Virginia Department of Health

Office of the Chief Medical Examiner

Ten Years and Counting: The Persistence of Lethal Domestic Violence in Virginia

Final Report with Recommendations from The Fatal Domestic Violence Workgroup

December, 2010

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The Persistence of Lethal Domestic Violence in Virginia

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Introduction

Pursuant to Virginia Code § 32.1-283.3, the Office of the Chief Medical Examiner (OCME) in the Virginia Department of Health conducts family and intimate partner homicide surveillance and provides training, technical assistance and resources to Virginia's local and regional fatality review teams. What is family and intimate partner homicide surveillance? What is fatality review? Conducted in the spirit of public health and with the knowledge that violent deaths are both premature and preventable, homicide surveillance and death review teams examine the specific circumstances of fatal events for several reasons:

- to document the magnitude of lethal domestic violence in Virginia;
- to describe groups who are at risk for injury and violence;
- to identify strengths and gaps in domestic violence-related services, training, interagency coordination, funding, policy, and legislation;
- to strengthen community capacity to coordinate a response to domestic violence; and
- to reduce future injury and death by making empirically based suggestions for intervention and prevention.

July 1st of 2009 marked the ten-year anniversary of the passage of Virginia law establishing a family abuse homicide surveillance project and permitting the formation of local and regional family abuse fatality review teams in Virginia. At that time, seven years of domestic violence related homicide had been documented and twelve local/regional fatality review teams had been established. New teams were underway in a number of communities.

To mark the anniversary of these projects, the Chief Medical Examiner convened a *Fatal Domestic Violence Workgroup* in 2009, hereafter called the Workgroup, to assess findings from state and local fatality review and surveillance efforts and, on the basis of that information, to develop ideas and recommendations for future work in this area. Ten years after the legislation was enacted, what had we learned about family and intimate partner violence from homicide surveillance and from careful reviews done by local and regional teams? What strengths and challenges in community response had been uncovered? What were the statewide patterns in family and intimate partner homicide? Who was at risk? What lethality factors were present in

these homicides? What did data findings and themes suggest about future directions to reduce violence in our communities? These were the main questions considered by the Workgroup.

The Workgroup was funded by a grant from the United States Department of Justice's Office of Violence Against Women through the Grant to Encourage Arrest Policies and the Enforcement of Protection Orders Program (GEAP).[1] Convening this Workgroup was a GEAP grant objective with tasks assigned to the OCME.

Members of the Workgroup were drawn from three groups:

- chairs/coordinators of Virginia's twelve local or regional fatality review teams;
- representatives from each of the GEAP partnership agencies; and
- critical domestic violence stakeholders from other state agencies and organizations.

See Appendix A for a complete list of Workgroup members.

Another GEAP grant objective involved intensive work with 14 Virginia communities.[2] Together, GEAP partners had traveled to these localities to provide training and technical assistance on local community response to domestic violence. Using a community assessment tool focused on law, policy, and best practice in the area of domestic violence arrest policies and the enforcement of protection orders, multidisciplinary groups from each community identified strengths, challenges, and priorities in their communities. Members of the Workgroup also reviewed summary findings from these visits.

To sum up, the Workgroup reviewed homicide data trends, findings and themes from local fatality review teams, the strengths and challenges of local fatality review, and insights from community assessments performed in the fourteen GEAP localities. Using this information and their own professional and personal experiences with domestic violence, Workgroup members identified recommendations to strengthen and improve Virginia's domestic violence response.

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[1] The GEAP grant supported a statewide partnership consisting of staff from six agencies – the Virginia Department of Criminal Justice Services, the Supreme Court of Virginia, the Virginia State Police, the Virginia Sexual and Domestic Violence Action Alliance, the Office of the Attorney General, and the OCME. Grant Number 2005-WE-AX-0117 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the U.S. Department of Justice, Office on Violence Against Women.

[2] These communities were: the Counties of Albemarle, Dickenson, Fairfax, Henry, Lee, Russell, Scott, Washington and Wise; the Cities of Charlottesville, Martinsville, Norfolk, and Roanoke; and the University of Virginia.

Statewide Trends in Homicide

The Workgroup first examined summary data trends and findings from the OCME's Family and Intimate Partner Homicide Surveillance Project for the years 1999 through 2007.[3] Using information from death investigation records and newspapers, these data provide information about all homicides in Virginia and distinguish those homicides related to domestic violence. For purposes of data review, family and intimate partner homicides are classified by the relationship between the victim and the alleged offender in the following typology:

- intimate partner, where the victim was killed by a current or former spouse, boyfriend or girlfriend, or dating partner;
- intimate partner associated, where the victim dies when s/he is caught in the crossfire of an intimate partner relationship;
- child by caregiver;
- elder by caregiver;
- family associated, where the victim was killed as a result of violence in a familial relationship; and
- other family, where a victim is killed by an individual related to them by biology or marriage.

The Workgroup discussion focused most intensely on intimate partner homicides. Main findings for the years 1999-2007 included the following trends:

- One of three homicides is related to conflict and violence among family members and intimate partners. Despite changes in law, policy and practice, this ratio has not changed over time.
- With regard to the prevalence of family and intimate partner homicide, the number of intimate partner homicides vacillated over the nine year period, from highs of 72 in 1999 and 83 in 2000 to lows of 49 in 2006 and 51 in 2007. In other words, Virginia observed 1 intimate partner homicide every 5 to 7 days between 1999 and 2007.

[3] The full report of these data is available at the following website (Accessed on August 2, 2010): http://www.vdh.virginia.gov/medExam/familyandintimatepartnerviolence.htm

Rates of family and intimate partner death ranged from a high of 2.1 per 100,000 in 1999 and 2000 to a low of 1.6 per 100,000 in 2007.

- Intimate partner homicide and intimate partner-associated homicide are the most common forms of domestic violence homicide in Virginia. Women are more often the victims of intimate partner homicide while men are more often the victims of intimate partner associated homicide.
- In addition to gender, other social disparities are also clear from the data. While White Virginians die in an intimate partner homicide more frequently than Black Virginians, Black Virginians have a higher rate of intimate partner homicide than White Virginians. Age trends suggest the highest risk rates for intimate partner homicide among persons 18-24, 35-44, and 25-34.
- Intimate partner homicides occur most frequently in the Central Health Planning Region of Virginia, and are consistently lower in the Northern Health Planning Region.
- Other themes uncovered through this project reveal that victims are typically in a relationship with the alleged offender as a spouse or a boy/girlfriend, that most intimate partner fatal injuries occur in a residence that is familiar to the victim, that children witness roughly one-quarter of intimate partner homicides, and that firearms are used in more than half of intimate partner homicides with sharp instruments used in an additional 20% of cases.
- Risk factors present in intimate partner homicides that increase the probability of violence include a history of physical assault, a history of threats from the abusive partner, a protective order in place at the time of fatal injury, and a record of police calls to the residence for domestic violence.

Findings and Themes from Local Fatality Review Teams

In addition to looking at broad trends in domestic violence homicide, the Workgroup also looked at published findings from multidisciplinary local/regional team reviews of fatal domestic violence events.

Five of the twelve teams had published their Team findings and recommendations.[4] Because these reviews are carried out at the local level and key stakeholders and critical information is directly available to team members, findings are nuanced and comprehensive. At the same time, many themes in these reports mirror conclusions drawn from the family and intimate partner homicide surveillance project. The Workgroup reviewed and discussed the following themes from these reports:

- Firearms were the most common mechanism of injury, followed by sharp instrument and then asphyxia. Some teams found that perpetrators used firearms even when their criminal histories revealed that they should not have had firearms in their possession.
- Common lethality risk factors associated with the homicide included:
  - the ending of a relationship or the beginning of a new relationship;
  - a history of physical and emotional violence in relationship, including stalking, destruction of property, threats of harm, jealous rages, and attempts at intimidation;
  - public displays of violence;
  - a criminal history, including pending charges on domestic violence;
  - a history of 9-1-1 or police calls to the home for domestic violence and a history of assault and battery within the context of domestic violence without arrest and/or prosecution;
  - a history of protective orders issued on previous violent events; and
  - threats of homicide and/or of suicide made by batterers to victims of domestic violence.

[4] Copies of several of these team reports are available at http://www.vdh.virginia.gov/medExam/Violence.htm#DomesticViolenceFatalityReviewTeams, which was accessed on September 7, 2010.

In addition,

- Family members and friends of the perpetrator and the victim, including children, frequently knew about the violence. In several cases, children either directly or indirectly witnessed the violence.
- Specific characteristics of perpetrators included substance use problems and unemployment. Some had participated in batterer intervention programs.
- Specific characteristics of victims included substance abuse problems. Some victims had received mental health services or accessed domestic violence services, including shelters.
- In addition to local law enforcement, several local agencies, such as the schools and child protective services, were often aware of family problems.
- Several victims were in a dating relationship with the alleged perpetrator at the time of the homicide; they were not living together or married, nor did they have a child in common.

Strengths and Challenges Associated with the Process of Fatality Review

In order to focus on the process of fatality review at the local and regional level, Workgroup members also heard from representatives of Virginia's local/regional teams with regard to strengths and ongoing barriers to conducting fatality review. While recognizing the clear importance of death review for understanding a community's response to domestic violence, Workgroup members noted that death review is strongest when:

- team leadership is stable over a reasonable period of time;
- team coordinators or chairs can devote time and assign resources to the work of the team;
- the team has a committed core group of local stakeholders;
- there is diverse, multidisciplinary representation on teams;
- teams are supported by community agencies and organizations;

- teams establish clear policies and procedures, particularly governing record review, confidentiality, and membership; and
- the team is able to get its work out the door via reports, recommendations, and press releases.

At the same time, Team chairs and coordinators described the following ongoing challenges.

- Because domestic violence creates an atmosphere of isolation and secrecy for its victims, there are some cases where a victim accessed no domestic violence services in her community. This was troublesome to team members. After all, they represent the domestic violence stakeholders and responders in their communities and are committed to reducing its incidence and prevalence.
- Some teams struggle to get all information on each case because records are purged by agencies that provided services or are otherwise not available for the Team's review. For instance, records from domestic violence service providers are not currently available for death review teams due to confidentiality considerations.
- Multidisciplinary review of deaths requires buy-in from all critical stakeholders in the community and, most importantly, the development of trust and collaboration among those key stakeholders and their agencies. Some teams, particularly multi-jurisdictional teams, reported challenges with establishing or maintaining this atmosphere. Fatality review offers an opportunity to strengthen and improve community response, but also requires the capacity and willingness to share information (and by extension vulnerability) about a potentially preventable death. Getting all vested agencies and organizations to the table for death review, particularly judges, magistrates, school personnel, and mental health representatives, remains a challenge in some communities.
- Local/regional fatality review teams are accomplished through the commitment and energy of its leadership and members, many of whom volunteer their time to attend team meetings. These are not typically funded efforts, but a responsibility that is

added to an already full plate. Many teams described the challenges of getting the work of the team accomplished without dedicated staff and funding.

Insights from Community Assessments in Virginia Localities

The Workgroup also reviewed and discussed findings from the GEAP Partners' work with 14 Virginia communities.[5] Using a community assessment tool focused on law, policy, and best practice in the area of arrest policies and the enforcement of protection orders, multidisciplinary groups from these communities identified strengths, challenges, and priorities in their communities.

- Local communities unanimously identified as strengths their domestic violence stakeholders and their relationships with one another. Local professionals and their agencies are genuinely dedicated and committed to reducing sexual and domestic violence. There is vast potential in the existing collaborative relationships among area professionals. An additional strength is that several localities have staff positions dedicated to domestic violence response work in their communities: prosecutors, law enforcement officers, social workers, and domestic violence advocates.
- At the same time, several concrete challenges were identified.
  - There is a lack of routine and ongoing training in domestic violence law, policy, and response for allied professionals.
  - There is no coordinated community response team established or an existing coordinated community response team is not active or productive.
  - There is a lack of knowledge of law, policy, and procedure in other domestic violence responding agencies.
  - Court safety and security is weak, particularly in small and rural communities.
  - There is inadequate funding for domestic violence response and services.

[5] These communities were: the Counties of Albemarle, Dickenson, Fairfax, Henry, Lee, Russell, Scott, Washington and Wise; the cities of Charlottesville, Martinsville, Norfolk, and Roanoke; and the University of Virginia.

- Service of protective orders is both inefficient and untimely.

- When asked to prioritize actions to be taken, localities were virtually unanimous in citing the need to strengthen coordinated community response and capacity for collaboration among local agencies. Other important actions include:
  - sharing information among local agencies and organizations to improve response and services;
  - dedicating resources for domestic violence response and prevention from local governments;
  - providing routine training for all allied professionals on domestic violence law, policy, and response;
  - providing education programs on healthy relationships and domestic violence in local schools;
  - establishing a local or regional fatality review team;
  - establishing and/or strengthening batterer intervention program services;
  - ensuring that written and oral information on protective orders is offered to victims by magistrates and law enforcement officers; and
  - addressing policy issues at the local level, such as:
    - compliance with state and federal firearm laws
    - court security
    - misdemeanor domestic violence cases
    - law enforcement agency policies on domestic and sexual violence cases
    - effective service of protective orders
    - notification to petitioners when service is not accomplished

Recommendations

With this information as a base, members of the Workgroup discussed their own insights and brainstormed ideas for intervention and prevention. Over and over, they returned to the concept of capacity building at both the state and local levels, the need for additional funding and resources, as well as changes to Virginia law. They also discussed the significant budgetary

constraints shaping capacity at the local, state, and national levels. They recognized that some of their recommendations would not be feasible in the short run. But wanting to take full advantage of this unique opportunity to look back over the past ten years and forward to the next ten, the Workgroup members offer the following suggestions to improve domestic violence response in the Commonwealth.[6]

Capacity Building at the State Level

1. Convene a multi-agency workgroup to propose changes to the *Code of Virginia* that accomplish the following:
   a. Recognizes differences between assault and battery and an accelerating pattern of lethal domestic violence by defining "domestic violence" in statute.
   b. Includes provisions for domestic violence within the context of dating violence.
   c. Creates penalties for domestic violence offenses to fit varying levels of lethality associated with domestic violence events.
   d. Creates a differential response system for community and law enforcement response to domestic violence that is consistent with varying levels of violence.
   e. Provides for the removal/confiscation of firearms in protective order and other criminal cases related to domestic violence.
   f. Revises Virginia protective order statutes by clarifying definitions and review dates and by creating uniform language and processes for different types of protective orders.
2. Fund a Domestic Violence Fatality Review Coordinator in the Office of the Chief Medical Examiner to support family violence fatality review teams established pursuant to Virginia Code § 32.1-283(B). The Coordinator would provide training, technical assistance, and resources to local communities interested in developing teams. Coordinator duties would also include establishing a Coordinating Council on Fatal Family Violence in the Office of the Chief Medical Examiner. The Council would review data and findings from the fatal

[6] These recommendations reflect the consensus ideas of the Workgroup and not necessarily the opinion of its individual members or the organizations they represent.

family violence surveillance project and fatality review teams and produce a bi-annual report of findings and recommendations.

3. Reinstate the mandate for family life education in K-12 education levels. The Department of Education should partner with the Virginia Sexual and Domestic Violence Action Alliance to revise and update the Standards of Learning, emphasizing healthy relationships and evidence-informed violence prevention strategies.
4. Add a domestic violence in the workplace component to the Commonwealth of Virginia's existing policy on workplace violence.
5. Establish a Magistrate Inquiry and Review Commission that is patterned after the Judicial Inquiry and Review Commission.

Capacity Building at the Local Level

6. Establish and maintain a Domestic Violence Community Response Team in each Virginia community for purposes of planning and implementing a coordinated community response to domestic violence.
7. Fund primary prevention initiatives to develop or enhance local capacity through evidence informed domestic violence prevention programs and projects. Provide additional funding to state agencies to accomplish these goals. Target prevention initiatives include:
   - Culturally sensitive and age-appropriate services for victims of domestic violence and for children who are exposed to domestic violence.
   - Services to children who live with victims and/or perpetrators of violence.
   - Local or regional coordinated community response teams.
   - Programs that focus on youth in African-American communities, are community based, and/or partner with faith based organizations.
   - Programs that target men.

Training and Education Efforts

8. Ensure that all court personnel – District and Circuit Court judges and clerks, substitute judges, magistrates, interpreters, and Guardians *ad litem* – receive annual training on

Virginia law and court process in the area of domestic violence, including federal and state firearms laws.

9. Develop and implement a plan for cross-training the staff of courts, law enforcement agencies, and court services units to accomplish effective coordination of efforts in domestic violence cases. The Supreme Court of Virginia, the Virginia Association of Chiefs of Police, the Virginia Sheriffs' Association, and the Virginia Department of Juvenile Justice should lead this effort with input from local agencies.
10. Develop and implement a plan for cross-training eligibility workers, adult protective services workers, aging services providers, and domestic violence advocates on domestic violence assessment and referral processes. The Virginia Department of Social Services, the Virginia Department for the Aging, and the Virginia Sexual and Domestic Violence Action Alliance should lead this effort with input from local departments of social services and local area agencies on aging.
11. Require health care providers in women's health, emergency services, mental health, family practice, internal medicine, and pediatrics to receive training on the identification and referral of patients experiencing domestic violence. Incorporate required education and training on the identification and referral of patients experiencing domestic violence for residents in women's health, emergency services, mental health, family practice, internal medicine, and pediatrics.
12. Develop a curriculum on risk/lethality assessment for professionals who respond to domestic violence. The Virginia Department of Behavioral Health and Developmental Services, the Virginia Department of Health, and the Virginia Sexual and Domestic Violence Action Alliance should lead this effort.
13. Develop partnerships between local community services boards and local domestic violence agencies to train staff on response and treatment modalities for clients presenting with mental health and/or substance abuse problems who are also experiencing or perpetrating domestic violence.
14. Train public defenders and prosecutors on the dynamics of domestic violence, to include lethality assessment and appropriate referrals for domestic violence services.

Improved Information Sharing, Data Collection, and Distribution

15. Fund a position in the Virginia Department of State Police to support improvements to the Protective Order Registry as established in Virginia Code §§ 19.2 – 387.1 and 52-45 and outlined in Executive Order 93 (2009), "Establishing Virginia's Sexual and Domestic Violence Workgroup." Expand the Virginia State Police protective order audit program which was implemented with funds from the Grant to Encourage Arrest Policies and the Enforcement of Protection Orders to ensure the continued provision of critical feedback to local law enforcement on their accuracy and timeliness of entry and service of protective orders.
16. Enhance the usefulness of family and intimate partner homicide data provided by the Office of the Chief Medical Examiner by (a) publishing the number, percentage, and rate of family violence fatalities for each Virginia locality in its annual report on family and intimate partner homicide; (b) reaching beyond domestic violence stakeholders and educating all members of communities on fatal family and intimate partner homicides, and (c) establishing a database and report writing tool for use by Virginia's family violence fatality review teams.

Appendix A
Fatal Domestic Violence Workgroup Membership List

Eileen Addison
Commonwealth's Attorney
York County/City of Poquoson
Colonial Area Family and Intimate Partner Violence Fatality Review Team[7]

Eleanore Ashman
Training and Program Assistance Virginia Department of Criminal Justice Services

Beth Bonniwell
Special Victims Unit
Henrico County Division of Police
Henrico County Family Violence Fatality Review Team

Jane Sherman Chambers
Staff Attorney
Commonwealth's Attorneys' Services Council

Susan Clark
Victim/Witness Director
Lynchburg Office of the Commonwealth's Attorney
Lynchburg City Family Violence Fatality Review Team

Cathy Maxfield Coleman
Outreach Coordinator
Virginia Sexual and Domestic Violence Action Alliance

Laurie Crawford
Health Care Outreach Coordinator
Virginia Department of Health

Deb Downing
Training and Program Assistance
Virginia Department of Criminal Justice Services

Philip G. Evans, II
Senior Deputy Commonwealth's Attorney
City of Norfolk
Norfolk Domestic Violence Fatality Review Team

Pete Fagan
Lieutenant
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Jayne Flowers
Sexual Violence Prevention Coordinator
Virginia Department of Health

Janett Forte
Program Director
Institute for Women's Health
Virginia Commonwealth University

Nancy Fowler
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Lisa G. Furr
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Central Virginia Task Force on Domestic Violence in Later Life
Virginia Center on Aging

Madelynn Herman
Senior Domestic Violence Program Analyst
Office of the Executive Secretary
Supreme Court of Virginia

John W. Jones
Executive Director,
Virginia Sheriff's Association

[7] The name of the team is provided in italics when a Workgroup member was also a member of a family and intimate partner fatality review team.

Patrician Jones-Turner
Coordinator
Chesterfield County Domestic Violence and Sexual Violence Resource Center
Chesterfield County Intimate Partner and Family Violence Fatality Review Team

Gwen Kitson
Program Director
Project Hope at Quin Rivers
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Thomas Kohlbeck
Virginia Criminal Information Network (VCIN) Analyst
Virginia State Police

Mary Langer
Deputy Commonwealth's Attorney
City of Richmond
Richmond Family Violence Fatality Review Team

Rose Leone
Community Advocacy Coordinator
Virginia Sexual and Domestic Violence Action Alliance

Ruth Micklem
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Virginia Sexual and Domestic Violence Action Alliance
Virginia Maternal Mortality Review Team

Synetheia Newby
Director
Newport News Victim Services Unit
Office of the Commonwealth's Attorney
Newport News Domestic Violence Fatality Review Team

Dana G. Schrad
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Virginia Association of Chiefs of Police

Susheela Varky
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Corie Tillman Wolf
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Marcy Wright
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Transitions Family Violence Services
Hampton Family Violence Fatality Review Team

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Nicole Lynn Lee
Coordinator, Family and Intimate Partner Homicide Surveillance

Meg Norling
Coordinator, Domestic Violence Fatality Review

Virginia Powell
Coordinator, Child Fatality Review