ANNUAL REPORT:
DOMESTIC VIOLENCE RELATED HOMICIDES IN CUYAHOGA COUNTY (1998)

FATALITY REVIEW COMMITTEE of the DOMESTIC VIOLENCE COORDINATING COUNCIL OF GREATER CLEVELAND

Presented by: Marcia K. Petchers, Ph.D., Committee Chairperson
February 26, 2001

ACKNOWLEDGMENTS:

This report is being issued by the Fatality Review Committee; a membership roster is attached. The Committee is hosted by the Cuyahoga County Coroner's Office, under the leadership of Dr. Elizabeth Balraj, County Coroner. The Committee could not operate without the support of the cooperating agencies and departments represented on the committee.

In addition, cooperation was received from the following agencies not represented on the committee: Police Departments of East Cleveland, Lakewood, Parma, Rocky River, South Euclid, and Warrensville Heights; domestic violence programs of the YWCA of Cleveland, DOVE, and East Side Catholic Center and Shelter.

The Committee acknowledges receipt of a one-year VAWA grant for research consultant staff support in facilitating the review process. Finally, the following people have provided additional support to assist in our efforts: Pam Vacca, Witness Victim Service Center; Liz Tidwell, Coroner's Office; Julian Dooley, M.A., Cleveland Municipal Court Psychiatric Clinic; John Neill, M.S., Dr.P.H., City of Cleveland Department of Public Health, and Lt. Paul Amato and Officer John Mott of the Cleveland Police Department Data Processing Unit.

BACKGROUND:

In 1996, the Domestic Violence Coordinating Council of Greater Cleveland, under the leadership of Judge Ronald Adrine, established this Fatality Review Committee to begin the process of tracking and retrospectively reviewing domestic violence related homicides in the county. Similar fatality review committees have been formed and are operating all around the country to learn how to improve practices.

The Committee charge is:

- *To review the precipitating circumstances surrounding and leading to the homicides.*
- *To review the demographics and histories of victims and perpetrators.*
- *To review the systems and agencies involvements in cases prior to the homicides.*

The goals are:

- ✏*To identify service accessibility barriers, systems gaps, and needed systems linkages.*
- ✏*To test and improve domestic violence lethality risk assessment.*
- ✏*To generate discussion and strategies for reducing domestic violence related homicides.*

The Cuyahoga County Fatality Review Committee has met monthly to review records of domestic violence 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 the review process. Through gained experience, we are trying to improve the completeness and efficiency of the investigation. The process is one of fact finding not blaming and is focused on identifying gaps to improve future practices.

Fatality review is a challenging yet arduous process. The Committee acknowledges the continuing need for staff support to facilitate the committee's process and to manage the research, investigation and reporting processes.

The Committee invites agency representatives to provide additional relevant information such as police detectives to report on specific cases as needed. Membership was extended to additional police, probation and prosecution representatives from various suburban jurisdictions and health care professionals.

The Committee is continuing its review process. We are now turning our attention to 1999 domestic violence and related homicides. All members have gained valuable experience that continues to inform and expedite our next year's work. Meetings are held on the first or second Tuesday of the month at 1:15 p.m. at the County Coroner's Office except as otherwise noted.

The review of 1998 domestic violence related homicides has been completed and is contained herein. This is our third annual report. A summary of findings will be disseminated through the committee's representatives.

FATALITY REVIEW PROCESS:

The Committee screened and identified 32 domestic violence and related homicide cases through reviewing all 112 county residents' homicides (as ruled by the Coroner) that occurred in the county during 1998. This represents 29% of all homicides occurring in Cuyahoga County during the year 1998. Cases from two years earlier were selected to obtain closed cases; all of the 32 reviewed cases had a final disposition.

Four related suicides associated with five of the homicide cases were also studied. These four

suicides represented 2.7% of all suicides in Cuyahoga County in 1998. 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. As yet Ohio does not have a legislative mandate to identify and review domestic violence homicides as is the case for all child fatalities.

26 cases met the legal definition of family or household member as defined in the domestic violence statute (2919.25) in the Ohio Revised Code. Six other homicides were deemed domestic violence related because the victim or the suspect were third parties to the domestic relationship (e.g., police shooting perpetrator during domestic violence intervention; friend or relative of the victim becoming a homicide victim or perpetrator).

Using data from multiple record sources, the Committee investigated all 32 domestic violence related homicides determined to have occurred in 1998. Results are presented in the aggregate with either the total numbers of cases and/or percentages given to reflect a particular condition. Note, percentages have been rounded and thus, may not always add to 100%.

LIMITATIONS:

The Committee's identified domestic violence related homicides and then searched existing records. For each case, individual committee members checked records kept by the coroner, courts, prosecution, probation, police, batterers' programs, victim services, children and family services, adult protective services and tried to discern any other service contacts. Four local domestic violence agency's shelter and counseling services and intake records and four batterers' programs were checked; other local shelters' records or anger management programs were not checked. Note, anonymous hotline records could not be checked, thus, all such contact is unknown.

Homicide records are factual and do not necessarily contain psycho-social circumstances and lethality indicators. Prior histories of domestic violence, substance use history and agency contacts were not verified. In some cases, the findings indicated that the victim and/or perpetrator may have or have had prior incidents of domestic violence but not necessarily with each other. 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 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.

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 risk escalation patterns of such problems as domestic violence, substance abuse, or mental illness. Hence, totals likely represent an undercount.

Some additional barriers to records research were noted. The names of perpetrators, victims, and family members were sometimes incorrectly recorded. Social security numbers or permanent addresses 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. 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.

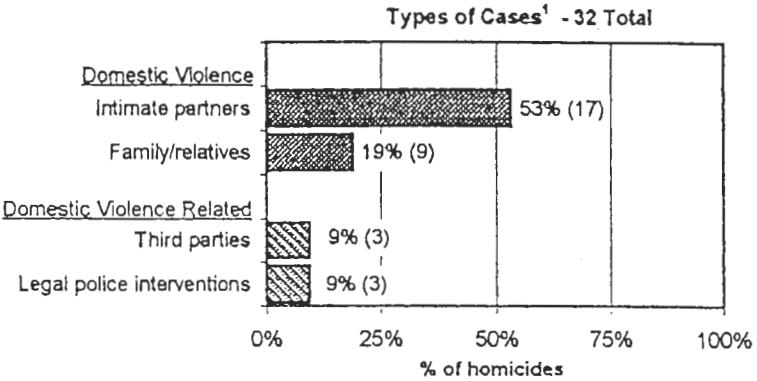
FINDINGS SUMMARY:

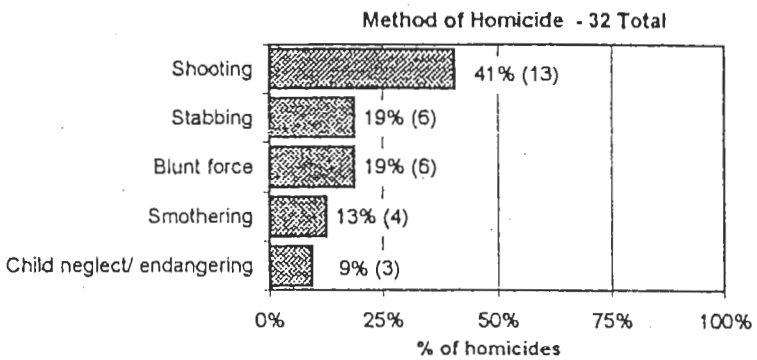
All data are from the 32 cases analyzed which constitute all identified domestic violence related cases involving county residents occurring in a single year, 1998 (29% of 112 county resident homicides). The 1998 findings mirror the 1997 and 1996 findings in most respects; one noted difference is the larger number of intimate partner cases relative to family/relatives cases. Despite the small number of cases, the pattern of findings over three years adds confidence to their generalizability.

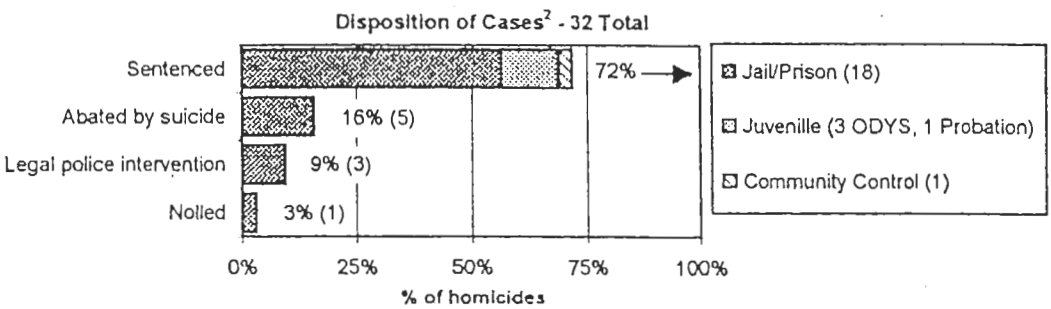
From the information obtained, the Committee presents a descriptive statistical findings summary of case characteristics and demographics, homicide dyad, victim and perpetrator profiles, as well as systems' contacts. Based on these findings, the Committee has made general conclusions about trends and observed lethality risk factors. Finally, recommendations and action steps are offered in several major areas: law enforcement, criminal and justice systems, and related service interventions, education and training, and data collection and information systems management.

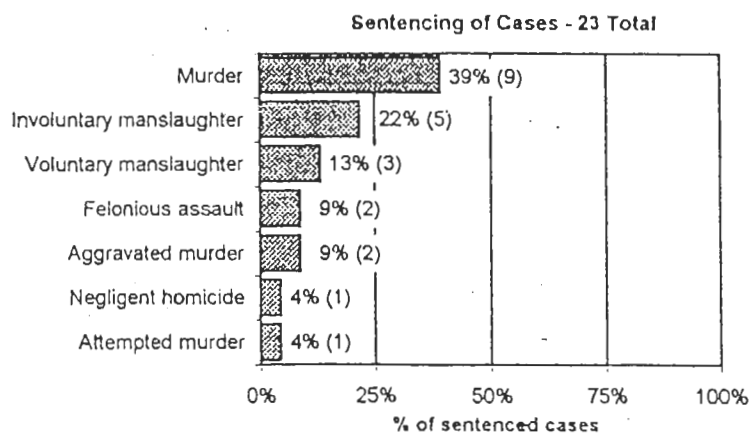
There are lessons to be learned from these observations, even from a single case. The Committee is learning from fatality reviews ways to improve domestic violence risk assessment, intervention, lethality risk reduction and community control strategies. Questions remain as to how to identify the lethality-risk population, how to connect affected populations with services and how to monitor effectively. The Committee is encouraging greater dialogue to promote potential ways to prevent or reduce the future domestic violence related homicides. That said, the benefits of hindsight are just that: any recommendations cannot be taken to mean that the homicides were actually preventable.

For additional copies of this report, please contact Pam Vacca, Witness Victim Service Center at 216 443-7399. For follow-up issues and further discussion about the Fatality Committee and its work, contact Dr. Marcia Petchers, Consulting Services by phone/fax (216) 231-5862 or <mkpetchers@aol.com> by email or any of the listed committee members.



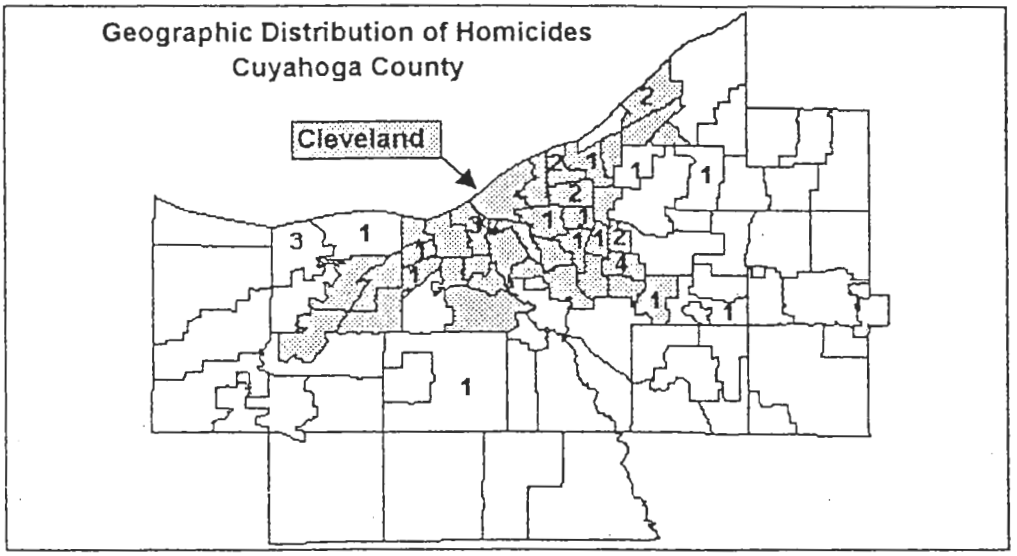






1. Domestic violence defined in accordance with Ohio Revised Code.
Intimate partners includes those not residing together. The number of cases is based on number of victims.
2. 5 cases were abated by suicides among 4 male perpetrators.
43% of primary aggressors were either killed or killed themselves.

Domestic Violence Related Homicides (1998) - Demographics



Distribution of Cases by Homicide Location[1]

Location	cases	% of cases
Cleveland	**24**	**75%**
Buckeye-Shaker	2	6%
Central	1	3%
Cudell	1	3%
Fairfax	1	3%
Glenville	1	3%
Hough	2	6%
Kinsman	1	3%
Lee-Miles	1	3%
Mt. Pleasant	4	13%
North Collinwood	2	6%
Ohio City/Near West Side	3	9%
St. Clair-Superior	2	6%
West Boulevard	1	3%
Woodland Hills	1	3%
Suburbs	**8**	**25%**
East Cleveland	1	3%
Lakewood	1	3%
Parma	1	3%
Rocky River	3	9%
South Euclid	1	3%
Warrensville Heights	1	3%

1. 94% of homicides occurred at home or home property.

Cleveland Police District

District	cases
District #1	3
District #2	2
District #3	1
District #4	8
District #5	6
District #6	4

Domestic Violence Related Homicides (1998) - Profiles

Profile of Dyads[1] (29 Total)

- In 84% of homicide dyads, at least one party had reported substance use/abuse
- 31% of homicide incidents had reported substance use/abuse involvement
- In 72% of cases at least one party had a criminal history
- All but one (97%) homicide occurred within common racial/ethnic groups
- Two-thirds of dyads were minorities
- 52% of intimate partner homicides occurred within relationships (48% separated)
- 72% of cases were opposite sex homicides

Profile of Victims (32 Total)

	victims	% of total
Adults		
Female	15	47%
Male	11	34%
Total	26	81%
Children		
Female	2	6%
Male	4	13%
Total	6	19%
Race/ethnicity		
Caucasian	10	31%
Minorities	22	69%

- 62% of adult victims had criminal conviction records
- 69% of adult victims had an alleged/reported domestic violence history
- 15% of victims had a previous incarceration
- 77% of adult victims had a reported substance abuse history
- 6% of victims had a disability condition (1 psychiatric, 1 chronic illness)
- 22% of victims were on public assistance at time of homicide
- 25% of victims were the primary aggressor in the incident
- Age range was neonatal to 60
- 56% of adult victims were positive for alcohol/drugs at autopsy

Profile of Perpetrators[2] (28 Total)

	perpetrators	% of total
Adults		
Female	6	21%
Male	18	64%
Total	24	86%
Juveniles		
Female	2	7%
Male	2	7%
Total	4	14%
Race/ethnicity		
Caucasian	8	29%
Minorities	20	71%

- 75% of adult perpetrators had criminal conviction records
- 61% of adult perpetrators had an alleged/reported domestic violence history
- 46% of perpetrators had a previous incarceration
- 82% of adult perpetrators had a reported substance abuse history
- 22% of perpetrators had a disability condition (5 psychiatric, 1 chronic illness)
- 14% of perpetrators were on public assistance at time of homicide
- 68% of perpetrators were the primary aggressor in the incident.
- Age range was 14 to 63 years old

1. Excludes 3 cases involving police.
2. One perpetrator committed two homicides; excludes police

Domestic Violence Related Homicides (1998) - Systems Contacts

Systems contacts with multiple victims, perpetrators and dyads

- Probation histories were present for at least one party in 53% of cases
- DCFS had past case records for 9% of victims' families and 25% of perpetrators
- Juvenile Court had past records on 28% of victims and 32% of perpetrators
- Victims and perpetrators had very few recent contacts with social service interventions
- Few mental health treatment contacts (1 victim and 5 perpetrators had psychiatric diagnoses)

Systems contacts with a single victim, perpetrator or dyad

- One perpetrator was out on bond (domestic violence case related to homicide victim)
- One victim was out on bond (unrelated case)
- One case had a current temporary protection order (open misdemeanor case)
- One case had a no contact order (probation)
- One victim had contact with a batterer treatment program
- One victim had contact with Witness Victim Service Center
- One victim had multiple hospital contacts (1 related injury - 1 month prior; no police report made)

Systems contacts which did not occur among cases

- No civil restraining orders had been obtained
- No cases had outstanding warrants for arrest or capias
- No current parole or probation violations were involved in cases
- No cases had pending divorce, custody or visitation disputes in Domestic Relations Court
- No cases had recent referrals or open files with Department of Children and Family Services
- No cases had known services from domestic violence shelter or counseling programs
- Few, if any, cases had social service interventions

Domestic Violence Related Homicides (1998) - Observations

Lethality Risk Factors Observed

1. **Early childhood instability**
   (Juvenile Court, DCFS cases)

2. **Criminal history**
   (assault, theft, drugs, alcohol, DUI, domestic violence, soliciting)

3. **Police involvement**
   (police calls, arrests, complaints, charges, convictions, incarceration, probation and violations)

4. **Substance use/abuse history**
   (long term alcohol, poly drug use, drug related charges)

5. **Psychiatric diagnosis and sulcidal ideation**

6. **History of family and other violence**
   (alleged/reported complainants/respondents)

7. **Unstable relationships**
   (new relationships, jealousy, threats of separation)

8. **Multiple public system contacts history**
   (police calls, citizen complaints, DHS benefits)

9. **No or minimal treatment/advocacy contacts**
   (social work, mental health, domestic violence)

10. **No or minimal use of civil remedies**
    (restraining orders, divorce, custody, visitation disputes)

11. **Access to weapons**
    (firearms not removed from offenders)

12. **Access to victims**
    (living together, in contact, accessible)

Major Conclusions

- Homicide victims and perpetrators had limited or no recent contact yet had extensive history with multiple law enforcement, prosecution and criminal justice systems

- Homicide victims and perpetrators had very limited if any treatment history with relevant child abuse, domestic violence, mental health, substance abuse, human and social services yet had multiple public systems' records with income maintenance, children and family services, and juvenile court

- Homicide victims and perpetrators have fairly similar histories to one another

RECOMMENDATIONS:

1. ACTION STEPS:

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

☞ b. To lobby for a State of Ohio legislative reporting mandate requiring identification and review of all domestic violence related homicides in each county.

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

☞ d. To obtain and compare findings of fatality review committees in other jurisdictions.

☞ e. To identify barriers to service access.

2. LAW ENFORCEMENT:

☞ a. To train law enforcement to file domestic violence police reports on all related dispatched calls, make arrests whenever probable cause exists and refer to domestic violence programs wherever feasible.

☞ b. To implement wherever feasible the Brady bill prohibiting domestic violence perpetrators (convicted under ORC 2919.25 (a)(b)) from owning a weapon.

☞ c. To geographically target law enforcement efforts to Cleveland's east side.

☞ d. To standardize background information reports on abuse, mental illness, substance abuse obtained by police homicide units.

3. CRIMINAL AND JUVENILE JUSTICE SYSTEM:

☞ a. To continue to conduct more evidence-based (without victim participation) domestic violence prosecutions.

☞ b. To charge and prosecute domestic violence cases whenever evidence supports it and when a provable case cannot be made to recommend prosecutor's hearings and/or other forms of intervention wherever feasible and document in the record.

☞ c. To include assessment by evaluator for batterers' intervention, anger management, substance abuse, mental health or other appropriate treatment as a condition of sentence or probation in violent and/or drug abusing offenders with extensive criminal histories.

☞ d. To request pre-sentence and bond investigations including domestic violence risk, psychiatric, substance abuse, batterers, anger management, service eligibility assessment and follow treatment recommendations as appropriate for violent and/or drug abusing offenders with extensive criminal histories.

☞ e. To train all probation officers and bond investigators to conduct pre-sentence and bond investigations including domestic violence risk, psychiatric, substance abuse, batterers, anger management and treatment eligibility assessment as appropriate for violent and/or drug abusing offenders with extensive criminal histories.

☞ f. To expand Juvenile Court's use of community resources in resolving parent-teen conflicts.

4. SERVICE INTERVENTIONS:

☞ a. To monitor and follow-up on child and elder abuse cases reported to systems to ensure that services were provided and cases are kept open as long as risk remains.

☞ b. To develop greater strategies linking victims and perpetrators to domestic violence services.

☞ c. To develop greater linkages between social and domestic violence service agencies and police, courts, medical facilities, substance abuse programs, and criminal and juvenile justice.

☞ d. To require universal risk assessment for new mothers giving birth in hospital obstetrics facilities and for pregnant teens in school systems and make referrals to appropriate programs.

☞ e. To implement domestic violence protocols to assess risk by health care facilities, hospitals and primary care physicians and school nurses.

☞ f. To follow-up on cancelled emergency medical and police calls (EMS/911).

5. EDUCATION AND TRAINING:

☞ a. To train mandated reporters and administratively reinforce mandatory abuse reporting in health care, hospitals, primary care physicians, human services, domestic violence, and educational systems.

☞ b. To conduct general community media campaigns and service systems' outreach on domestic violence issues and emphasizing risk factors and service resources options.

☞ c. To encourage local public and private schools to develop prevention programming with domestic violence content schools in health classes and in special teen pregnancy or sexually transmitted disease curricula.

☞ d. To promote gun control community wide.

6. DATA COLLECTION AND INFORMATION SYSTEMS MANAGEMENT:

☞ a. To improve data collection and record keeping and records' access in public systems to obtain and make available all relevant case history.

☞ b. To conduct records reviews of multiple public systems and inter-departmentally to obtain all relevant case history when working with victims or perpetrators of domestic violence.

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

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

☞ e. To centrally report and computerize child abuse, elder abuse and domestic violence records on a county-wide standard incident report relational computer system.

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