DOMESTIC VIOLENCE RELATED HOMICIDES

IN CUYAHOGA COUNTY, 1999

The 2001 Annual Report of the

DOMESTIC VIOLENCE FATALITY REVIEW COMMITTEE

Presented by

Marcia K. Petchers, Ph.D., LISW, Committee Chairperson

on February 4, 2002 to the

DOMESTIC VIOLENCE COORDINATING COUNCIL
OF GREATER CLEVELAND

DOMESTIC VIOLENCE RELATED HOMICIDES - 1999

The 2001 Annual Report of the Domestic Violence Fatality Review Committee

ACKNOWLEDGMENTS

The Domestic Violence Fatality Review Committee is issuing its fourth Annual Report. A 2001 membership roster is attached. The Committee is hosted by the Cuyahoga County Coroner's Office, under the leadership of Dr. Elizabeth K. Balraj, Cuyahoga County Coroner. We could not operate without the support of the current 24-member public and private agencies and department representatives serving on the committee.

In addition, we wish to acknowledge the help of the following other cooperating agencies that shared data with the committee: Police Departments of East Cleveland (Lt. David Miklovich), Euclid (Det. Raymond Jorz), Lakewood (Det. Scott Eschweiler), and Cleveland Heights (Det. Mark Schmitt); the YWCA of Cleveland (Ms. Bonnie Morris/ Ms. Judy Masnick), DOVE (Ms. Diane Miller/ Mr. Scott Lee), East Side Catholic Center and Shelter (Mr. Don See/ Ms. Michelle Clay), Jewish Family Services Association's Project Chai (Ms. Brynna Fish), and the City of East Cleveland Municipal Court (Ms. Deborah Black) domestic violence programs as well as the Lesbian/Gay Community Center (Ms. Jennifer Krieger/ Mr. Bob Bucklew).

Finally, we appreciate the additional assistance of other staff who have provided support to the committee's efforts: Ms. Pam Vacca of the Witness Victim Service Center, Ms. Elizabeth K. Tidwell and Ms. Joyce Avondet of the County Coroner's Office, Mr. Ken Thomas of the Probation Department of Cleveland Municipal Court and Det. Frances Stevers of the Cleveland Police Homicide Department.

For additional copies of this report, please contact Charlotte Mann, Witness Victim Service Center at (216) 443-3077 or <cncmm@www.cuyahoga.oh.us>. For follow-up issues or 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 listed committee members.

Marcia K. Petchers, Ph.D.
Committee Chair

BACKGROUND

In 1996, the Domestic Violence Coordinating Council of Greater Cleveland, under the leadership of Judge Ronald Adrine, established this Domestic Violence Fatality Review Committee in collaboration with Dr. Elizabeth K. Balraj, the County Coroner. Judge Adrine appointed the Committee's founding co-chairs, Mr. Craig Tame, of the County's Office of Criminal Justice Services, and Dr. Marcia Petchers, Consulting Services, a non-profit organization and research consultant. As co-chairs, Mr. Tame and Dr. Petchers initiated the Committee structure, membership and procedures. Mr. Tame has since stepped down as co-chair though continues to support the Committee's efforts. Dr. Petchers continues serving as Committee Chair.

The Committee's intent is to focus attention on domestic violence homicides, the most extreme end of domestic violence. The committee's charge is to track their occurrences in the county, to develop a better understanding of why they occur and to learn how they can be reduced or prevented. Similar fatality review committees have been formed in major Ohio counties and are operating all around the country.

MISSION

The mission of the Fatality Review Committee of the Domestic Violence Coordinating Council of Greater Cleveland is to retrospectively identify and constructively examine domestic violence related deaths, to seek ways to prevent domestic violence cases from escalating into homicide.

FATALITY REVIEW PROCESS

SCOPE OF WORK

The Domestic Violence Fatality Review Committee's charge is to review all domestic violence related homicides in the county. The process is one of fact not fault finding or blaming. The committee reviews fatalities of any adults and children deemed to result directly or indirectly from a domestic violence incident or conflict. This Committee examines the domestic violence nature of the primary relationship that brings about the homicide.

Domestic violence is defined in accordance with the Ohio Revised Code. Additionally, the Committee at its discretion includes cases closely related to domestic violence incidents. A more inclusive definition allows us to learn from cases that actually require the same interventions to avert, but are outside of the legislative definition of domestic violence.

The Committee reviews cases with closed criminal investigations and a final judicial disposition (either adjudicated or dismissed). No pending or open cases are reviewed.

Not all deaths due to domestic violence may have been detected or ruled as homicides as some may have been ruled accidental or suicidal. In addition, some cases remain unsolved, and thus, were not reviewed by the Committee. Thus, case totals may represent an undercount.

The child deaths are also reviewed by the Child Review Committee, which examines all child deaths due to any cause from a public health perspective. To facilitate coordination and minimize any duplication of efforts, the Domestic Violence Fatality Committee and the Child Death Review Committee have some overlapping membership.

The Committee's focus is entirely on fatal cases ruled as homicides. Hence, conclusions cannot be extended to non-fatal or near-fatal cases, suicides, attempted suicides or accidents that may have actually been domestic-violence related. These may be important areas of future inquiry, which would entail expanding the Committee's work and staff support. It might also be helpful to broaden our scope in the future to fully include domestic violence related suicides.

Further, the Committee is not currently charged with reviewing near-fatality or serious injury cases where lives may have been saved by interventions of community agencies. We realize, however, that many domestic violence victims do contact and access service agencies and that help may well be instrumental in saving lives.

The State of Ohio does not have a legislative mandate to identify and review domestic violence homicides. Such a legislative mandate would enable the receipt of confidential records, as is the case for all child fatalities. [The Child Death Review Committee reviews all child deaths.] Advocacy efforts are underway in Ohio advocating for a legislative mandate for domestic violence fatality review.

GOALS AND OUTCOMES

The aim is prevention. The focus is on identifying systems gaps, needed services and linkages in order to improve future practices.

The Committee's goals are to review:

- ***Precipitating circumstances surrounding and leading to the homicides***
- ***Demographics and histories of victims and perpetrators***
- ***Systems and agencies involvements in cases prior to the homicides***

The intended outcomes are to:

- ***Identify service accessibility barriers, systems gaps, and needed systems linkages***
- ***Validate and improve domestic violence lethality risk assessment***
- ***Generate discussion and strategies for reducing domestic violence related homicides***

The Fatality Review Committee has met monthly to review records of domestic violence related homicides. 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 operates by consensus.

Fatality review is a challenging yet arduous process. The Committee acknowledges the continuing need for funded staff support to manage the review, research, investigation and reporting processes. The Committee continues to evolve the review process –in which, through gained experience, we are trying to improve the completeness and efficiency of the investigation.

The Committee invites staff of other agencies to provide additional relevant information on specific cases as needed. Membership is reviewed annually. We consider inviting additional agencies to join based on the case review needs.

The review of 1999 domestic violence related homicides has been completed and the results are reported herein. The Data Review Subcommittee is comprised of: Ms. Holly Bednarski, Ms. Nancy Fleming, Dr. John Neill and Dr. Marcia Petchers. The Annual Report Review Subcommittee is comprised of: Ms. Suzie Demosthenes, Dr. Marcia Petchers and Ms. Judith Sheehan. The annual report is approved by the Committee members, and is presented to the Domestic Violence Coordinating Council, under the leadership of Judge Robert Triozzi, and disseminated through the Committee's representatives.

The Committee is continuing its review process. In the year 2002, we are now turning our attention to domestic violence and related homicides from the year 2000. All members have gained valuable experience that continues to inform and expedite our next year's work. Meetings are generally scheduled the first Tuesday of the month at 1:15 p.m. at the Coroner's Office.

CASE SCREENING

Case screening of all Cuyahoga County Coroner's case homicides was necessary since homicides are not currently categorized as domestic violence related. The Case Screening Subcommittee is comprised of: Lt. Thomas Brickman, Dr. Marcia K. Petchers, Lt. Joseph Petkac, Det. Frances Stevers and Ms. Elizabeth K. Tidwell.

During the year 2001, we conducted a preliminary review of all 99 homicides as ruled by the Coroner, which had occurred in Cuyahoga County during the 1999 calendar year. From these, 27 cases were selected for presentation to the full Committee. Of those, 3 cases were briefly reviewed and deemed not to be domestic violence related, and thus, have been omitted from the results. In the final tally, 24 cases were classified as domestic violence related; this represents 24% of all homicides occurring in Cuyahoga County during the year 1999 as follows:

> Twenty cases met the legal definition of family or household member as defined in the Ohio Revised Code domestic violence statute (ORC 2919.25) including domestic partners (opposite and same-sex couples) as well as other blood relatives, household and family members.
>
> Four other homicides fall outside the ORC legislative language yet were deemed closely related to domestic violence. These included non-cohabitating intimate partners and collateral parties (relatives, friends, former or current partners) to a domestic violence conflict who themselves became a homicide victim or suspect. In some cases, collateral parties killed the potential homicide perpetrator and thus saved the life of the intended victim. In other cases, the collateral party was killed trying to save the life of the intended victim.
>
> In three homicide cases, associated suicides were also studied. These three suicides were not counted in our statistical review of 24 domestic violence deaths. Two of these represented 1.4 % of the coroner's 139 suicide cases in Cuyahoga County in 1999, whereas one occurred in Ashtabula County.

CASE REVIEW

The Committee reviews all adult and child death cases in which domestic violence is considered a significant factor. Fatalities are reviewed specifically from the perspective of domestic violence circumstances and dynamics contributing to the death.

Only those cases that met the Committee's criteria were fully reviewed. Using data from multiple record sources, the Committee investigated the 24 domestic violence related homicides determined to have occurred in 1999.

Agency records to determine any contact with the victim, perpetrator and/or her/his family and significant others. All relevant information is presented at the case review. Committee members try to collect information from other agencies involved with the case, where other systems contacts are identified.

The initial case presentation is opened by the Coroner's report on method and cause of death resulting in the homicide ruling. This is followed by the police investigation report, the prosecutor's case report, and then all other agency reports. Each agency representative and guest

presenter reports on their case involvement and answers questions on the case. The entire Committee then discusses each case, identifies risk factors, salient issues and the need for any follow-up information. Each case is explored until each member of the Committee is satisfied that all questions have been answered. The Committee identifies any cases to be revisited at the subsequent case review.

The Data Collection Subcommittee records the data presented at the case review. Data reports are collected and retained by the Chair. Any follow-up issues and missing data elements or agency contacts are noted. At the end of the Committee's discussion, each case is either completed or determined to need revisiting.

DATA SOURCES

The Committee searched selected existing records for the parties involved in the domestic violence related homicide cases. For each case, we checked records kept by the coroner, courts, prosecution, probation, police, batterers' programs, victim services, children and family services, adult protective services and income maintenance to discern any service contacts. Other identified service providers (hospitals, crisis services) were checked whenever possible.

Six local domestic violence services providers (Domestic Violence Center, Witness Victim Service Center, East Side Catholic Center and Shelter, City of East Cleveland Domestic Violence Program, YWCA of Cleveland, Project Chai and the West Side Catholic Shelter) searched their available intake records including counseling, shelter, support groups, classes and advocacy. Five local batterers programs' records were checked (the Cuyahoga County Batterers Intervention Program, The Family Counseling Center, DOVE Program, YWCA of Cleveland, Domestic Violence Center, the City of East Cleveland Domestic Violence Program). Other identified homeless shelters, transitional housing, parenting and anger management program records were consulted where a service contact was noted in the case record.

Homicide records are factual and often have dates, times, locations and situational details. Prior histories of domestic violence, substance use history and agency contacts were identified and verified, whenever possible. In some cases, the victim and/or perpetrator may have or have had prior incidents of domestic violence but not necessarily with each other.

The names of victims, perpetrators and family members were recorded and checked on all cases. Social security numbers or permanent addresses were always obtained and corrected if found to be in error. Agency computerized management information systems were checked to locate cases through queries under all relevant surnames.

Marital and employment status and substance abuse history were obtained, wherever possible. The coroner's autopsy tested for alcohol and drug toxicology levels in victims. Perpetrator/ suspect substance use at the time of the incident, and past abuse, were obtained through secondary sources.

Residential movement across jurisdictions was tracked when possible by checking with jurisdictions of prior residences. Criminal histories were searched through local, county and state databases. Wherever practical, local police dispatch records were checked for all reported prior calls to victims' or perpetrators' addresses. In addition, attempts were made to contact other police jurisdictions or municipalities as well as to search multi-state databases.

Police and prosecutors shared with the Committee prior investigations and prosecutors' interviews with family members, friends and neighbors, employers and other individuals who were familiar with the cases, wherever available. At our meetings, Committee members also debriefed guest presenters about their contacts with and knowledge of family and friends as relevant to the cases.

DATA LIMITATIONS

A note of caution: all findings are based only on what is known through the case records review. An absence of data in the record cannot be interpreted as meaning the factor was not present in the case. Where we report no known service or agency contact, it means only there is no documented contact, it cannot be said with certainty that there was no actual contact. In addition, it cannot be assumed that all involved parties may have been eligible for any particular service, protection or other benefit on which data are collected. Therefore, the absence of a particular systems contact does not mean it actually could have been obtained but was not.

The research does not show whether victims attempted to access services, chose to avail themselves of known services but were not served, did not choose to avail themselves of services and/or did not know about available services. In addition, crisis hotline records could not be checked due to the anonymity of calls.

Homicide records do not always contain the full range of psychosocial factors or lethality indicators. Prior histories of domestic violence, substance use history and agency contacts are not always known or could not always be verified. Perpetrators/suspects are not routinely tested for toxicology levels by law enforcement unless arrested for specific substance abuse related offenses.

It is possible that police calls were made but no reports were generated since police officers responding to a location do not always submit formal police reports. Some police reports may be titled something other than domestic violence in the record but may have actually been domestic violence related such as criminal damaging, robbery, rape and/or felonious assault.

There are some notable additional barriers to records research. These include: the names of perpetrators, victims, and family members were sometimes incorrectly recorded;. social security numbers or permanent addresses were not always known; and agency computerized management information systems were not always able to locate cases that may be filed under related or different surnames, may be lost, or those which pre-date a computerized system.

The Committee's efforts are constrained due to record confidentiality in several sectors. Agencies providing mental health treatment, substance abuse counseling and medical care are legally restricted from releasing individual client records although some have been able to provide aggregate information. However, wherever possible such information was obtained from secondary reports. Only a legislative mandate for domestic violence fatality review boards would enable obtaining the full range of confidential records.

Marital and employment status and substance abuse history are sometimes difficult to obtain. Residential mobility, within and between towns, counties and/or states, makes tracking more difficult as does the passage of time over the life span. Available computerized criminal histories may be incomplete.

Further, in secondary records, it is hard to determine risk escalation patterns of such problems as domestic violence, substance abuse or mental illness. In the absence of in-depth interviews using a standardized protocol, prior unreported threats or strangulation attempts could not always be known. The Committee review does not include contact or interviews with surviving family members and significant others.

The risk factors and conclusions presented as general observations differ in magnitude from each other. However, they are significant indicators. The factors listed may benefit understanding and identification of domestic violence cases in which intimate partners and family, or household members are at more serious risk. Certainly all characteristics are not present in all reviewed cases: any one characteristic may or may not be present in any single case.

FINDINGS

FINDINGS SUMMARY

The following data are from our case review of 24 domestic violence related homicides out of the coroner's 99 identified homicide cases from the year 1999. Findings are based on a review of all identified domestic violence related homicides, not merely a sample.

Results mirror the three prior years in most respects. A consistent pattern over four years adds confidence in the validity of the findings.

From the information obtained, the Committee presents quantified results in the findings section that includes case characteristics, demographics, victim and perpetrator profiles and systems involvement. Results are presented in the aggregate with either the actual numbers of cases and/or percentages given to reflect a particular condition. For some data elements, as noted, percentages are taken out of the total adults and children are excluded. Where used, percentages have been rounded and may not always add to 100%. Actual numbers rather than percentages are used for systems contacts since it cannot be assumed that all individuals would be eligible for all reviewed programs, services or court orders.

Based on this year's case review findings, the Committee puts forward a series of general observations. There is a summary of ten observed lethality risk factors and major conclusions about domestic violence homicide cases.

Finally, the Committee offers recommendations based on our findings and conclusions. First, we highlight key action steps for the Committee's work. We offer recommendations of strategies for six other major areas: data collection/information systems management, law enforcement, criminal and juvenile justice systems, medical health care providers, social service providers, and education/training.

CASE CHARACTERISTICS

Cause of death: 63% shot, 17% blunt violence, 8% arson, 4% stabbed, 4% strangled, 4% other.

13% of homicides accompanied by perpetrator's suicide (3 males).

71% of cases involved reported (or allegations of) substance use at the time of the incident.

In 33% of the cases, the primary domestic violence aggressors died or were injured: 3 were killed, 3 killed themselves, and 2 were wounded. All were males.

In 21% of the cases, another party outside the homicide dyads was also injured.

DEMOGRAPHICS

79% of the homicides occurred within the City of Cleveland, of these 74% were located in east-side central city (see maps of Cleveland cases by Statistical Planning Areas and Police Districts).

79% of the homicide dyads involved at least one African-American, although African-Americans comprise 28% of the county population.

92% of the homicides occurred within the same racial/ethnic groups.

Females comprised 58% of the domestic violence homicide victims, although females comprise only 27% of all county homicide victims.

Domestic/intimate partner (46%), intimate partner related involving a collateral party (13%) and family/relatives (42%) homicides are represented.

Intimate partner and related homicides occurred within intact relationships (43%) and in separated relationships (57%).

83% of domestic violence deaths occurred at home, compared to 43% of all county homicides.

50% of cases occurred between individuals of the opposite sex (couples, other family/household members), 50% occurred between those of the same sex (family, household members, collateral parties or couples).

In 82% of intimate partner cases, couples were opposite sex, 18% were same sex (both gay male couples).

VICTIMS PROFILE

83% were adults, 17% were children.

Females comprise 50% of adult victims, all the child victims were female.

The age range was from infant to 77 years.

75% were African-American, 25% were Caucasian.

8% were diagnosed with a psychiatric condition, 8% had another chronic medical illness.

Of the 20 adult victims:

60% had reported criminal histories

25% had prior incarceration histories

80% had alleged or reported domestic violence incidents

15% were alleged to be the primary aggressors in the incidents

35% were on public assistance at the time of the homicides,
70% had public assistance histories

55% had reported substance abuse histories

60% tested positive for alcohol or other drugs upon autopsy

5% attempted suicide, at least 5% made threatened suicide

PERPETRATORS PROFILE

100% were adults.

92% were males, 8% females.

Age range was 20 to 87 years.

71% were African-American, 29% were Caucasian.

12% were diagnosed with a psychiatric condition, 12% with another chronic illness or injury.

71% had reported criminal histories.

29% of perpetrators had prior incarceration histories.

58% had alleged or reported previous domestic violence incidents.

88% were the primary aggressors in the incidents.

17% were on public assistance at the time of the homicides, 62% had public assistance histories.

50% had reported substance abuse histories.

54% had reported substance use at time of homicide.

13% of homicide perpetrators committed suicide, 8% were wounded during the incident.

Dispositions:

18 (75%) sentenced: 15 incarcerated, 3 community control;
6 (25%) not sentenced: 3 prosecutions abated by suicide, 1 (4%) nolled, 1 (4%) no billed, 1 (4%) found not guilty.

Eighteen sentenced cases:

3 (17%) aggravated murder, 5 (28%) murder, 2 (11%) voluntary manslaughter, 4 (22%) involuntary manslaughter, 1 (6%) negligent homicide, 1 (6%) attempted involuntary manslaughter, 1 (6%) felonious assault [offense charged 8 years before it resulted in homicide], 1 (6%) domestic violence (M4) [lesser included offense, found not guilty of involuntary manslaughter].

Note: for statistical purposes, 24 perpetrators were counted. One perpetrator killed two victims (and was counted twice); in two other cases, each had two alleged suspects (for each case only the primary suspect was counted).

SYSTEMS INVOLVEMENT

Two perpetrators had current parole cases and 1 had prior parole, no victims on parole.

One case had a recent police call to the address, related to incident leading to homicide, and 5 other cases had prior police calls to the address.

Two victims had outstanding warrants for arrest or capias, but no perpetrators.

One victim was out on bond (in a current unrelated case), but no perpetrators.

There were no active Restraining or Protection Orders, but one case had a current No Contact Order. Four victims (2 Restraining, 1 No Contact, 1 Civil Protection Order) and 2 perpetrators had obtained prior orders.

One perpetrator was currently on probation (Cleveland Municipal Court), probation histories were present for 5 victims and 13 perpetrators; 3 victims and 8 perpetrators had prior probation violations.

No cases had pending divorce, custody or visitation disputes in the Cuyahoga County Court of Common Pleas, Domestic Relations Division; 2 victims and 2 perpetrators had previous contacts with Domestic Relations Court.

Custody cases with Department of Children and Family Services were open on 1 victim and 1 perpetrator, with past case records on families of 3 (13%) victims and 2 (8%) perpetrators. No abuse or neglect cases were open on the child homicides.

Custody cases with the juvenile court were open on 1 victim and 2 perpetrators, there were past juvenile records on 11 (46%) victims and 11 (46%) perpetrators.

Numerous perpetrators and victims had prior citizen contacts (as complainants and/or respondents) with the City of Cleveland Prosecutor's Intake Office (mostly unrelated to the homicide case).

Victims or perpetrators had very few recent contacts with social service interventions.

No cases had known stays by victims at domestic violence shelters in the county.

Victims and perpetrators had multiple prior hospital contacts.

No perpetrators had any known contact with domestic violence services, one victim had documented prior contact with a victim advocate and one domestic violence victim program had current contact briefly serving 1 victim (started 1 class same week as homicide).

One perpetrator had been previously served by one homeless shelter.

Two victims and 3 perpetrators had psychiatric diagnoses but few mental health treatment contacts.

Two perpetrators but no victims had completed batterers treatment programs.

One of the perpetrators but none of the victims had prior contact with parenting programs.

GENERAL OBSERVATIONS

LETHALITY RISK FACTORS

One of the Committee's major goals is to identify and validate lethality risk factors in domestic violence related homicides. These red flag lethality risk factors were observed, within the limits of data collected, among this year's reviewed cases. The Committee found these factors to be significant indicators of serious risk for cases involving intimate partner, family and household members. Risk factors found to be significant vary in magnitude; they may not be present in all cases; and may not necessarily be present in any single case.

A summary of ten major factors, based on the data collected this year, is numbered below but in unranked order. These were derived from the more specific quantified findings, supporting each factor, reported under the case characteristics, victim and perpetrator profiles findings sections.

1 Unstable family environment history such as Juvenile Court, Department of Children and Family Services custody, paternity and abuse or neglect cases.

2 Law enforcement and/or criminal justice system involvement such as police calls, arrests, complaints, charges, convictions, incarceration, probation violations and/or contempt of court findings, for a variety of offenses --including assault, theft, alcohol or other drugs, DUI, domestic violence and/or soliciting.

3 Substance use or abuse history such as long-term alcohol, poly-drug use and drug related charges.

4 Diagnosed or undiagnosed emotional, behavioral, psychiatric symptoms or other chronic medical illness.

5 History of alleged or reported family threats and other violence complaints.

6 New relationships, jealousy, relationship triangles, blended families with step-children, threats of or actual relationship separation.

7 History of multiple contacts with governmental agencies such as police calls, citizen complaints to prosecutors, and Department of Human Services --contacts did not necessarily lead to services or treatment.

8 No or minimal treatment and/or service system advocacy services received such as counseling, social work, mental health, domestic violence, and substance abuse treatment.

9 No or minimal use of civil remedies such as protection, divorce, custody or visitation orders.

10 Access to firearms, knives and other weapons.

MAJOR CONCLUSIONS

Another of the Committee's major goals is to identify patterns among domestic violence related homicides. A summary of major trends, based on the data collected this year, is presented below, in unranked order. Not all conclusions were based on findings of equal magnitude; they may not have occurred in all reviewed cases; and may not necessarily be present in any single case.

1 A high percentage of domestic violence homicide victims and perpetrators were African-American and resided on the east side of Cleveland.

2 A high percentage of these homicides involved a shooting.

3 About half had recently contemplated or threatened to separate, or actually terminated the relationship.

4 A small number (a high percentage compared to the general population) had psychiatric diagnoses –an even larger number may have had undiagnosed emotional, behavioral or psychiatric conditions.

5 Adult homicide victims had limited or no known recent safety plans, use of panic buttons or domestic violence or victim advocacy.

6 Child homicide victims had no open neglect/abuse cases and limited or no recent services with the Cuyahoga County Department of Children and Family Services.

7 Elderly homicide victims had no open neglect/abuse cases and limited or no recent services with the Cuyahoga County Department of Adult Protective Services.

8 Homicide victims and perpetrators have largely parallel histories to each other, as noted below --both had:

a. Multiple governmental systems contacts such as public assistance, children and family services and Juvenile Court.

b. Limited or no recent known criminal justice system contacts; yet extensive criminal histories.

c. Limited or no recent documented official domestic violence records; yet extensive general non-related criminal histories.

d. Limited or no recent documented police calls to address, or investigations; yet extensive alleged, unreported domestic violence histories.

e. Very limited, if any, known recent or current voluntary treatment services; yet extensive substance abuse, domestic violence, and psychosocial difficulties; mandated treatment services were not always accessed, delivered or completed.

f. Limited or no recent known protection or no contact orders; yet extensive alleged, unreported domestic violence histories.

g. Limited or no known recent services from domestic violence programs, justice system advocacy or batterers programs; yet extensive alleged, unreported domestic violence histories.

ACTION STEPS AND RECOMMENDATIONS

These recommendations build on those promulgated by the Committee in its three previous years' annual reports. Our intent is to raise public awareness about domestic violence related fatalities as a serious community issue and promote strategies for preventing or reducing domestic violence related fatalities.

The Committee puts forward a set of key action steps, central to our Committee's future work, and then some recommendations for improving data collection efforts. Finally, we list strategies for review and implementation by community policy makers and administrators in the areas of law enforcement, criminal and juvenile justice, medical services, social services, education and training.

DOMESTIC VIOLENCE FATALITY REVIEW COMMITTEE

a. Secure county funding for staffing and operating expense support of the Committee's work.

b. Expand dissemination of this annual report broadly to all public officials and agencies throughout Cuyahoga County, especially those involved in the judiciary, law enforcement, criminal justice, and medical and social services to create and implement innovative prevention and risk reduction strategies.

c. Advocate for statewide legislation that would require identification and review of all domestic violence related homicides in each county.

d. Stay current with statewide and national trends and compare findings with other similar fatality review committees in other jurisdictions.

e. Validate and improve lethality risk assessment tools including past histories of homicide threats, suicide attempts or threats, attempted strangulations and psychiatric symptoms.

f. Identify and better understand service barriers or gaps, including any racial, ethnic, geographic, cultural or other accessibility factors that may limit or inhibit service access in high-risk populations and areas.

g. Conduct records reviews of multiple public systems across departments and jurisdictions to obtain relevant case histories on victims and perpetrators of domestic violence.

h. Encourage closer collaboration between and among agencies working to prevent domestic violence.

i. Promote inter-agency communications and coordination by information sharing and formal protocols among agencies so procedures are known and access can be obtained.

DATA COLLECTION / INFORMATION SYSTEMS MANAGEMENT

a. Conduct comprehensive records reviews to obtain all relevant case histories from agencies working with victims or perpetrators of domestic violence (VINE, LEADS, NCIC) within limits of confidentiality.

b. Implement fully and keep current a central computerized registry of all protection orders in a single countywide system.

c. Centrally computerize, fully implement, and keep updated all local police jurisdiction records on a countywide system.

d. Report and centrally computerize, fully implement, and keep updated all child abuse, elder abuse and domestic violence records; use a countywide standard incident report form and relational computer system within limits of confidentiality.

e. Assess community perceptions of law enforcement, criminal justice, medical and social service system responses to domestic violence victims.

LAW ENFORCEMENT

a. Train law enforcement to file domestic violence police reports on all related dispatched calls, make arrests whenever probable cause exists, and refer parties to appropriate domestic violence victim assistance programs.

b. Strictly enforce the Brady Bill provision that prohibits certain convicted domestic violence perpetrators from acquiring or possessing firearms.

c. Fully enforce domestic violence laws across the county with increased vigilance in Cleveland's three east side police districts (Districts 4, 5, 6) and other high-risk areas.

d. Standardize background information reports on domestic violence, mental illness, substance abuse and suicide attempts obtained by homicide and other police units.

e. Encourage full police investigations of underlying domestic violence relationships in homicides accompanied by suicides and those committed by collateral parties.

f. Follow up on cancelled 911 police calls.

CRIMINAL AND JUVENILE JUSTICE SYSTEM

a. Conduct more evidence-based domestic violence prosecutions, regardless of the level of victim participation or cooperation.

b. Charge and prosecute domestic violence cases whenever evidence supports it. In cases of insufficient evidence, recommend prosecutor's hearings and/or other forms of intervention wherever feasible, and then document it in the record.

c. Expand Juvenile Court's use of community resources for resolving parental custody, paternity issues, and juvenile delinquency and unruly cases.

d. Interview family members and significant others of victims and perpetrators in homicide cases to identify past lethality factors and child survivors in need of services.

e. Encourage full prosecutors investigations of the underlying domestic violence relationships in homicides accompanied by suicides and those committed by collateral parties.

f. Train all probation officers and bond investigators to conduct pre-sentence and bond investigations on violent and/or drug abusing offenders with extensive criminal histories; include assessments for domestic violence risk, psychiatric/mental, and substance abuse. Determine eligibility for batterers intervention, anger management, and other programs, as appropriate.

g. Request courts to order assessments in pre-sentence reports prior to setting bond or sentencing violent and/or drug abusing offenders with extensive criminal histories; include assessments for domestic violence risk, psychiatric/mental, and substance abuse. Determine eligibility for batterers intervention, anger management, and other programs, as appropriate. Request court orders for resulting treatment recommendations as a condition of probation.

h. Reinforce current practice of consistent, timely follow-up by all probation officers on all court referrals ordered for mandated assessment, treatment and batterers intervention programs to ensure offender compliance.

i. Streamline the processing of probation violations through the courts by expediting the requesting of a capias after an offender's failure to report to a probation officer or non-compliance with terms of probation including treatment mandates.

MEDICAL SERVICE PROVIDERS

a. Require universal risk assessment for new and adolescent mothers in hospital obstetrics facilities, clinics, emergency rooms, pediatrics departments and for pregnant teens in school systems, and make referrals and linkages to appropriate programs.

b. Implement fully uniform domestic violence risk assessment protocols by health care facilities, hospitals, primary care physicians and school nurses.

c. Incorporate inquiries about lethality risk factors and access to weapons, by specialists as well as primary care providers, in psychiatric assessments.

d. Reinforce mandatory child and elderly abuse reporting requirements and train mandated reporters in health care, hospitals, private medical practices, human services, domestic violence and educational systems.

e. Follow up on cancelled emergency medical calls (EMS/911).

f. Follow-up on all psychiatric crisis team calls.

g. Train medical first responders to: conduct a standardized basic domestic violence risk assessment; provide referral information to victims; to be aware of preserving the crime scene; and notifying law enforcement of any suspicious or unnatural deaths and circumstances that may require a follow-up investigation.

SOCIAL SERVICE PROVIDERS

a. Monitor and follow up on child and elder abuse cases reported to systems to ensure services were provided and/or cases are kept open as long as lethality risk remains.

b. Reinforce mandatory child and elderly abuse reporting requirements and train mandated reporters in all human services agencies.

c. Expand inter-agency case conferences for review of domestic violence cases, and develop standardized domestic violence information sharing protocols.

d. Develop strategies for increasing access to domestic violence services by high-risk groups in high fatality geographic areas, helping link both victims and perpetrators to services.

e. Improve communication, monitoring and coordination of services through closer linkages between social and domestic violence service agencies and police, medical facilities, substance abuse and batterers' programs, and criminal and juvenile justice systems.

f. Educate victims about lethality risk assessment and available services, identify options and safety planning for making relationship transitions.

g. Identify child witnesses and victims of domestic violence and refer to appropriate services, such as the Children Who Witness Violence Program.

h. Provide domestic violence information packets to victims and other at-risk populations.

i. Develop and implement services across the county, especially in geographically higher-risk areas such as Cleveland Police Districts 4, 5, 6. [Based on this finding last year, a support group was offered by the Domestic Violence Center last year in District 5 but clients did not access it.]

j. Encourage victims services programs to follow-up with surviving family members of homicide victims and perpetrators.

EDUCATION/TRAINING

a. Promote gun control community wide.

b. Encourage local public and private schools to develop risk prevention programming including domestic violence content in health curricula.

c. Conduct general community media campaigns and social services outreach on domestic violence issues, emphasizing lethality and risk factors and available resources for victims and perpetrators.

e. Target school-age children with focus on anger management, coping skills and conflict resolution.

f. Conduct ongoing training for professionals and non-professionals to increase awareness of available services. Convene in various community sites such as churches, community centers, schools, hospitals and clinics across the county, especially in high fatality geographic areas.

CONCLUSION

The Committee is learning from its case reviews ways to improve domestic violence lethality risk assessment. There are lessons to be learned from these observations about fatal cases, even from a single case. The Committee has reviewed precipitating circumstances surrounding and leading to the homicides, the demographics and histories of victims and perpetrators, and documented systems and agencies involvements in cases prior to the homicides.

The annual report puts forward strategies for improved domestic violence and allied interventions, risk reduction for victims and better community control of offenders. The report puts forward conclusions about domestic violence fatalities and identifies lethality risk factors that may put intimate partners, family, household members and/or collaterals at serious risk. We have identified service accessibility barriers, systems gaps and needed systems linkages.

Through sharing the benefits of hindsight, the Committee disseminates its findings and makes recommendations for prevention and intervention, strategies, services, program policies and procedures. The Committee aims to generate discussion and strategies for preventing and reducing domestic violence related homicides.

Questions remain as to how to identify and reach the high-risk population, how to inform and connect affected populations with services and how to monitor domestic violence cases effectively. Implementing the Committee's recommendations may result in greater community safety by decreasing and preventing domestic violence homicides. That said, these recommendations should not be taken to mean that previously occurring homicides were indeed preventable.

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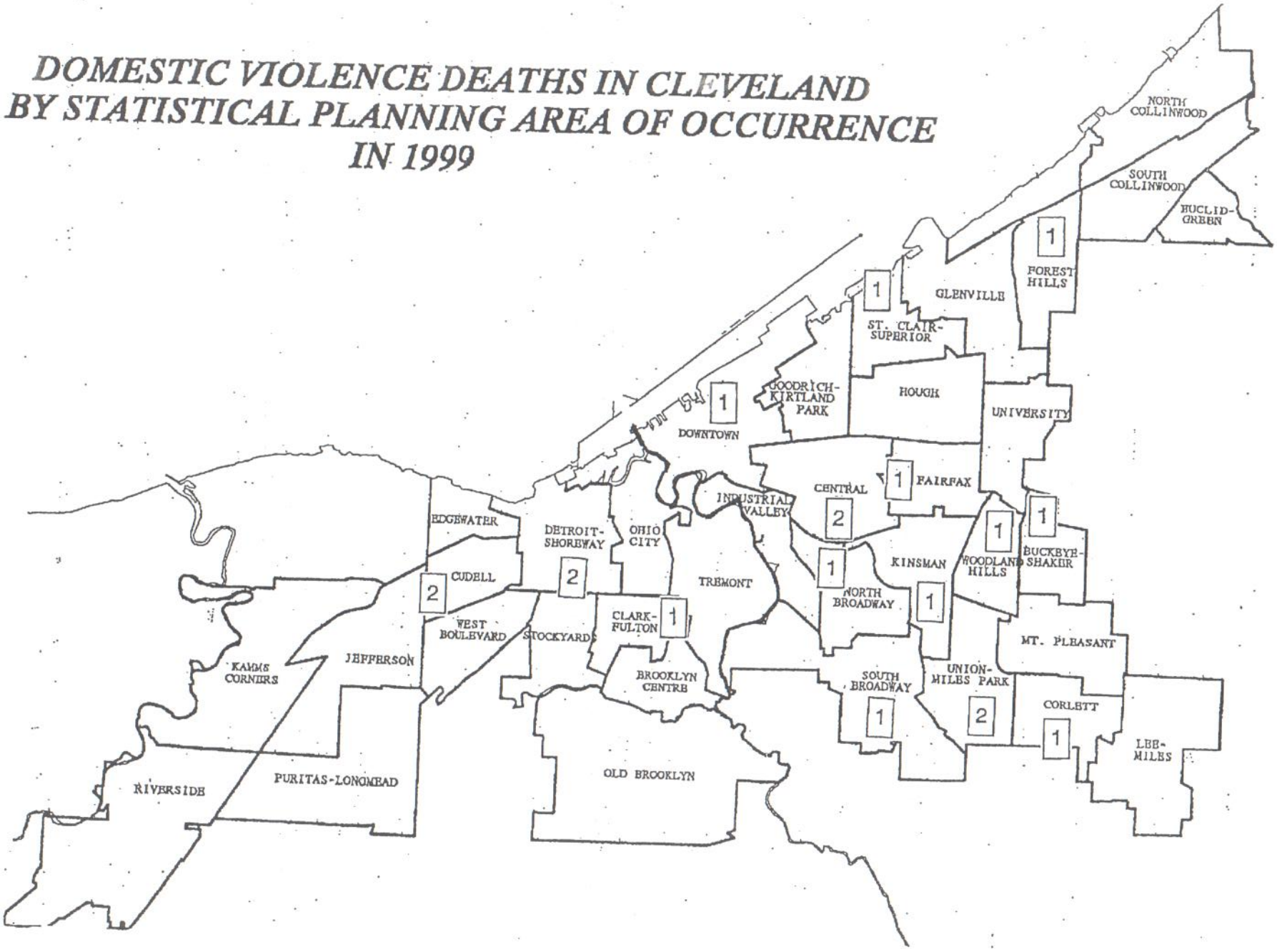
parentheses indicate past members

DOMESTIC VIOLENCE DEATHS IN CLEVELAND BY STATISTICAL PLANNING AREA OF OCCURRENCE IN 1999



DOMESTIC VIOLENCE DEATHS IN CLEVELAND BY POLICE DISTRICT IN 1999

By Residential Address	
District #	Frequency
1	3
2	2
3	3
4	6
5	1
6	1

By Occurrence Address	
District #	Frequency
1	3
2	2
3	4
4	5
5	4
6	1