Montgomery County
Domestic Violence Death Review Committee

Fourth Annual Report
Data Summary and Recommendations

May 2005

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, Kettering Municipal Court, 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, 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 or civil litigation is pending.

Throughout this report reference is made to the *documented* history of domestic violence in these

homicide cases. In this report, *documented* is defined as any physical embodiment of information or ideas, e.g. a police reports, hospital records, letters, witnesses comments noted in prosecutors' or investigators' files, etc. 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 31 cases of intimate partner homicide occurring between 1995 and 2004. These 31 cases included five (5) homicide-suicides, bringing the total deaths to 36. In addition, three (3) 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 31 homicides reviewed: 1) history of domestic violence in the relationship; 2) recent termination of the relationship; 3) lack of contact with victim services.

In 23 (74%) 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 seven (30%) of these 23 domestic violence victims had received services of domestic violence agencies (in addition, one received outreach but refused services). Perhaps most significantly, of 22 female victims, 18 (82%) were in the process of ending the relationship. Two of these homicides occurred at the moment the victim told the perpetrator of her plans to leave, and at the scene of one of the homicide/suicides, a letter from the victim telling the perpetrator the relationship was over was found near the perpetrator's personal effects.

B. Gender

All of the cases reviewed involved heterosexual relationships. Of perpetrators, 22 were male and nine were female. In the five homicide/suicide cases all of the perpetrators were male. 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

Nineteen of the 31 victims had children living in the home at the time of the homicide. Of those 19 cases, in 11 (58%) of the cases, children were present at the time of the incident. Of those 11 cases in which children were on the scene, the children witnessed the incident 55% of the time. The level of involvement was relatively direct, with some children reportedly escaping through windows. Some attempted to intervene and were injured. A total of 45 dependent children lost at least one parent in these 31 homicide cases. (In addition, some of the victims had adult children who lived independently.)

D. Age

Average age of victim: 36
Average age of perpetrator: 49

E. Race

90% of homicides involved people with the same racial/ethnic identity
14 cases – Caucasian perpetrator and victim
14 cases – African-American perpetrator and victim
1 case – Caucasian perpetrator and African-American victim
1 case – African-American perpetrator and Caucasian victim
1 case – Latino perpetrator and Caucasian victim

F. Relationship

68% of homicides occurred in couples that were never married.

6 – current spouse
4 – ex-spouse, or in process of divorcing
10 – live-in intimate partner
5 – ex live-in intimate partner
4 – dating, never lived together
2 – intimate partners who were never married to each other. It is not known whether they ever lived together.

G. Cause of death

17 - firearm (55%)
8 - stabbing (26%)
2 - strangulation (6%)
1 – either strangulation or blunt force, both occurred (3%)
1 - automobile (3%)
1 - burning (3%)
1 – drowning (3%)

H. Domestic Violence History

Twenty-three of 31 cases (74%) had documented domestic violence history. In six (19%) of the 31 cases, domestic violence charges were pending at the time of the homicide. Additionally, three perpetrators had domestic violence-related charges dismissed within three months of the homicide. (In one of these cases, the charges were dropped because the Prosecutor's Office could not locate the victim to serve her. The victim was staying in the shelter at the time.) Domestic violence charges were not taken against one perpetrator because the victim did not appear at the Prosecutor's Office. (The victim failed to appear because she was in the hospital recovering from abuse-related surgery.) Thus, 32% of homicides occurred in the wake of pending or recent domestic-violence related criminal cases or violent conduct that could have been charged.

I. Protection Orders

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

J. Victim Services

In the 23 cases of documented domestic violence, 7 victims (30%) received services from domestic violence agencies; two from shelter and court outreach; three from court outreach and ongoing service; one from court accompaniment and a subsequent hotline call, but no follow up services; and one from a hotline call, but no follow up services. One victim 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 23 cases of known domestic violence, five perpetrators had completed a batterer intervention program and one perpetrator had recently been in a batterer intervention program.

L. Alcohol/Drug

Alcohol or drugs were present at the time of the homicide in 17 victims (55%). Seven perpetrators (23%) were known to be using drugs/alcohol at the time of the homicide. In many cases, alcohol/drug use could not be determined due to the time lapse between the offense and the arrest. It is impossible to comment on the role of alcohol and drugs in these homicides and homicide/suicides with the information available.

M. Aggregate Lethality Assessment Analysis

The Committee conducted Lethality Assessments in 21 cases based on the information available. It is likely the Committee was unaware of the presence of additional indicators of lethality in some cases.

Frequency of Lethality Indicators Present

Lethality Factor	No. of Cases
History of Criminal Activity	12
Victim Was Attempting to Separate	12
Repeated or Escalated Violence	11
Drug/Alcohol Abuse	10
Threats to Kill	10
Perpetrator Has Access to Weapons	8
Serious Injury	8
Obsessive Behavior (following, monitoring, substantiated telephone harassment)	7
History of Assaults on Others	6
More Than One Police Run	6
Ownership - Sees Victim as Property	6
Prior DV Arrests/Convictions	6
Prior Treatment for DV	6*
Property Damage Intended to Intimidate/Control	6
Stalking Behavior	6
Strangulation/Choking of Victim	6
Threats with Weapons	6
Use of Weapons	6
Violence or Threats in Public	6
Homicidal/Suicidal Threats	5
Ignores Police/Court/Probation Orders	5
Isolation of Victim (Social/Physical/Financial)	5
Pending Criminal Charges	5
Prior Violation of Protection/Restraining Orders	4
Any Other Unusual or Concerning Behavior Reported by Victim	3
Depression	3
Violence in Presence of Children	3
Forcible Entry to Gain Access to Victim	2
Perpetrator Interfered with Victim's Access to Emergency Services (i.e. Pulled Phone from Wall)	2
Sexual Assault/Abuse	2
Threats to/Harassment of Victim's Family/Friends	2

Frequency of Lethality Indicators Present (Cont.)

Lethality Factor	No. of Cases
Child Abuse	1
Perpetrator has Weapons Training	1
Threats of Abuse of Animals	1
Threats of Sexual Assault/Abuse	1
Threats to Abduct Child	1
Abuse of Animals	0
Sadistic/Terrorist/Hostage Acts	0
Violence During Pregnancy	0

Number of Cases Where Lethality Was Assessed	21
Highest Number of Lethality Factors Present	20
Average Number of Lethality Factors Present	9

*In the 21 cases where Lethality Assessments were conducted only 2 offenders received prior treatment for domestic violence. However, out of the 31 cases reviewed by the Committee a total of 6 perpetrators received batterer intervention prior to the homicide.

IV. Trends over time

Two significant trends appear when examining the cases over time.

1) In many lethal cases there were zero or few police runs to the victims' or perpetrator's residence prior to the homicide.

Data on the number of police runs to either the victim's or perpetrator's residence was available in 21 cases. In 11 (or 52%) of those cases, there were zero or only one police run. In 4 (or 19%) of the cases, there were between two and five police runs. In 3 (or 14%) of the cases there were six to ten police runs, and in 3 (or 14%) of the cases there were 11 or more police runs.

The implications for the court system are that homicidal batterers may have few contacts with the police prior to a homicide. Because highly lethal batterers may not stand out as repeat offenders, it is imperative that criminal justice system professionals conduct lethality assessments at various points in the criminal justice process.

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

While the number of cases where a party had contact with victim service agencies is still low, there was more such contact in cases that occurred in 1998 through 2003. 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 12 cases with known domestic violence history from 1998 to 2003, six (50%) 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.

The data supports continued emphasis on the following recommendations which are explained in detail below:

1. Improve Communication
2. Institute the Cross-Jurisdictional Database
3. Healthcare Screening for Domestic Violence
4. Educate Systems Partners about the Danger Suicidal Abuser's Represent to Victims
5. Document Suicide/Homicide Threats in Police Reports
6. Improve Access to Victim Services
7. Improve Victim's Access to CPOs and Counsel
8. Civil Attorneys Should Receive Training
9. Enforce CPOs/TPOs and Prosecute Violations Aggressively
10. Prosecute Even Without the Complaining Witness
11. Follow Up If Complaining Witness Fails to Appear
12. Enhance Offenses to Felonies
13. Utilize Lethality Assessment in Setting Bond
14. Utilize Lethality Assessment for First Time Offenders
15. Reduce Offenders' Access to Weapons
16. Fast-Track Offenders into Batterer Intervention
17. Provide a Batterer Intervention Victim Liaison
18. Analyze Domestic Violence Sentencing
19. Conduct a Criminal Justice System Analysis
20. Increase Community Education
21. Increase Public Awareness of Safety Planning and Danger of Leaving
22. Provide Services for Children

1) Improve Communication.

Systems partners must continue to work on improving communication between agencies. In one case, the prosecutor's office did not charge a perpetrator because they could not locate the victim to notify her to appear at the Prosecutor's Office. The victim was staying at the shelter at the time. Even though shelter staff and victim advocates are bound by confidentiality, investigators and prosecutors should contact them when they have questions for or are trying to locate a victim. When a victim has not signed a release allowing the shelter or victim advocacy agency to communicate with the prosecutor or police about the victim's case, shelter staff and victim advocates may relay information from the police or prosecutor to the victim without confirming that they are in contact with or providing services to the victim.

2) Institute the Cross-Jurisdictional Database

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 fine-tuning this database and to use lethality assessments in decision making.

3) Healthcare Screening for Domestic Violence
Screening for domestic violence should occur at all entry points into the health care system.

4) Educate Systems Partners about the Danger Suicidal Abuser's Represent to Victims
Healthcare providers, mental health providers, and legal justice professionals should be educated about the significance of an abuser's suicidal threats, which are an indicator of lethality. Organizations, institutions, and individuals that work with domestic violence victims or perpetrators should collaborate on establishing protocols for identifying and minimizing the danger the combination of suicide and domestic violence poses to intimate partners and others. Advocates should always ask a victim about the abuser's suicidal behaviors. If there is a history of suicidal ideation, they should inform and educate victims about the risk of homicide and intensify safety planning.

5) Document Suicide/Homicide Threats in Police Reports
Law enforcement officers should always document threats of homicide and suicide in their reports. When domestic violence and suicide threats co-exist, officers should recognize the increased danger to the victim. In such an instance, police should provide the victim with information about the increased risk of homicide and make a referral to a community-based domestic violence program for safety planning and other services.

6) 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 Montgomery County Domestic Violence 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, language fluency, 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.

7) Improve Victims' Access to CPOs and Counsel

A substantial number of civil domestic violence cases continue to go forward without legal representation or advocacy due to inadequate staffing for outreach at the Court of Domestic Relations. Courts issuing Civil Protection Orders should work with community-based victim advocates to ensure that victims are informed of the services available to them, and that safety planning is offered. Victims should be informed of the heightened risk that their abusers will escalate once they are served with *ex parte* Protection Orders. Victims should also be informed of expiration/limits of criminal protection orders and advised of options for civil relief. Resources and safety planning are imperative given that separation, a condition of Civil Protection Orders, is a clear risk factor for increased danger/lethality.

8) Civil Attorneys Should Receive Training.
Attorneys who represent victims in Civil Protection Order and other family law cases should receive training in the dynamics of domestic violence and safety planning. Some victims feel a false sense of security when the Court issues an *ex parte* CPO because they do not realize that their abuser may escalate when he is served with the *ex parte* CPO and notice of the full hearing. Attorneys should be prepared to advise their clients of the increased risk and either do safety planning with their clients or refer them to the domestic violence hotline for safety planning.

9) Enforce CPOs/TPOs and Prosecute Violations Aggressively
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 charges are pending.

10) Prosecute Even Without the Complaining Witness
Criminal courts must engage in all reasonable efforts to prosecute cases, even without the complaining witness. Twenty-two (or 71%) of the 31 homicide cases had contact with the criminal justice system for previous domestic violence. In 13 (or 59%) of 22 cases where the parties had contact with the criminal justice system before the homicide, 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, law enforcement policies must emphasize thorough evidence collection at the scene as well as follow-up investigations, and prosecutors must pursue 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.

11) Follow Up If Complaining Witness Fails to Appear
If a victim fails to appear at the Prosecutor's Office, the prosecutor and/or investigators should follow up with the victim to ensure the victim is not in danger. Prosecutors and investigators are encouraged to communicate with victim advocates and shelter staff regarding the victim's safety.

12) Enhance Offenses to Felonies
All reasonable and practical efforts must be made to prosecute enhanceable 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. This points to the necessity for thorough police reporting and use of the domestic violence database.

13) Utilize Lethality Assessment in Setting Bond
Lethality factors must be considered in setting and reduction of bond. Judges should have access to in-depth pre-sentencing reports to inform decision making about sentencing conditions and options. In several cases, bonds were reduced or set low in cases where indicators of high lethality were present, such as additional cases pending against the perpetrator.

14) Utilize Lethality Assessment for First Time Offenders
Lethality factors should be assessed for first time offenders. Severity of the assault, threats of suicide or homicide, or violations of protection orders must be considered even if this is the offender's first domestic violence charge.

15) Reduce Offenders' Access to Weapons
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 has a similar policy, perhaps a longer holding period should be considered. Another consideration would be to devise a method to expedite the issuance of a TPO.

Every jurisdiction in Montgomery County should establish a protocol for gun removal for convicted domestic violence offenders and domestic violence offenders subject to protective orders. Judges should inquire specifically about abusers' access to weapons, should order abusers to surrender weapons as part of temporary and permanent protection orders, and should make surrender of weapons a condition of pre-trial release for domestic violence charges. Domestic violence supplemental forms include questions that prompt officers to ask suspects about access to, location of and use of weapons. Officers should attempt to remove guns from the home, especially when the abuser has a history of homicidal or suicidal threats.

16) Fast-Track Offenders into Batterer Intervention

Offenders should be fast-tracked into batterer intervention, and the intervention ordered should closely follow the Protocol recommendations. One homicide occurred while the offender was on probation, awaiting entrance into a batterer intervention program. The Batterer Intervention Partnership in collaboration with the Criminal Justice Council Subcommittee on Domestic Violence and the Family Violence Collaborative conducted a survey to assess each of the local batterer intervention program's compliance with the criteria set out in the Montgomery County Domestic Violence Protocol. Judges are encouraged to become familiar with the survey results and be guided by the degree to which each program complies with the Protocol. In addition, probation offices should have domestic violence victim advocates on staff who can contact partners of abusers, and provide resources and safety planning.

17) Provide a Batterer Intervention Victim Liaison

Batterer intervention programs should have a victim liaison to contact victims in person or by phone. The liaison should be separate from the abuser group leader. Batterer intervention programs should be required to give victims accurate information in plain language about the limitations of batterers' intervention and the conditions under which it is more likely to be effective, including complete citations to literature on the topic.

18) Analyze Domestic Violence Sentencing

Domestic violence sentencing should also be analyzed for any potential significance in predicting homicide. Given that 71% of the perpetrators were involved in criminal domestic violence proceedings prior to the homicide, a study should determine what criminal sanctions had been previously placed upon the offender.

19) Conduct a Criminal Justice System Analysis

A criminal justice system analysis should be conducted to understand the significance of the frequency of calls to the police prior to the homicide. In addition, police and sheriff's departments should have mechanisms in place to monitor the quality of domestic violence incident reports. Law enforcement officers who respond to 911 calls are in the best position to gather information in a domestic violence case because victims are most likely to provide useful information at that time. The quality of the information in the incidence report is critical to the successful prosecution of the case.

20) Increase Community Education

Community education efforts should be increased. Victims, children and the general public should receive education about non-violent controlling behaviors, such as monitoring. People who work with teens in any capacity should receive training regarding teen dating violence, and teen advocacy resources in the community. 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 help to prevent children from becoming a perpetrator or victim of domestic violence.

21) Increase Public Awareness of Safety Planning and Danger of Leaving

Increase public awareness of safety planning when leaving a relationship. Seventy-seven percent (77%) of the 22 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. In a third case, a homicide/suicide, a letter from the victim to the perpetrator expressing the victim's intent to leave the relationship was found near the perpetrator's personal effects. 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.

22) Provide Services for Children

Children at the scene of a domestic violence homicide should receive immediate services. Forty-five dependent children lost at least one parent as a result of the 31 homicides reviewed between 1995 – 2004. Of the cases where children were living in the home, children were present in the home when the homicide occurred 58% of the time, and 55% of those children witnessed the homicide.

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, was instituted briefly and should be considered for re-implementation.