestic violence related homicides occurring in other years.

There are lessons to be learned from these observations, even from a single case, if it suggests potential ways to prevent or reduce the future domestic violence and related homicides. That said, the benefits of hindsight are just that: any retrospective suggestions cannot be taken to mean the homicides which occurred could have in actuality been prevented.

First general observations about trends among the homicide cases studied are summarized below. Following this more specific case data is presented.

MAJOR TRENDS:

✡Domestic/intimate partner (50%) and family/relatives (50%) homicides were equally represented.

✡ 85% of homicides occurred within intact relationships; Relationship separation was a factor in 2 (15%) cases .

✡Shooting (38%) and blunt force (34%) were the two major homicide methods used.

DEMOGRAPHICS:

✡The City of Cleveland had majority of cases in county (58%); with 80% of those located in east-side central city; Suburban cases (42%) may be growing in number.

✡African Americans were 81% of the homicide dyads - disproportionately represented compared to county population.

✡Females were 58% of the homicide victims - disproportionately represented compared to 22% female county homicides victims.

✡Young, under age 30, comprised 58% of the homicide dyads.

SYSTEMS' INVOLVEMENT:

✡Probation histories were present for at least one party in 85% of cases; only four homicide dyads without probation history.

✡Few cases with current probation involvement; 1 victim/2 perpetrators on probation (unrelated offenses); 1 perpetrator's probation terminated due to homicide related offense.

✡2 perpetrators were out on bond (1 unrelated felony rape/ kidnaping/homicide threats to former domestic partner 1 month prior to homicide).

✡1 perpetrator had an prior outstanding warrant for arrest (1 related case).

✡No current parole or protection orders involved in cases.

✡No divorce, custody or visitation disputes in Domestic Relations Court.

✡Department of Children and Family Services had referral records on 4 of 7 (43%) child victim cases with the named homicide perpetrator- 1 open, 2 recently closed 1-2 months before homicide following perpetrators completion of DCFS' anger management classes.

✡Department of Children and Family Services had child victim case history records on 3 of 19 (16%) adult homicide victims and 8 of 25 (32%) homicide perpetrators.

✡Department of Children and Family Services had perpetrator case history records on 4 of 19 (21%) adult homicide victims and 4 of 25 (16%) homicide perpetrators.

✡Juvenile Court reported 1 of 6 (17%) of child victim case records; 1 re-opened case is not reported.

✡Juvenile Court had case records on 10 of 19 (53%) of adult victims and 12 of 25 (48%) perpetrators.

✡Few recent contacts with social service interventions for victims or perpetrators.

✡Multiple hospital contacts (1 related offense- 2 weeks prior; no police report made).

✡Witness Victim Services Center contacts (2 victims; 2 perpetrators - unrelated offenses; 1 unrelated domestic violence- 1 month prior; danger noted).

✡Almost no recent domestic violence program contact; 1 victim-domestic violence shelter; 2 weeks prior (related offense; no police report made).

✡Few mental health treatment contacts; 4 perpetrators had psychiatric diagnoses.

✡No batterers' treatment program contact.

✡1 arson-related perpetrator present at 9 major structural arson fires; no prior arrests.

CASE CHARACTERISTICS (26 homicide cases):

⇨ Case dispositions: 14 (54%) sentenced; 1 (4%) found not guilty; 5 (19%) no indictment; 3 (12%) abated by 2 suicides; 2 (8%) dismissed; 1 (4%) re-opened.

⇨ Case sentencing (14): 3 (21%) murder; 2 (14%) aggravated murder; 1 (7%) attempted murder/probation violation on previous felonious assault case; 3 (21%) voluntary manslaughter; 5 (31%) involuntary manslaughter.

⇨ Cases involved: 13 (52%) family relations; 12 (46%) spouses/partners; 1 (4%) intimate partners not residing together).

⇨ 96% of homicides occurred within racial/ethnic groups.

⇨ 85% of cases occurred at home - compared to 47% of homicide occurrences overall.

⇨ 58% of cases in the City of Cleveland; mostly in central east side.

⇨ Methods of homicide were 38% shot; 34% blunt force; 12% stabbed; 8% smothered; 4% burned; 4% arson.

⇨ 3 homicides were accompanied by suicide involving 3 female victims; 2 male perpetrators.

⇨ 73% of victim and perpetrator dyads were opposite sex; 27% of dyads were same sex.

VICTIMS' PROFILE (26 homicide victims):

⇨ 19 (73%) were adults; 7 (27%) were children.

⇨ Adults were 63% female; Children were 43% female.

⇨ Age range was 2 months to 98 years.

⇨ 22 (85%) were African American; 4 (15%) were Caucasian.

⇨ 6 (86%) of child victims were African American; 1 (14%) was Caucasian.

⇨ 1 (4%) had a physical disability.

⇨ 1 (4%) was pregnant.

⇨ 80% were employed at time of the homicide.

⇨ 21% were on public assistance at time of homicide.

⇨ 53% had reported substance abuse history (19 adults only): 6 cocaine; 6 alcohol; 3 cannabis (duplicated count).

⇨ 42% had criminal conviction records (adults only).

⇨ 42% tested positive for alcohol/drugs upon autopsy; 4 alcohol; 2 cocaine; 1 alcohol & cannabis; 1 cannabis.

PERPETRATORS' PROFILE (25 perpetrators; note, 1 perpetrator had 2 victims):

⇨ 96% were adults; 1 a juvenile.

⇨ 64% were males; 62% of adult and 100% of juvenile perpetrators.

⇨ 38% were females; 5 (71%) child abuse homicides were perpetrated by females.

⇨ Age range was 17 to 69 years.

⇨ 20 (80%) were African American; 5 (20%) were Caucasian.

⇨ 4 (16%) had a known psychiatric disability.

⇨ 1 (4%) was pregnant.

⇨ 28% were employed at time of the homicide.

⇨ 21% were on public assistance at time of homicide.

⇨ 48% had reported substance abuse history: 10 cocaine; 8 alcohol; 6 cannabis; 1 pcp (duplicated count).

⇨ 56% had criminal conviction records.

DOMESTIC VIOLENCE HISTORY:

⇨ Of the 11 (42%) homicide cases with domestic violence histories in the dyad: 9- prior abuse by homicide perpetrator of homicide victim; 2 mutual combat abuse.

⇨ Of the 13 homicide cases with domestic violence histories outside the dyad: 7 - prior abuse by homicide perpetrator as perpetrator; 5 prior abuse of homicide victim as victim; 3- prior abuse of homicide perpetrator as victim (duplicated count).

⇨ Of the 3 females who killed 3 male partners: 1- homicide as mutual combat; 2- homicide perpetrators had past mutual combatants with homicide victim.

⇨ Of the 9 males who killed 10 female partners: 4 - homicide perpetrators had prior abuse of homicide victim; 4- homicide perpetrators had prior abuse of other female victims.

⇨ Of the 7 adults who killed 7 child victims: 3- DCFS record of child abuse/neglect of victim: 1 open; 2 - closed 6 months prior; 1- DCFS referral of child abuse neglect of victim-no case.

⇨ Of the 1 adult who killed frail elderly victim: 1 - APS record of abuse of victim: 1 - closed 2 weeks prior to homicide due to nursing homes failure to notify APS.

ACTION STEPS FOR FATALITY REVIEW PROCESS:

☞To obtain grant funds and/or inkind resources for staff and related expenses to manage the committee process, report writing, data collection, data analysis, and computerization, source investigation, records' review, and data reconciliation.

☞ To identifying domestic violence homicide risk factors and differentiate lethality risk factors from general domestic violence risk assessment.

☞ To mandate identifying domestic violence and related homicides on a county basis throughout the state. Toward this end, a State of Ohio legislative reporting mandate similar to the one for child fatalities would be a major step forward.

☞ To centrally computerize all protection orders in a single agency on a county-wide system.

☞ To centrally computerize all local police jurisdiction records on a county-wide system.

☞ To allow regulatory exception for agencies that provide mental health treatment, drug abuse counseling or medical care to legally release individual client's records or information for fatality review process.

☞ To disseminate broadly the Committee's report and findings to Cuyahoga County and City of Cleveland officials and relevant judicial, law enforcement, criminal justice and social service agencies.

☞ To challenge the greater Cleveland community to create and mount innovative domestic violence and related homicide risk reduction strategies.