DOMESTIC VIOLENCE RELATED HOMICIDES

IN CUYAHOGA COUNTY, 2000

The 5th Annual Report of the

DOMESTIC VIOLENCE FATALITY REVIEW COMMITTEE
of Cuyahoga County

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DOMESTIC VIOLENCE RELATED HOMICIDES in 2000

The Annual Report of the
Domestic Violence Fatality Review Committee of Cuyahoga County

ACKNOWLEDGMENTS

The report reflects the input, review and approval of all committee members. A full membership roster is attached on p.21.

This report was drafted and edited by Marcia Petchers, with assistance from Larry Bruner.

The Committee's work was well divided among the members. The Case Screening Committee (with Dr. Balraj, Lt. Thomas Brickman, Lt. Joseph Petkac) screened cases to be reviewed. Lt. Brickman contacted the suburban police departments and scheduled their presentations. Judy Nash contacted suburban Probation Departments. Sue DiNardo, Nancy Fleming, Kelly Kimble, John Neill, and Maggie Tolbert as the Operations Subcommittee took care of the data collection and coding procedures. Nancy Fleming and her staff assistant organized and coded the data files. John Neill provided the geographic case distribution maps. Nancy Fleming and Marcia Petchers analyzed the data for the report.

In addition, the Committee acknowledges the help of the following other cooperating agencies that shared data with the committee: Police Departments of Euclid (Sergeant James Baird and Detective Joe Bensi), North Olmsted (Detectives James Yost and Mel McGrath), Parma (Detective Andrew Suchan), Parma Heights (Sergeant Jeff Krepina), Shaker Heights (Detective Marvin Lamuel), Warrensville Heights (Detective Mike McKeon); the YWCA of Cleveland (Ms. Bonnie Morris / Ms. Judy Masnick), DOVE Program of the Family Violence Center (Ms. Diane Miller / Mr. Scott Lee), East Side Catholic Center and Shelter (Ms. Michelle Clay), and Jewish Family Services Association's Project Chai (Ms. Brynna Fish); Angeline Christian Home (Ms. Pat Hissom), Zelma George Family Shelter (Ms. Maureen Hunt), and Salvation Army (Ms. Sonya Rembert).

Finally, the Committee appreciates the additional assistance of other agency staff who have provided support to the committee's efforts: Ms. Charlotte Mann, Pam Vacca and Eve Bonvissuto of the Witness Victim Service Center, Ms. Elizabeth K. Tidwell, Ms. Joyce Avondet and Ms. Kathy Fana of the County Coroner's Office, and Det. Frances Stevers of the Cleveland Police Homicide Department.

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

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For follow-up issues or further discussion about the Committee and its work, contact any listed committee members or Dr. Marcia Petchers, Consulting Services, phone/fax 216/231-5862 MKPetchers@aol.com.

INTRODUCTION

The Committee is issuing its fifth Annual Report. The Committee is hosted by the Cuyahoga County Coroner's Office, under the leadership of Dr. Elizabeth K. Balraj, Cuyahoga County Coroner. The Committee could not operate without the support volunteered by the current 24-member public and private agencies and department representatives serving on the Committee.

The Domestic Violence Fatality Review Committee has met monthly to review records of domestic violence related homicides. The Committee membership is representative of diverse public and private agencies and offers broad interdisciplinary expertise.

All Domestic Violence Fatality Review Committee members have signed and adhere to confidentiality agreements. The Committee operates by consensus and is inclusive of all points of view. Meetings are not public and the proceedings are confidential. Meetings are generally scheduled the first Tuesday of the month at 1:15 p.m. at the Coroner's Office.

Using data from multiple record sources, the Committee reviews all adult and child homicide 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.

Fatality review is a challenging and arduous process. The Committee prioritizes its continuing need for operating support to manage the research, investigation and reporting processes. The Committee continues to use this experience to improve the completeness and efficiency of the investigation.

BACKGROUND

The Domestic Violence Fatality Review Committee of Cuyahoga County was established in 1996. The all-volunteer Committee is self-governing and freestanding. The intent is to focus attention on domestic violence homicides in Cuyahoga County, the most extreme end of domestic violence. Similar fatality review committees have been formed and funded in major Ohio counties, and operate in many states around the country.

The State of Ohio does not yet 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. Advocacy efforts continue in Ohio advocating for a legislative mandate for domestic violence fatality review.

The Committee continues efforts to seek county and other funding. Financial support is needed for staffing and operating expenses.

MISSION

The mission of the Domestic Violence Fatality Review Committee of Cuyahoga County is to identify and constructively examine domestic violence related fatalities and to seek ways to prevent domestic violence cases from escalating into homicide.

The committee's charge is to track such deaths in the county, develop a better understanding of why they occur and learn how they can be reduced or prevented.

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 lethality risk assessment***
- ***Generate discussion and strategies for reducing domestic violence related homicides***

FATALITY REVIEW PROCESS

SCOPE OF WORK

The Domestic Violence Fatality Review Committee reviews all county domestic violence related homicides. The process is one of fact, not fault finding or blaming. The Committee reviews any fatalities deemed to result directly or indirectly from a domestic violence incident or domestic relationship conflict. The Committee examines the domestic violence family conflict and the primary intimate partner relationship that brings about the homicide.

The Committee's focus is on Cuyahoga County cases ruled as homicides. Not all deaths due to domestic violence may have been detected or ruled as homicides as some may have escaped detection and 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 Committee reviews cases from the prior two years. Generally, the reviewed cases are closed criminal investigations with a final judicial disposition. Pending or open cases are reviewed only in a cursory fashion until the final judicial disposition is made.

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. The Committee realizes, however, that many domestic violence victims do contact and access service agencies and that help may well be instrumental in saving lives. 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 entail expanding the Committee's work and staff support. It might be very helpful to broaden our scope in the future to fully include domestic violence related suicides.

The Committee invites staff of other agencies to provide additional relevant information on specific cases as needed. The Committee's membership needs are reviewed annually. The Committee considers inviting additional agencies to join based on case review needs.

The review of the year 2000 domestic violence related homicides is complete. The results are reported herein. The annual report is approved by Committee members and disseminated through the Committee's representatives.

The Committee is continuing its review process. In the year 2003, the Committee is now turning its attention to domestic violence and related homicides from the year 2001. All members have gained valuable experience that continues to facilitate and expedite our next year's work.

CASE SCREENING

Since homicides are not currently categorized as domestic violence related, case screening must be done of all County Coroner's ruled homicide cases occurring in Cuyahoga County. Domestic violence is defined in accordance with the Ohio Revised Code (ORC 2919.25, see p.22). In addition, the Committee at its discretion includes cases closely related to domestic violence, i.e., homicides that are traceable to domestic violence.

A more inclusive definition allows the Committee to learn from cases that may have the same context, but are outside the legislative definition. These include cases in which the domestic abuse extended to effect the homicide of a collateral party.

Cuyahoga County's Child Death Review Committee (which tracks child deaths from a public health perspective) and the Domestic Violence Fatality Review Committee have some overlapping membership to facilitate coordination and minimize any duplication of efforts. In 2000, of the ten Cuyahoga County child homicides, eight were domestic violence related.

During the year 2002, the 94 Cuyahoga County ruled homicides from 2000 were screened. From these, 31 cases were classified as domestic violence related to the full Committee. These cases represent 33% of all homicides occurring in Cuyahoga County during the year 2000 and can be further categorized as follows:

- 14 involved intimate partners
- 10 involved family, relatives, or other household members
- 7 involved collateral parties (current or former intimate partners who killed their intimate partners or current or former partners or offspring)

In one homicide case, the suspect's suicide was part of our case review. However, the suicide is not counted in the review of 31 domestic violence deaths. This represented 0 .7% of the 138 ruled suicide cases in Cuyahoga County in 2000. In one other case, the suspect attempted suicide at the time of the homicide incident.

In another reviewed case, the perpetrator killed another victim in an earlier incident, to get the gun with which he killed the domestic violence victim the Committee counted. Although the prior victim arguably was related to the domestic violence, by a few hours, the additional homicide is not counted in our statistical review.

CASE REVIEW

The Fatality Review Committee's participating agencies search records to determine any contact with the victim, perpetrator and/or their families and significant others. All relevant information is presented at the case review. At the time of review, where other systems contacts are identified, the Committee contacts the involved agencies for more information.

The initial case presentation opens with the Coroner's report on mode and cause of death. This is followed by law enforcement, the County Prosecutor's disposition, Probation Departments,

Juvenile Court, Department of Family and Children's Services, 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 discusses each case, identifies risk factors, salient issues and need for any follow-up information. The Committee identifies any missing information to be collected and cases to be revisited at the subsequent case review.

The Operations Subcommittee records the data presented at the case review. Confidential 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 continued for the following month.

DATA SOURCES

The Committee searches selected existing records for the parties involved (victims, perpetrators, significant others) in the domestic violence related homicide cases. For each case, records are checked 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. The Committee also identifies and checks other identified service providers (hospitals, crisis services) whenever possible. Contacts include pre- and post-homicide.

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 of JFSA, local victims services providers, searched their available intake records including counseling, shelter, support groups, classes and advocacy. Records of the following local batterers programs were checked: the Cuyahoga County Batterers Intervention Program, DOVE Program of The Family Counseling Center, YWCA of Cleveland and Domestic Violence Center. Women's shelters West Side Catholic Center & Shelter, Angeline Christian Home, Zelma George Family Shelter and Salvation Army also searched their records. MetroHealth Hospital was the only participating medical facility. Where other service contacts were noted in the case record, these were also counted in the data.

Coroner and police homicide records of victims are factual, with dates, times, locations and situational details. When possible, the Committee further identifies and verifies prior agency contacts and domestic violence histories. In some cases, the victim and/or perpetrator may have had prior incidents of domestic violence with each other and/or other intimate partners or family members. The Committee checks local police dispatch records for all reported prior calls to victims' or perpetrators' addresses.

The Committee queries agency computerized management information systems on all cases, comparing victim and perpetrator names under relevant surnames and aliases. The Committee reviews, and if necessary corrects, permanent addresses and social security numbers. The Committee records the names of family members. When there is residential movement across jurisdictions, the Committee checks with police jurisdictions of prior residences. The Committee searches criminal histories through local, county, Ohio and other state databases.
If possible the Committee also includes other information such as marital and employment status.

The coroner's autopsy provides test results for victims' alcohol and drug toxicology levels. The Committee then also checks, if available, perpetrator/ suspect substance use at the time of the incident and past abuse for victim and perpetrator through secondary sources.

Police and prosecutors share with the Committee prior investigations and prosecutors' interviews with family members, friends and neighbors, employers and other individuals who are familiar with the cases. At monthly meetings, Committee members also obtain facts relevant to the case by debriefing guest presenters about contacts with and knowledge of the family and friends.

DATA LIMITATIONS

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 the Committee reports 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. All involved parties may not have been eligible for any particular service, protection or other benefit on which data was collected. Thus, it should not be implied that the absence of a particular systems contact means a service actually could have been obtained but was not.

The research does not show whether victims attempted to access services but were not served, nor 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 psycho-social 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.

Not all police who respond to calls submit formal police reports. Some police reports are not titled domestic violence in the record but may have actually been domestic violence related such as criminal damaging, robbery, rape and/or felonious assault.

The Committee's ongoing efforts are constrained by the confidentiality of records 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. Specifically, agencies that participate on the Committee but are constrained from sharing data include the Cuyahoga County Mental Health Board including Children Who Witness Violence and Mental Health Services. However, wherever possible such information has been provided by secondary reports. Only a legislative mandate for domestic violence fatality review would enable obtaining the full range of confidential records.

In secondary records, it is difficult 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 does not have direct contact or interviews with surviving family members and significant others.

FINDINGS

FINDINGS INTRODUCTION

Data is from 31 domestic violence related homicides, (33%) of the coroner's 94 ruled homicide cases from Cuyahoga County in 2000.

The findings section outlines case characteristics, relationship subtypes, profiles of victims and perpetrators and systems contacts. Results are presented in the aggregate with either the actual numbers of cases and/or percentages given to reflect a particular condition. Where used, percentages have been rounded and may not always add to 100%.

CASE CHARACTERISTICS

[Four cases had two or more alleged perpetrators. All were considered within these case characteristic statistics.]

Mode of homicide: 11 (35.5%) stabbed, 9 (29.0%) shot, 7 (22.6%) assaulted, 1 (3.2%) strangled, 1 (3.2%) poisoned by carbon monoxide, 1 (3.2%) drowned, 1 (3.2%) fell-due to maternal neglect. This compares to 17% stabbed, 55% shot, 14% assault, 1% strangled, and 13% other across all county homicides.

24 (77.4%) of the homicides occurred within the City of Cleveland, which comprises 34% of the county's population. 7 cases (22.6%) occurred in other municipalities in Cuyahoga County: 1 in Shaker Heights, 2 in Euclid, 1 in Warrensville Heights, 1 in North Olmsted, 1 in Parma and 1 in Parma Heights. Maps showing cases by municipality and in more detail for the City of Cleveland's Statistical Planning Areas and Police Districts are in an appendix on pages 25 and 26.

20 (64.5%) of the homicide dyads involved at least one African-American victim and/or perpetrator. African-Americans comprise 28% of the county population. All but three of the homicides (90.3%) occurred within the same racial/ethnic groups.

Females comprised 52% of the domestic violence homicide victims although females comprised only 29% of all county homicide victims.

29 (93.5%) of domestic violence deaths occurred at home, 25 (80.6%) of these at the suspect or victim's home, 4 (12.9%) at another home. 1 occurred on the street and in 1 case, the body was found in a car, location of homicide unknown. This compares to 52 (55.3%) of all 94 county homicides that occurred at home.

Alcohol or other drugs were involved in at least 27 (87.1%) cases based on a combination of indicators. In 26 (83.9%) of the cases, victims and/or perpetrators had prior reported histories of substance abuse; 15 (48.4%) cases, victims and/or perpetrators were reported as under the influence at the homicide incident; 10 (32.3%) cases, victims' toxicologies tested positive.

RELATIONSHIP OF VICTIM & PERPETRATOR

Homicides are grouped into three major categories based on the type of relationship involved. 14 domestic/intimate partner, 10 family/relatives/other household members and 7 collateral party homicides are represented. Demographics are summarized for each of the three subgroups in a chart on page 23. The relationship types and status within each category is outlined below.

- 14 involved intimate/domestic partners
  - 11 current
    - 4 boyfriend killed girlfriend
    - 3 girlfriend killed boyfriend
    - spouses
      - 3 husband killed wife
      - 1 wife killed husband
  - 3 ex-boyfriend killed ex-girlfriend

In all 14 intimate partner cases, couples were opposite sex.

11 (78.6%) of the 14 intimate partner homicides occurred within intact relationships, and of these, 4 (28.6%) victims and 1 (7.1%) perpetrator were contemplating or attempting a separation at the time of the homicide incident. 3 (21.4%) of cases occurred within separated relationships.

- 10 involved relatives, family or other household members
  - 4 mother killed minor child (lived together)
  - 2 father killed minor child (did not live together)
  - 3 adult son killed mother (lived together)
  - 1 adult great nephew killed uncle (lived together)

In the 10 family/household homicides, 6 (60%) involved a parent killing their own minor child, 3 (30%) were adult son killing mother, and 1 (10%) involved other relatives.

8 were in the same household and of these, 2 (20%) victims and 1 (10%) perpetrator were contemplating or attempting a relationship separation at the time of the homicide incident. 2 perpetrators were non-custodial biological fathers who lived in different household than their minor child victims. 1 case had a collateral party (non-custodial parent) threatening to take custody of the minor child from the custodial parent.

Of the 8 minor victims (under age 18), fathers killed 4, mothers killed 2, mother's boyfriend killed 1 and an adult boyfriend killed 1 teen girlfriend.

- 7 involved collaterals
  - 6 current boyfriend killed his current girlfriend's
    - 2 ex-boyfriend
    - 1 ex-husband
    - 1 estranged husband
    - 1 ex-boyfriend's adult son
    - 1 minor child
  - 1 ex-boyfriend killed (his ex-girlfriend's) current boyfriend

6 (85.7%) collateral death cases involved separated or terminated relationships, 1 was in an intact relationship. In 6 (85.7%) of the collateral deaths, both perpetrator and victim were male.

VICTIMS PROFILE

[Each victim is treated as one case.]

Demographics 23 (74.2%) were adults, 8 (25.8%) were minors (under age 18).

Age range was from infant to 92 years. 6 (19.4%) were ages 69-92.

18 (58.1%) of the victims were female, 13 (41.9%) were male. 12 females comprise 52.2% of the adult victims, 6 (75%) of the child victims were female. 1 (3.2%) victim was pregnant at the time of the homicide.

16 (51.6%) were African-American, 1 (3.2%) Hispanic (white), 14 (45.2%) other Caucasian.

10 (32.3%) were on public assistance at the time of the homicides; in all, 15 (48.4%) had public assistance histories.

Psycho-Social 1 (3.2%) had a psychiatric diagnosis, 1 (3.2%) mental retardation/developmental disabilities, 1 (3.2%) chronic medical illness and 1 (3.2%) other disability.

4 (12.9%) had establishment of parent-child relationship in Juvenile Court. 1 had been previously adjudicated delinquent.

2 (6.5%) were divorced from their perpetrator.

7 (22.6%) had reported alcohol/drug abuse histories. 7 (22.6%) tested positive for alcohol and 3 (9.7%) for other drugs upon autopsy toxicology.

1 (3.2%) had a prior known attempted suicide.

4 (12.9%) had prior citizen contacts with the City of Cleveland Prosecutor's Intake Office unrelated to the homicide case, including 1 (3.2%) victim as a respondent.

7 (22.6%) had an unstable childhood family environment.

Criminal History 8 (25.8%) had reported criminal histories. 3 (9.7%) had a prior weapons offense, 4 (12.9%) had a prior alcohol and other drugs related offenses. 1 (3.2%) had a prior criminal record as a perpetrator of sex crimes.

7 (22.6%) had prior incarceration histories.

3 (9.7%) had reported domestic violence incidents in the current relationship. 8 (25.8%) had history as domestic violence perpetrators.

6 (19.4%) had a prior probation history; none were currently on probation. 1 (3.2%) had a prior probation violation.

3 (9.7%) had at least one prior capias (outstanding court order), none had outstanding warrants.

1 (3.2%) was the subject of a current protection order. 3 (9.7%) had prior orders.

PERPETRATORS PROFILE

[Only the primary suspect is reflected in these statistical profile and systems contacts sections.]

Demographics 100% were adults.

Age range was 18 to 90 years. 2 (6.5%) perpetrators were ages 74-90.

23 (74.2%) of perpetrators were male, 8 (25.8%) were female. 3 (37.5%) of the 8 female perpetrators acted in concert with a male alleged perpetrator.

19 (61.3%) were African-American, 1 (3.2%) Hispanic (white), 11 (35.5%) were other Caucasian.

4 (12.9%) were on public assistance at the time of the homicides; in all, 17 (54.8%) had public assistance histories.

Psycho-Social 7 (22.6%) had a psychiatric diagnosis, 2 (6.5%) mental retardation/ developmental disabilities, borderline IQ or learning disability, 4 (12.9%) another chronic illness.

4 (12.9%) had establishment of parent-child relationship in Juvenile Court, 7 (22.6%) had previously been adjudicated delinquent.

2 (6.5%) perpetrators were divorced related to the victim, 4 (12.9%) were divorced unrelated to the victim.

19 (61.3%) had an alcohol and other drug abuse history, 11 (35.5%) were reported under the influence at time of homicide, 3 (9.7%) unknown.

1 (3.2%) perpetrator committed suicide, 1 (3.2%) attempted suicide at time of homicide; 4 (12.9%) had known multiple suicide attempts, 2 (6.5%) died of natural causes prior to trial.

9 (29.0%) had an unstable childhood family environment.

Criminal History 22 (71.0%) had reported criminal histories. 5 (16.1%) had a prior weapons offense. 12 (38.7%) had substance related offenses. 3 (9.7%) had a prior criminal record as a perpetrator of sex crimes.

11 (35.5%) had prior incarceration histories.

2 (6.5%) had pending domestic violence cases, 15 (48.4%) had reported previous incidents.

17 (54.8%) had a prior probation history; two were currently on probation, 6 (19.4%) had a prior probation violation and 1 (3.2%) a current probation violation.

10 (32.3%) had at least one prior capias [outstanding court order], 1 (3.2%) a current warrant, 3 (9.7%) were out on bond.

3 (9.7%) were the subject of a current criminal protection order, 2 (6.5%) had prior orders.

OTHER SYSTEMS INVOLVEMENT PRE-HOMICIDE

4 victims (12.9%) (including 1 (3.2%) as respondent and 3 (9.7%) as perpetrators had prior citizen contacts with the City of Cleveland Prosecutor's Intake Office; all unrelated to the homicide case.

Of the 8 child homicide victims, Department of Children and Family Services (DCFS) contacts consisted of: 2 (25%) were open abuse or neglect cases, 3 (37.5%) had been closed within 12 months of the homicide and 1 (12.5%) of these had a new referral; 3 (37.5%) cases had no contact.

1 adult victim also had an active DCFS case (as a mother) at time of homicide. 1 adult victim had a prior DCFS case as a child and 1 as an alleged perpetrator.

2 (6.5%) perpetrators were in prior DCFS custody as minors and 2 (6.5%) perpetrators had prior DCFS allegations of abuse or neglect.

1 (3.2%) case had a police run to the address, 1 (3.2%) called police with no resulting run to address, each during the incident leading to homicide; 6 (19.4%) other cases had prior police calls to the address.

Witness Victim Service Center had served 3 (9.7%) victims as prior victims, 1 with the same perpetrator, 2 with different perpetrators.

No cases had known stays by victims at domestic violence shelters, 1 (3.2%) victim had a prior stay in a women's homeless shelter. 1 (3.2%) perpetrator had been previously served by a men's homeless shelter.

Victims and perpetrators had multiple prior hospital contacts (at least 10 (32.3%) victims and 11(35.5%) perpetrators had known prior contact).

1 (3.2%) victim had a safety plan [steps to protect self or escape] and 1 (3.2%) intended victim in a collateral homicide had a panic button [one phone button to call 911 in an emergency].

2 (6.5%) perpetrators and 2 (6.5%) victims had completed batterers treatment or anger management programs.

1 (3.2%) victim had prior skilled nursing care at home.

2 (6.5%) victims and 7 (22.6%) perpetrators had prior mental health, psychiatric and/or counseling treatment (in some cases a long time prior to the homicide).

4 (12.9%) victims and 5 (16.1%) perpetrators had prior substance abuse treatment or detoxification program.

CASE DISPOSITIONS

Adjudications: 23 (74.2%) sentenced: 23 (74.2%) incarcerated, 0 community control.

Twenty-three sentenced cases: 7 (22.6%) aggravated murder, 3 (9.7%) murder, 6 (19.4%) voluntary manslaughter, 6 (19.4%) involuntary manslaughter, 1 (3.2%) reckless homicide.

Eight (25.8%) not sentenced: 1 (3.2%) prosecution abated by suicide, 2 (6.5%) prosecutions abated by death, 4 (12.9%) no billed, 1 (3.2%) dismissed Rule 29 (court acquitted based on insufficient evidence).

MAJOR CONCLUSIONS

A summary of major pattern trends among domestic violence related homicides, based on the data collected from this year's case records, is presented below. The conclusions should be considered in unranked order. Some are lethality risk factors. Not all comments are 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.

- Home is the highest risk location for domestic killings. This is contrary to the public perception and fear of crimes outside of their homes. Almost exclusively, domestic violence fatalities (93.5%) occurred at home. [This compares to 55% of all county homicides].
- Just over three-quarters of cases (77.4%) were in the City of Cleveland police jurisdiction, which comprises 34% of the county's population. In 2000, Cleveland's 5th Police District had a domestic violence related homicide rate twice as high as other areas of the city.
- Access to firearms and other weapons is a lethality risk factor. In 2000, the primary mode of homicide was stabbing (35.5%) followed by shooting (29.0%). In prior years, shooting was the primary mode of homicide. [This compares to 17% stabbed, 55% shot, 14% assault, 1% strangled, and 13% other across all county homicides.]
- Alcohol or other drugs were involved in at least 27 (87.1%) cases based on a combination of indicators. A high percentage of the victims and perpetrators were characterized by long-term alcohol, poly-drug use and/or alcohol and other drug-related offenses.
- The threat of separation as well as actual separation is a lethality risk factor. Less than half of victims and perpetrators had actually terminated relationships at the time of homicide. Related risk factors include: relationship triangles, transitioning from one relationship to another, blended families with stepchildren and offspring from multiple relationships.
- Many of both homicide victims and perpetrators had extensive alleged and reported domestic violence histories, with alleged or reported family/relationship threats, disputes and other violence complaints. Yet:
    - Homicide victims and perpetrators had limited or no known recent safety plans, use of panic buttons, services from domestic violence shelters, counseling, justice system advocacy or batterers programs.
    - There were few or no documented domestic violence-related police runs to address or citizen complaints to prosecutors.
    - There was little or no use of civil remedies such as protection, divorce, custody or visitation orders.
- In almost two-thirds (64.5%) of county-wide cases, at least one victim and/or perpetrator was African-American. [This compares to African-Americans comprising 28% of the county population].

- All but three of the homicides (90.3%) occurred within the same racial/ethnic groups.
- Females comprised 52% of the domestic violence homicide victims. [This compares to females comprising only 29% of all county homicide victims.]
- A high percentage of cases [compared to the general population] involved a victim and/or perpetrator with a previously diagnosed condition including: psychiatric, mental retardation, borderline IQ, learning disability, chronic medical illness, seizures or other disability.
- Few child homicide victims had open neglect/abuse cases and those who did had limited or no recent services with the Cuyahoga County Department of Children and Family Services.
- Elderly homicide victims had no historical referrals to the Cuyahoga County Department of Adult Protective Services (APS). However, victims over age 50 would not necessarily have been deemed incompetent or functionally impaired to be eligible for APS services.
- At least half of the cases involved at least one party with early childhood family instability as indicated by involvements with Department of Children and Family Services, Juvenile Court and/or Department of Human Services.
- Both homicide victims and perpetrators had limited or no known recent criminal justice system contacts. Many perpetrators and to a lesser extent victims had criminal histories for a variety of offenses including assault, theft, alcohol and other drug-related and domestic violence.

ACTION STEPS AND RECOMMENDATIONS

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

Central to our Committee's work is the establishment of key action steps. The Committee lists strategies for cross-systems follow-up / monitoring / assessment, education / training, data collection / research, management information systems, law enforcement, criminal and juvenile justice systems, medical and social service providers. Some action steps would entail additional costs or budget authority. Others involve existing procedures and can be put in place without budget impact.

CROSS-SYSTEMS

FOLLOW-UP / MONITORING / ASSESSMENT

- Create, implement, and evaluate innovative domestic violence prevention and risk reduction strategies.
- Increase outreach to provide domestic violence information packets to victims and other at-risk populations.
- Conduct records reviews of multiple public systems across departments and jurisdictions to obtain relevant case histories on victims, perpetrators of domestic violence and their significant others. Require and encourage more frequent use of lethality assessment across systems dealing with abuse cases.
- Encourage closer collaboration and information sharing, within the limits of confidentiality, between and among agencies working to prevent and reduce domestic violence.
- Further investigate the capability for key community service providers to develop a uniform process for communication, information sharing, intervention and follow-up.

EDUCATION / TRAINING

- Encourage cross training of domestic violence, child/elder abuse service and support workers about interrelated risk factors.
- Promote gun control and gun safety community wide.
- Encourage local public and private schools to expand their health curricula to include risk prevention for child and elder abuse, substance abuse and domestic violence.
- Conduct general community media campaigns and social services outreach on child and elder abuse and domestic violence issues, emphasizing lethality and risk factors and available resources for victims and perpetrators.
- Target school-age children with focus on anger management, coping skills and conflict resolution.

- Increase awareness of available services by providing training in such settings as churches, community centers, schools, hospitals and clinics across the county, especially in high fatality geographic areas.
- Encourage mandatory child and elderly abuse reporting following legal requirements in health care, hospitals, private medical practices, human services, domestic violence and educational systems.

DATA COLLECTION / RESEARCH

- Identify social, cultural and economic barriers or gaps that may limit or inhibit service access in high-risk populations and areas.
- Assess community knowledge of services provided by law enforcement, criminal and juvenile justice, medical and social service systems that assist victims of domestic violence.

MANAGEMENT INFORMATION SYSTEMS

- Create a comprehensive linked database, integrated across systems to obtain all relevant case histories from agencies working with victims or perpetrators of domestic violence (VINE, LEADS, NCIC) within limits of confidentiality.
- Implement fully and keep current a county-wide computerized system of protection orders.
- Centrally computerize, fully implement, and keep updated all local police, sheriffs, and metropolitan law enforcement records. Integrate law enforcement records across systems so each jurisdiction can access full history of offenders.
- Report and centrally computerize, fully implement, and keep updated all child abuse, elder abuse and domestic violence records. Use a county-wide standard incident report form and relational computer system within limits of confidentiality.

LAW ENFORCEMENT

- Monitor for consistent enforcement of Ohio's preferred arrest and/or Cleveland's mandatory arrest policies across the county with increased vigilance in Cleveland and other high-crime risk areas and with prior domestic abusers. Continue ongoing training of officers on domestic violence arrest policies.
- Encourage follow up on all police calls, weapons threats, 911 calls (including cancelled calls) and custodial parent complaints of child kidnapping.
- Train law enforcement to file domestic violence police reports on all related dispatched calls, make arrests whenever probable cause exists.
- Strictly enforce the Brady Bill provision, where applicable, to prohibit certain convicted domestic violence perpetrators from acquiring or possessing firearms.
- Standardize background information reports on domestic violence, mental illness, substance abuse and suicide attempts obtained by homicide and other police units.
- Make a standardized practice of referring parties to appropriate domestic violence victim assistance /advocacy programs. Educate law enforcement about the availability of this

service. Require victim advocates be informed of the identity of domestic violence victims.

CRIMINAL AND JUVENILE JUSTICE

- Require Clerks of courts to attach dispositions to criminal records, especially in domestic violence cases, so appropriate charges can be filed on repeat offenders.
- Encourage more evidence-based domestic violence prosecutions, even in cases where victim does not file charges or participate with prosecutors.
- Charge and prosecute domestic violence offenders 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.
- Train probation officers and investigators to conduct pre-sentence and bond investigations on domestic violence offenders with extensive criminal or drug use histories; include assessments of domestic violence risk, psychiatric/mental problem and substance abuse.
- Determine appropriate eligibility for batterers' intervention, anger management, induced-violent behavior and other programs, as appropriate.
- 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 conditions and substance abuse history.
- Request court orders for mandated treatment recommendations as a condition of probation. Avoid court orders for marital counseling in domestic violence cases.
- 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.
- Streamline probation violations processing through the courts by expediting capias requests after an offender's failure to report to a probation officer or non-compliance with terms of probation including treatment mandates.
- Expand Juvenile Court's use of community resources for resolving parental custody, paternity issues, juvenile delinquency/unruly cases, and treatment services for adolescents.

SERVICE PROVIDERS

MEDICAL

- Make referrals and linkages to appropriate programs for domestic abuse.
- Psychiatric assessments should include inquiries about lethality risk factors and access to weapons when spousal abuse is found.

SOCIAL SERVICE

- Monitor and follow up on all child, elder and spousal abuse cases reported to systems to consistently ensure services were provided and/or cases are kept open as long as lethality risk remains. Monitor safety plan. Assess child in person and follow up with related domestic violence case service providers before case closure.
- Consistently investigate thoroughly protective services and child abuse/neglect referrals through direct contact with collateral contacts within the limits of confidentiality. Encourage staff follow-up of medical assessments.
- Increase education of victims of domestic violence about lethality risk assessment and available services; identify options and safety planning for making relationship transitions.
- Expand inter-agency case conferences for review of domestic violence cases, and develop domestic violence information sharing protocols, including child and elder abuse systems where appropriate.
- Develop strategies for increasing access to domestic violence services in high fatality geographic areas, helping link both victims and perpetrators to services.
- Refer child witnesses and victims of domestic violence to appropriate services, such as the Department of Children and Family Services, Department of Senior and Adult Services and the Children Who Witness Violence Program.
- Encourage programs that provide services to victims to follow-up with services referrals to meet the needs of surviving family members of homicide victims and perpetrators.
- Implement a county-wide advocacy program assuring that all victims have an advocate available to assist them after incidents of domestic violence.

MAJOR LESSONS LEARNED

The Committee is learning ways to improve lethality risk assessment. There are lessons to be learned from these case reviews, 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. That being said, these recommendations should not be taken to mean that previously occurring homicides were indeed preventable.

The statistics should remind us to honor those who have died, the children left without parents. No death should be in vain. The numbers on paper do not fully reflect the impact on the community of the many lives lost, or the meaning to family and friends who have survived and are affected by these fatalities.

The Committee has now reviewed five years, and results from 2000 mirror the four prior years in most respects. A consistent pattern over five years adds confidence in the validity of the findings.

While the total number of homicides in Cuyahoga County decreased in the years 1996-2000, the number of domestic violence related homicides in general did not decrease. This resulted in an increase in the percentage of homicides related to domestic violence. However, the Committee's case finding methods may be identifying a larger number of domestic related homicides since the Committee began collecting data in 1996. The numbers are shown in the graph on p. 24.

The Domestic Violence Fatality Review Committee seeks funding for its operating and staff expenses to:

- Expand dissemination of this annual report.
- Advocate for statewide legislation to mandate domestic violence homicide review.
- Follow up on the Committee's systems recommendations.
- Validate and improve lethality risk assessment.
- Improve and extend Domestic Violence Fatality case review methods.
- Compare findings with similar fatality review committees.
- Research statewide and national trends.
- Determine how to identify and reach the high-risk population. Educate the community as to available services.

Our goal from these expanded and improved efforts is greater community safety. The Committee's work would focus community efforts on prevention to reduce the numbers of domestic violence homicides in Cuyahoga County. 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 annual report puts forward strategies for improved interventions for domestic violence, risk reduction for victims and better community control of offenders. The report offers conclusions about domestic violence fatalities, identifies lethality risk factors, 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.

DOMESTIC VIOLENCE FATALITY REVIEW COMMITTEE
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Cuyahoga County Adult Protective Services

○ - Case Screening Committee
* - Operations Subcommittee

from the Ohio Revised Code:

Domestic Violence
2919.25 ...

(E) ...

(1) "Family or household member" means any of the following:

(a) Any of the following who is residing or has resided with the offender:

(i) A spouse, a person living as a spouse, or a former spouse of the offender;

(ii) A parent or a child of the offender, or another person related by consanguinity or affinity to the offender;

(iii) A parent or child of a spouse, person living as a spouse, former spouse of the offender, or another person related by consanguinity or affinity to a spouse, person living as a spouse, or former spouse of the offender;

(b) The natural parent of any child of whom the offender is the other natural parent or is the putative other natural parent.

(2) "Person living as a spouse" means a person who is living or has lived with the offender in a common law marital relationship, who otherwise is cohabiting with the offender, or who otherwise has cohabitated with the offender within five years prior to the date of the alleged commission of the act in question.

Domestic Violence Related Homicides

in Cuyahoga County, 2000
Relationships Demographics

Relationship Type		*age*		*sex*		*race*		
victims		*range*	*note*	*Male*	*Female*	*Caucasian*	*Black*	*White/Hispanic*
Intimate	**I**	17-92	*a*	4	10	9	5	0
Family	**F**	0-75	*b*	7	3	5	5	0
Collateral	**C**	2-41	*c*	1	6	0	6	1
	V total	0-92		12	19	14	16	1
perpetrators								
Intimate	**I**	19-90	*d*	10	4	7	7	0
Family	**F**	18-52		6	4	4	6	0
Collateral	**C**	20-37		7	0	0	6	1
	P total	19-90		23	8	11	19	1

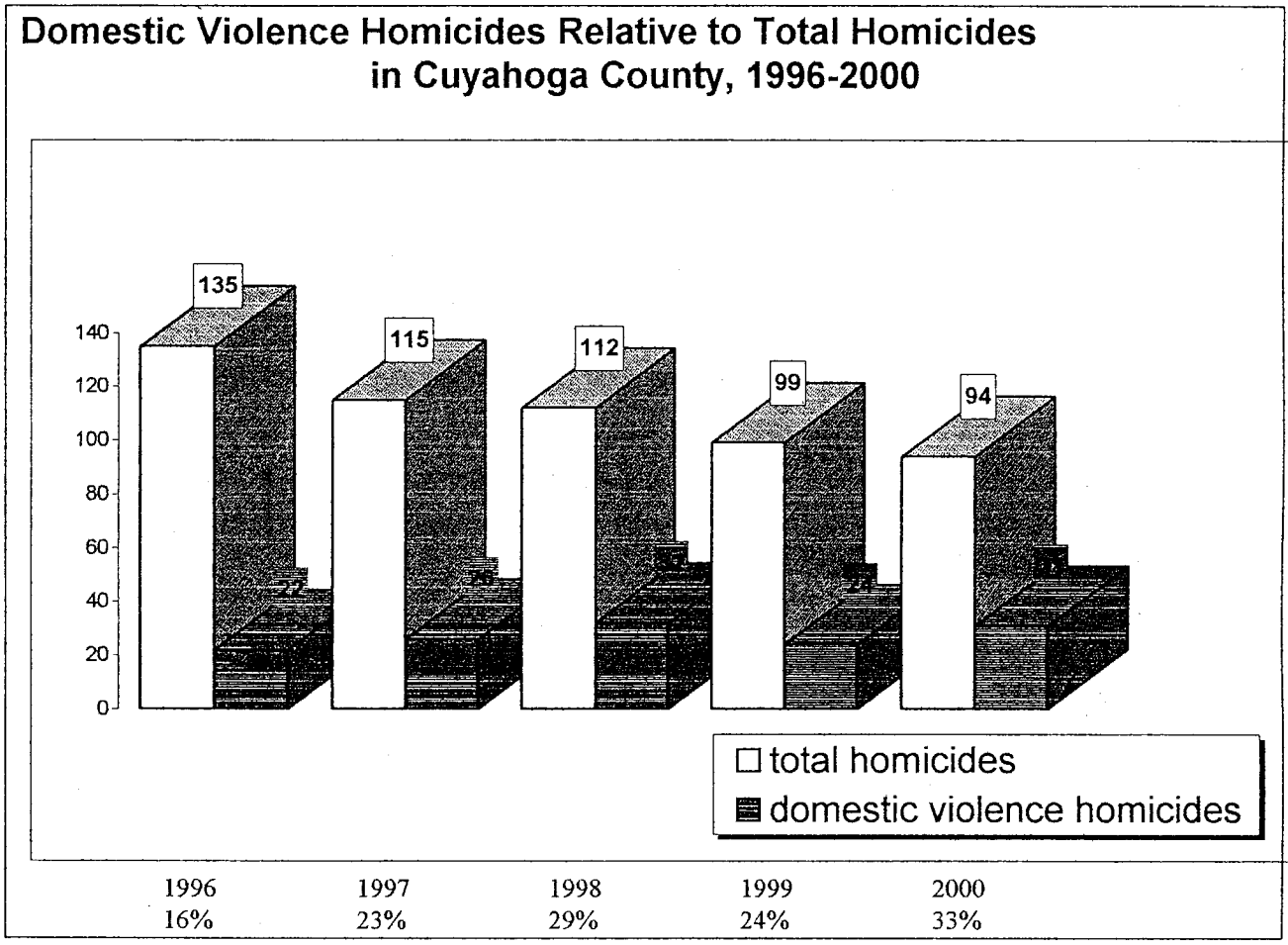
		occurrence		*mode*				
		Cleveland	*Other Municipality*	*stabbed*	*shot*	*strangled*	*assaulted*	*other*
Intimate	**I**	9	5	6	4	1	3	0
Family	**F**	8	2	4	0	0	3	3
Collateral	**C**	7	0	1	5	0	1	0
	total	24	7	11	9	1	7	3

I 14 Intimate partners
F 10 Family, relatives, other household members
C 7 Collateral victims

n = 31

notes: a - 3 elderly, 10 adults, a pregnant teen
b - 3 elderly, 1 adult, 6 children
c - 6 adults, 1 child

d - 12 adults, 2 elderly



NOTES:

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Total homicides in Cuyahoga County as ruled by the County Coroner.

Domestic violence related homicides as reviewed by the Domestic Violence Fatality Review Committee.