# Montgomery County
# Domestic Violence Death Review Committee

## Third Annual Report
## Data Summary and Recommendations

**September, 2001**

# I. Introduction

The Domestic Violence Death Review committee is comprised of professionals from the criminal justice, health care, victim services, children's services and batterer intervention fields. The goal of the committee is to prevent domestic violence deaths by examining the circumstances of these deaths, by making recommendations arising out of these death reviews and by increasing coordination and communication between agencies and systems.

The burgeoning development of domestic violence fatality review committees across the Country is in response to the recognition that many domestic violence fatalities could be preventable deaths. "A preventable death is one in which, with retrospective analysis, it is determined that a reasonable intervention (e.g., medical, social, legal, psychological) might have prevented the death (Colorado Child Fatality Review Commission Annual Report and Conference Proceedings, p. 15, 1991). This philosophy is a dramatic shift from historical perspectives that incidents of domestic violence are acts of spontaneous rage and passion. It is the belief of the Montgomery County Death Review Committee that there are lessons to be learned by reviewing these homicides, and that implementation of the recommendations included herein could reduce domestic violence deaths in this community.

The members of the Death Review Committee are experts in their fields. The goal of the Committee's review and findings is not to present a scientifically valid statistical analysis, but to draw upon the members' combined experience and expertise to identify trends and procedures for best practice in domestic violence cases.

Membership:

The Domestic Violence Review Committee is comprised of members from the following agencies: Chairman, Montgomery County Coroner, Vandalia Municipal Court, Dayton Police Department, Miami Valley Regional Crime Laboratory, YWCA Shelter & Housing Network, Montgomery County Children Services, Montgomery County Domestic Relations Court, Montgomery County Health Care Task Force on Domestic Violence, Montgomery County Association of Chiefs of Police, Montgomery County Common Pleas Court and Prosecutor's Office, Artemis Center, Dayton Prosecutor's Office, Wright State University PATH Program, Montgomery County Sheriff's Office, City of Dayton Probation Department, The Batterers' Group and Montgomery County Family Violence Collaborative.

# II. Definitions

The Committee reviews homicides committed by intimate partners and former intimate partners. The Committee reviews only those cases prosecuted as homicides, or ruled as a homicide/suicide by the County Coroner. The Committee reviews cases after all legal action has ceased. The Committee does not review cases when criminal litigation is pending.

Throughout this report reference is made to the *documented* history of domestic violence in these homicide cases. It should be noted that domestic violence is one of the most under-reported crimes. The lack of *documented* domestic violence history does not imply that *no* history is present.

## III. Overview of Data

To date, the Committee has reviewed 24 cases of intimate partner homicide occurring between 1995 and 2000. These 24 cases included three homicide-suicides, bringing the total deaths to 27. In addition, three people sustained life-threatening injuries in the act of the homicide, including a friend, a child and a sibling of the homicide victims.

### A. Risk Factors

Nationwide, communities are searching for predictors of homicide. While there is consensus on what indicators could signify dangerousness, there are no sure signals that a perpetrator could escalate to committing homicide. In the Committee's review, three factors emerged as significant common denominators in the 24 homicides reviewed: 1) history of domestic violence in the relationship; 2) recent termination of the relationship; 3) lack of contact with victim services.

In 19 (79%) of the homicides, there was a documented history of domestic violence that had come to the attention of law enforcement, criminal and/or domestic relations court. Only five (26%) of these 19 domestic violence victims had received services of domestic violence agencies (in addition, one received outreach but refused services, and one female perpetrator who was a battering victim received services following the homicide). Perhaps most significantly, of 15 female victims, 13 (87%) were in the process of ending the relationship; two of these homicides occurred at the moment the victim told perpetrator of her plans to leave.

### B. Gender

All of the cases reviewed involved heterosexual relationships. Of perpetrators, 15 were male and nine were female. The three homicide/suicide cases were male perpetrators. This is consistent with national data which indicates that the predominant majority of homicide/suicide acts are committed by men.

Also consistent with national statistics, of the nine female perpetrators, six were known to have previously been battered by the man they killed. One female had been charged several times with domestic violence. In two cases, there was no known history of any domestic violence, although one of those perpetrators had experienced significant violent trauma perpetrated by someone else not long before the homicide.

## C. Children

Sixteen of the 24 victims had children living in the home at the time of the homicide. Of those 16 cases, in 10 of the cases (63%), children were present at the time of the incident. Of those 10 cases in which children were on the scene, 60% of the children witnessed the incident. The level of involvement was relatively direct, with some children reportedly escaping through windows. Some attempted to intervene and were injured. A total of 37 children lost at least one parent in these 24 homicide cases.

## D. Age

Average age of victim: 36
Average age of perpetrator: 40

## E. Race

92% of homicides involved people with the same racial/ethnic identity
11 cases – Caucasian perpetrator and victim
11 cases – African-American perpetrator and victim
1 case – Caucasian perpetrator and African-American victim
1 case – African-American perpetrator and Caucasian victim

## F. Relationship

71% of homicides occurred in couples that were never married.
3 - current spouse
4 - ex-spouse, or in process of divorcing
8 - live-in intimate partner
5 - ex live-in intimate partner
4 - dating, never lived together

## G. Cause of death

13 - firearm (54%)
7 - stabbing (29%)
2 - strangulation (8%)
1 - automobile (4%)
1 - burning (4%)

## H. Domestic Violence History

Nineteen of 24 cases (79%) had documented domestic violence history. In five of those 19

(26%), charges were pending at time of homicide. Additionally, two perpetrators had charges dismissed within three months of the homicide. Thus, 37% of homicides occurred in the wake of pending or recent criminal cases.

### I. Protection Orders

Only three cases had a TPO or CPO pending at the time of the homicide. In two recent homicides, TPOs had been dismissed within three months prior due to dismissal of the criminal case.

### J. Victim Services

In the 19 cases of documented domestic violence, five of the victims received services from domestic violence agencies; one from shelter and court outreach; three from court outreach and ongoing service, one court accompaniment and subsequent hotline call, but no other follow up services. One declined any service at court outreach. (See Section 4 for a discussion of why victims may not be able to utilize services at the time they are offered.)

### K. Batterer Intervention

Of 19 cases of known domestic violence, five perpetrators had completed a batterer intervention program.

### L. Alcohol/Drug

Alcohol or drugs were present at the time of the homicide in 58% of victims (14). Six (25%) perpetrators were known to be using drugs/alcohol at the time of the homicide. In many cases, use could not be determined. It is impossible to comment on the role of alcohol and drugs between victims and offenders with the information available.

## IV. Trends over time

Two significant trends appear when examining the cases over time.

1) Lethal cases seem to have less police contact in the years following implementation of preferred arrest policies.

It is apparent in the Committee's review that homicides occurring from 1995-96 had far more prior police contact at the residence than homicides that occurred in later years. In cases during 1995 and 1996, there were numerous calls to police for domestic violence, from two to 35 police contacts to any one individual household. The cases reviewed which occurred in 1997 through 2000 showed a markedly different pattern, with none having more than one or two police contacts with the household, and overall less contact with the criminal justice system by either party.

Possible explanations of this trend include repercussions of the implementation of Ohio�s preferred arrest policy. In Montgomery County, domestic violence arrests more than doubled in 1995. The implications for the court systems are that homicidal batterers are still likely to be repeat offenders, but may have less contact with the police. It is imperative that the Criminal Justice System conduct a lethality assessment at various points in the criminal process, since a homicidal batterer may not stand out as a repeat offender

2) Contact with victim agencies appears to be increasing over time.

While the number of cases that had contact with victim service agencies is still low, there was more contact in cases that occurred in 1998 through 2000. Of 11 cases with known domestic violence history from 1995 through 1997, only one (9%) received services, and one declined services when approached by outreach workers at court (note that safety or perceived safety may affect a victim's willingness to accept services). However, of the nine cases with known domestic violence history from 1998 to 2000, four (44%) received at least outreach services.

## V. Implications and Recommendations

The aggregate data continues to support the recommendations of the Domestic Violence Review Committee's previous reviews. Of those recommendations, none have been completely accomplished, although progress has been made in several areas. At the time of this writing, there have been no known intimate partner homicides in Montgomery County in 2001. Rather than becoming complacent, now is the time to strengthen our practices and continue this positive trend.

The data supports continued emphasis on the following previous recommendations, as well as additional recommendations as noted:

1) The cross-jurisdictional database recommended for effective bond setting and adjudication of domestic violence offenders is in the process of being instituted in Montgomery County. The Death Review Committee continues to support this effort and encourages all criminal justice agencies to participate in the implementation of this database and use of lethality factors in decision making.

2) Criminal courts must engage in all reasonable efforts to prosecute cases, even without the complaining witness.

Seventy-nine percent (79%) of the homicide cases had contact with the criminal justice system for previous domestic violence. In 10 of 19 cases with contact with the criminal justice system, numerous prior misdemeanor domestic violence charges were dismissed due to lack of

participation of the complaining witness. While prosecuting a case without the testimony of the victim is certainly a challenge, the system must engage in efforts to hold domestic violence perpetrators accountable for their crimes. As stated in the Montgomery County Domestic Violence Protocol, "*criminal charges can and should be filed, and convictions obtained, in domestic violence cases irrespective of the cooperation of the victim, where there is sufficient independent corroborative evidence of the elements of the crime and the identity of the perpetrator*". In order to achieve this, police agencies must emphasize thorough evidence collection at the scene as well as follow-up investigations, and, prosecutors must encourage evidence-based prosecution independent of victim testimony. Courts should hear domestic violence cases whether or not the complaining witness is present, as they do in homicide cases.

3) Criminal and civil protection orders must be enforced by all police agencies, and violations must be prosecuted aggressively. Violations of protection orders, including non-violent violations, indicate a dangerous offender. Courts should consider revoking the bond of offenders who violate court orders while criminal charge are pending.

4) All reasonable and practical efforts must be made to prosecute enhancable offenses as felonies. The vast majority of jurisdictions in Montgomery County do not have dedicated domestic violence detectives assigned to do follow-up investigations, which are often necessary to make felony filings.

5) Lethality factors must be considered in setting and reduction of bond. In several cases, bonds were reduced or set low in cases where high lethality was present, such as additional cases pending against the perpetrator.

6) Lethality factors should be assessed for first time offenders.

Severity of the assault, threats to kill, or violations of protection orders must be considered even if this is the offender's first domestic violence charge.

7) Increase public awareness of safety planning when leaving a relationship.

Eighty-seven percent (87%) of the 15 women killed by their partners in the cases reviewed were in the process of leaving the relationship. At least two women were killed within moments after disclosing to the partner their intent to separate. This is consistent with national findings, which indicate that separation is a risk factor for increased violence and homicide. The implication is that safety planning could be critical in reducing risk during the separation process. It is imperative that the public and professional community be made aware of this through education.

8) Improve access to victim services.

Given the necessity of safety planning, utilization of victim service agencies must be encouraged by all who have contact with domestic violence victims. The Protocol states that the Victim Information Sheet should be distributed by police at every domestic violence call. In addition,

literacy levels should be considered when distributing printed information. Professionals in any discipline who come in contact with domestic violence victims should insure that referrals are communicated in the most effective manner possible, particularly to those victims who may have limited reading skills, access to telephones, etc. The community should receive continuing news and education services about domestic violence and available resources, so that informal systems, such as the workplace or place of worship, can better assist victims.

The 24-hour domestic violence hotline remains the single point of contact for victims of domestic violence in Montgomery County, linking victims and service providers and providing immediate access to crisis intervention and safety planning. The Death Review Committee recommends continuation of this vital service.

9) Offenders should be fast-tracked into batterer intervention.

One homicide occurred while the offender was on probation, awaiting entrance into a batterer intervention program.

10) Screening for domestic violence should occur at all entry points into the health care system.

11) Opportunities for victims to obtain civil protection orders and have access to counsel must be increased and improved. A substantial number of civil domestic violence cases continue to go forward without legal representation or advocacy, and that number will increase as funding for one civil domestic violence advocate was recently lost. Victims should be informed regarding expiration/limits of criminal protection orders and advised of options for civil relief. Resources and safety planning must be provided given that separation, a condition of CPO's, is a clear risk factor.

12) Children at the scene of a domestic violence homicide should receive immediate service.

Of the cases where children were living in the home, 63% were home at the time of the homicide, 60% witnessed the incident directly. Thirty-seven children lost at least one parent as a result of the 24 homicides reviewed between 1995 -2000. The recommendation for a multi-disciplinary team, working in concert with law enforcement and Montgomery County Children Services to respond to the needs of children in the wake of a domestic violence homicide, has been instituted.

The community should be reminded that efforts to reduce domestic violence not only protect adults from serious injury and death, but also protect children from serious physical and psychological harm, as well as helping to prevent them from becoming a perpetrator or victim of domestic violence.

13) A criminal justice analysis should be conducted to understand the significance of the decline in calls to the police.

14) Domestic violence sentencing should also be analyzed for any potential significance in predicting homicide. Given that 79% of the perpetrators were involved in criminal justice proceedings prior to the homicide, a study should determine what criminal sanctions had been previously placed upon the offender.

15) The community should take action to reduce domestic violence offenders' access to weapons. More domestic violence homicides were accomplished by means of a firearm than all other methods combined. Quincy, Massachusetts, a community that eliminated domestic violence homicides for more than ten years, has a countywide policy of removing firearms at the time of the issuance of a protection order. While Montgomery County also does, perhaps a longer holding period should be considered. Another consideration would be to devise a method for a quicker issuance of a TPO.