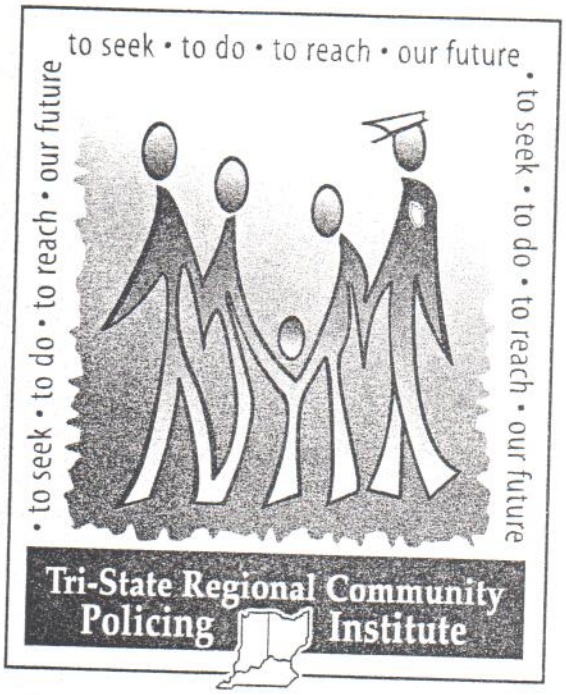
HAMILTON COUNTY DOMESTIC VIOLENCE COORDINATING COUNCIL

FATALITY REVIEW REPORT

Released October 1999



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Hamilton County Death Review Panel

REPORT

May 1999

INTRODUCTION

The Hamilton County Domestic Violence Death Review Team has met monthly since July 1996. Initial work included establishing operating guidelines, developing a data form to record information from the review and testing of the data form. The formal review process of cases began approximately one year later. Reviews of individual cases were carefully thought through with each case review lasting at least one and one half to two hours.

The Domestic Violence Death Review Team reviewed 13 deaths that occurred in the years 1994 through 1996. Cases selected for review included all cases which were identified by law enforcement as domestic violence cases. These thirteen cases only included intimate partner violence; elder and sibling deaths were not review. Child deaths also were not reviewed by this team as these deaths are reviewed by the Hamilton County Child Fatality Review Team.

As some of the deaths occurred as long as four years ago, it was not always possible to get all the information the Team wanted to collect. However, in most instances the Team was able to access the majority of information needed to perform a comprehensive review.

The following is a summary of some of the more significant information collected on the reviewed cases.

DEMOGRAPHIC INFORMATION

- Of the 13 cases reviewed, 11 victims were female and two were male. Ages of the victims ranged from 20 to 71, with the average age being 41. Six victims were Caucasian and seven were African American.

- In eight cases, the victim was either married to the perpetrator or living with the perpetrator. In three cases, the perpetrator was not a live-in partner; and in one case, the perpetrator was an ex-spouse. In one case the relationship was described as "other," with the perpetrator believing the victim to be his girlfriend and the victim describing him as a stalker.

- In five of the thirteen cases reviewed, the victims' children were living in the victims' homes. In four of those instances, the perpetrator was also a parent of the victims' children. In one case, this information was not available. Other individuals were also living in the home in four instances.

- In one instance, the victim was pregnant by the perpetrator at the time of the death. In seven cases, the victims were employed. In two cases, the victims were unemployed. In two cases, the victims were on public assistance. The source of income and employment status for two victims was unknown.

INFORMATION RELATED TO FATALITY INCIDENT

- In six cases, the cause of death was gunshot wounds. In three cases, the cause of death was stabbing. In three cases, the cause was blunt trauma and in one case the cause of death was strangulation.

- In 11 cases, the incident occurred in the victims' home. In the remaining two cases, the deaths occurred in the homes of the victims' parents. Five of the incidents occurred in the bedroom, four in the family or living room and the others were in various other rooms or immediately outside the house.

- At four of the deaths, children were present at the scene. In three of those instances, the children actually witnessed the incident. Other adults or relatives were present in four other cases.

PRIOR VIOLENCE

- In five cases, the police had been called to the victims' homes for domestic violence or related charges, prior to the victims' deaths. Additionally, police were called for similar reasons to one perpetrator's residence who had a different address from the victim.

- Ten of the thirteen perpetrators had prior police records. In most of these cases, there was more than one charge. The offenses were multiple and varied, but the largest groupings were as follows: five perpetrators had felonies that involved violence resulting in a charge other than domestic violence; four perpetrators had previous domestic violence charges; three perpetrators had charges related to substance abuse and six perpetrators had charges that involved criminal trespassing, threats and other misdemeanors of that type.

- In five cases, the previous charges were related to violence against the victims. In four of the five cases, the previous charges were domestic violence. All of the previous domestic violence charges were dismissed and in three cases this was due to the victims' reluctance to testify due to stated fear of the perpetrator. In one of the three cases, the victim requested dismissal telling the court she was in fear of the perpetrator.

- In four cases the victims had a previous record. These were all traffic violations except for one which involved theft.

SUBSTANCE ABUSE

- In four instances both the perpetrator and the victim were under the influence of either alcohol, illicit drugs or both at the time of the fatality. In three cases, only the perpetrator was under the influence, and in two cases only the victim was under the influence.

- There was also a history of substance abuse by the perpetrator in eight cases. In two cases the victim also had a history of substance abuse.

CHARGES RELATED TO DEATH

- Criminal charges were filed in eleven cases. In the other two cases no charges were filed as the perpetrators committed suicide after killing the victims. Nine murder charges, one involuntary manslaughter charge and one voluntary manslaughter charge were filed.

- Ten perpetrators were convicted. Some of the convictions were for lesser charges than the original charge. In one case the perpetrator was found not guilty by reason of insanity.

AGENCY INVOLVEMENT

- In the five years prior to the victims' deaths, many victims and perpetrators had contact with agencies in the community. These contacts were varied and sometimes the victim or perpetrator had contact with multiple agencies.

- Six victims had contact with Women Helping Women, four victims had contact with Domestic Relations Court, three victims had contact with law enforcement agencies, three with Municipal Court, and three with either the City or County Prosecutor's Office. In addition, Common Pleas Court, Children's Services, a mental health provider and a medical provider each had one contact with a victim. None of the victims ever resided at the YWCA Battered Women's Shelter.

- Ten perpetrators had contact with law enforcement agencies, six had contact with Municipal Court, eight with either the City or County Prosecutor's Office, five with Common Pleas Court, three with the YWCA Amend Program, three with Domestic Relations Court, one with a mental health provider and one with a medical provider.

ISSUES IDENTIFIED

There were several issues identified during the Team review related to the deaths of the 13 victims. Again, these issues were varied and often more than one issue was listed for each case. The details of these issues are as follows:

- In four cases, substance abuse was known to be a problem for the perpetrator.
- In one case, substance abuse was known to be a problem for the victim.
- Interagency communication between law enforcement agencies was found to be an issue in four cases.
- In four cases, there was a history of domestic violence related charges. The majority of those cases were dismissed.
- Utilization of services for perpetrators was found to be an issue in four cases.
- In one case each, services for elders, parole accountability, education about elder abuse and education about domestic violence was found to be an issue.
- In three of the four cases involving prior domestic violence against the victim by the perpetrator, the victim had been a reluctant witness – that is, had testified for the defendant, changed their story, or had not wanted to testify at all.

COMMUNITY RESPONSE PROBLEMS

Community response problems were identified in seven of the 13 cases. More than one issue arose in several of the cases found.

- In four cases there were no court or probation ordered sanctions against the perpetrator.
- In one case there was a lack of communication between police departments from different counties.
- In one case there was a lack of domestic violence history recorded by the police department.
- In one case the YWCA Amend program was not used as a resource.
- In one case the judge ignored the recommendations of Amend, the request of the prosecutor and the fear of the victim.
- In one case the Amend assessment was not included in the court's decision making process.
- In two cases, there was lack of awareness on the part of family, friends and the victims of the seriousness of the perpetrator's behavior.
- In one case, there was a lack of assessment for mental health problems.
- In all prior cases involving domestic violence in which victims were reluctant to testify against the perpetrator, the cases were dismissed.

INDICATORS/PREDICTORS OF THE DEATH

In nine of the 13 cases there were indicators or predictors of the fatality as indicated below:

- In four cases there were threats by the perpetrator and in four cases there was substance abuse by the perpetrator.
- In four cases there was a history of previous violent or criminal behavior.
- In three cases a weapon (gun) was involved.
- In three cases the victim was separated from the abuser.
- In three cases there was a rapid escalation of the violence, including stalking of the victim or vandalism.
- In one case each, the perpetrator was reported to have expressed jealousy, did not complete the Amend program and had mental health problems.
- In addition, fear was expressed by the victim in two cases.
- In three of four cases involving prior charges of domestic violence against the victim by the defendant, the cases were dismissed.

CONCLUSIONS

The thirteen deaths known to be caused by domestic violence in Hamilton County from 1994 through 1996 are tragic. The goal of the Hamilton County Domestic Violence Death Review Panel is to identify common factors in these domestic violence fatalities in order to prevent future deaths. Thankfully, the number of fatalities in Hamilton County was small. Valuable information was gained from the review process. Ideally, this information can be used to decrease such future deaths/murders.

First, the review panel found that the local incidence of domestic violence deaths mirrors many of the national patterns of domestic violence deaths. For example:

1. In eleven of the thirteen cases, the victims were female.

2. There was a significant relationship between the victim and the perpetrator in nine cases, such as marriage, divorce or a live-in arrangement.

3. Previous domestic violence by the perpetrator was documented in six cases, and in most incidents was directed at the victim who died.

4. The majority of the fatalities (11 of 13) occurred in the victim's home.

5. The primary weapon used in the cases reviewed was a gun.

6. Substance use by the perpetrator, victim, or both, was known to be a factor in nine of thirteen cases (69%), particularly apparent by the perpetrators.

Continued:

7. The majority of perpetrators had prior criminal records.

8. The vast majority of the perpetrators charged criminally were convicted.

9. Many victims and perpetrators had contact with agencies in the community. However, the extent of the contact is unknown, so it is difficult to draw any conclusion about this issue.

10. Problems were identified in the community's response to victims in a majority of the cases.

11. The indicators/predictors of lethality found in a majority of cases were:
    - history of violence
    - threats by the perpetrators
    - substance abuse and/or mental health problems
    - separation from the perpetrator
    - rapid escalation of the violence
    - stalking behavior exhibited by the perpetrators

SUMMARY OF RECOMMENDATIONS

EDUCATION

The Team submits several recommendations for implementation by various professionals in the community. Education is a key theme of these recommendations with suggested educational efforts focused on the victim, friends and family of the victim and the general community. The Team also recommends educational efforts be made with court personnel and the medical community. The specific recommendations are as follows:

Victim

- ✓ Education concerning stalking: what it is, how to get help and how to develop a safety plan.
- ✓ Develop outreach programs for men with concerns about domestic violence.
- ✓ Education concerning development of a Safety Plan.

Friends and Family of Victim

- ✓ Education for those people who are aware of abuse about interventions and resources for victims of domestic violence.
- ✓ Education concerning development of a Safety Plan.
- ✓ Education about separation assault.

Community

General Education:

- ✓ Education about a loaded gun in the house related to domestic violence.
- ✓ Education about use of alcohol and or drugs and incidence of domestic abuse.
- ✓ Education about separation assault.
- ✓ Public education about verbal violence as a precursor of later physical violence.
- ✓ Education of community about reoccurring patterns of abuse and escalation of violence.

Courts:

- ✓ Education of courts about long term batterers treatment.
- ✓ Education of judges about reluctance and fear as lethality red flags.

Medical Community:

- ✓ Continued education of medical community about domestic violence.
- ✓ Education to encourage recognition of abuse during pregnancy.

ASSESSMENTS

Upon review, the Team found a lack of identification of domestic violence and secondary issues by the various professionals involved. The Team recommends more thorough assessments be completed; these being:

- Thorough assessment for mental health and substance abuse of perpetrator before sentencing for effective intervention.
- Thorough assessment of victim reluctance to testify.
- Universal safety evaluation by court or private attorney at time of filing for divorce.
- Lethality assessments need to be conducted at the pre-sentence, sentencing and treatment phases of the criminal proceedings.

CONCRETE INTERVENTIONS

Finally, the Team recommends thirteen concrete interventions to the community when dealing with victims and perpetrators of domestic violence. These are:

1. Take death threats seriously.

2. Develop and coordinate aftercare services for children witnessing the murder of a parent.

3. Effectively enforce parole/probation conditions.

4. Enforce clear and consistent legal consequences of non-compliance with court orders regarding the Amend program.

5. Develop a domestic violence database to collect interagency information.

6. Train employers to recognize domestic violence and take appropriate action, such as calling law enforcement, safety planning with the victim, etc.

7. Make lethality assessments available to the court.

8. Provide continued support for reluctant/fearful victims and witnesses.

9. Increase networking between domestic violence service providers such as mental health, medical, law enforcement, social service, clergy and court systems.

10. Enhance communication between police agencies, within the county, county-to- county and state-to-state.

Continued:

11. Provide training for police officers (recruits and experienced officers) on domestic violence.

12. Adequately allocate law enforcement personnel to address the community's domestic violence problem.

13. Develop a lethality assessment tool to be used by the court.

HOMICIDE STATISTICS

Domestic homicide is often the culmination of an escalating history of abuse.

- female homicide victims are more than twice as likely to have been killed by an intimate partner than are male homicide victims.
  Bureau of Justice Statistics: Female Victims of Violent Crime, December, 1996.

- 88% of victims domestic violence fatalities had a documented history of physical abuse.
  Florida Governor's Task Force on Domestic and Sexual Violence, Florida Mortality Review Project, 1997, pp. 46-48, tables 12-21.

- 44% of victims of intimate homicides had prior threats by the killer to kill victim or self. 30% had prior police calls to the residence. 17% had a protection order.
  Florida Governor's Task Force on Domestic and Sexual Violence, Florida Mortality Review Project, 1997, pp. 46-48, tables 12-21.

- for homicides in which the victim-killer relationship was known, 31% of female victims were killed by an intimate. 4% of male victims were killed by an intimate.
  Bureau of Justice Statistics Special Report: Sex Differences in Violent Victimization, 1994 (NCJ-164508), September, 1997, p.1.

- 70% of intimate-partner homicide victims are women.
  Bureau of Justice Statistics Selected Findings: Violence Between Intimates (NCJ-149259) November, 1994.

- a woman is the perpetrator in 19% of domestic homicides.
  Florida Governor's Task Force on Domestic and Sexual Violence, Florida Mortality Review Project, 1997, p. 44, table 7.

- when a woman is the perpetrator of a domestic homicide, typically the abuser was killed during an assaultive incident in which the woman was the victim.
  Browne, When Battered Women Kill, pp. 135-137 (1987).

Continued:

- of women killed in 1992, their relationship to the killer was known in 69% of homicides. Of this percent, 28% were killed by spouse, ex-spouse, boyfriend or ex-boyfriend.
  Bureau of Justice Statistics: National Crime Victimization Survey, 1995.

- of men killed in 1992, their relationship to the killer was known in 59% of homicides. Of this percent, 3% were killed by spouse, ex-spouse, girlfriend, ex-girlfriend.
  Bureau of Justice Statistics: National Crime Victimization Survey, 1995.

Source:

American Bar Association 750 N. Lake Shore Dr., Chicago, IL 60611, 312/988-5000 info@abanet.org

Http://www.abanet.org/domviol/stats.html
Data retrieved 7/22/98

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The Honorable Carl L. Parrot, Jr., MD
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Additional individuals who served on the Review Team, but are no longer members:

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Hamilton County Domestic Violence Death Review Panel

Operating Guidelines

MISSION OF PANEL

The mission of the Hamilton County Domestic Violence Death Review Panel is to prevent domestic violence cases from escalating into murder by constructively examining the circumstances of past and future deaths by domestic violence, by making recommendations arising out of these death reviews, and by increasing coordination and communication between agencies and systems.

The Primary Goals Of The Panel Are:

1. to conduct a formal review of all agency and court involvement in domestic violence death cases from 1993 to the present;

2. to conduct a formal review of all future homicide and suicide cases in which domestic violence is considered a significant factor;

3. to collect uniform statistics on homicide and suicide cases in which domestic violence is considered to be a significant factor;

4. to identify commonalities and/or trends among domestic violence death cases;

5. to identify any service gaps found in domestic violence death cases;

Continued:

6. to evaluate protocols and procedures for investigation and intervention in domestic violence cases; and

7. to make recommendations based on the death reviews as to public health and public safety issues relating to domestic violence.

AUSPICES OF THE PANEL

The Panel is organized under the auspices of the Hamilton County Domestic Violence Coordinating Council. The Hamilton County Coroner shall serve as Chair of the Panel and will have responsibility for convening meetings, notifying members of domestic violence deaths, compiling data sheets as case reviews are completed, and reporting the Panel's findings to the Coordinating Council.

PANEL MEMBERSHIP

Regular Panel members will be representatives of the following agencies/organizations: Hamilton County Courts; Cincinnati Police Department; Hamilton County Prosecuting Attorney's Office; Hamilton County Probation Department; Women Helping Women; YWCA; Hamilton County Department of Human Services; Hamilton County Coroner's Office; Hamilton County Sheriff's Office; Hamilton County Department of Pre-Trial Services; Cincinnati Health Commissioner; the Community Treatment and Diagnostic Center, Blue Ash Police Department; Hamilton County Child Fatality Review Team; Domestic Violence Coordinating Council; and Domestic Violence Coordinating Council - Medical Work Group.

Representatives of other agencies or organizations will be invited to attend whenever such participation would be helpful to a specific case review.

Meetings will be closed to the general public and the media. Only Panel members and invited guests will be permitted to attend Panel meetings.

CONFIDENTIALITY

All Panel members must sign a confidentiality agreement agreeing not to disclose information discussed during the meetings or contained in agency records, reports or investigations, or resulting staff reports. Violation of this confidentiality agreement will result in removal for the Panel.

No case specific records or notes from any agency or organization will be distributed before or during Panel meetings. Individual case records will be the responsibility of the agency that presents material from those records. Any agency can ask other Panel members to sign its own confidentiality form that is specific to a case being discussed.

Data will be reported to the public in aggregate form only via official reports of the Panel as approved by the Coordinating Council. Any data forms completed during a Panel meeting shall be retained only by the Coroner. No Panel member but for the Chair and the Lead Convener of the Coordinating Council shall speak with the media about the work of the Panel.

CASES TO BE REVIEWED

The Panel will review all cases of adult deaths from domestic violence (defined as partner violence) as identified by the Coroner. The Panel also will review all death cases in which domestic violence is considered a significant factor. The Panel will also review any cases suggested for review by any Panel member.

CASE REVIEW

When the Coroner or another Panel member identifies a case for review, the Chair shall communicate case identifying information (i.e., name, address, date or birth, date of death, cause of death, sex and race) to the Panel by fax or by mail. Panel members will review their own agency's records to determine if there has been contact with the deceased or her/his family. If so, they are to bring this information to the case review. If Panel members are aware that other agencies besides team members were involved with the deceased, the Panel members shall so advise the Chair who shall invite the agency representative.

The initial case presentation will be made by the Coroner. This will be followed by a police report, medical reports and agency reports. Each member agency shall discuss its involvement with the case. The entire Panel will then discuss the case.

Data resulting from the Panel review shall be recorded on the Data Form at the meeting and retained by the Chair. Issues that develop from the discussion will be noted on the data collection form and the Panel will be expected to make a plan to address those issues. Issues and suggested recommendations will also be addressed in an annual report and forwarded to the Coordinating Council. Additional reports may be forwarded, when the Panel deems necessary.

Continued:

Each case will be explored until each member of the Panel is satisfied that all questions have been answered.

PANEL RECOMMENDATIONS

A simple majority of the Panel must be present for a Panel review to occur. Ideally, all recommendations of the Panel shall be reached through agreement of all Panel members present. However, an agreement of two thirds of those present will be sufficient for a recommendation to be recorded by the Panel.

REPORTS

The annual report that the Panel issues will contain:

1. Number of deaths annually;
2. Causes of death;
3. Demographics of victims who died;
4. Any trends that can be observed; and
5. Policy recommendations.

Domestic Violence Coordinating Council of Hamilton County, Ohio

Domestic Violence Death Review Panel Data Form

Review Panel Case Number_____

Date Review Initiated _____

Date Review Completed _____

1. Number of children living in the victim's home _____ Age(s)_____

   a. Relationship of victim to children:

   parent stepparent relative none other

   b. Relationship of perpetrator to children:

   parent stepparent relative none other

2. Number of others living in the victim's home _____

3. Perpetrator's relationship to victim:

   spouse live in partner ex-spouse/partner

   non live in partner other

4. Was victim pregnant? yes no

   Was the perpetrator the father? yes no

5. Victim's source of income:

   Employed Public Assistance

   Spousal Support Other

6. Cause of death? _____

7. Where did the incident occur?

   victim's home perpetrator's home

   other (List where) _____

   If occurring in a home, list what room

   _____

8. Were children present at the time of the incident?
   yes no

   Did any of the children witness the incident?
   yes no unknown

9. Were others present? yes no

10. Number of known police runs or calls to victim's residence._____

Reason:_____

11. Number of known police runs or calls to perpetrator's residence (if different).

Reason:_____

_____

12. Does the perpetrator have a previous record?
yes no

a. If so, what are the charges? (list each one and corresponding disposition)

_____

_____

b. Are these charges related to the deceased victim? yes no

If not, explain

_____

c. Any prior reports of animal abuse by perpetrator? yes no

13. Does the victim have a previous record?
yes no

a. If so, what are the charges? (list each one and corresponding disposition)

_____

_____

b. Are these charges related to the perpetrator?
yes no

If not, explain

_____

_____

14. a. Were domestic violence related criminal charges with the deceased victim ever dismissed against this perpetrator? yes no

How many times? _____

Official reason for dismissal:

_____

_____

b. Were domestic violence related civil charges with the deceased victim ever dismissed against this perpetrator? yes no

How many times? _____

Official reason for dismissal:

_____

15. Had the deceased victim suffered prior injuries as a result of domestic violence?
yes no unknown

a. If yes, specify nature of each injury:

_____

b. Was treatment administered? yes no

c. Was the perpetrator of these injuries the person who killed the deceased? yes no

If no, list perpetrator _____

16. Is there an indication that the victim testified for the defendant, changed her story or did not want to testify?
yes no

a. If known, describe why the victim was reluctant.

_____
_____

b. What was the outcome of the case(s)?

_____

_____

17. Was a protection order in effect at the time of that fatality? yes no

What type? TPO CPO TRO
Stay-away order Out-of-State Order

18. Were either the victim or the perpetrator under the influence of any substances at the time of the death? yes no

a. If yes, specify whom:
victim perpetrator both

b. If known, list the substance(s):

_____

19. Did the victim or perpetrator have a history of substance abuse? yes no

a. If yes, specify whom:
victim perpetrator both

b. If known, list the substance(s):

_____

20. Were criminal charges filed that were related to the death? yes no

a. What was the charge?_____

b. What was the disposition? _____

21. To the panel's knowledge were any of the following agencies involved with the victim or the perpetrator in the past five years prior to victim's death? (Check all that apply.)

Victim	Perpetrator	
		Women Helping Women
		YWCA (list program)
		Hamilton County Sheriff's Dept.
		Other Police Agencies (list agency)
		City Prosecutor
		County Prosecutor
		Common Pleas Court
		Juvenile Court
		Domestic Relations Court
		Municipal Court
		Mental Health Provider (list agency)
		Drug Addiction Services (list agency)
		Medical Services (list agency)
		Children's Services
		Other Social Service Agencies (list agency)
		None

22. Problems/issues identified during team review related to death. (Check all that apply and explain)

___ Services for victims
___ Disposition of past D.V. charges
___ Services for perpetrators
___ Follow-through on protection orders
___ Substance abuse of the victim
___ Interagency communication/cooperation
___ Substance abuse of the perpetrator
___ Social/economic status
___ Investigation of past D.V. charges
___ Child Abuse/Neglect
___ Prosecution of past D.V. charges
___ Others

23. Were there community response problems that may have contributed to the cause of death?
yes no

If yes, please explain

_____

24. Were there indicators/predictors of the death?
yes no

If yes, please explain

_____

25. What, if any, recommendations did this panel make as a result of this case review?