Domestic Violence Homicide

A Multi-Disciplinary Analysis by the Oklahoma Domestic Violence Fatality Review Board

Annual Report
September 2002-September 2003

A Publication of the Oklahoma Criminal Justice Resource Center for the
Oklahoma Domestic Violence Fatality Review Board, 2003

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Acknowledgements

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Oklahoma State Bureau of Investigation
Office of the Chief Medical Examiner
Oklahoma Department of Mental Health & Substance Abuse Services
Oklahoma Department of Human Services
Oklahoma State Department of Health

Many thanks to all of the County Sheriffs, Police Chiefs, District Attorneys and Court Clerks and their staffs who have helped us gather the case materials in these cases. We realize many of you are already pushing the boundaries of time and we appreciate your hard work.

A special thank you to the Oklahoma Violence Against Women Act Board through the District Attorney's Council for awarding the Violence Against Women Act Grant funds to this project. Without their support this project would not be possible.

An extra special thank you to the Oklahoma State Department of Health Injury Prevention Services for printing this report and executive summary.

Domestic Violence Fatality Review Board Membership

Office Represented	Member	Designee
Listed Directly In Statute		
Chief Medical Examiner	Fred B. Jordan, M.D.	Ray Rupert
Designee of the Commissioner of the Department of Mental Health and Substance Abuse Services	Domestic Violence & Sexual Assault Division	Julie Young
State Commissioner of Health	Leslie Beitsch, M.D., J.D., Commissioner	Sue Vaughn Settles, L.S. W.
Director of the Criminal Justice Resource Center	K.C. Moon, Director	Carol Furr, J.D.
Chief of Injury Prevention Services, State Department of Health	Sue Mallonee, MPH, R.N., Chief	Sheryll Brown, MPH
Oklahoma Council on Violence Prevention Member	Jeff Hamilton, Chair	Margaret Goldman
Oklahoma State Bureau of Investigation Director	DeWade Langley, Director	David Page, Assistant Director
Appointed by the Commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services (Terms expire June 30, 2005)		
Oklahoma Sheriffs Association	County Sheriff	Jimmie Bruner, Sheriff
Oklahoma Association of Chiefs of Police	Chief of Police	Don Murray, Chief
Oklahoma Bar Association	Private Attorney	G. Gail Stricklin, J.D. ‡
District Attorneys Council	District Attorney	Richard Smothermon, District Attorney, District 23
Oklahoma State Medical Association	Physician	Howard A. Shaw, M.D. †
Oklahoma Osteopathic Association	Physician	Sheila Simpson, D.O.
Oklahoma Nurses Association	Nurse	Janet Wilson, R.N., Ph.D.
Oklahoma Coalition Against Domestic Violence and Sexual Assault	Citizen to Represent Domestic Violence Survivors	Juskwa Burnett
Oklahoma Coalition Against Domestic Violence and Sexual Assault	Citizen	Marcia Smith, OCADVSA Director

†Chair
‡ Vice-Chair

Domestic Violence Fatality Review Board Past Members

Office Represented	Designee	Tenure
State Commissioner of Health	Sally Carter	July 2001-March 2003
Oklahoma Association of Chiefs of Police	Carolyn Kusler	July 2001-March 2003
Oklahoma Osteopathic Association	Trudy Milner, D.O.	July 2001- May 2003
District Attorneys Council	Gene Christian	July 2001-June 2003
Oklahoma Coalition Against Domestic Violence and Sexual Assault	Terrie Evans	July 2001-June 2003

The Oklahoma Criminal Justice Resource Center provided staff and administrative support to the Board.

David Wright, Ph.D.	Director of Research
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Oklahoma Domestic Violence Fatality Review Board

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December 19, 2003

Dear Reader,

The Oklahoma Domestic Violence Fatality Review Board is pleased to present this Second Annual Report as required by statute to the Oklahoma Legislature and to you our fellow citizens.

The first report took a significant first step in defining the issues at the core of domestic homicide in our state. The very diverse areas of expertise represented on this multi-disciplinary board have afforded each of us opportunities to explain our perspective, share our knowledge, and understand the many roles and systems that must interlace to prevent and resolve domestic violence homicides. This interaction has opened a "culture of safety" within our Board, affording open dialogue, leading to extremely honest exchange of ideas and examination of key issues.

The dialogue consistently focused on the systems that intersect the paths of the victims, perpetrators, and innocent bystanders. We have learned that practitioners, regardless of discipline, are diligent and dedicated in their efforts. This has allowed us to focus singularly upon the methodologies that might be used to alter the devastating outcomes.

The information gleaned this year supplemented facts previously reported to further define and clarify the portrait of domestic violence homicide in Oklahoma. In the pages that follow, we detail the information now available. Next we share the insights gained during our examination of the facts, ensuing dialogue and candid discussion. As a result, we make twenty-four recommendations for action providing enhancements, adjustments or new protocols designed to reduce domestic violence in Oklahoma.

Sincerely,

Howard A. Shaw, M.D.
Chair, Oklahoma Domestic Violence Fatality Review Board

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EXECUTIVE SUMMARY

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MISSED OPPORTUNITIES

Police confined a woman on an Emergency Order of Detention after she put a gun to her boyfriend's head and pulled the trigger (he was not hurt). The woman walked away from the mental health facility and a day later killed her boyfriend. The facility's staff did not call police to let them know she left without permission.

A man who killed his estranged wife had acquired a rifle 11 days prior to the murder/ suicide. On his ATF screening statement, the perpetrator responded "No" to the question "have you been convicted in any court of a misdemeanor crime of domestic violence?" The man had a 1996 conviction for domestic assault and battery, which should have disqualified him from purchasing a firearm.

A man who was on probation for violating a Protective Order (PO) was being held in the county jail for another violation. He continued the violation by calling his victim -- from the jail's telephone -- and making death threats. When the victim reported the calls to city police, officers told her to call the sheriff's office and report the calls herself. Two days after being released from jail, the man killed the woman.

A man who kidnapped and raped his ex-girlfriend began threatening suicide. His family took him to a hospital five days later for in-patient mental health treatment. Two doctors and a counselor told the man's family his condition was not bad enough for him to be hospitalized. They referred the man to a private counselor. He killed his girlfriend and himself 12 days later.

A court issued an arrest warrant for a man accused of violating a PO filed by his estranged wife. The sheriff did not serve the warrant. Local police, despite responding to DV calls at the woman's home, were not aware of the arrest warrant. The man killed his wife and himself 21 days after the warrant was issued.

A man was arrested for violating the PO his estranged wife had filed against him. He posted bail. Hours later he killed his estranged-wife's boss and shot her.

The Chief of Police knew about death threats made against the victim by her estranged husband. The chief failed to serve an emergency ex-parte order because he had heard the couple had reached a property settlement. The man killed his estranged wife and himself.

A woman made several reports to police and her boyfriend's parole officer regarding her boyfriend's physical abuse. The police gave the reports to the DA. No charges were filed, and parole was not revoked. The perpetrator killed the victim less than a month later.

Of the 113 Reviewed Cases

- In 57% of the cases there was a documented history of domestic violence between the victim and perpetrator.
- Firearms were used in 59% of the homicides.
- A current or former intimate partner was the perpetrator in 61% of the cases

THE PROBLEM

Domestic violence is an issue with far reaching medical, emotional, personal, economic, professional and legal consequences for many people. According to the National Center for Injury Prevention and Control, close to 5.3 million intimate partner victimizations occur each year among women ages 18 and older in the United States — some 1,300 women lose their lives as a result of this violence. Based on these numbers, intimate partner violence costs the United States more than an estimated $5.8 billion dollars annually — close to $4.1 billion for medical and mental health care, $0.9 billion in lost productivity, and $0.9 billion in homicide lost earnings. These numbers do not even begin to account for the cost to the criminal justice system — law enforcement, prosecution, courts, and the penal system.

- In 2002, spouses, family members, boyfriends/ girlfriends, and/or member of romantic triangle committed 2,450 (17%) murders in the United States.[1, 2]
- In Oklahoma, 174 (32%) murders fit the definition of domestic violence by statute from 1998-2000.
- In a surveillance from 1981-1998, the Centers for Disease Control ranked Oklahoma 4th in the nation for rate of intimate partner homicide per 100,000 population for white females and 3rd in the nation for black females. [3]
- In 2001, Oklahoma ranked 10th in the nation for number of females killed by males in single victim, single offender incidents. This is up from 19th in 2000.[4]

In a time when most agencies and service providers are facing budget cuts it is important that a systematic approach be applied in determining the causes and resolutions of domestic violence. With costs that can number in the billions annually when all things are considered, the use of a multidisciplinary systems approach assists agencies and service providers involved with domestic violence to determine how to best utilize their limited resources to serve those in need. Throughout this report the Oklahoma Domestic Violence Fatality Review Board (DVFRB) has focused on systems issues which, if improved, could save the lives of victims.

OKLAHOMA DOMESTIC VIOLENCE FATALITY REVIEW BOARD

This report summarizes the work of the Oklahoma DVFRB created by the Oklahoma State Legislature in 2001. The multi-disciplinary review team has met monthly since September 2001 to review deaths of Oklahomans due to domestic violence. Board members represent the disciplines of the multiple stakeholders involved in resolving domestic violence homicides. As such, the members are sensitive to the concerns and purposes of the organizations and fields of expertise they represent. Inclusion of this variety of professionals ensures that every effort will be made to maintain the short-term veracity and the long-term credibility of the findings and recommendations. In addition, the spirit of collaboration is considered essential to the success of continuing efforts to reduce domestic violence homicides using a holistic, interlocking approach to prevention, interdiction and resolution.

". . . the spirit of collaboration is considered essential to the success of continuing efforts to reduce domestic violence homicides using a holistic, interlocking approach to prevention, interdiction and resolution."

DVFRB members represent the Chief Medical Examiner, the Department of Mental Health and Substance Abuse Services, the State Commissioner of Health, the Director of the Criminal Justice Resource Center, the Chief of Injury Prevention of the State Department of Health, the Oklahoma Council on Violence Prevention, the Director of the Oklahoma State Bureau of Investigation, the Oklahoma Sheriff's Association, the Oklahoma Association of Chiefs of Police, the Oklahoma Bar Association, the District Attorneys Council, the Oklahoma State Medical Association, the Oklahoma Osteopathic Association, the Oklahoma Nurses Association and two individuals from the Oklahoma Coalition Against Domestic Violence and Sexual Assault, one of whom shall be a survivor of domestic violence. Additionally, the Board is staffed by research professionals from the Oklahoma Criminal Justice Resource Center.

1 Federal Bureau of Investigation. (2003). Crime in the United States 2002: Uniform Crime Reports. Washington, DC: U.S. Government Printing Office.
2 Figures are based on 14,054 murder victims for whom Supplementary Homicide Reports were received.
3 Paulozzi, L.J., Saltzman, L.E., Thompson, M.P., & Holmgreen, P. (2001, October). Surveillance for Homicide Among Intimate Partners—United States, 1981-1998. Morbidity and Mortality Weekly Reports (MMRW) Surveillance Summaries, 50, 1-16.
4 Violence Policy Center. (2003). When Men Murder Women: An analysis of 2001 data. Washington, DC: Author.

KEY FINDINGS

During the past year the DVFRB focused on the 159 cases identified from 1998 and 1999. Of these, it reviewed 38 cases, adding to the body of work initiated by the Pilot Project. To date the DVFRB has reviewed a total of 113 cases.

While there were many cases in which victims accessed services and were known to service providers, there were just as many cases in which the systems designed to protect victims did not work optimally. Review discussions were often emotional for DVFRB members. All of the deaths were tragic; many were horrific. Each review pinpointed areas of need, as well as areas of success. This report presents the findings of the case reviews. It concludes with systemic recommendations for change. DVFRB members are adamant that the victims' lives and deaths should not be in vain. The review of each death and those events leading to it suggests recommendations and strategies to bring changes in our legal, law enforcement, health care and service systems. Ultimately, the DVFRB believes adoption of these recommendations will save lives.

Of the 113 reviewed cases:

- Average age of victims was 37 years old and 38 years of age for perpetrators
- 79% of the victims were White, 16% were Black and 5% were American Indian.
- Nearly 4% of victims were of Hispanic or Latino origin
- In 56% of the cases, the perpetrator and victim were cohabitating
- 9% of victims told someone the perpetrator was stalking them prior to their death
- 67% of the homicides occurred at the victim's residence
  - 30% occurred in the bedroom
  - 27% occurred in the living room
- Charges were filed in 72% of the cases
  - 89% were convicted
- 96% of those convicted were sentenced to prison
  - The average sentence was 21.11 years (not including life or life without parole)
  - 14 received life in prison
  - 19 received life without parole

SYSTEMIC CONCERNS AND RECOMMENDATIONS

Concern:

All providers should document any type of domestic violence their client may be experiencing or inflicting.

In at least 9 cases, family, friends, and/or neighbors report alerting law enforcement to prior incidents of violence between the victim and perpetrator. No incident reports or follow-up documentation of these responses were found.

Recommendation:

- *Health Care:* Health care providers should seek domestic violence screening, assessment, and recognition training in all hospitals (in & out patient), long term healthcare & community care providers, Emergency Rooms, Primary Care, Obstetrician/Gynecologists, Health Departments, Planned Parenthood, etc. [Partner with Oklahoma State Department of Health] to improve screening, assessment, identification & documentation of domestic violence risk factors.
- *Law Enforcement:* Document and file incident reports on all domestic violence contacts – regardless if the original call designation specified the event to be a domestic situation.

SYSTEMIC CONCERNS AND RECOMMENDATIONS

Concern:
Screening performed by service providers should assess the lethality of the situation when there is on-going domestic violence.

Recommendation:
- *Courts:* Courts should perform lethality assessment before setting bail on domestic violence offenses.
- *Department of Mental Health and Substance Abuse Services:* Review Emergency Order of Detention assessments, strengthen lethality risk by utilizing outside sources [DMHSAS & private facilities].
- *Law Enforcement:* Law Enforcement should perform Danger/Lethality Assessments on all domestic violence calls – with particular attention to weapon accessibility & presence.

Law enforcement responded to prior domestic violence incidents in the month preceding death in at least 15 cases. In 11 of those cases, the homicide was committed with a firearm.

Concern:
Providers across the board should perform domestic violence screening.

14% of victims had contact with the Department of Mental Health & Substance Abuse Services prior to death. 50% of victims had contact with the Department of Human Services in the year prior to death.

Recommendation:
- *Department of Human Services:* Improve capacity of DHS workers to assess danger to children by including domestic violence screening and response.
- *Department of Mental Health & Substance Abuse Services:* Standardize assessments in mental health to include screening for domestic violence and appropriate referral/care [DMHSAS & work with Health Care Authority-Licensed Behavioral Health Specialists].
- *District Attorneys:* Support DMHSAS efforts that DUI offenders be tested for propensity to violence in cases of court-ordered counseling.
- *Health Care:* Health care providers should provide domestic violence screening, lethality assessment and identification for specific intervention to reduce risk (or vulnerability) and increase safety, especially of women, children, people with disabilities and elders (i.e. referral resources, safety planning).

*Requires Legislative Action

SYSTEMIC CONCERNS AND RECOMMENDATIONS

Concern:
Domestic violence offenses appear to carry little consequence within the criminal justice system beyond initial law enforcement response.

Recommendation:
- *District Attorneys:* Make second and subsequent violation of PO a felony.*
- *District Attorneys:* Increase penalty range for Domestic Assault & Battery – After Former Felony Conviction.*

Protective Orders were utilized in 19% of the reviewed cases. Over half of those POs were violated at least once prior to the death event.

Concern:
The breadth of services and service providers should be expanded. Those providing services should strive to continually educate themselves in order to ensure the safety of their clients.

There were witnesses in 58% of the cases.

- *Adults witnessed the homicide in 45% of the cases.*
- *Children were present for 36% of the slayings.*
  - *16% were eyewitnesses to the event.*

Recommendation:
- *Department of Human Services:* Identify and make referrals to services available for victims of domestic violence and their children.
- *Department of Mental Health & Substance Abuse Services:*
  - Continue to strengthen integrative services – screening for domestic violence, mental health, and substance abuse should occur at all entry points into the system.
  - Continue to review, revise and strengthen minimum standards for Batterers Treatment.
- *Domestic Violence Advocates:*
  - Seek to expand services – geographic and variety.
  - Develop targeted outreach programs to reach those victims who have no contacts with the system, especially in rural areas.
- *Legal:* Training/Education on representing victims of violence: Target all attorneys who work in divorce/family law through law school and Continuing Legal Education Units.
- *All Systems:*
  - Develop Family Justice Centers for comprehensive service and support for victims of domestic violence. Centers should be designed to improve victims' access to critical services by housing them in one location.
  - Increase cultural competency.
- Funding should be prioritized for domestic violence services in all areas — support for Domestic Violence Emergency Response Teams (DVERT), prosecution of domestic violence offenses including protective order violations, etc.

*Requires Legislative Action

SYSTEMIC CONCERNS AND RECOMMENDATIONS

Concern:
Providers should implement policies that ensure the increased safety of the victim.

In 57% of the cases, someone else knew of the ongoing domestic violence prior to the homicide.

- *59% Family*
- *50% Friends*
- *44% Law Enforcement*

Recommendation:

- *Courts:* Stipulate that as a condition of bond, defendants make no contact with the victim.
- *Courts:* Increase awareness of the role of the judiciary in preventing domestic violence, specifically in the areas of victim safety and offender accountability.
- *District Attorneys:* Provide *Evidence Based Prosecution* and *Domestic Violence 101* Training to all District Attorneys and Assistant District Attorneys that prosecute domestic violence.
- *Domestic Violence Advocates:* Public information campaign, i.e., How Do I Help?

CONCLUSION

Domestic violence is a continuing problem in Oklahoma, and one with extreme costs to citizens. It is important to use a multidisciplinary systems approach to resolve issues surrounding these life-threatening situations. This report is essential to understanding the complexity and severity of intimate partner violence in our society. The use of real life, empirical data illustrates the need for all systems to band together to protect the lives of Oklahomans.

If all the systems that may be contacted by an individual in a domestic violence situation are (1) prepared and informed about the dynamics of domestic violence, and (2) have policies and procedures in place to support their assistance to that individual, a significant reduction in the number of cases that result in homicide can be realized.

The DVFRB has come a long way since inception. It is the sincere hope that the hard work done in 2003 will aid in the prevention of domestic violence homicides in Oklahoma. Recommendations for this year's reports were more specific than last year's due to the growth of the database, and the maturation of the DVFRB itself. Framed recommendations will become more precise in the following years for the same reasons. The DVFRB expresses gratitude to those who have already implemented change, and issues a challenge to systems to use this data and these recommendations to aid future and current victims of domestic violence and save lives.

*Requires Legislative Action

DOMESTIC VIOLENCE FATALITY REVIEW BOARD

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OKLAHOMA
DOMESTIC VIOLENCE
FATALITY REVIEW
BOARD

If you or someone you know needs help in a Domestic Violence situation, please call:

Safeline – 1-800-522-7233

If you need general information about Domestic Violence, please call:

Oklahoma Coalition Against Domestic Violence
and Sexual Assault – (405) 848-1815

If you need more information about the Oklahoma Domestic Violence Fatality Review Board, please call:

Oklahoma Criminal Justice Resource Center –
(405) 524-5900

If you are in an emergency situation please dial 911 immediately.

This Executive Summary was prepared by the Oklahoma Criminal Justice Resource Center, Statistical Analysis Center on behalf of the Oklahoma Domestic Violence Fatality Review Board, 2003.

Written by: Brandi Woods-Littlejohn, MCJ, Project Director; Carrie Duncan, MA, Project Specialist

Printing provided by the Oklahoma State Department of Health, Injury Prevention Services

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The Problem

Domestic violence is an issue with far reaching medical, emotional, personal, economic, professional and legal consequences for many people. According to the National Center for Injury Prevention and Control, close to 5.3 million intimate partner victimizations occur each year among women ages 18 and older in the United States—some 1,300 women lose their lives as a result of this violence. Based on these numbers, intimate partner violence costs the United States more than an estimated $5.8 billion dollars annually—close to $4.1 billion for medical and mental health care, $0.9 billion in lost productivity, and $0.9 billion in homicide lost earnings.[1] These numbers do not even begin to account for the cost to the criminal justice system—law enforcement, prosecution, courts, and the penal system.

In a time when most agencies and service providers are facing budget cuts, it is important that a systematic approach be applied in determining the causes and resolutions of domestic violence. With costs that can number in the billions annually when all things are considered, the use of a multidisciplinary systems approach assists agencies and service providers involved with domestic violence to determine how to best utilize their limited resources to serve those in need. Throughout this report the Oklahoma Domestic Violence Fatality Review Board (DVFRB) has focused on systems issues, which, if improved, could save the lives of victims.

- In 2002, spouses, family members, boyfriends/ girlfriends, and/or member of romantic triangle committed 2,450 (17%) murders in the United States.[1, 2]
- In Oklahoma, 174 (32%) murders fit the definition of domestic violence by statute from 1998-2000.
- In a surveillance study from 1981-1998, the Centers for Disease Control ranked Oklahoma 4th in the nation for rate of intimate partner homicide per 100,000 population for white females and 3rd in the nation for black females.[4]
- In 2001, Oklahoma ranked 10th in the nation for number of females killed by males in single victim, single offender incidents. This is up from 19th in 2000.[5]

In 2002, the Federal Bureau of Investigation (FBI) Crime in the United States[2] reported that spouses, family members, boyfriends/girlfriends, and/or member of a romantic triangle committed 2,450 (17% of the total) murders in the US.[3] In Oklahoma, there were 964 murders reported to the Oklahoma State Bureau of Investigation (OSBI) from 1998-2002.[4] Of those, 259 or 27% were reported as domestic violence homicides to OSBI. Numbers are even higher because not all homicides are reported to OSBI, and those reported may or may not be categorized as domestic violence homicides. In fact, there were 1,313 homicides reported to the Oklahoma Office of the Chief Medical Examiner (OCME) from 1998-2002. The DVFRB has found 369 (28% of the total) homicides, including those reported to OSBI, that fit the state definition of domestic violence. A recent surveillance study for homicides among intimate partners in the United States from 1981-1998 by the Centers for Disease Control ranked Oklahoma 4th in the nation for rate of intimate partner homicide per 100,000 population for white

[1] National Center for Injury Prevention and Control. (2003). Costs of Intimate Partner Violence Against Women in the United States. Atlanta, GA: Centers for Disease Control and Prevention.
[2] Federal Bureau of Investigation. (2003). Crime in the United States 2002: Uniform Crime Reports. Washington, DC: U.S. Government Printing Office.
[3] Figures are based on 14,054 murder victims for whom Supplementary Homicide Reports were received.
[4] Oklahoma State Bureau of Investigation. (2002). Crime in Oklahoma: 2002 Uniform Crime Reports. Stillwater, OK: CareerTech Printing Services.

females and 3rd in the nation for black females.[5] Until 2000, when Oklahoma fell to 19th, Oklahoma has consistently ranked in the top ten among states in the number of females killed by males in single victim, single offender incidents.[6] Oklahoma is ranked 10th in the nation for this statistic in 2001.

In order to begin to address this problem, in 2001 the Oklahoma legislature mandated a multi-disciplinary team to systemically review deaths that have occurred in Oklahoma as a direct result of domestic violence. The DVFRB reviews all such deaths as a means to improve methods of prevention, intervention and resolution of domestic violence in Oklahoma. The legislature charged the Board to report annually to key policy and decision makers prior to each legislative session.

Board members represent the multiple disciplines of the stakeholders involved in resolving domestic violence-related homicides. As such, the members are sensitive to the concerns and purposes of the organizations and fields of expertise they represent. Including this array of professionals ensures that every effort will be made to maintain the short-term veracity and the long-term credibility of the findings and recommendations. In addition, the spirit of collaboration is considered essential to the success of continuing efforts to reduce domestic violence homicides using a holistic, interlocking approach to prevention, interdiction and resolution.

Through the fatality review process, the Board recognized many missed opportunities for intervention. In many cases, family, friends and professionals potentially could have identified the escalating danger created by the abuser. Often, victims sought help from law enforcement for assaults, told others about an abuser's death threats, and had been clear that they were in fear of their lives. Many opportunities for intervention were lost. It is a basic tenet of the DVFRB that at least some domestic violence homicides are preventable. By examining the lives that are lost to domestic violence, the Board hopes to learn how to increase professional and community involvement in the prevention of domestic violence, thereby ultimately reducing the death toll.

Mission

The mission of the Oklahoma Domestic Violence Fatality Review Board is to reduce the number of domestic violence related deaths in Oklahoma. The DVFRB will perform multi-disciplinary case reviews of statistical data and information derived from disciplines with jurisdiction and/or direct involvement with the case to develop recommendations to improve policies, procedures and practices within the systems involved and between agencies that protect and serve victims of domestic abuse.

[5] Paulozzi, L.J., Saltzman, L.E., Thompson, M.P., & Holmgreen, P. (2001, October). Surveillance for Homicide Among Intimate Partners—United States, 1981-1998. Morbidity and Mortality Weekly Reports (MMRW) Surveillance Summaries, 50, 1-16.
[6] Violence Policy Center. (2003). When Men Murder Women: An analysis of 2001 data. Washington, DC: Author.

Purpose

The Domestic Violence Related Fatality Review Board shall have the power and duty to:

1. Coordinate and integrate state and local efforts to address fatal domestic violence and create a body of information to prevent domestic violence deaths;
2. Collect, analyze and interpret state and local data on domestic violence deaths;
3. Develop a state and local database on domestic violence deaths;
4. Improve the ability to provide protective services to victims of domestic violence who may be living in a dangerous environment;
5. Improve policies, procedures and practices within the agencies that serve victims of domestic violence; and,
6. Enter into agreements with other state, local or private entities as necessary to carry out the duties of the DVFRB.

Definitions

One of the first tasks undertaken by the DVFRB was to select a definition of domestic violence, which could be supported by all members. A review of various efforts across the nation and a review of the literature available revealed a wide range of definitions of domestic violence. Oklahoma statutes contain very specific definitions in the Protection from Domestic Abuse Act Title 22, O.S., §60.1and the Domestic Abuse Reporting Act Title 74, O.S., §150.12B. The DVFRB decided to use the definition in statutes.

1. ***Domestic Abuse*** *means any act of physical harm, or the threat of imminent physical harm which is committed by an adult, emancipated minor, or minor age thirteen (13) years of age or older against another adult, emancipated minor or minor child who are family or household members or who are or were in a dating relationship;*
2. ***Stalking*** *means the willful, malicious, and repeated following of a person by an adult, emancipated minor, or minor thirteen (13) years of age or older, with the intent of placing the person in reasonable fear of death or great bodily injury;*
3. ***Harassment*** *means a knowing and willful course or pattern of conduct by a family or household member or an individual who is or has been involved in a dating relationship with the person, directed at a specific person which seriously alarms or annoys the person, and which serves no legitimate purpose. The course of conduct must be such as would cause a reasonable person to suffer substantial emotional distress, and must actually cause substantial distress to the person. Harassment shall include, but not be limited to, harassing or obscene telephone calls in violation of Section 1172 of Title 21 of the Oklahoma Statutes and fear of death or bodily injury;*
4. ***Family or household members*** *means spouses, ex-spouses, present spouses of ex-spouses, parents, including grandparents, stepparents, adoptive parents and foster parents, children, including grandchildren, stepchildren, adopted*

children and foster children, persons otherwise related by blood or marriage, persons living in the same household or who formerly lived in the same household, persons who are the biological parents of the same child, regardless of their marital status, or whether they have lived together at any time. This shall include the elderly and handicapped;

5. ***Dating relationship*** *means a courtship or engagement relationship. For purposes of this act, a casual acquaintance or ordinary fraternization between persons in a business or social context shall not constitute a dating relationship.*

Other terms used by the DVFRB are defined as follows:

- ***Intimate Partners***:
    - Current spouses
    - Common-law spouses
    - Current non-marital partners
        - Dating partners, including first date (heterosexual or same-sex)
        - Boyfriends/girlfriends (heterosexual or same-sex)
    - Former marital partners
        - Divorced spouses
        - Former common-law spouses
        - Separated spouses
    - Former non-marital partners
        - Former dates (heterosexual or same-sex)
        - Former boyfriends/girlfriends (heterosexual or same-sex)
- ***Domestic violence fatalities*** refer to those homicides caused by, or related to, domestic violence or abuse.
- ***Preventable death*** is one that, with retrospective analysis, might have been prevented given a reasonable intervention (e.g., medical, social, legal, psychological).
- ***Reasonable*** means taking into consideration the condition, circumstances or resources available.

Domestic violence fatality review describes the deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence or abuse, for examination of the systemic interventions in consideration of an altered systemic response to avert future domestic violence-related deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to reduce and eradicate domestic violence.

The data collection methods and a discussion of the limitations of the data can be found in Appendix C.

Findings

There were 369 domestic violence homicides in Oklahoma from 1998 to 2002 (Table 1). This means 10.7 Oklahomans per 100,000 die each year due to domestic violence (Figure 1 and Table 2). Of these, 277 (75% of the total) were reported to the OSBI specifically as domestic violence homicides. The others were discovered through direct reports from investigating agencies when information was requested on other cases or through newspaper archive searches.

As of August 2003, the DVFRB had reviewed 71% (113 of 159) of the cases from 1998 and 1999. The 113 cases represent 126 victims and 126 perpetrators. The findings leading to its recommendations are reported below.

Table 1. Homicides in Oklahoma.

	Total Homicides Reported to OCME	Total Homicides Reported to OSBI	DV Homicides Reported to OSBI*	Actual DV Homicides*	Actual # of DV Homicide Cases
1998	267	204	63	84	74
1999	300	231	65	88	85
2000	248	181	46	70	67
2001	268	185	55	66	59
2002	230	163	48	61	57
Total	1313	964	277	369	342

*Count given by number of victims

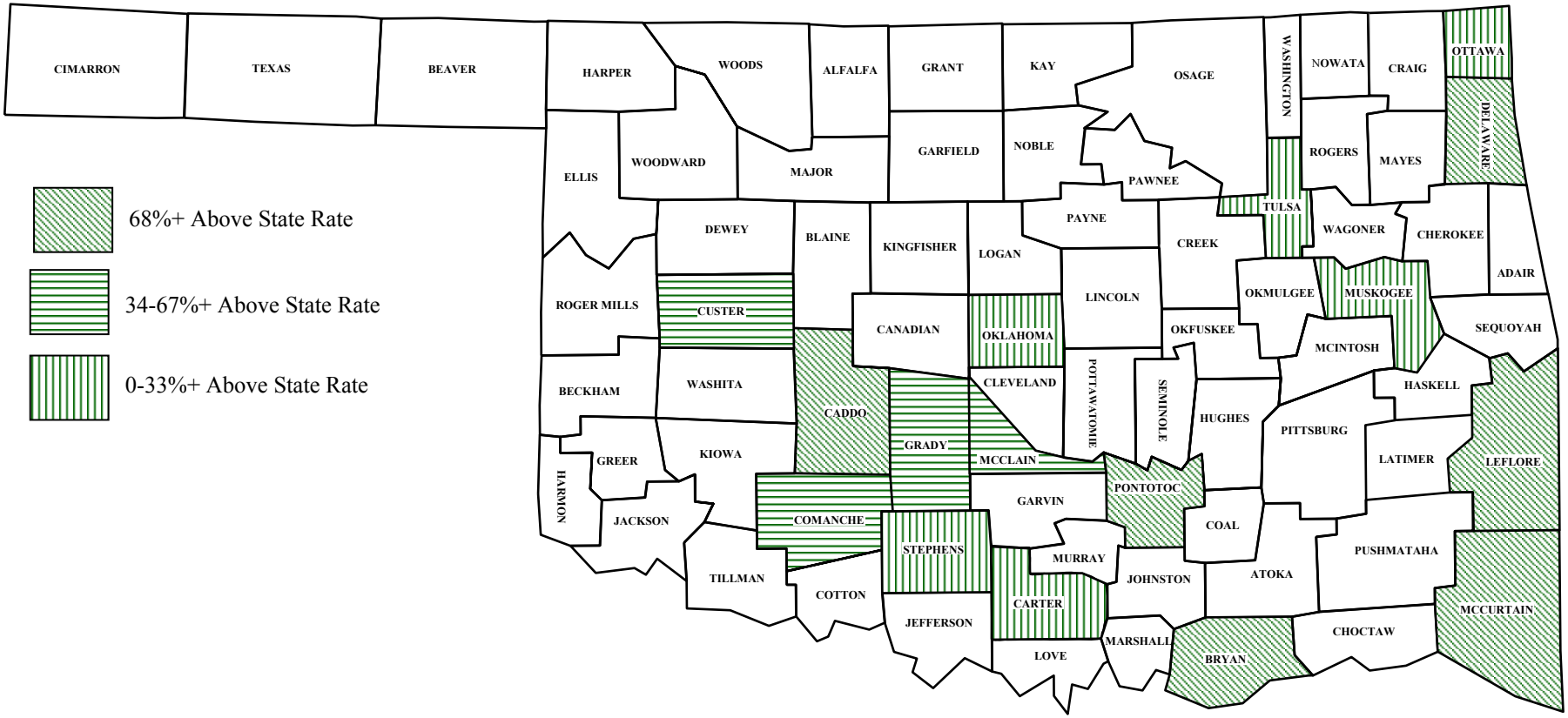
Table 3 provides demographic characteristics of the victims and perpetrators. On average, victims were 37 years old and perpetrators were 38 years of age. The youngest victim was less than a day old; the eldest 91. Most of the victims were white (79%), followed by Black (16%) and American Indian (5%). Just over 4% of victims were of Hispanic or Latino origin. The youngest perpetrator was 15 years of age; the eldest was 89 years old. The majority of perpetrators were white (74%), followed by Black (20%) and American Indian (6%). Some 4% of perpetrators were of Hispanic or Latino origin. Overall, the majority of homicides were homogeneous, only 9 (8%) were interracial homicides.

Table 3. Characteristics

	Victims				Perpetrators			
	Female (N=58)		Male (N=55)		Female (N=26)		Male (N=87)	
Age (average, in years)	38.5		36.3		38.04		38.6	
Race								
White	49	84%	40	73%	19	73%	65	75%
Black	5	9%	13	24%	5	19%	17	20%
American Indian	4	7%	2	4%	2	8%	5	6%
Of Hispanic or Latino Origin	2	3%	3	5%			5	6%
Previous Domestic Violence	38	66%	26	47%	15	58%	55	63%
Acute/Chronic medical conditions	17	29%	10	18%	8	31%	18	21%
Mental Health History	10	17%	3	5%	7	27%	25	29%
Pregnant at time of death	2	3%			1	4%		

Two victims were reported to be pregnant at the time of death. There was documented history of domestic violence for 57% of the victims. Twenty-four percent of victims had a known history of acute and/or chronic medical conditions and 12% of victims had a known history of mental and/or emotional problems. Of those victims with known medical and/or mental/emotional conditions, 36% had seen a doctor or counselor within a week

Figure 1. Domestic Violence Homicides per 100,000 Population*
1998-2002



*Only Counties with populations over 25,000 are represented on map.

Table 2. Domestic Violence Homicide Rate per 100,000 population, 1998-2002.

Geographic area	Total Population	Size Rank	Homicides	Rate per 100,000	% Above/Below State Rate
Haskell	11,792	53	4	33.9	68%+ above
McCurtain	34,402	28	11	32.0	68%+ above
Le Flore	48,109	14	15	31.2	68%+ above
Harmon	3,283	76	1	30.5	68%+ above
Craig	14,950	45	4	26.8	68%+ above
Pontotoc	35,143	27	9	25.6	68%+ above
Caddo	30,150	32	7	23.2	68%+ above
Love	8,831	63	2	22.6	68%+ above
Grant	5,144	71	1	19.4	68%+ above
Bryan	36,534	26	7	19.2	68%+ above
Delaware	37,077	25	7	18.9	68%+ above
Grady	45,516	17	8	17.6	34-67% above
Pushmataha	11,667	54	2	17.1	34-67% above
Coal	6,031	69	1	16.6	34-67% above
Comanche	114,996	4	18	15.7	34-67% above
McIntosh	19,456	41	3	15.4	34-67% above
Custer	26,142	36	4	15.3	34-67% above
Cotton	6,614	66	1	15.1	34-67% above
McClain	27,740	34	4	14.4	34-67% above
Hughes	14,154	46	2	14.1	0-33% above
Tulsa	563,299	2	70	12.4	0-33% above
Oklahoma	660,448	1	81	12.3	0-33% above
Ottawa	33,194	30	4	12.1	0-33% above
Seminole	24,894	37	3	12.1	0-33% above
Stephens	43,182	20	5	11.6	0-33% above
Muskogee	69,451	7	8	11.5	0-33% above
Carter	45,621	16	5	11.0	0-33% above
Woods	9,089	62	1	11.0	0-33% above
Tillman	9,287	61	1	10.8	0-33% above
State	**3,450,654**		**369**	10.7	
Kay	48,080	15	5	10.4	0-33% below
Mayes	38,369	24	4	10.4	0-33% below
Canadian	87,697	5	9	10.3	0-33% below
Kiowa	10,227	60	1	9.8	0-33% below
Adair	21,038	38	2	9.5	0-33% below
Johnston	10,513	59	1	9.5	0-33% below
Cherokee	42,521	21	4	9.4	0-33% below
Latimer	10,692	57	1	9.4	0-33% below
Payne	68,190	8	6	8.8	0-33% below

Geographic area	Total Population	Size Rank	Homicides	Rate per 100,000	% Above/Below State Rate
Noble	11,411	56	1	8.8	0-33% below
Okfuskee	11,814	52	1	8.5	0-33% below
Murray	12,623	50	1	7.9	0-33% below
Sequoyah	38,972	23	3	7.7	0-33% below
Marshall	13,184	49	1	7.6	0-33% below
Garvin	27,210	35	2	7.4	0-33% below
Atoka	13,879	48	1	7.2	0-33% below
Kingfisher	13,926	47	1	7.2	0-33% below
Jackson	28,439	33	2	7.0	34-67% below
Pittsburg	43,953	19	3	6.8	34-67% below
Osage	44,437	18	3	6.8	34-67% below
Lincoln	32,080	31	2	6.2	34-67% below
Pottawatomie	65,521	10	4	6.1	34-67% below
Washington	48,996	13	3	6.1	34-67% below
Pawnee	16,612	43	1	6.0	34-67% below
Creek	67,367	9	4	5.9	34-67% below
Texas	20,107	39	1	5.0	34-67% below
Okmulgee	39,685	22	2	5.0	34-67% below
Rogers	70,641	6	3	4.2	34-67% below
Wagoner	57,491	12	2	3.5	34-67% below
Logan	33,924	29	1	2.9	68%+ below
Cleveland	208,016	3	4	1.9	68%+ below
Garfield	57,813	11	1	1.7	68%+ below
Alfalfa	6,105	67	0	0.0	N/A
Beaver	5,857	70	0	0.0	N/A
Beckham	19,799	40	0	0.0	N/A
Blaine	11,976	51	0	0.0	N/A
Choctaw	15,342	44	0	0.0	N/A
Cimarron	3,148	77	0	0.0	N/A
Dewey	4,743	72	0	0.0	N/A
Ellis	4,075	73	0	0.0	N/A
Greer	6,061	68	0	0.0	N/A
Harper	3,562	74	0	0.0	N/A
Jefferson	6,818	65	0	0.0	N/A
Major	7,545	64	0	0.0	N/A
Nowata	10,569	58	0	0.0	N/A
Roger Mills	3,436	75	0	0.0	N/A
Washita	11,508	55	0	0.0	N/A
Woodward	18,486	42	0	0.0	N/A

of their homicide. One perpetrator was reported to be pregnant at the time of the homicide. Sixty-two percent of perpetrators had a documented history of committing domestic violence. Nearly a quarter of perpetrators had a known history of acute and or chronic medical problems and 27% of perpetrators had a known history of mental and or emotional problems; 23% had seen their practitioner within a week of the homicide. Sixteen victims (14%) and 24 perpetrators (21%) had at least one known contact with the Department of Mental Health and Substance Abuse Services prior to their death (Table 4). Although 92% of victims had domestic violence services available within their county of residence, only three victims were known to have contacted domestic violence services and only two victims were known to have stayed in a domestic violence shelter. Two perpetrators contacted domestic violence services and one was reported to have stayed in a domestic violence shelter.

Table 4. ODMHSAS & ODHS Contacts

	Victims		Perpetrators	
Contact with ODMHSAS ever	16	14%	24	21%
Alcohol/Drug Treatment Center	5		9	
Community Mental Health Center	13		16	
Dual Diagnosis Treatment Center			1	
Domestic Violence Services			1	
State Hospital			4	
Contact with ODHS ever	56	50%	64	57%
Child Welfare	1			
Child Support	40		46	
Adult Protective Services	3		2	
Child Protective Services	2		8	
DHS Other (specific unknown)	34		32	
Foster Care	1		2	
Temporary Assistance for Needy Families	1		1	

*30 Victims had multiple contacts with ODMHSAS &/or ODHS

*37 Perpetrators had multiple contacts with ODMHSAS &/or ODHS

Alcohol and drug use was higher among perpetrators (61%) than victims (37%). Ten percent of victims had received substance abuse treatment prior to their death. Close to a fifth of perpetrators had received substance abuse treatment at least once prior to the homicide. Over two-fifths of both victims (42%) and perpetrators (42%) were known to be intoxicated at the time of the homicide (Table 5).

Table 5. Substance use and treatment

	Victims		Perpetrators	
Known to regularly use drugs or alcohol at the time of death	42	37%	69	61%
Received alcohol/substance abuse treatment	11	10%	21	19%
Positive Toxicology report at death (P:N=25)	47	42%	7	28%
If alive, the perpetrator appeared intoxicated/was intoxicated at time of death event (N=88)			41	47%
Of all perpetrators, number that appeared intoxicated/were intoxicated at time of death event			48	42%

In 56% of the cases the perpetrator and victim were cohabitating. A current or former intimate partner killed 64% of all the victims in the reviewed cases (Table 6). Forty-three percent of victims had children under the age of eighteen living in their home; of those children, 69% were present at the time of death. Of the victims with children, 51% had children with the perpetrator and 98% had children with a former partner. There were witnesses in 58% of the cases reviewed. Adults witnessed the homicide in 45% of the cases, with one to 17 adult witnesses in any of the cases. Children either saw or heard 36% of the slayings and in 16% of the cases they

Table 6. Perpetrators relationship to Victim

boyfriend/girlfriend	20	19%	in-law	7	7%
common law spouse	7	7%	former in-law	1	1%
spouse	28	26%	grandchild	1	1%
estranged spouse	4	4%	grandchild's boyfriend/girlfriend	2	2%
former boyfriend/girlfriend	3	3%	other family	7	7%
former common law spouse	2	2%	Other**	5	5%
former spouse	4	4%	Parent/step-parent	10	9%
former partner/current partner*	8	8%	parent's boyfriend/girlfriend	6	6%
child/step-child	6	6%	sibling	5	5%

+Total relationships does not equal number of victims as some perpetrators had multiple relationships with victims.

*This category includes those relationships where a person's current/former partner murders their current/former partner, ie. New husband murders wife's ex-husband

** This category includes roommates and others involved in committing homicide that may not have familial relationship to victim, ie. Friends of perpetrator who helped commit murder.

were eyewitnesses to the event. In cases with child witnesses, anywhere from one to 30 children witnessed the homicide, and ranged in age from less than one year to 17 years of age with an average age of 7 years old.

Out of the 21 cases in which the victim and perpetrator had children under age 18 in common, the victim and perpetrator were living separately in 12 of those cases. Additionally, in two cases there was a joint custody agreement between either the perpetrator or victim and a new partner (for example, victim has joint custody with ex-wife, ex-wife's new husband is the perpetrator). Overall, in ten cases there were joint custody arrangements.[7] In one case, the perpetrator took the children and hid them from the victim for a period of time, in essence kidnapping the children. In four of the cases, the perpetrator used the children to pass threatening messages to the victim. Three of the homicides occurred during a child exchange (Table 7).

Table 7. Joint Custody

Cases where joint custody agreement existed	10	100%
Cases where perpetrator kidnapped children	1	10%
Perpetrator passed threatening messages to victim through children	4	40%
Homicide occurred during child exchange	3	30%

Firearms were used in 59% of the reviewed homicides (Table 8). The majority of all of the homicides occurred at the victim's residence (67%), with the majority of those occurring in the bedroom (30%) or the living room (27%).

Table 8. Weapons used & location of death event

No known weapons or bodily force	4	4%	Highway	2	2%
Bodily Force	16	14%	City Street	4	4%
Blunt Object	6	5%	Rural Road	2	2%
Cutting or Piercing instrument	13	12%	Body of Water	2	2%
Long Gun (e.g., shotgun, rifle)	14	12%	Public Driveway/Parking area	2	2%
Handgun	51	45%	Private Driveway/Parking area	2	2%
Firearm, Type Unknown	2	2%	Other Private Property	4	4%
Another Type of Weapon	7	6%	Residence of Victim	76	67%
			Other Residence	5	4%
			Victim's Place of Employment	2	2%
			Residence of Perpetrator	11	10%
			Motel/Hotel	1	1%

[7] 7 court ordered, 3 mutually agreed by involved parties

Table 9. Prior convictions and arrests.

	Victims		Perpetrators	
Any prior conviction	25	22%	48	43%
Prior felony conviction	17	15%	32	28%
Prior misdemeanor conviction	17	15%	32	28%
Prior arrest	29	26%	48	43%
On probation or parole at the time of death event	7	6%	19	17%

Seventy-eight percent of victims and 58% of perpetrators did not have a prior conviction record (Table 9), while, 74% of victims and 58% of perpetrators had never been arrested before. Of those with prior arrest and conviction records, the average number of convictions for victims was 3.4 with a range of one to 22; and 4.4 for perpetrators, with a range of one to thirty. Driving under the influence (DUI) was the primary crime for which both victims and perpetrators had been arrested and/or convicted. Seventeen (15%) victims had at least one prior arrest for DUI, with eleven (10%) of those leading to a conviction. Nineteen (17%) perpetrators had at least one prior arrest for DUI, with eleven (10%) of those arrests leading to a conviction.

Protective orders (PO) had been utilized in 19% of the reviewed cases. The breakdown of who filed the protection order can be seen in Table 10. In over half of the cases where a protective order did exist, the defendant violated the PO. The average number of violations was 2.26 with a range of one to eighteen. The outcomes of those violations can be seen in Table 11. Eight victims told others that the perpetrator was stalking them prior to the death event. The victims reported stalking behavior to law enforcement (5), family (5), friends (3), employer (1), and the court through filing for a protective order (1).

Table 10. Protective Orders & Stalking

The Victim had filed a PO against the perpetrator	11	10%
The Perpetrator had filed a PO against the victim	5	4%
A relative of the victim had a PO filed against the Perpetrator	8	7%
The victim had told others the perpetrator was stalking him/her	8	7%

Table 11. Protective Order Outcomes

Case ID	Type of PO in existence	# times PO violated	PO Active at time of death	Outcome
980008	Permanent	1	Yes	V reported one violation to police, and phoned police the next day to follow up. Because of a holiday, the officer did not file the report with the DA's office before P killed V.
980010	Permanent	12	Yes	Never reported any violations to police.
980016	Ex Parte		No	Filed in 1990, dropped.
980021	Permanent		No	Dropped.
980022	Ex Parte		No	Dropped.
980031	Temporary		Yes	PO between P and V's ex-wife. Had not been served.
980041	Permanent	5	Yes	PO between P and V's daughter. She had reported 4 violations to law enforcement, DA decline to file.
980046	Permanent		No	Dropped.
980049	Permanent		Yes	Sister-in-law filed for the PO after she was threatened by P.
980050	Permanent	3	Yes	Violations occurred 3 months prior to death and were dismissed by the court.

Table 11 (Continued). Protective Order Outcomes

Case ID	Type of PO in existence	# times PO violated	PO Active at time of death	Outcome
980052	Permanent	18	Yes	V repeatedly contacted police about violations. They told her she needed to follow up with DA. P was calling her repeatedly from county jail while he was there for violating the PO. She reported this to police who told her to tell the sheriff that P was violating the PO from jail.
980055	Permanent	2	Yes	PO between V and P's wife (V's ex-wife). Violations reported but not enforced due to joint custody order with no restrictions on calls or V coming by residence to check on daughter.
980056	Ex Parte		No	PO between P and V's wife (P's ex-girlfriend). Dismissed Failure To Appear.
980066	Permanent		Yes	Made permanent 2 days prior to homicide.
990014	Temporary		Yes	V filed for PO in late Dec., a Temporary Restraining Order (TRO) was granted and dismissed at hearing; V filed for TRO again in late Feb., three days later P kidnapped her and threatened her life, three days after that the TRO was granted, hearing was set, dropped due to V's death.
990017	Temporary		No	PO between P and V's mother. Dropped.
990019	Temporary	1	Yes	V reported violation to police (used visitation w/children to have them deliver threat letter to V). Warrant issued for arrest for violation of PO. Sheriffs office had not executed service at time of death 20 days later, nor had they forwarded warrant to local police department.
990020	Permanent	1	No	PO was filed in another state in 1991 (good for 1 year) V violated it one week later - outcome unknown. Another was filed in 1993, dismissed-Failure to appear. Since then V & P had moved to OK and cohabitated.
990042	Permanent	1	Yes	P's estranged wife had PO against P, P violated PO and was arrested, P bonded out of jail and killed V (and shot his wife) the next day.
990044	Permanent	2	Yes	2 violations reported to police. First reported when V entered home 2 years after service of PO. At time P made statement that V continually entered her home. Reported 2nd violation while V was awaiting trial for first violation. He called P 14 times from county jail. P reported violations to police, they in turn notified the sheriff of the violation calls coming from the county jail.
990061	Temporary		No	Voluntary dismissal.
990072	Ex Parte		No	Never served, court dismissed failure to appear.

Law enforcement had responded to domestic disturbances in at least 32% of the cases. For the cases in which law enforcement responded, the average number of responses was 2.31 with a range of one to eighteen documented responses. This number could potentially be higher as it only counts documented responses. If an officer responded, but did not fill out a report or if the report was not included in the documentation received from law enforcement it is unaccounted for in this number.

In many cases several people were aware of the violence occurring. Someone else knew of the ongoing domestic violence in 57% of the reviewed cases. Of those, the

Table 12. Who knew?

Family	38	59%
Friends	32	50%
Law Enforcement	28	44%
Court - PO	11	17%
Neighbor	6	9%
Medical/Doctor	5	8%
DHS	4	6%
Court	3	5%
DV services	2	3%
Employer/Co-workers	2	3%
Mental Health	2	3%
Attorney	1	2%

*40 Victims had reported abuse to more than one party.

majority who were aware of the violence were family members (59%), friends (50%), and law enforcement (44%). Table 12 reveals the other people and entities that had contact with the victim and were aware of the violence. In 40 (35%) cases, more than one person or entity was aware of the violence.

As to the outcome of the cases, charges were filed in 72% of the cases. Table 13 details the charges filed against the perpetrators, and those they were convicted of committing. Twenty-seven perpetrators had more than one charge filed against them, and 22 were convicted of more than one offense. Convictions were attained in 89% of the cases that were filed. Five (4%) were acquitted of the charges (although they admitted to the events causing the death), three (6%) died before the completion of prosecution and one (1%) was found not guilty by reason of insanity. It took an average of one year and two months to complete each case from the date of death to conviction, with a range of 36 days to 3 years and 3 months. Of those convicted as adults, two-fifths were found guilty by a jury (40%), over a third pled guilty (39%), nearly a sixth pled Nolo Contendere (16%), three were found guilty by a judge (4%) and one entered a blind plea (1%).

Table 13. Charges

	Filed		Convicted	
Conspiracy to Commit Murder I	1	1%	2	2%
Manslaughter I	3	3%	22	19%
Murder I	67	59%	32	28%
Murder II	10	9%	13	12%
Possession of Firearm AFC			1	1%
Unknown OJA			1	1%

* 17 Perpetrators had more than one charge filed against them

* 15 Perpetrators had more than one conviction stem from the case

Table 14. Sentences.

	Female		Males	
Prison only	15	83%	43	83%
Prison and Probation	3	17%	6	12%
Probation only			2	4%
OJA Youthful Offender			1	2%
Average sentence*	18.3 years		22.5 years	
Life	4	22%	10	19%
Life without parole	2	11%	17	33%
Death			1	2%

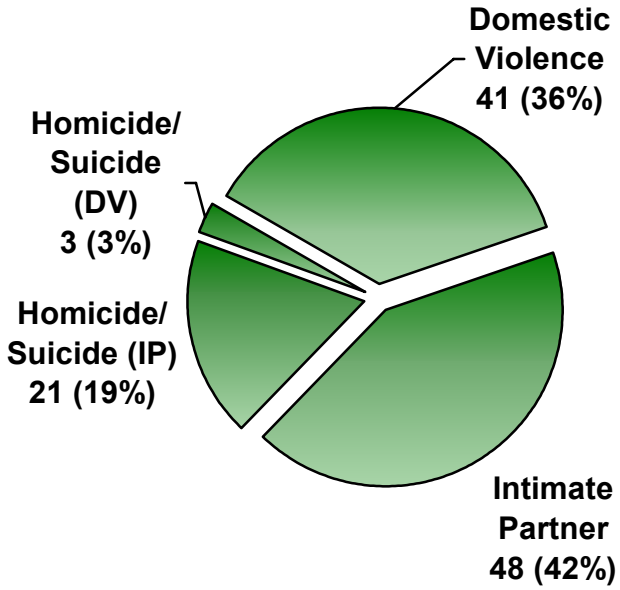
*Average excludes life and life without parole sentences.

Of those convicted and sentenced, 83% were sentenced to prison; 13% received a split prison and probation sentence; two received probation only; and one was sentenced as a youthful offender under the Office of Juvenile Affairs (Table 14). The average sentence is 21.11 years, not including those sentenced to life or life without parole. Sentences ranged from 4 years to 91 years. Fourteen were sentenced to life in prison; nineteen were sentenced to life without parole; and one was sentenced to death.

For a complete review of all of the data collected see our publications at our website at www.ocjrc.net/dvfrb.htm.

Intimate Partner Homicide

Of the 113 cases reviewed from 1998-1999, 69 (61%) were committed by intimate partners (IP) and 44 (39%) were committed by other family members (DV). Of the 44 Domestic Violence Homicides, 3 were Homicide/Suicide cases. Of the 69 Intimate Partner Homicides, 21 were Homicide/Suicide cases.



Intimate Partner Case Characteristics

As reported in the DVFRB's first report, there was a great interest in the cases involving intimate partner relationships and requested additional analysis on this subset of cases for this report. The findings are reported as follows.

Tables 15-16 depict demographic characteristics and relationships of the victims and perpetrators. On average, the victim's age was 40 years, with a range of 15 to 91 years. Perpetrators average age was 40 years, with a range of 15 to 86 years. Most victims were female (71%), and most perpetrators were male (69%). Most victims and perpetrators were White, and Non-Hispanic/Latino. In a substantial number

Table 15. Cohabitation & Status of Relationship

		Female (N=49)		Male (N=20)	
Victim was cohabitating with the Perpetrator		29	59%	15	75%
The victim was attempting to or in the process of leaving the perpetrator at the time of death event	No	15	52%	15	100%
	Yes	7	24%	0	0%
	Unknown	7	24%	0	0%
Victim was NOT cohabitating with the Perpetrator		20	41%	5	25%
The victim was attempting to or in the process of leaving the perpetrator at the time of death event	No	5	25%	3	60%
	Yes	13	65%	1	20%
	Unknown	2	10%	1	20%

of female victim/male perpetrator cases, the levels of education were unknown (61% victims, 44% perpetrators). The largest category of known education level among female victims was "Some College" at 14%. For male perpetrators, the highest known level of education was "High School Graduate" in 21% of cases. When socioeconomic status was known, most female victims (27%) and male perpetrators (33%) made $15,000 or below per year.

Table 16. Characteristics

	Victims				Perpetrators			
	Female (N=49)		Male (N=20)		Female (N=21)		Male (N=48)	
Age (average, in years)	40		42		36.01		38.08	
Race								
White	41	84%	13	65%	14	67%	37	77%
Black	4	8%	6	30%	5	24%	8	17%
American Indian	4	8%	1	5%	2	9%	3	6%
Of Hispanic or Latino Origin	4	4%	0	0%	1	5%	2	4%
Separated, Divorce pending	7	14%	2	10%	1	5%	7	15%
Married, Living Separately	3	6%	1	5%	1	5%	4	8%
Divorced (not remarried)	7	14%	2	10%	5	24%	5	11%
Married	17	35%	6	30%	5	24%	16	33%
Common Law Married	4	8%	3	15%	3	13%	4	8%
Single/Never Married	6	13%	3	15%	4	19%	9	19%
Widowed	0	0%	1	5%	1	5%	0	0%
Unknown/not stated	5	10%	2	10%	1	5%	3	6%
Spouse					7	33%	22	46%
Common-Law Spouse					4	19%	3	6%
Divorced Spouse					0	0%	3	6%
Former Common-Law Spouse					0	0%	1	2%
Separated Spouse or Common-Law Spouse					0	0%	4	9%
Girl/Boy Friend					8	38%	12	25%
Former Girl/Boy Friend					2	10%	3	6%
$15,000 or below	13	27%	5	25%	12	57%	16	33%
$15,001 to $25,000	5	10%	0	0%	1	5%	6	13%
$25,001 to $50,000	5	10%	4	20%	3	14%	5	10%
$50,000 to $75,000	1	2%	0	0%	0	0%	1	2%
$100,000 or above	0	0%	1	5%	0	0%	0	0%
Unknown	25	51%	10	50%	5	24%	20	42%
Less than High School	3	6%	0	0%	6	27%	8	17%
High School Graduate	4	8%	4	20%	4	19%	10	21%
Vocational/Technical	2	4%	0	0%	0	0%	2	4%
Some College	7	14%	0	0%	2	10%	6	12%
Associate Degree	1	2%	2	10%	0	0%	0	0%
Bachelor's Degree	2	4%	0	0%	2	10%	0	0%
Graduate Degree	0	0%	0	0%	2	10%	1	2%
Unknown	30	61%	14	70%	5	24%	21	44%

Most victims and perpetrators were married at the time of the death event, and 46% of perpetrators were spouses. The majority of victims and perpetrators were cohabitating. When the victim was cohabitating with the perpetrator, the victim was also in the process of leaving the perpetrator in a significant number of cases. The average length of time the victim and perpetrator were in a relationship was 9.85 years, with a range of 2.5 months to 62 years. As found in the 2002 DVFRB report, victims were typically poor, middle aged, white females who were married to and living with the perpetrator. Generally, perpetrators again had similar characteristics to the victims, with the main exception being that they were male.

A significant number of victims (86%) and perpetrators (62%) had no known criminal convictions (Table 17). The minimum number of convictions for victims was 0, and the maximum was 22. The minimum number of convictions for perpetrators was 0, and the maximum number was 30. Six percent of victims were serving a prior sentence at the time of the death event (Table 17). Sixteen percent of perpetrators were serving a prior sentence at the time of the death event.

Table 17. Total Number of Prior Convictions (Felony and Misdemeanor)

	Victims		Perpetrators	
0	59	86%	43	62%
1-2	8	13%	11	16%
3-5	1	1%	10	15%
6-10	1	1%	3	4%
11+	0	0%	2	3%
On Probation/Parole at the time of death	4	6%	11	16%

Among the victims, 40% were known to use drugs/alcohol, while 57% of perpetrators were known to use drugs/alcohol (Table 18). For victims, 20% had not received substance abuse treatment; 32% of perpetrators did not receive substance abuse treatment. A substantial number of victims and perpetrators had unknown medical histories (Table 19). When medical histories were known, 24% of victims had acute/chronic medical problems, while 28% of perpetrators had acute/chronic medical problems. A significant number of victims and perpetrators had no mental health history. For those whose mental health history was available, 14% of victims and 26% of perpetrators had a history of psychological/ emotional issues.

Table 18. Substance use and treatment

	Victims		Perpetrators	
Known to use drugs/alcohol at time of death				
Yes	28	40%	39	57%
No	15	22%	11	16%
Unknown	26	38%	19	27%
# times received drug/alcohol treatment				
0	14	20%	22	32%
1-4 times	7	11%	11	16%
Unknown if needed	27	39%	17	25%
Unknown if received	9	13%	10	14%
Not applicable, no history of use	12	17%	9	13%

Table 19. Medical and Mental Health

History of Acute/Chronic Medical Condition	Victims		Perpetrators	
No	26	38%	21	30%
Yes	17	24%	19	28%
Unknown	26	38%	29	42%
History of Psychological/ Emotional Issues				
No	55	80%	46	67%
Yes	10	14%	18	26%
Possible	0	0%	1	1%
Unknown	4	6%	4	6%

Table 20 displays the victims' and perpetrators' violence histories. Among the victims 13% had a history of committing violence other than domestic violence, while 32% of perpetrators had a history of committing other types of violence. There is a large difference between victims and perpetrators with regards to history of committing domestic violence. Indeed, 23% of victims and 64% of perpetrators had a history of committing domestic violence. Among perpetrators, only one was ever sentenced to a Batterer's Intervention Program. The completion of the program is unknown.

Table 20. Violence History

	Victims		Perpetrators	
History of committing violence other than Domestic Violence				
No	34	49%	19	28%
Yes	9	13%	22	32%
Possible (one source)	2	3%	1	1%
Unknown	24	35%	27	39%
History of Committing Domestic Violence				
No	23	33%	11	16%
Yes	16	23%	44	64%
Possible (one source)	11	16%	3	4%
Unknown	19	28%	11	16%

Table 21. Ever made death threat against the Perpetrator/Victim prior to the death event?

	Victims		Perpetrators	
No	32	47%	13	19%
Yes	2	3%	23	33%
Possible (one source)	3	4%	8	12%
Unknown	32	46%	25	36%

The most common day of death event occurrence was Saturday with 25% of deaths occurring on that day, followed by Friday with 19% (Table 22). Most death events (23%) occurred the pre-dawn hours between 1:00 a.m. and 5:59 a.m.; followed by evening hours from 4:00 p.m. to 8:59 p.m. (20%). The majority of deaths occurred in the Victim's Residence (72%) and in the Bedroom (34%) or Living Room (29%). The weapon of choice in 63% of the homicides was a firearm (Table 23). Drug and/or alcohol use by the victim, perpetrator or both was associated with the death event in 57% of the cases.

Table 23. Mechanism/Cause of Death

Cut/Pierce	10	15%
Drowning/Submersion	1	1%
Fire/Burn – Fire/Flame	1	1%
Firearm	43	63%
Poisoning	1	1%
Struck By/Against	2	3%
Suffocation	1	1%
Strangulation	2	3%
Automobile	1	1%
Head Trauma	4	6%
Undetermined	3	5%

The Perpetrator made death threats against the Victim or someone known to the Victim prior to the death event in 33% of the cases, while the victim made death threats against the perpetrator in only 3% of the cases (Table 21).

Table 22. Death Event Characteristics

Day of Death Event		
Monday	8	12%
Tuesday	10	14%
Wednesday	6	9%
Thursday	5	7%
Friday	13	19%
Saturday	17	25%
Sunday	9	13%
Unknown	1	1%
Time of Death Event		
Pre-Dawn (1:00 a.m.-5:59 a.m.)	16	23%
Morning (6:00 a.m.- 10:59 a.m.)	11	16%
Mid-day (11:00 a.m.- 3:59 p.m.)	7	10%
Evening (4:00 p.m.- 8:59 p.m.)	14	20%
Night (9:00 p.m.- 12:59 p.m.)	10	15%
Unknown	11	16%
Scene of Death Event		
Highway	2	3%
City Street	1	1%
Rural Road	2	3%
Body of Water	1	1%
Public Driveway/Parking Area	2	3%
Other Private Property	2	3%
Residence of Victim	49	72%
Other Residence	2	3%
Victim's Place of Employment	1	1%
Residence of Perpetrator	6	9%
Other	1	1%
If death event occurred in residence or workplace, where?		
Living Room/Main Area	20	29%
Kitchen	1	1%
Office/Study	1	1%
Bedroom	23	34%
Hallway	2	3%
Entryway	3	4%
Front Yard	4	6%
Other	3	4%
Unknown	1	2%
Not Applicable	11	16%

In 48% of the intimate partner homicides there were witnesses to the death event; in 25% of the cases a child was a witness to the death event. Of those child witnesses, 13% were eyewitnesses to the death event.

Table 24. Protective Order Filing

Victim filed PO against Perpetrator	11	16%
Perpetrator filed PO against Victim	5*	7%

*In one case the judge ordered a mutual protective order.

Sixteen percent of victims had filed a Protective Order (PO) against their perpetrator (Table 24). Seven percent of perpetrators filed a PO against their victim. Table 25 displays the status of the POs at the time of the death event. Of the POs filed, 81% had been served prior to the death event, and 62% were active at the time of death. The POs had been violated in over half of the cases, the number of violations ranged from one to eighteen.

In 75% of the cases, at least one other person or entity had knowledge of the existence of domestic violence/sexual assault between the perpetrator and victim. Families were aware of the violence in 63% of the cases (Table 26). Law enforcement knew of the domestic violence/sexual assault in 56% of the cases and had been called to homes on domestic violence calls and average of two times with a range of one to eighteen times. Friends also knew of the violence in 56% of the cases.

Table 25. Of the filed Protective Orders (N=16)

	PO had been served		PO was active		PO had been violated	
No	1	1%	6	37%	1	1%
Yes	13	81%	10	62%	9	56%
Unknown	3	18%	1	1%	7	43%

The following tables summarize charges, sentences, and dispositions of cases. Criminal charges were filed in 62% of the cases. In 35% of the cases the perpetrator committed suicide.

Table 26. Who knew?*

No evidence of DV/SA	11	16%
Unknown	6	9%
Medical	6	12%
Social Services	1	2%
Law Enforcement	29	56%
Family Court/VPO	11	21%
Domestic Violence Program	2	4%
Family	33	63%
Neighbors	3	6%
Friends	29	56%
Co-worker/Employer	2	4%

*In 52 cases at least one entity/person knew of DV/SA between victim and perpetrator. The percentages are figured based on the number of cases in which someone else knew.

Table 27. Charges

	Charges Filed		Charges Convicted Of	
Manslaughter I	1	2%	11	15%
Murder I	43	62%	21	30%
Murder II	3	4%	6	8%
Aquitted			1	1%
Unknown OJA			1	1%

Table 28. Sentencing

4 years	1	1%
5 years	1	1%
10 years	5	7%
12 years	1	1%
15 years	2	3%
27 years	1	1%
28 years	1	1%
30 years	1	1%
35 years	2	3%
Life	9	13%
Life w/o Parole	14	20%

Murder I charges were filed in 62% of the cases (Table 27). Of those charged, 81% were convicted and sentenced to prison. Thirty percent of perpetrators were convicted of Murder I, and 15% were convicted of Manslaughter I. A jury found 23% of perpetrators guilty. Of those convicted, 20% received Life without Parole for their crime (Table 28). The average sentence length was 18.7 years not including the life and life without parole sentences.

Homicide-Suicide

Of the 113 1998-1999 cases reviewed, 24 were Murder/Suicides (21%).

Table 29. Homicide/Suicide Characteristics

	Victims		Perpetrators	
Age (average, in years)	40.76		46.74	
Female	21	88%	1	4.00%
Male	3	13%	23	96%
Race				
White	20	83%	18	75%
Black	3	13%	5	21%
American Indian	1	4%	1	4%
Separated, Divorce pending	5	21%	5	21%
Married, Living Separately	2	8%	2	8%
Married	6	25%	7	29%
Divorced	2	8%	2	8%
Common Law Married	3	13%	4	17%
Single/Never Married	5	21%	2	8%
Widowed	0	0%	1	4%
Unknown/not stated	1	4%	1	4%
Spouse	12	50%	12	50%
Common-Law Spouse	2	8%	2	8%
Divorced Spouse	1	4%	1	4%
Separated Spouse or Common-Law Spouse	2	8%	2	8%
Girl/Boy Friend	2	8%	2	8%
Former Girl/Boy Friend	2	8%	2	8%
Child/Step-Child	3	13%	0	0%
Parent/Step-parent	0	0%	3	13%
$15,000 or below	5	21%	5	21%
$15,001 to $25,000	1	4%	1	4%
$25,001 to $50,000	5	21%	5	21%
Unknown	13	54%	13	54%
Less than High School	1	4%	0	0%
High School Graduate	2	8%	4	17%
Vocational/Technical	1	4%	0	0%
Some College	4	17%	3	13%
Associate Degree	1	4%	0	0%
Bachelor's Degree	2	8%	0	0%
Graduate Degree	0	0%	1	4%
Unknown	13	54%	16	67%

Table 29 displays some of the general characteristics of the victims and perpetrators of homicide/suicide cases reviewed by the DVFRB. Victims were predominately female; All but one of the perpetrators of homicide-suicide were male. The average age of victims was 40 years of age, and 46 years of age for perpetrators. The majority of both victims and perpetrators were white, only one victim and no perpetrators were of Hispanic or Latino Origin. Twenty-five percent of victims were divorced from their spouse; twenty-nine percent of perpetrators were divorced. Half of the perpetrators were the victims' spouses. When socio-economic level was known, 21% of both victims and perpetrators were in the $15,000 or below category and 21% of both victims and perpetrators were in the $25,001 to $50,000 category. Regarding education, victims were known to have a higher percentage of college (either some college or a college degree) than perpetrators. The average length of the relationship between victims and perpetrators was 19 years, with a range of one year to 70.6 years.

Over half of the victims were not cohabitating with the perpetrator at the time of the death event. Further, 58% were in the process of leaving the perpetrator at the time of the homicide-suicide (Table 30.)

Table 30. Cohabitation & Status of Relationship

	Victim was attempting to or in the process of leaving the perpetrator at the time of death event							
	Yes		No		Unknown		Total	
Victim was cohabitating with the perpetrator	10	42%	0	0%	0	0%	10	42%
Victim was NOT cohabitating with the perpetrator	14	58%	0	0%	0	0%	14	58%
	14	58%	7	29%	3	13%	24	100%

A significant number of victims (96%) and perpetrators (83%) had no known criminal convictions (Table 31). In fact, only one victim had any prior convictions; that victim had four prior convictions for obtaining a controlled dangerous substance by forgery or fraud. The minimum number of convictions for perpetrators was 0, and the maximum number was 4. Four perpetrators had prior convictions. The first had a prior conviction for aggravated assault-family, the second had a prior conviction for distribution of a controlled dangerous substance (cocaine), the third had a prior conviction for petty larceny, and the last had convictions for reckless driving (reduced from DUI), two convictions for carrying a concealed weapon, and one for disorderly conduct (reduced from assault and battery). None of the perpetrators was serving a prior sentence at the time of the death event.

Table 31. Total Number of Prior Convictions (Felony and Misdemeanor)

	Victims		Perpetrators	
No Priors	23	96%	20	83%
1 Prior			3	13%
4 Priors	1	4%	1	4%

Table 32. Substance use and treatment

	Victims		Perpetrators	
Known to use drugs/alcohol at time of death				
Yes	2	8%	6	25%
No	10	42%	7	29%
Unknown	12	50%	11	46%
# times received drug/alcohol treatment				
0	2	8%	7	29%
1 time	0	0%	1	4%
Unknown if needed	11	46%	8	34%
Unkown if ever received treatment	0	0%	1	4%
Not applicable, no history of use	11	46%	7	29%

Among the victims, only 8% were known to regularly use drugs and/or alcohol at the time of death, while 25% of perpetrators were known to regularly use drugs and/or alcohol (Table 32). None of the victims were known to have received substance abuse treatment; only one perpetrator was known to receive substance abuse treatment.

Table 33. Medical and Mental Health

History of Acute/Chronic Medical Condition	Victims		Perpetrators	
No	7	29%	7	29%
Yes	6	25%	5	21%
Unknown	11	46%	12	50%
History of Psychological/ Emotional Issues				
No	23	94%	19	79%
Yes	0	0%	3	13%
Possible	0	0%	1	4%
Unknown	1	6%	1	4%

A substantial number of victims and perpetrators had unknown medical histories (Table 33). When medical histories were known, 25% of victims had acute/chronic medical conditions, while 21% of perpetrators had acute/chronic medical conditions. None of the victims were known to have any history of psychological or emotional problems, and 13% perpetrators were known to have such conditions.

Among the victims, none had a known history of committing violence other than domestic violence; further none had a known history of committing domestic violence (Table 34). Seventeen percent of perpetrators had a history of committing other types of violence and 42% had a history of committing domestic violence. None of the perpetrators were known to have been sentenced to a Batterer's Intervention Program.

Table 34. Violence History

	Victims		Perpetrators	
History of committing violence other than Domestic Violence?				
No	16	67%	8	33%
Yes	0	0%	4	17%
Unknown	8	33%	12	50%
History of Committing Domestic Violence?				
No	15	63%	7	29%
Yes	0	0%	10	42%
Possible (one source)	0	0%	1	4%
Unknown	9	37%	5	25%

Table 35 shows that 42% of the time, the Perpetrator made death threats against the Victim or someone known to the Victim prior to the death event, while the victims were never known to have made death threats against the perpetrator. In six (25%) of the cases the perpetrator had threatened suicide prior to the death event, and in one case the perpetrator attempted suicide. In four of the cases, the perpetrator had been violent to the children in the home as well as the victim.

Table 35. Ever made death threat against the Perpetrator/Victim prior to the death event?

	Victims		Perpetrators	
No	16	67%	7	29%
Yes	0	0%	10	42%
Possible (one source)	0	0%	1	4%
Unknown	8	33%	6	25%

The most common days of death occurrence were Monday, Friday, and Saturday with 63% of deaths occurring on one of those days (21% on each day). Most death events (37%) occurred in the morning between 6:00 a.m. and 10:59 a.m.; followed by evening hours from 4:00 p.m. to 8:59 p.m. (25%). The majority of deaths occurred in the Victim's Residence (63%) and in the Living Room/Main Room (38%) followed by the Bedroom (25%). The homicide-suicides were distributed evenly (25% in each category) among population of death event location (Table 36).

The weapon of choice in 92% of the homicides was a firearm, primarily handguns (Table 37). In all, twenty-nine people died as a result of the twenty-four cases. Twenty-four were the primary victims, five were secondary victims who were there at the time of the death event; three of the five were the perpetrators children.

Table 37. Mechanism/ Cause of Victim's Death

Firearm	22	92%
Shotgun/Rifle	*3*	*13%*
Handgun	*19*	*79%*
Strangulation	1	4%
Cut/Pierce	1	4%

Two of the victims had a positive toxicology report for alcohol, and seven perpetrators had a positive toxicology report. In all drugs and/or alcohol use by the victim, perpetrator or both was associated with the death event in seven cases. In 58% of the homicide-suicides there were witnesses to the death event; in 25% of the cases a child was a witness to the death event.

Table 36. Death Event Characteristics

Day of Death Event		
Monday	5	21%
Tuesday	4	17%
Wednesday	3	12%
Friday	5	21%
Saturday	5	21%
Sunday	2	8%
Time of Death Event		
Pre-Dawn (1:00 a.m.-5:59 a.m.)	1	4%
Morning (6:00 a.m.- 10:59 a.m.)	9	37%
Mid-day (11:00 a.m.- 3:59 p.m.)	4	17%
Evening (4:00 p.m.- 8:59 p.m.)	6	25%
Night (9:00 p.m.- 12:59 p.m.)	1	4%
Unknown	3	13%
Scene of Death Event		
Highway	1	4%
City Street	1	4%
Rural Road	1	4%
Public Driveway/Parking Area	1	4%
Other Private Property	1	4%
Residence of Victim	15	63%
Other Residence	1	4%
Victim's Place of Employment	1	4%
Residence of Perpetrator	2	9%
If death event occurred in residence or workplace, where?		
Living Room/Main Area	9	38%
Office/Study	1	4%
Bedroom	6	25%
Front Yard	2	8%
Other	1	4%
Not Applicable	5	21%
Population of death event location		
1 - 2,500 people	6	25%
2,501 - 10,000 people	6	25%
10,001 - 100,000 people	6	25%
Over 100,001 people	6	25%

Table 38. Of the filed Protective Orders

	PO had been served		PO was active		PO had been violated	
No	1	14%	3	43%	1	14%
Yes	5	72%	4	57%	3	43%
Unknown	1	14%	0	0%	3	43%

Twenty-nine percent (7) of victims had filed a Protective Order (PO) against their perpetrator. In one case, a judge ordered mutual protective orders when the victim filed for a PO. Of the POs filed,

72% had been served prior to the death event, and more than half were active at the time of death. In three cases (43%) the POs were known to have been violated (Table 38).

In 45% of the cases, at least one other person or entity had knowledge of the existence of domestic violence/sexual assault between the perpetrator and victim (Table 39). Of those cases, law enforcement knew of the domestic violence/sexual assault in 54% of the cases, followed by family court/PO and family members each with 18% of the cases. In addition, four victims reported to others that the perpetrator was stalking them prior to the death event, and 17% of perpetrators told someone their intentions before the death event occurred.

Table 39. Who knew?*

Law Enforcement	6	54%
Family Court/PO	2	18%
Family	2	18%
Friends	1	10%

*In 11 cases at least one entity/person knew of DV/SA between victim and perpetrator. The percentages are figured based on the number of cases in which someone else knew.

2003 DVFRB Systemic Concerns

From the findings that have been documented in this report the DVFRB developed areas of concern and recommendations that could alleviate the identified issues. The following areas were highlighted by Board members:

- The breadth of services and service providers should be expanded. Those providing services should strive to continually educate themselves about the dynamics and issues surrounding domestic violence in order to ensure the safety of their clients.

- All providers should document any type of domestic violence their client may be suffering or inflicting.

- Providers should implement policies that ensure the increased safety of the victim.

- All providers should to perform domestic violence screening.

- Screening performed by service providers should assess the lethality of the situation when there is ongoing domestic violence.

- Domestic violence offenses appear to carry little consequences within the criminal justice system beyond initial law enforcement response.

2003 DVFRB System Recommendations

Courts

1. Make no contact with victim a condition of bond.
2. Court should perform lethality assessment before setting bail on domestic violence offenses.
3. Increase awareness of the role of the judiciary in preventing domestic homicides through:
    a. Victim Safety
    b. Offender Accountability

Department of Human Services

1. Identify and refer services available to victims of domestic violence and their children.
2. Improve capacity of DHS workers to assess danger to children by including Domestic Violence screening and response.

Department of Mental Health and Substance Abuse Services (DMHSAS)

1. Continue to strengthen integrative services – screening for domestic violence, mental health, and substance abuse should occur at all entry points into the system.
2. Review Emergency Order of Detention assessments. Strengthen lethality risk by utilizing outside sources [DMHSAS & private facilities].
3. Standardize assessments in Mental Health to include screening for domestic violence and appropriate referral/care [DMHSAS & work with Health Care Authority-Licensed Behavioral Health Specialists].
4. Continue to review, revise and strengthen minimum standards for Batterers Treatment.

District Attorneys

1. Make second and subsequent violation of Protective Order a felony. *
2. Increase penalty range for Domestic Assault & Battery –After Former Felony Conviction. *
3. Provide Evidence Based Prosecution and Domestic Violence 101 Training to all District Attorneys and Assistant District Attorneys that prosecute domestic violence.
4. Support DMHSAS efforts that DUI offenders be tested for propensity to violence in cases of court-ordered counseling.

Domestic Violence Advocates

1. Seek to expand services – geographic and variety
2. Develop targeted outreach programs to reach those victims who have no contacts with system, especially in rural areas through:
    a. Targeting natural listeners (hair stylists, nail technicians, bartenders, convenience store clerks, etc.)
    b. Targeting undocumented immigrant women.
3. Implement a public information campaign.
    a. How Do I Help?

* Requires Legislative Action

Health Care

1. Healthcare providers should seek domestic violence screening, assessment, and recognition training in all hospitals (in & out patient), long term healthcare & community care providers, Emergency Rooms, Primary Care, Obstetrician/Gynecologists, Health Departments, Planned Parenthood, etc. [Partner with Oklahoma State Department of Health] to improve screening, assessment, identification & documentation of domestic violence risk factors.
2. Health Care Providers should provide domestic violence screening, lethality assessment and identification for specific intervention to reduce risk (or vulnerability) and increase safety, especially of women, children, people with disabilities and elders (e.g., referral resources, safety planning).

Law Enforcement

1. Perform Danger/Lethality Assessments on all domestic violence calls – with particular attention to weapon accessibility & presence.
2. Document and file incident reports on all domestic violence contacts – regardless of original call designation.

Legal

1. Training/Education on representing victims of violence:
    a. Target all attorneys who work in divorce/family law through law school and Continuing Legal Education Units.

Overall Systems

1. Develop Family Justice Centers for comprehensive service and support for victims of domestic violence. Centers should be designed to improve victims' access to critical services by housing them in one location.
2. Increase cultural competency.
3. Funding should be prioritized for Domestic Violence Services in all areas. Support for Domestic Violence Emergency Response Teams (DVERT), prosecution of domestic violence offenses including protective order violations, etc.

Board Impact

In order to assess the impact of the DVFRB it was determined it would be necessary to track the progress that has occurred from either the work of the DVFRB or as a result of recommendations made by the DVFRB.

In the 2002 report the DVFRB recommended the Child Abuse Training Coordination Council (CATC) Board take a stronger approach to incorporating domestic violence into its training on child abuse. In January 2003 the DVFRB attended a CATC Council meeting to begin dialogue on how best to achieve this goal. After several discussions, the CATC and the DVFRB held a joint training in June 2003 bringing in Dr. Neil Websdale, considered by many the expert on domestic violence fatality reviews. The CATCC also sponsored three nationally known speakers

at the Oklahoma Coalition Against Domestic Violence and Sexual Assault Annual Conference in June 2003.

As part of his participation on the Board, Chief Don Murray of the Walters Police Department instituted a new policy that reports would be written on all domestic violence calls responded to by his officers. An unexpected outcome of the 2002 Annual Report was a Tulsa attorney having the report submitted as evidence of persuasive authority against joint child custody in cases where domestic violence was present between the parents.

Conclusion

The second annual Domestic Violence Fatality Review Board report has shown the importance of a systematic approach in determining the causes of domestic violence. Because domestic violence is a continuing problem in Oklahoma, and one with extreme costs to citizens, it is important to use a multidisciplinary systems approach to resolve issues surrounding these life-threatening situations. This report is essential to understanding the complexity and severity of intimate partner violence in our society. The use of real life, empirical data illustrates the need for all systems to band together to protect the lives of Oklahomans.

There have been successes in the past year due to a systems response toward victims of domestic violence. These successes are proof that by utilizing empirical data, as shown in this report, intelligent, important changes can be made to save lives. It is the hope of the DVFRB that there be continued successful multidisciplinary responses to domestic violence. As stated in the past year, if all systems coming into contact with an individual in a domestic violence situation are prepared and informed about the dynamics of domestic violence, and have policies and procedures in place to support their assistance to that individual, a significant reduction in the number of cases that result in homicide can be realized. The DVFRB's recommendations proved helpful in the past year, and will continue to be a useful tool to instigate change in the coming year.

To further encourage the understanding of domestic violence and proper responses to complex situations and in turn promote change, the DVFRB recognizes the following as possible future studies.

- Conduct studies of survivors who left their abusive relationship, identify accessed services and support networks, risk factors, and systematic needs.
- Assess and implement early intervention strategies for both victims and perpetrators.
- Investigate the intersection of domestic violence and firearms.
- Determine methods to see how many domestic violence homicides were possibly prevented and the means of occurrence.
- Conduct studies identifying and assessing follow-up with children involved in domestic violence situations.
- Ascertain the needs of women in rural areas and how to better serve them.
- Document which DVFRB recommendations are implemented and the impact of those recommendations on the system in preventing domestic violence homicides.

The DVFRB has come a long way since inception. It is the sincere hope that the hard work done in 2003 will aid in the prevention of domestic violence homicides in Oklahoma. Recommendations for this year's report were more specific than last year's due to the growth of the database and the maturation of the DVFRB itself. Framed recommendations will only become more precise in the following years for the same reasons. The DVFRB expresses gratitude to those who have already implemented change, and issues a challenge to systems to use this data and these recommendations to aid current and future victims of domestic violence and save lives.

ENROLLED HOUSE
BILL NO. 1372

By: Askins and Gilbert of the House

and

Horner of the Senate

An Act relating to domestic violence; establishing the Domestic Violence Fatality Review Board; stating powers and duties of Board; authorizing rule promulgation by Board; establishing membership of Board; amending 25 O.S. 1991, Section 307, as last amended by Section 10, Chapter 1, O.S.L. 1999 (25 O.S. Supp. 2000, Section 307), which relates to executive sessions of state boards; authorizing Domestic Violence Fatality Review Board to conduct executive sessions; providing for codification; providing an effective date; and declaring an emergency.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1601 of Title 22, unless there is created a duplication in numbering, reads as follows:

A. There is hereby created until July 1, 2007, in accordance with the Oklahoma Sunset Law, the Domestic Violence Fatality Review Board within the Oklahoma Criminal Justice Resource Center. The Board shall have the power and duty to:

1. Coordinate and integrate state and local efforts to address fatal domestic violence and create a body of information to prevent domestic violence deaths;

2. Collect, analyze and interpret state and local data on domestic violence deaths;

3. Develop a state and local database on domestic violence deaths;

4. Improve the ability to provide protective services to victims of domestic violence who may be living in a dangerous environment;

5. Improve policies, procedures and practices within the agencies that serve victims of domestic violence; and

6. Enter into agreements with other state, local or private entities as necessary to carry out the duties of the Domestic Violence Fatality Review Board.

B. In carrying out its duties and responsibilities, the Board shall:

1. Promulgate rules establishing criteria for identifying cases involving a domestic violence death subject to specific, in-depth review by the Board;

2. Conduct a specific case review of those cases where the cause of death is or may be related to domestic violence;

3. Establish and maintain statistical information related to domestic violence deaths, including, but not limited to, demographic and medical diagnostic information;

4. Establish procedures for obtaining initial information regarding domestic violence deaths from law enforcement agencies;

5. Review the policies, practices, and procedures of the domestic violence protection and prevention system and make specific recommendations to the entities comprising the domestic violence prevention and protection system for actions necessary for the improvement of the system;

6. Review the extent to which the state domestic violence prevention and protection system is coordinated with law enforcement and the court system and evaluate whether the state is efficiently discharging its domestic violence prevention and protection responsibilities;

7. Request and obtain a copy of all records and reports pertaining to a domestic violence death case of the victim, perpetrator or any other person cohabitating in the domicile at the time of the fatality that is under review, including, but not limited to:

a. the medical examiner's report,

b. hospital records,

c. school records,

d. court records,

e. prosecutorial records,

f. local, state, and federal law enforcement records, including, but not limited to, the Oklahoma State Bureau of Investigation (OSBI),

g. fire department records,

h. State Department of Health records, including birth certificate records,

i. medical and dental records,

j. Department of Mental Health and Substance Abuse Services and other mental health records,

k. emergency medical service records, and

l. Department of Human Services' files.

Confidential information provided to the Board shall be maintained by the Board in a confidential manner as otherwise required by state and federal law. Any person damaged by disclosure of such confidential information by the Board or its members which is not authorized by law may maintain an action for damages, costs and attorney fees pursuant to the Oklahoma Governmental Tort Claims Act;

8. Maintain all confidential information, documents and records in possession of the Board as confidential and not subject to subpoena or discovery in any civil or criminal proceedings; provided, however, information, documents and records otherwise

available from other sources shall not be exempt from subpoena or discovery through those sources solely because such information, documents and records were presented to or reviewed by the Board;

9. Conduct reviews of specific cases of domestic violence deaths and request the preparation of additional information and reports as determined to be necessary by the Board including, but not limited to, clinical summaries from treating physicians, chronologies of contact, and second opinion autopsies;

10. Report, if recommended by a majority vote of the Board, to the President Pro Tempore of the Senate and the Speaker of the House of Representatives any gross neglect of duty by any state officer or state employee, or any problem within the domestic violence prevention and protection system discovered by the Board while performing its duties; and

11. Exercise all incidental powers necessary and proper for the implementation and administration of the Domestic Violence Fatality Review Board.

C. The review and discussion of individual cases of a domestic violence death shall be conducted in executive session. All other business shall be conducted in accordance with the provisions of the Oklahoma Open Meeting Act. All discussions of individual cases and any writings produced by or created for the Board in the course of determining a remedial measure to be recommended by the Board, as the result of a review of an individual case of a domestic violence death, shall be privileged and shall not be admissible in evidence in any proceeding. The Board shall periodically conduct meetings to discuss organization and business matters and any actions or recommendations aimed at improvement of the domestic violence prevention and protection system which shall be subject to the Oklahoma Open Meeting Act. Part of any meeting of the Board may be specifically designated as a business meeting of the Board subject to the Oklahoma Open Meeting Act.

D. The Board shall submit an annual statistical report on the incidence and causes of domestic violence deaths in this state for which the Board has completed its review during the past calendar year including its recommendations, if any, to the domestic violence prevention and protection system. The Board shall also prepare and make available to the public, on an annual basis, a report containing a summary of the activities of the Board relating to the review of domestic violence deaths, the extent to which the state domestic violence prevention and protection system is coordinated and an evaluation of whether the state is efficiently discharging its domestic violence prevention and protection responsibilities. The report shall be completed no later than February 1 of the subsequent year.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1602 of Title 22, unless there is created a duplication in numbering, reads as follows:

A. The Domestic Violence Fatality Review Board shall be composed of sixteen (16) members, or their designees, as follows:

1. Seven of the members shall be:

a. the Chief Medical Examiner,

b. a designee of the Commissioner of the Department of Mental Health and Substance Abuse Services. The designee shall be a person assigned to the Domestic Violence and Sexual Assault Services Division of the Department,

c. the State Commissioner of Health,

d. the Director of the Criminal Justice Resource Center,

e. the Chief of Injury Prevention Services of the State Department of Health,

f. a member of the Oklahoma Council on Violence Prevention, and

g. the Director of the Oklahoma State Bureau of Investigation; and

2. Nine of the members shall be appointed by the Commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services, shall serve for terms of two (2) years and shall be eligible for reappointment. The members shall be persons having training and experience in matters related to domestic violence. The appointed members shall include:

a. a county sheriff selected from a list submitted by the executive board of the Oklahoma Sheriff's Association,

b. a chief of a municipal police department selected from a list submitted by the Oklahoma Association of Chiefs of Police,

c. an attorney licensed in this state who is in private practice selected from a list submitted by the executive board of the Oklahoma Bar Association,

d. a district attorney selected from a list submitted by the District Attorneys Council,

e. a physician selected from a list submitted by the Oklahoma State Medical Association,

f. a physician selected from a list submitted by the Oklahoma Osteopathic Association,

g. a nurse selected from a list submitted by the Oklahoma Nurses Association, and

h. two individuals, at least one of whom shall be a survivor of domestic violence, selected from lists submitted by the Oklahoma Coalition Against Domestic Violence and Sexual Assault.

B. Every two (2) years the Board shall elect from among its membership a chair and a vice-chair. The Board shall meet at least quarterly and may meet more frequently as necessary as determined by the chair. Members shall serve without compensation but may be reimbursed for necessary travel out of funds available to the Oklahoma Criminal Justice Resource Center pursuant to the State Travel Reimbursement Act; provided, that the reimbursement shall be paid in the case of state employee members by the agency employing the member.

C. With funds appropriated or otherwise available for that purpose, the Criminal Justice Resource Center shall provide administrative assistance and services to the Domestic Violence Fatality Review Board.

SECTION 3. AMENDATORY 25 O.S. 1991, Section 307, as last amended by Section 10, Chapter 1, O.S.L. 1999 (25 O.S. Supp. 2000, Section 307), is amended to read as follows:

Section 307. A. No public body shall hold executive sessions unless otherwise specifically provided in this section.

B. Executive sessions of public bodies will be permitted only for the purpose of:

1. Discussing the employment, hiring, appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or employee;

2. Discussing negotiations concerning employees and representatives of employee groups;

3. Discussing the purchase or appraisal of real property;

4. Confidential communications between a public body and its attorney concerning a pending investigation, claim, or action if the public body, with the advice of its attorney, determines that disclosure will seriously impair the ability of the public body to process the claim or conduct a pending investigation, litigation, or proceeding in the public interest;

5. Permitting district boards of education to hear evidence and discuss the expulsion or suspension of a student when requested by the student involved or his parent, attorney or legal guardian;

6. Discussing matters involving a specific handicapped child;

7. Discussing any matter where disclosure of information would violate confidentiality requirements of state or federal law; or

8. Engaging in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.

C. Notwithstanding the provisions of subsection B of this section, the following public bodies may hold executive sessions:

1. The State Banking Board, as provided for under Section 306.1 of Title 6 of the Oklahoma Statutes;

2. The Oklahoma Industrial Finance Authority, as provided for in Section 854 of Title 74 of the Oklahoma Statutes;

3. The Oklahoma Development Finance Authority, as provided for in Section 5062.6 of Title 74 of the Oklahoma Statutes;

4. The Oklahoma Center for the Advancement of Science and Technology, as provided for in Section 5060.7 of Title 74 of the Oklahoma Statutes;

5. The Oklahoma Savings and Loan Board, as provided for under subsection A of Section 381.74 of Title 18 of the Oklahoma Statutes;

6. The Oklahoma Health Research Committee for purposes of conferring on matters pertaining to research and development of products, if public disclosure of the matter discussed would interfere with the development of patents, copyrights, products, or services;

7. A review committee, as provided for in Section 855 of Title 62 of the Oklahoma Statutes;

8. The Child Death Review Board for purposes of receiving and conferring on matters pertaining to materials declared confidential by law;

9. The Domestic Violence Fatality Review Board as provided in Section 1 of this act;

10. All nonprofit foundations, boards, bureaus, commissions, agencies, trusteeships, authorities, councils, committees, public trusts, task forces or study groups supported in whole or part by public funds or entrusted with the expenditure of public funds for purposes of conferring on matters pertaining to economic development, including the transfer of property, financing, or the creation of a proposal to entice a business to locate within their jurisdiction if public disclosure of the matter discussed would interfere with the development of products or services or if public disclosure would violate the confidentiality of the business; and

~~10.~~ 11. The Oklahoma Indigent Defense System Board for purposes of discussing negotiating strategies in connection with making possible counteroffers to offers to contract to provide legal representation to indigent criminal defendants and indigent juveniles in cases for which the System must provide representation pursuant to the provisions of the Indigent Defense System Act, Section 1355 et seq. of Title 22 of the Oklahoma Statutes.

D. An executive session for the purpose of discussing the purchase or appraisal of real property shall be limited to members of the public body, the attorney for the public body, and the immediate staff of the public body. No landowner, real estate salesperson, broker, developer, or any other person who may profit directly or indirectly by a proposed transaction concerning real property which is under consideration may be present or participate in the executive session.

E. No public body may go into an executive session unless the following procedures are strictly complied with:

1. The proposed executive session is noted on the agenda as provided in Section 311 of this title;

2. The executive session is authorized by a majority vote of a quorum of the members present and the vote is a recorded vote; and

3. Except for matters considered in executive sessions of the State Banking Board and the Oklahoma Savings and Loan Board, and which are required by state or federal law to be confidential, any vote or action on any item of business considered in an executive session shall be taken in public meeting with the vote of each member publicly cast and recorded.

F. A willful violation of the provisions of this section shall:

1. Subject each member of the public body to criminal sanctions as provided in Section 314 of this title; and

2. Cause the minutes and all other records of the executive session, including tape recordings, to be immediately made public.

SECTION 4. This act shall become effective July 1, 2001.

SECTION 5. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the House of Representatives the 18th day of May, 2001.

/s/
Presiding Officer of the House of Representatives

Passed the Senate the 18th day of May, 2001.

/s/
Presiding Officer of the Senate

OFFICE OF THE GOVERNOR
Received by the Governor this 21st
Day of May, 2001, at 3:10, o'clock p.m.

By: /s/ Judy Terry

Approved by the Governor of the State of Oklahoma the 31st day of May 2001, at 10:30, o'clock a.m.

/s/ Frank Keating
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE
Received by the Secretary of State this 31st
day of May, 2001, at 1:20, o'clock p.m.

By: /s/ Mike Hunter

Methods

The data collection tool utilized by the DVFRB was initially created during the pilot project. In developing the survey instrument, staff and members researched a number of protocols already in existence. Those reviewed included the Oklahoma Child Death Review Board, the Centers for Disease Control (CDC), and those being used by other researchers and other Domestic Violence Fatality Review Boards across the nation. The result was an application of the CDC model modified to meet the particular data needs of the project. In the past year, the codebook has been fine-tuned. Variables of interest to the DVFRB were added, and variables that did not seem pertinent to the DVFRB, as well as variables that consistently could not be answered concretely by case materials were removed. The codebook currently stands at 254 variables assessing a wide range of personal, relational, and system contact characteristics.

Finally, the DVFRB determined to review only those cases considered *closed*, that is, those cases where:

- A jury had found the perpetrator not guilty of the *charges filed* (in all of these cases the perpetrator admitted to causing the death)
- The District Attorney had declined to prosecute because the circumstance was indicated that filing of criminal charges was not in the best interest of the State or unwarranted (i.e., murder/suicide or self-defense)
- A jury or judge had convicted the perpetrator
- The perpetrator had plead guilty or reached a plea agreement

This decision eases the data collection process, as many entities are uncomfortable releasing case information during an ongoing investigation or litigation. This also allows the DVFRB to review the case through the entire system.

Confidentiality. Due to the nature of the cases and the records used in DVFRB reviews, confidentiality is of utmost importance to the DVFRB. All members and staff sign a memorandum of confidentiality before participating in any case reviews. All case records are kept in locked file storage cabinets or are under the supervision of staff at all times. The enabling legislation also provides for the protection and strict confidentiality of the case records maintained by the DVFRB.

Secure List of Cases. Once the definitions and codebook were established, the next step was the collection of data related to the identified domestic violence homicide cases. To begin the data collection process staff must first compile a list of cases occurring in a given year. There are two steps involved in creating the list of cases for the DVFRB to review. First, the DVFRB support staff requests a list of homicides resulting from domestic violence from the OSBI. To this initial list, staff adds cases discovered through news archives. Newspaper websites and Internet and microfilm archives were visited to gather both information on cases staff were already aware of and also to identify any case that may have gone unreported as a "domestic violence homicide" by reporting law enforcement agencies. The Oklahoma Historical Society provided microfilm archives of smaller papers, and staff searched Internet websites of larger papers purchasing subscriptions when necessary.

At times, cases that failed to meet the definition of domestic violence by statute appeared on the list received from OSBI. In these instances, the DVFRB, after reviewing the pertinent details of the case and determining that the case indeed does not fit the criteria can vote to remove the case from the list.

Retrieval of Pertinent Information from Legislated Sources. The list provided by the OSBI contains only the name of a reporting agency and a date on which the homicide was reported. DVFRB staff then contacted the appropriate law enforcement agencies to obtain (1) names of the perpetrator(s) and victim(s), and (2) status of the case – a) closed and adjudicated or b) open (non-adjudicated), as well as that agency's records on that case. If the case resulted in prosecution, the District Attorney's Office is contacted for access to their case materials.

Consideration of the workload of various offices and agencies in the system led to a decision to gather information in a manner causing the least possible inconvenience to the custodial agency. Staff gave responding law enforcement agencies, court clerks, and District Attorneys' offices the option of copying and mailing all their materials or having staff travel to their office to gather the needed materials, thus saving time and resources at many smaller offices with already straining limited resources.

In addition to law enforcement and prosecutorial records, staff requested materials from the eleven other sources listed in the legislation. The DVFRB has the authority to access the medical examiner's reports, hospital records, school records, court records, OSBI records (both investigation and criminal history records), fire department records, State Department of Health records, medical and dental records, DMHSAS and other mental health records, emergency medical service records and DHS' files. DOC information is also accessed through their public information website. Further, staff tracks public reports of the cases through local and state newspapers.

Analysis of Data. Once all information had been gathered, organized, and read, staff coded the cases using the codebook for entry into the database. Staff coded only facts that could be supported by materials in the case files. For variables involving witnesses and testimony, staff coded a concrete YES only if there were two or more sources quoted. If only one source was quoted, staff coded that variable as POSSIBLE. A triangulation standard of having two different sources for a "yes" helps ensure the reliability of the coded information. However in some cases, in particular murder/suicides, there may only be one source of information, in order to allow the DVFRB the knowledge that there may have been previous domestic violence the "possible" variable was added. A printed copy of the coding for each case is given to the DVFRB for review. Staff prepared a factual brief of the case for the DVFRB's review and discussion. Each review is further supported by a summary of the demographics, a summary of the death sequence of events, supplemental details, and the disposition of the case. Cases were given numbers and all identifiers were removed in the event that one or more DVFRB members were personally involved in the case. This "blind case review" methodology helps to maintain objectivity and focus upon the systemic issues. However, when a DVFRB member recognizes the case under review they are free to disclose that to the DVFRB and supply further information if necessary or requested.

Case Review by the DVFRB. In the past year, DVFRB members have reviewed an average of six cases at each meeting. This being said and the knowledge that there are some 245 total cases just from 1998-2000, the DVFRB has established procedures to narrow the scope of cases they actively review. The DVFRB has established that if the case involves an intimate partner homicide then it shall be processed for full review by staff. If the case is not an intimate partner homicide, staff then prepares a brief factual summary of the relationship and events surrounding the death. The DVFRB then votes on each case to determine whether or not it shall come under full review. All cases, whether fully reviewed by the DVFRB or not, are coded and entered into the database. This selection process actually serves two purposes; first it pares down the number of cases the DVFRB reviews. Secondly, it avoids the duplication of efforts by the Child Death Review Board (CDRB). Since the definition of domestic abuse includes the abuse of children, child deaths resulting from abuse by a family member fall under the scope of the DVFRB. The DVFRB, however, does not feel it necessary to summarily repeat the efforts of the CDRB every time. That is not to say the DVFRB has not reviewed cases involving the death of a child. They, however, try to only review those cases in which there was active abuse ongoing between the parental figures of the child.

Cases are reviewed and discussed in executive session during regularly scheduled meetings of the DVFRB. Staff is available to provide additional details pertinent to the discussion. Staff members note inquiries for additional information for follow-up. Identifiable areas of systemic concern are noted and recorded by staff. These comments along with DVFRB member notes are later compiled into a computer spreadsheet program for use at the end of the year in the annual report. These identified areas of concern along with the statistical database compiled from the cases form the basis of the recommendations made by the DVFRB annually.

After the June 2003 DVFRB training the DVFRB decided to begin primary case reviews of the cases starting in January 2004. This means the DVFRB members will review first-hand all case materials rather than relying solely on the staff summaries and coding. Staff will still be responsible for coding the case data for entry into the database. As a result of going to first-hand review of the materials the DVFRB expects to only review six to twelve cases in the coming year. Results of this new review process will be reported in the 2004 Annual Report.

Limitations

- The current sample size is relatively small and therefore should not be used to make generalizations about all domestic violence homicides. While patterns are beginning to emerge, caution is urged when using the data contained in this report.
- Deaths that occur on federal land such as American Indian reservations and military bases are not necessarily reported to the OSBI. As a result, it is possible that American Indian deaths and others occurring on federal lands were underreported in our reviews. Further, even when a case is known by the DVFRB to have occurred, the DVFRB can request information, but does not have the legal jurisdiction to demand the information.
- Oklahoma does not have a centralized reporting system for law enforcement data or victim protection orders. While information was obtained from these sources, the level of information may not be complete. For example, staff contacted the law enforcement agency reporting the homicide and the agency that investigated the homicide, if different. However,

either the victim or the perpetrator may have had contact with other law enforcement agencies or lived in other jurisdictions before the homicide. Similar limitations occurred when staff attempted to determine the use of protection orders.

- Medical and dental records were not necessarily obtained unless a specific source was cited in the case materials. There are many private medical and dental providers, making the resource expenditure to search for those records, if they even exist, enormous. In addition, confidentiality would be compromised in such a search.
- Limited information was available on the reviewed cases from the DHS.
- In terms of comparability, definitions of domestic violence and domestic violence homicide vary from state to state and should be reviewed before any comparisons are made between this data and the data of other states or municipalities.

History

In 1998, Oklahoma law enforcers responded to more than 21,000 domestic violence calls, reporting 119 domestic violence-related homicides in 1998 and 1999. Given this history, when the Oklahoma Council on Violence Prevention was setting its strategic plan for the following year, one of the projects proposed was an in-depth investigation into domestic violence-related homicides in Oklahoma.

The Council, in partnership with the Oklahoma Criminal Justice Resource Center, proposed legislation in the spring of 2000 to establish a Domestic Violence Fatality Review Board. The goal of the DVFRB is to *reduce the number of domestic violence deaths by performing multi-disciplinary review of data to identify common characteristics of these crimes, then develop recommendations to improve the systems involved to better protect and serve the victims of domestic violence.* However, the session ended just minutes before final action could be completed. Representatives Jari Askins and Darrell Gilbert and Senator Maxine Horner introduced HB 1372 in Spring 2001. The legislation passed with only one "no" in the House. Governor Frank Keating signed the enabling legislation on May 31, 2001. The life of the Board as established by the legislation is from July 1, 2001, through July 1, 2007. (For a full copy of the enabling legislation see Appendix A.)

Concurrent with the introduction of authorizing legislation in 2000, the Council initiated a one-year pilot project to prove the efficacy of a domestic violence-related homicide review process. Initial activities included organizing a multi-disciplinary work group, establishing operational policies, and determining investigative protocols and analysis procedures. In addition, the group was to identify difficulties and challenges encountered through the process.

Once the Governor signed the enabling legislation, work began to establish the membership of the DVFRB as prescribed by the legislation. Seven members are named directly to the DVFRB with no tenure expiration. The remaining nine members are submitted to the Commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services by their respective organizations and are appointed for a two-year term. After the membership was in place, plans for an initial meeting began. The first meeting of the Oklahoma DVFRB was in September of 2001. At this meeting the DVFRB reviewed the mission, by-laws, policies and procedures established during the Pilot Project. The DVFRB chose to maintain those same documents with few changes. The DVFRB adopted Robert's Rules of Order as the operating procedure to follow regarding meeting procedure.

Specific measures were agreed upon to insure confidentiality of the discussions. First, all case-specific information would be secured under lock and key by project staff, in a separate cabinet from other administrative files. Second, each board and staff member signed *Memorandum of Confidentiality* prior to reviewing any case. Third, case review and discussions would take place during Executive Sessions of regularly scheduled meetings of the board.

The DVFRB met monthly to review cases from 1998 and 1999. These years were chosen to finish the work begun by the Pilot Project work group and to establish a baseline for future comparison. Over the course of the year the DVFRB reviewed 38 cases, bringing the database to 113 cases with the inclusion of cases reviewed during the pilot project.