



# FACES OF FATALITY



Report of the Attorney General's Statewide Domestic Violence Fatality Review Team

**Volume IX • June 2019**

*The tragic loss of life as a result of domestic violence homicide continues to be an ongoing concern in our state. These senseless deaths lend credence to the important collaborative effort of domestic violence fatality review teams in seeking solutions to reduce and prevent future domestic violence fatalities. The teams work on behalf of the families of loved ones that were killed to increase the safety of survivors and their children and hold perpetrators accountable for their violent behavior. I am pleased to partner with the Florida Coalition Against Domestic Violence in co-chairing the Statewide Domestic Violence Fatality Review Team and honor the critical role of outstanding law enforcement officers, prosecutors, advocates and other team members who work diligently to enhance the safety of citizens by decreasing domestic violence homicide in Florida.*

—Attorney General Ashley Moody

*Every day across our state family members and friends grieve the loss of a loved one needlessly killed as a result of domestic violence homicide. The commitment of the Statewide Domestic Violence Fatality Review Team and the 25 local teams is to prevent domestic violence homicides by identifying systemic gaps while increasing safety and advocating for justice for survivors and their children. The Florida Coalition Against Domestic Violence, in partnership with the Office of the Attorney General, remains steadfast in supporting the work of the statewide team in implementing potential solutions to reducing future domestic violence homicides. We are grateful for the dedication of community partners for their ongoing collaborative efforts to reduce domestic violence homicide in Florida.*

—Tiffany Carr, President/CEO  
The Florida Coalition Against Domestic Violence

**This report is dedicated to the women, children and men  
who were killed by an act of domestic violence in Florida,  
to their loved ones, and to those who work every day to  
prevent these unthinkable deaths.**



# CONTENTS

Executive Summary	4
Findings	6
Recommendations	8
Fatality Review	10
Local Fatality Review Data Analysis	12
Breakdown of Known Risk Factors	21
Status of Prior Recommendations	22

# EXECUTIVE SUMMARY

Domestic violence homicides in Florida have continued to increase at an alarming rate. The Semi-Annual Uniform Crime Report (UCR) statistics released in November 2018 by the Florida Department of Law Enforcement (FDLE)<sup>1</sup> reflected a 4.7% increase in domestic violence murders between January-June 2018, compared with the first six months of 2017. Domestic violence manslaughter deaths increased by 83% during that same time period. There were a total of 281 domestic violence-related homicides in Florida since the release of the 2017 Faces of Fatality report.<sup>2</sup> This rise in domestic violence homicides compels a timely and coordinated response from our Florida communities to continue working together to protect survivors of domestic violence and their children.

The Florida Attorney General's Statewide Domestic Violence Fatality Review Team was created in 2009 following a sharp increase in domestic violence homicides in the state. The mission of the statewide team is to identify statewide trends, systemic gaps, and potential solutions that increase safety and justice for survivors and their children, and hold perpetrators accountable for their violence through coordinated community response efforts. The goal of the statewide team is to support community partners and systemic services in ongoing efforts to reduce and prevent domestic violence homicides in Florida. The statewide team is co-chaired by the Florida Attorney General's Office and the Florida Coalition Against Domestic Violence (FCADV). Members of the team represent state and local entities that interact with survivors, their children, and perpetrators, including representatives from the court system, law enforcement, probation, parole, faith-based organizations, educators, certified domestic violence centers, legal providers, and healthcare professionals.

Since 2009, the statewide team convenes semi-annual meetings to conduct comprehensive reviews of Florida domestic violence fatalities. The reviews include identification of the events leading up to the fatalities, analysis of data collected by local fatality review teams, and development of recommendations to bridge gaps in the delivery of services. The team's recommendations highlight interventions and strategies to enhance the safety of survivors and their children. Perpetrator accountability is an equally important component of the team's deliberations. Recommendations over the past ten years include proposed changes to statutes, outreach

to immigrant communities, increasing legal representation for survivors, the creation of an online domestic violence guide for media professionals, comprehensive training for stakeholders on responding to high-risk indicators for intimate partner homicide, and identifying the needs of child survivors of intimate partner homicide.

In addition to the statewide team, 25 local communities throughout Florida review domestic violence fatalities and near fatalities. All of the teams endorse a framework of collaboration and mutual respect as a solution-focused operational perspective to preventing domestic violence homicides. This "no-blame-no shame" philosophy is a hallmark of the fatality review process. All teams comply with Florida statutory mandates to maintain confidentiality and public records exemptions when reviewing fatality-related information.<sup>3</sup> The governing statutes require teams to exempt from disclosure the identities of victims and their children. All of the information and records obtained by domestic violence fatality review teams are not subject to discovery or introduction into evidence, and persons attending the meetings may not testify in any civil or criminal action or administrative or disciplinary proceeding if the information or records surfaced from matters that are the subject of evaluation and review by the domestic violence fatality review team. These statutory mandates ensure that team members may freely discuss the circumstances and issues relating to the fatalities.

The 2019 Faces of Fatality IX report includes the statewide team's review of a 2017 homicide/suicide and data analysis of 31 reviews completed by Florida's local domestic violence fatality review teams from January through December 2018. The inclusion of the local teams' data provides a demographic profile and a picture of the experiences of the decedents and perpetrators leading up to each death. The reviews reflect that 94% of the perpetrators were male and 90% of decedents (victims) were female. Reviewers identified that nearly 70% of perpetrators had a known prior history of committing acts of domestic violence against the decedent, and that 77% of perpetrators had a known history of substance abuse.

The data reported by local teams reflects high-risk indicators identified in published research materials relating to intimate partner homicides. Teams also



contribute unique findings and notable factors in their reviews to strengthen the understanding of domestic violence homicides in Florida. The perpetrator's prior history of domestic violence and domestic violence-related crime, abuse of or dependence on illegal drugs, extreme and violent jealousy, and prior threats to the decedent with a firearm were the most commonly reported high-risk indicators identified by local teams in this year's report. Twenty-six percent (26%) of those committing the homicides were known to have exhibited alleged stalking behavior as defined by Florida statute.<sup>4</sup> There were known allegations of death threats made by the perpetrator toward the decedent in more than 50% of the reviewed fatalities, and 17% were known to have made previous attempts to kill the decedent. The perpetrator used a firearm in 42% of the homicides. Threats to kill and impending or recent separation are additional high-risk indicators reported in the data. More than 50% of perpetrators were known to have made prior death threats to the decedent and nearly 60% of decedents had expressed an intention to leave the perpetrator prior to the homicide. The high-risk indicators of extreme and violent jealousy and obsessive jealousy are reflected in the 34% of decedents who were known to be in a new relationship at the time of the fatality. Thirty-six percent (36%) of perpetrators were known to carry or possess a weapon in such a way that it was used as a means of power and control, such as displaying weapons to the decedent or keeping a weapon in plain view within the home. Household items such as baseball bats, lighters or gardening tools may be considered weapons if they are used as a means of power and control.

Thirty-nine percent (39%) of decedents were the parent of children living in the home and there were known child witnesses in 23% of the domestic violence fatalities. After the homicide or near homicide, 17% of children were living with the non-offending parent, 67% were living with a relative of the decedent and 17% were living with a relative of the perpetrator. Twenty-three percent (23%) of decedents had known contact with the Department of Children and Families (DCF) prior to the homicide. Of the homicides reviewed, 62% occurred in a residence shared by the perpetrator and decedent, and 46% of decedents and perpetrators were known to be in the process of ending their relationship at the time of the homicide. Eighty-two percent (82%) of family members reported knowing about prior incidents or threats of violence made by the perpetrator.<sup>5</sup>

The fatality review process has the capacity to influence community-level change through multidisciplinary collaboration in recommending interventions and policies to increase perpetrator accountability and enhance safety for survivors and their children.<sup>6</sup> Fatality review findings correspond to high-risk indicators identified through research and underscore the importance of proactive responses to domestic violence in Florida to reduce the likelihood of future homicides. This report provides information for legislators, state agencies, social service organizations, certified domestic violence centers, and community members to strengthen their efforts to prevent domestic violence-related homicides and increase their communities' knowledge regarding the devastating impact of domestic violence on survivors, their children, family members, and communities.

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<sup>1</sup>[http://www.fdle.state.fl.us/FSAC/UCR/2018/2018SA\\_CIF.aspx](http://www.fdle.state.fl.us/FSAC/UCR/2018/2018SA_CIF.aspx)

<sup>2</sup>The eighteen month total includes data from the 2017 UCR released in May, 2017 and the UCR Semi-annual report released in November 2018.

<sup>3</sup>See s. 741.316 and s. 741.3165, F.S.

<sup>4</sup>See s. 748.048, F.S. The statute states that a person who willfully, maliciously, and repeatedly follows, harasses, or cyberstalks another person commits the offense of stalking.

<sup>5</sup>Information was obtained through media articles, police reports and/or interviews with family members.

<sup>6</sup>Storer, H. L., Lindhorst, T., & Starr, K. (2013). The Domestic Violence Fatality Review: Can It Mobilize Community-Level Change? *Homicide studies*, 17(4), 418-435.

# FINDINGS

The 2019 Faces of Fatality report contains descriptive statistics of domestic violence homicides or near homicides based on data collected by Florida's local fatality review teams between January and December 2018. The 31 homicides reviewed occurred between 2009 and 2018, with the majority of fatalities occurring from 2014 through 2018.

Aggregated data analysis helps to identify patterns and trends related to domestic violence homicides and emphasizes critical areas of focus related to improving policy and intervention strategies. The data in this report is generated from both qualitative and quantitative sources. The teams gathered information from public records, media reports, and conversations with proxy informants such as law enforcement and family members or friends of the deceased. The information provides a contextual view of the perpetrators' behaviors and the victims' experiences leading up to the homicides. The local teams utilize a uniform data collection mechanism to gather and report information regarding the characteristics of perpetrators and decedents' relationships with perpetrators, known domestic violence histories, criminal records, and observable risk factors, including but not limited to stalking, strangulation, abuse while the victim was pregnant, obsessive jealousy and a range of other violent behaviors. The data analysis in this Faces of Fatality report reflect updates to the uniform data collection tool that correlate with current research trends related to high-risk indicators and include expanded demographic data. The updates to the data collection mechanism offers a broader and more comprehensive perspective related to the characteristics of domestic violence homicide in Florida. Due to the changes to the data collection instrument, comparisons between the 2018 and 2019 findings could not be calculated and therefore, are not included in this report.

This report also presents a case study and findings based on the fatality review conducted by the statewide team of a murder/suicide. The perpetrator murdered a woman with four children leaving them without their mother. The perpetrator attempted to shoot the decedent's friend at the scene and then fatally shot himself after killing the victim. This tragic fatality and the traumatic effects of such a painful loss on surviving loved ones is evidence of the critical need for changes in systemic and community-based responses to the crime of domestic violence. This Faces of Fatality Report seeks to honor the victim's memory by developing recommendations intended to create safer outcomes for survivors and their children and prevent future domestic violence homicides in Florida.

## **Findings from the 2018-2019 fatality reviews submitted by local teams highlight several factors regarding decedent and perpetrator profiles, including factors that indicate a heightened risk of lethality:**

- 27% (7 of 26) of perpetrators were unemployed at the time of the homicide.
- 77% (20 of 26) of perpetrators were reported to have substance abuse histories.
- 45% (9 of 20) of perpetrators had a known mental health condition and/or received mental health treatment.

- In 26% (7 of 27) of the fatalities, there was known prior alleged stalking behavior on the part of the perpetrator as defined by F.S. 784.08<sup>7</sup>, and in 12% (3 of 25) of the fatalities, there was known alleged stalking behaviors that did not meet the statutory requirements.
- 36% (9 of 25) of perpetrators were known by family or friends to carry or possess a weapon in such a way that it was used as a means of power and control.
- 39% (11 of 28) of decedents and perpetrators were separated at the time of the homicide and 46% (12 of 26) of decedents and perpetrators were in the process of ending their relationship at the time of the fatality.
- In 34% of the fatalities, the decedents (9 of 26) were known to be in a new relationship.
- 58% (15 of 25) of decedents were known to express an intention to leave the perpetrator.
- 52% (12 of 23) of fatalities had known prior death threats made by the perpetrator towards the decedent.
- 67% (20 of 30) of perpetrators had a known non-domestic violence-related criminal history.
- 69% (20 of 29) of perpetrators had a known criminal history of domestic violence.
- In 82% (23 of 28) of the fatalities, family members reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator.
- In 31% (9 of 29) of the fatalities, there was a known criminal order of no contact issued against the perpetrator.
- In 13% (4 of 31) of the fatalities, there was a known petition for a civil injunction for protection filed against the perpetrator by the decedent.
- In 25% (6 of 24) of the fatalities, there was a known permanent civil injunction for protection by the court entered against the perpetrator by someone other than the decedent.
- 39% (12 of 31) of perpetrators died by suicide and an additional 3% (1 of 31) attempted but did not complete suicide.
- 24% (4 of 17) of perpetrators were known to have previously attempted suicide and 25% (6 of 24) of perpetrators were known to have made threats of suicide prior to the fatality.

### Findings based on the fatality review conducted by the statewide team:

There were several indicators of increased risk for lethality including:

- The perpetrator had a prior criminal history of domestic violence against a woman with whom he had a previous relationship, including assault with a deadly weapon.
- Friends reported that the decedent was attempting to end the relationship with the perpetrator.
- The perpetrator had access to firearms.

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<sup>7</sup>See s. 784.048, F.S.

# RECOMMENDATIONS

Law enforcement agencies often provide assistance to persons seeking police protection in situations where the potential for an escalation of violence is a legitimate concern. Examples of these “keeping the peace” or “standby” calls include one partner retrieving belongings from a shared residence or child custody exchanges. FCADV’s Intimate Violence Enhanced Services Team (InVEST) and FCADV’s Law Enforcement Enhanced Response Statewide Initiative should work with local law enforcement agencies to review the feasibility of developing protocols for informing survivors of the parameters and availability of this service to the community.

Domestic violence perpetrators utilize coercive control tactics including threats and intimidation to maintain power and domination over a survivor. A perpetrator may threaten harm if the survivor refuses to meet the perpetrator’s demand and survivors may meet the demand to try to prevent further violence despite safety risks. The perpetrator of the homicide reviewed by the statewide team demanded a meeting with the victim and her friend, who was reported to have expressed concern for the victim’s safety at the meeting. Law enforcement agencies respond to requests to accompany individuals to retrieve belongings when served with an injunction for protection, to stand by during child custody exchanges, and in other situations in which there is potential for violence to escalate. Law enforcement’s ability to respond is dependent upon the availability of personnel and volume and severity of ongoing calls for service. Domestic violence survivors may be unaware of the availability of this safety service often provided by law enforcement. FCADV should collaborate with state and local law enforcement partners to determine the feasibility of developing a protocol for survivors to access law enforcement support in situations at high risk for the violence to escalate. The protocol could include information on the parameters of the service, a system for prioritizing responses in situations with the potential for escalation of violence, and a process for distributing information about the availability and accessibility of such services to advocates and survivors.

**Coordinated Community Response (CCR) teams provide a comprehensive community-based approach to perpetrator accountability and victim advocacy in which local stakeholders such as law enforcement, criminal justice partners, social service organizations, healthcare providers, and certified domestic violence centers work together to coordinate a system wide response to domestic violence. CCR teams located in many communities around the state include local domestic violence councils/task forces, and other multidisciplinary workgroups that come together with the goal of improving their local response to domestic violence. CCR teams should work together with FCADV to enhance existing training curricula related to high-risk-indicators for intimate partner homicide for community partners and local stakeholders, including social service agencies, behavioral health providers, healthcare providers and the Department of Children and Families. The enhanced training should include a specialized component related to the risk of escalated violence and death when survivors leave or attempt to leave their abusive partners. Survivors are at a 75% or greater risk of being killed by their abusers after leaving the relationship.<sup>8</sup> Family members, friends and service providers may be unaware of the escalated risk and suggest that survivors leave the**



relationship. Leaving often requires that survivors consider strategies to help mitigate the risks, such as consulting with a trained victim advocate to receive safety planning assistance. The enhanced training should focus on the risks and barriers survivors face when attempting to leave, methods to hold the perpetrator accountable, and empowerment-based responses for offering resources and referrals for support, safety planning and advocacy for survivors.

The 2018-2019 data from the reviews conducted by local fatality review teams identified high-risk indicators for homicide related to separation prior to the homicide. Teams identified that 58% of decedents expressed an intention to leave the perpetrator, and 46% of the decedents and perpetrators were in the process of ending their relationship at the time of the fatality. These findings highlight the importance of understanding the risks associated with survivors separating from the perpetrator. Survivors' choices to leave a relationship are unique and personal. A survivor may only leave when she believes the circumstances are safe to do so or because she believes she will be killed if she stays. Safety plans are individualized plans that include information on ways that survivors can stay as safe as possible while remaining in the relationship, preparing to leave the relationship, or after ending the relationship with the perpetrator.<sup>9</sup> FCADV currently conducts comprehensive training for community partners related to tactics of coercive control, high-risk indicators for intimate partner homicide, conversation starters for screening for intimate partner violence, and helping survivors plan for safety when leaving the relationship. The focus on specialized training related to the risks associated with leaving will enhance the curricula related to survivor safety and perpetrator accountability that is currently provided to stakeholders.

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<sup>8</sup>United States Department of Justice, Bureau of Justice Statistics, Crime Victimization Survey, 1995.

<sup>9</sup><https://thehotline.org/help/path-to-safety/>

# FATALITY REVIEW

The statewide team convened three meetings during the 2018-2019 fiscal year. In addition to reviewing data from the local teams and discussing recommendations, the team conducted a review of a 2017 murder/suicide. The team utilized information from public records, including court documents, police reports, media reports, interviews with the law enforcement agency personnel that investigated the homicide/suicide, and a conversation with a family member of the victim to appropriately review this case.

In July 2017, S.G., age 27, murdered P.D, age 35, in the parking lot of a local retailer.<sup>10</sup> The victim was attempting to end a relationship with the perpetrator who continued to contact and harass her. Others observed him following the victim around while she was at work. He was also observed spending time socially with the decedent and her family. He attended a family gathering a few weeks prior to the murder, and people at the party noted that he and the decedent had a tense private conversation. The perpetrator asked to meet together with the decedent and one of her friends because he wanted an apology for the way she had ended their relationship. The perpetrator told them “no harm would be done.” On the night of the homicide, S.G. asked a relative if anyone was selling a gun. However, the source of the murder weapon was unknown at the time of the statewide team’s fatality review. The decedent agreed to meet with the perpetrator in a store parking lot. The decedent’s friend was concerned for her safety so he traveled separately to a site where he could observe the meeting between the perpetrator and decedent. The friend became concerned about the decedent’s safety when he heard what he believed to be a gunshot. He then drove to the site of the homicide. The perpetrator attempted to shoot the friend as he entered the parking lot but the shot missed and the friend was physically unharmed. The perpetrator fatally shot himself after the murder. P.D. is remembered as a caring, generous, family-oriented, and loving mother of four children, and friend who is deeply missed due to this horrific and tragic murder.

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<sup>10</sup>The initials of the victim and perpetrator have been changed to maintain their confidentiality and to respect the privacy of all affected persons.

### **The team identified the following information relevant to its review:**

- The perpetrator was adjudicated guilty of aggravated battery with a deadly weapon toward a past partner prior to his relationship with the decedent.
- The perpetrator was placed on probation and court-ordered to attend a batterer intervention program on the handwritten copy of the court order of probation. The stipulation to attend a batterer intervention program was not included on the final order of probation filed with the criminal court and there is no record of the perpetrator attending a batterer intervention program.
- Friends reported that the perpetrator exhibited tactics of coercive control by making repeated calls to the decedent prior to the homicide and asking to meet with her.



# LOCAL FATALITY REVIEW DATA ANALYSIS

The descriptive statistics in the 2019 report are based on information that local teams obtained from reviewing domestic violence homicides in their communities. The reviews may include both intimate partner homicides and other domestic violence-related deaths. When possible, the data points are based on information collected from all 31 reviews submitted by local teams. In some instances however, statistics are based on different totals. This is either due to non-applicability, or to missing information for any given review. Therefore, the totals may not always equal the total sum of 100. The total number of cases used to calculate each statistic is provided in parentheses. There were no instances in the 31 reviews of fatalities in which reviewers identified the perpetrator of the homicide as acting in self-defense. The existing research related to known risk factors is based on cases of intimate partner femicide, which are male perpetrated homicides on their female partners. Therefore, information on the breakdown of known risk factors contains data related to 29 deaths that teams identified as resulting from intimate partner femicide.

## YEAR OF INCIDENT<sup>11</sup>

## # OF REVIEWS

2009	1
2010	1
2012	1
2013	1
2014	4
2015	4
2016	8
2017	6
2018	5
<b>Total</b>	<b>31</b>

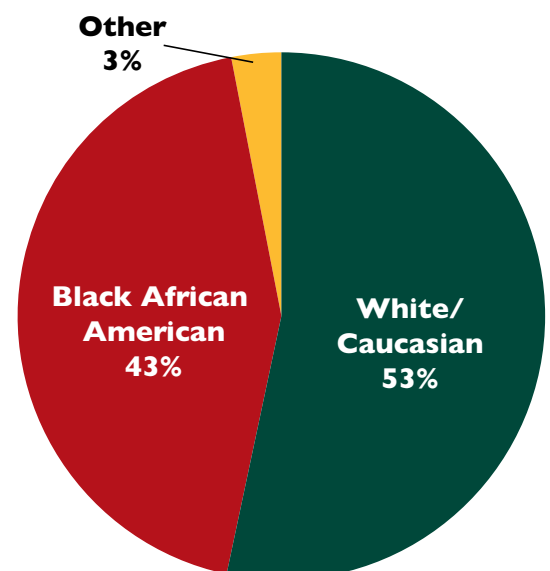
## Perpetrator Characteristics

94% male (29 of 31)  
6% female (2 of 31)

53% White/Caucasian (16 of 30)  
43% Black/African American (13 of 30)  
3% Other (1 of 30)

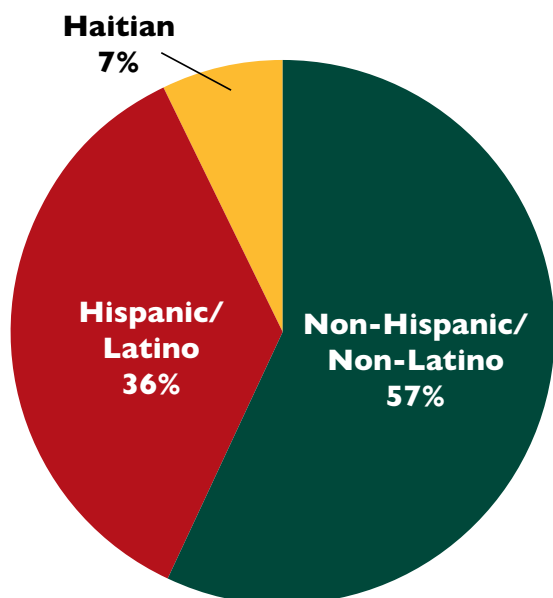
**Average age:** 42 (min: 23, max: 68)

## PERPETRATOR RACE





## PERPETRATOR ETHNICITY

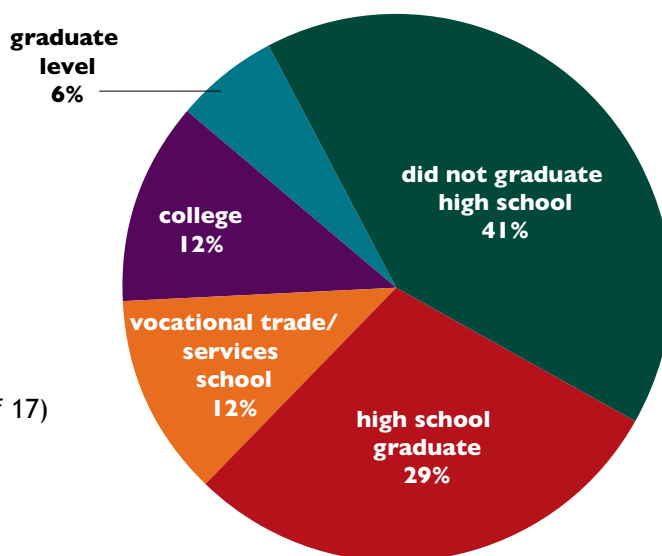


57% Non-Hispanic/Non-Latino (16 of 28)  
 36% Hispanic/Latino (10 of 28)  
 7% Haitian (2 of 28)

## PERPETRATOR EDUCATION LEVEL

### Perpetrator Education level:<sup>12</sup>

41% did not graduate high school (7 of 17)  
 29% high school graduate (5 of 17)  
 12% vocational trade/services school (2 of 17)  
 12% college (2 of 17)  
 6% graduate school (1 of 17)

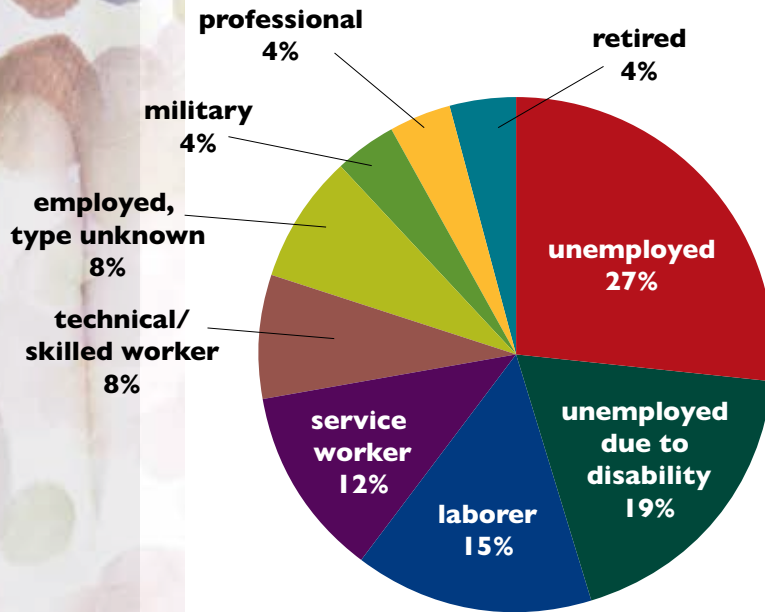


<sup>11</sup>There were no reviews conducted of domestic violence homicide/suicides that occurred in 2011.

<sup>12</sup>The teams were able to gather data on 17 perpetrators.

# LOCAL FATALITY REVIEW DATA ANALYSIS

## PERPETRATOR EMPLOYMENT



### Employment type:

27%	unemployed (7 of 26)
19%	unemployed due to disability (5 of 26)
15%	laborer (4 of 26)
12%	service worker (3 of 26)
8%	technical/skilled worker (2 of 26)
8%	employed, type unknown (2 of 26)
4%	military (1 of 26)
4%	professional (1 of 26)
4%	retired (1 of 26)

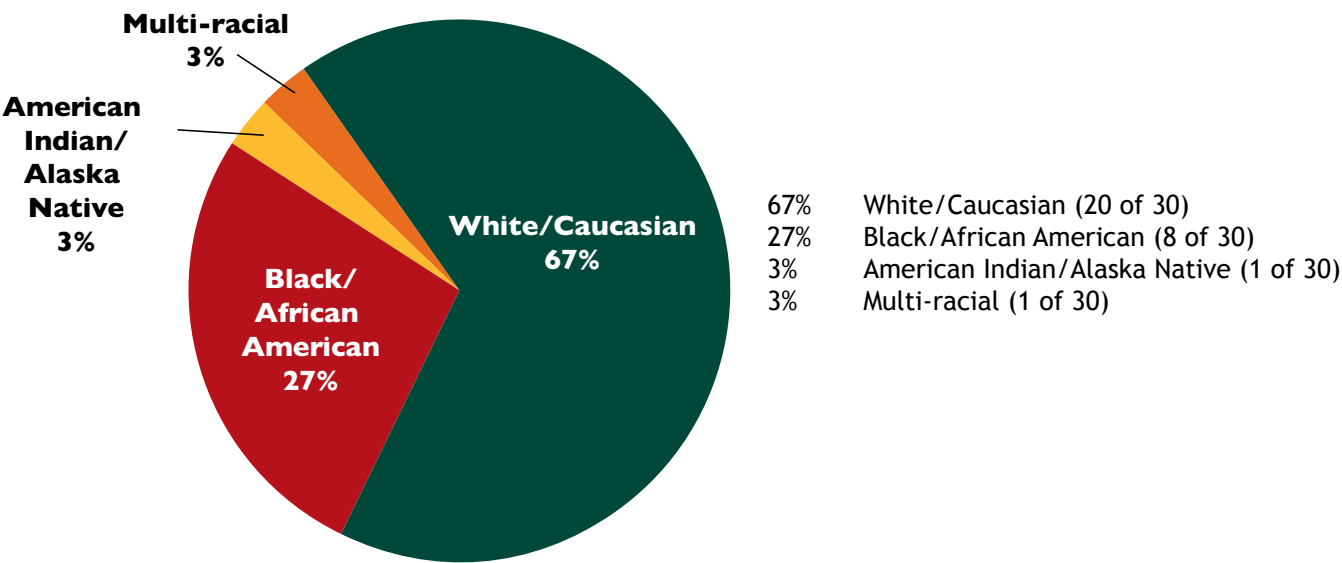
## Other Known Perpetrator Characteristics

- Reviewers reported that 45% of perpetrators (9 of 20) were thought to have a mental health condition<sup>13</sup> and/or received mental health treatment (based on various sources, e.g. police records, court documents and personal narratives from family members or friends).
- Reviewers reported that 77% of perpetrators (20 of 26) had a history of substance abuse (based on various sources, e.g. police records, court documents, and personal narratives from family members or friends).
- Reviewers reported that 24% of perpetrators (4 of 17) previously attempted suicide.
- Reviewers reported that 36% of perpetrators (9 of 25) were known to carry or possess a weapon in such a way that it was used as a means of power and control.
- Reviewers reported that 26% (7 of 27) of perpetrators exhibited alleged stalking behaviors as defined by F. S. 784.08.
- Reviewers reported that 12% (3 of 25) of perpetrators exhibited alleged stalking behaviors that did not meet the statutory requirements of F. S. 748.08.
- Reviewers reported that 52% (12 of 23) of perpetrators made death threats to the decedent prior to the fatality.
- Reviewers reported that 17% (4 of 23) of perpetrators were known to have previously attempted to kill the decedent prior to the fatality.
- Reviewers reported that 25% (6 of 24) of perpetrators were known to have made threats of suicide prior to fatality.

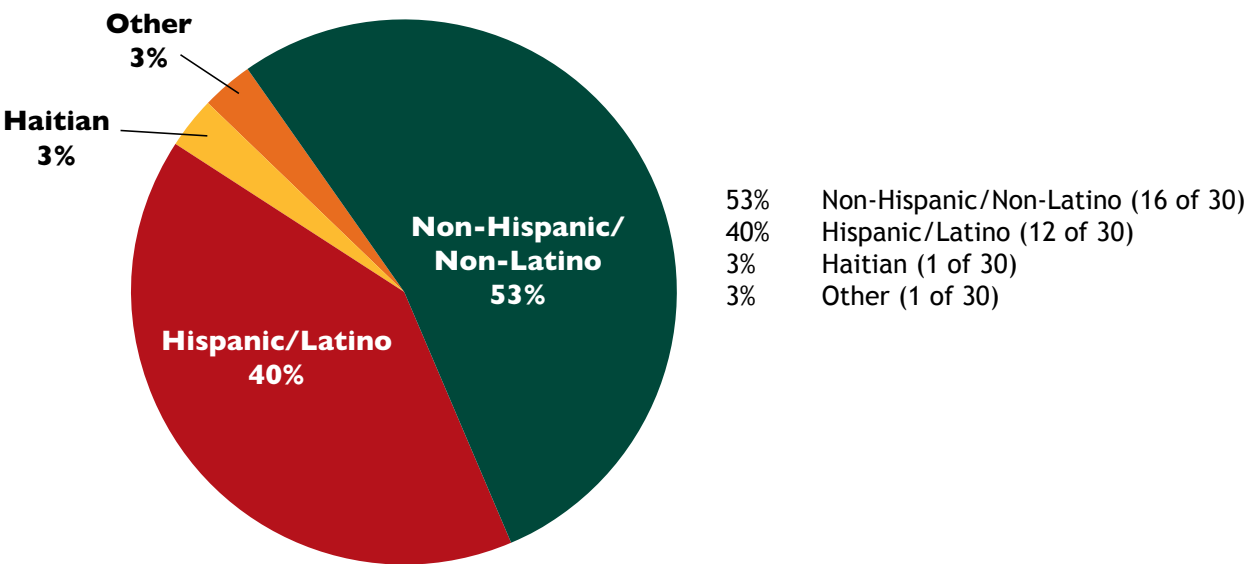
# Decedent Characteristics

Gender: 90% female (29 of 31), 10% male (3 of 31)

## DECEDENT RACE



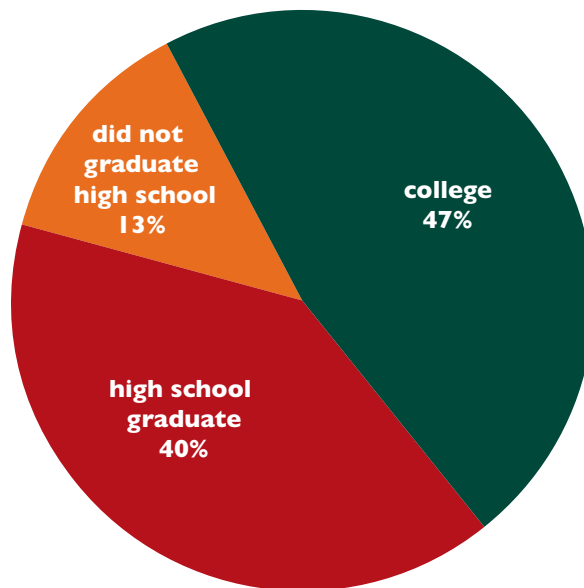
## DECEDENT ETHNICITY



<sup>13</sup>Includes anecdotal reports and personal narratives from family members and friends and does not specifically refer to a diagnosed mental health condition.

# LOCAL FATALITY REVIEW DATA ANALYSIS

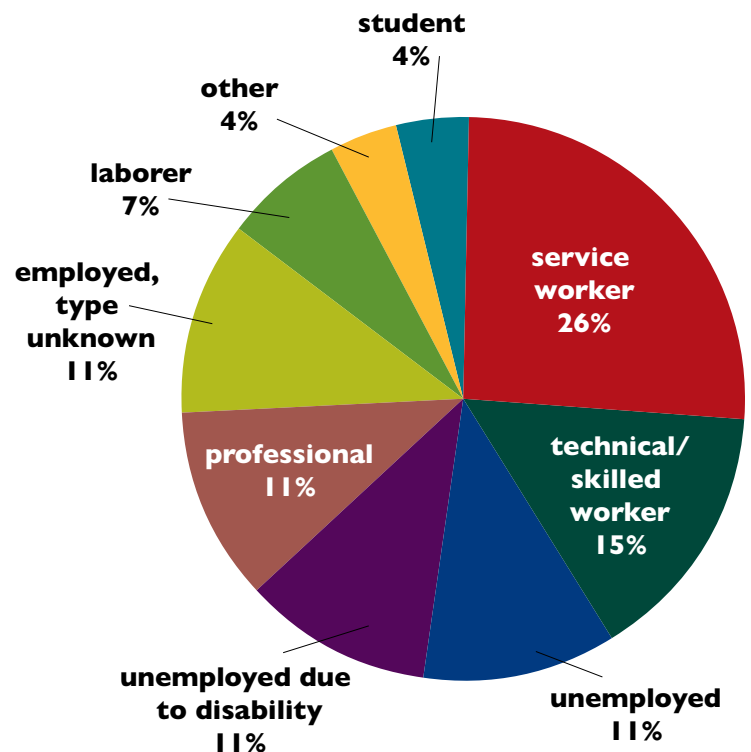
## DECEDENT EDUCATION LEVEL



### Education:

47%	college (7 of 15)
40%	high school graduate (6 of 15)
13%	did not graduate high school (2 of 15)

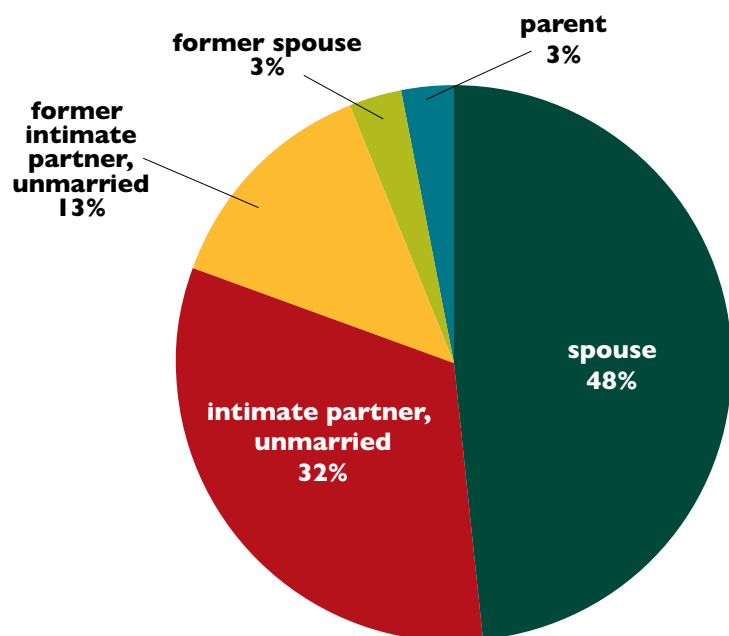
## DECEDENT EMPLOYMENT



26%	service worker (7 of 27)
15%	technical/skilled worker (4 of 27)
11%	unemployed (3 of 27)
11%	unemployed due to a disability (3 of 27)
11%	professional (3 of 27)
11%	employed, type unknown (3 of 27)
7%	laborer (2 of 27)
4%	other (1 of 27)
4%	student (1 of 27)



## RELATIONSHIP TYPE



48% spouse (14 of 29)  
 32% intimate partner, unmarried (9 of 29)  
 13% former intimate partner, unmarried (4 of 29)  
 3% former spouse (1 of 29)  
 3% parent (1 of 29)<sup>14</sup>

## Relationship Characteristics

### 39% (12 of 31) of decedents had children living in the home:

25% 1 child (3 of 12)  
 58% 2 children (7 of 12)  
 8% 4 children (1 of 12)  
 8% 6 children (1 of 12)

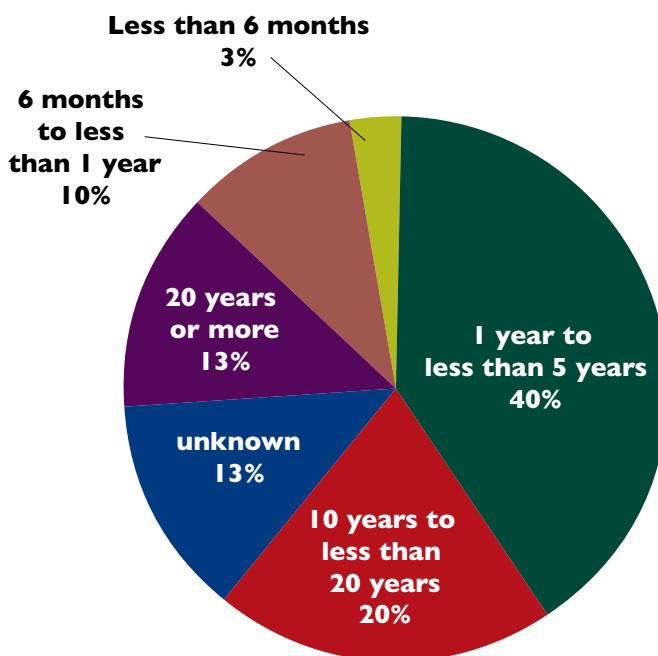
100% (6 of 6) of surviving children were living in the home of the non-offending parent, relatives of the decedent or perpetrator (based on various sources, e.g. police records, court documents, personal narratives from family members or friends).

17% non-offending parent (1 of 6)  
 67% relative of decedent (4 of 6)  
 17% relative of perpetrator (1 of 6)

There were known child witnesses in 23% (6 of 26) of the fatalities.

4% (1 of 28) of decedents were known to be pregnant at the time of the fatality. The length of that pregnancy was 5 months. It was unknown if the perpetrator was the father in that fatality.

## RELATIONSHIP LENGTH



40% 1 year to less than 5 years (12 of 30)  
 20% 10 years to less than 20 years (6 of 30)  
 13% Unknown (4 of 30)  
 13% 20 years or more (4 of 30)  
 10% 6 months to less than 1 year (3 of 30)  
 3% Less than 6 months (1 of 30)

<sup>14</sup>This fatality is excluded in data points in this section.



# LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

## Prior living arrangements and separation

- 62% (18 of 29) of decedents and perpetrators were known to be living together at the time of the fatality.
- 89% (8 of 9) of decedents and perpetrators who were not living together at the time of the fatality were known to have lived together previously.
- 46% (12 of 26) of decedents and perpetrators were known to be in the process of ending their relationship at the time of the fatality.
- 58% (15 of 26) of decedents were known to have expressed an intention to leave the perpetrator.
- 39% (11 of 28) of decedents and perpetrators were known to have ended their relationship (i.e., they were separated or divorced). Length of separation:
  - 40% Less than 3 months (4 of 10)
  - 10% 3 months or less than 6 months (1 of 10)
  - 30% 6 months or less than 1 year (3 of 10)
  - 20% More than 2 years (2 of 10)
- At the time of the fatality, 34% (9 of 26) of decedents were known to be in a new relationship.

## CRIMINAL RECORDS/HISTORY OF DOMESTIC VIOLENCE

### Perpetrator

- 69% (20 of 29) of perpetrators had a known history of domestic violence against the decedent based on criminal records and narrative reports.
- 67% (20 of 30) of perpetrators had a known (non-domestic violence-related) criminal history.
- 82% (23 of 28) of family members and/or friends reported knowing about prior incidents or threats of domestic violence by the perpetrator toward the decedent.
- 31% (9 of 29) of perpetrators had a known criminal order of no contact issued against them.
- 50% (13 of 26) of perpetrators had a known history of domestic violence toward other survivors/victims.
- 13% (4 of 31) of perpetrators had a known petition for a civil injunction for protection filed against them by the decedent. When a petition was filed, 25% (1 of 4) of perpetrators had a permanent injunction issued against them by the court.
- 25% (6 of 24) of perpetrators had a known petition for a civil injunction for protection filed against them by an individual other than the decedent.

## Decedent

- 20% (6 of 30) of decedents had a known prior domestic violence-related criminal history based on criminal records and narrative reports.
- 3% (1 of 29) of decedents had a known criminal order of no contact order issued against them.
- 0% (0 of 31) of decedents had a known petition for injunction for protection filed against them by the perpetrator.

## Domestic Violence and Social Services

- 23% (6 of 26) of decedents had known contact with the Department of Children and Families.
- 13% (3 of 24) decedents had known contact with victim support services.
- 12% (3 of 25) of decedents had known contact with a certified domestic violence center.
- 3% (1 of 29) of perpetrators were ordered to attend a batterer intervention program (BIP) as the result of a court case. When ordered to attend a BIP, 100% of perpetrators (1 of 1) completed the program.
- 10% (2 of 19) of perpetrators or decedents had known contact with a faith-based organization or clergy about prior domestic violence.

## Characteristics of the Fatality

- 39% (12 of 31) of perpetrators died by suicide and an additional 3% (1 of 31) attempted but did not complete suicide.
- At the time of the fatality, reviewers reported known substance abuse by 57% of perpetrators (16 of 28). This information is based on police records, court documents, and medical toxicology reports.

The breakdown is as follows:

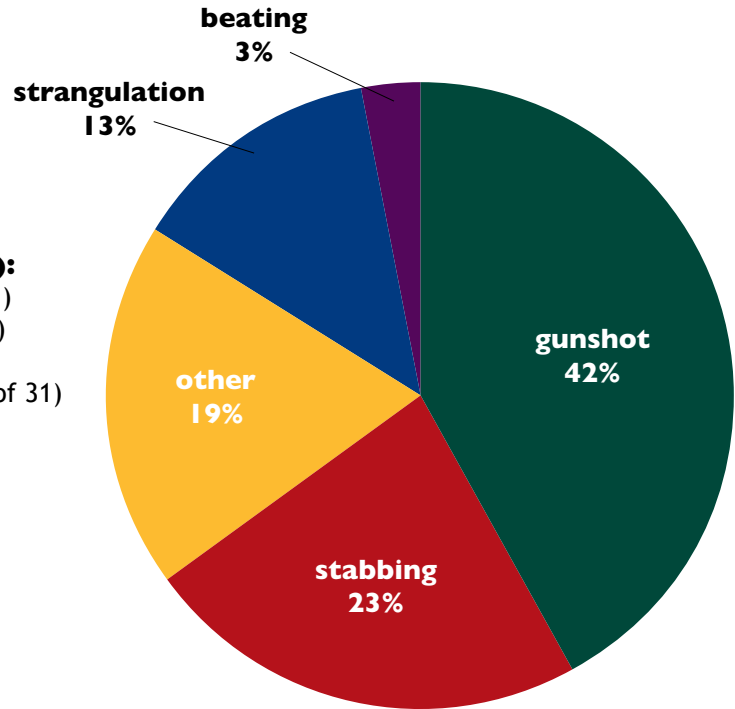
- 31%       Alcohol (5 of 16)
- 19%       Drugs (3 of 16)
- 50%       Drugs and alcohol (8 of 16)
- 61% (19 of 31) of perpetrators were arrested for the homicide/attempted homicide of the decedent/survivor.

# LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

## MANNER OF DEATH

### Manner of death (includes attempted):

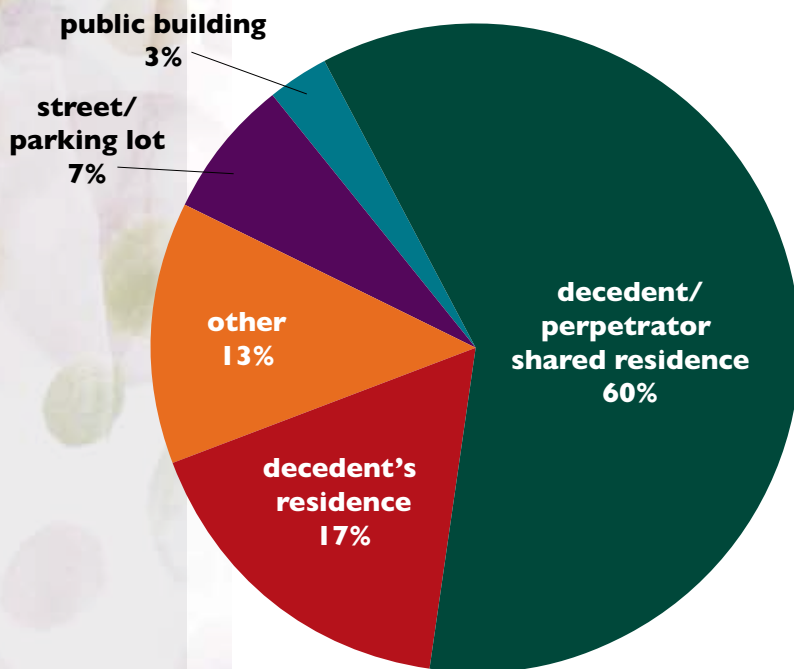
42%	gunshot (13 of 31)
23%	stabbing (7 of 31)
19%	other (6 of 31) <sup>15</sup>
13%	strangulation (4 of 31)
3%	beating (1 of 31)



## LOCATION OF HOMICIDE OR NEAR HOMICIDE

### Location of homicide or near homicide:

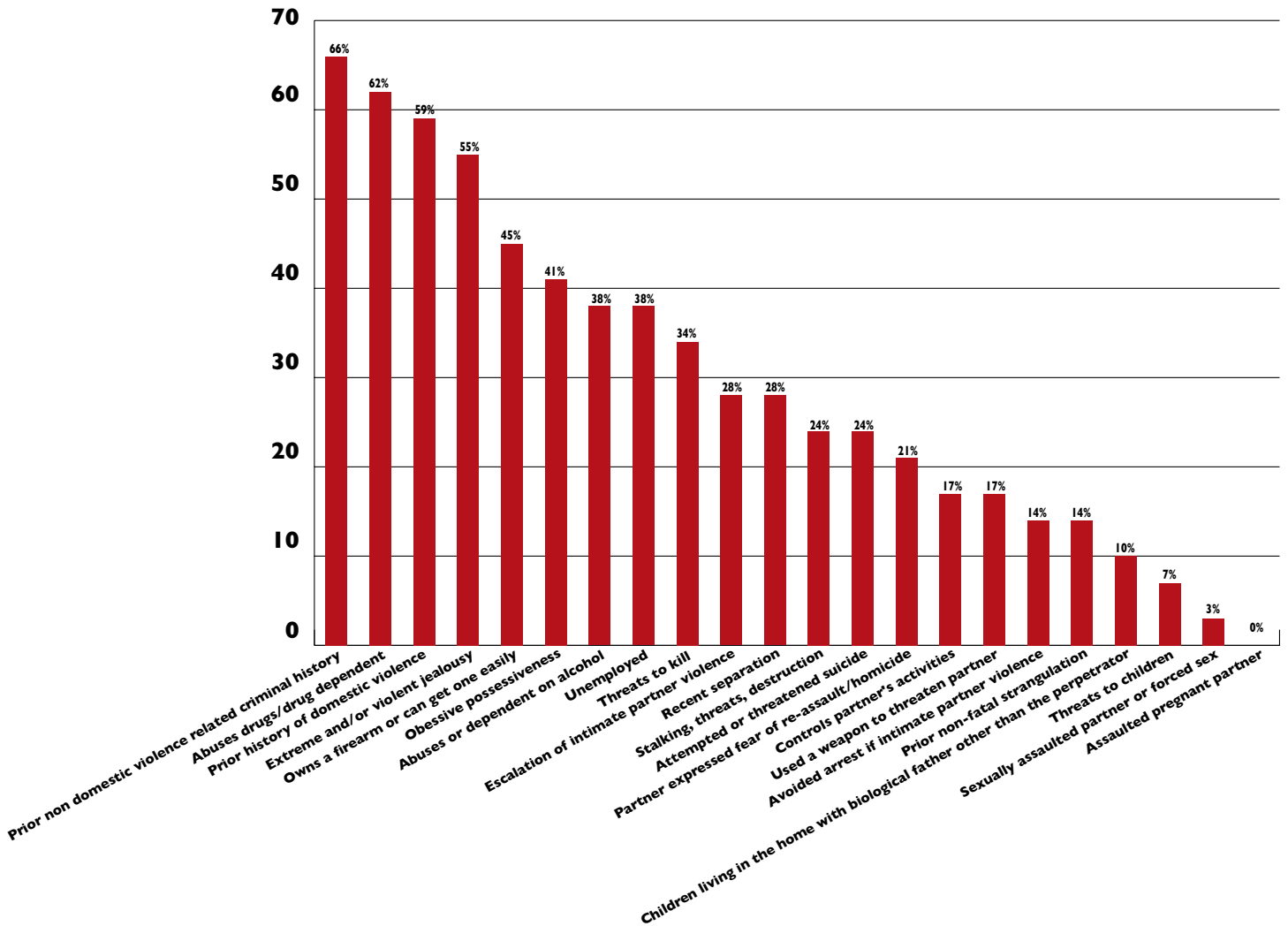
60%	decedent/perpetrator shared residence (18 of 30)
17%	decedent's residence (5 of 30)
13%	other (4 of 30)
7%	street/parking lot (2 of 30)
3%	public building (1 of 30)



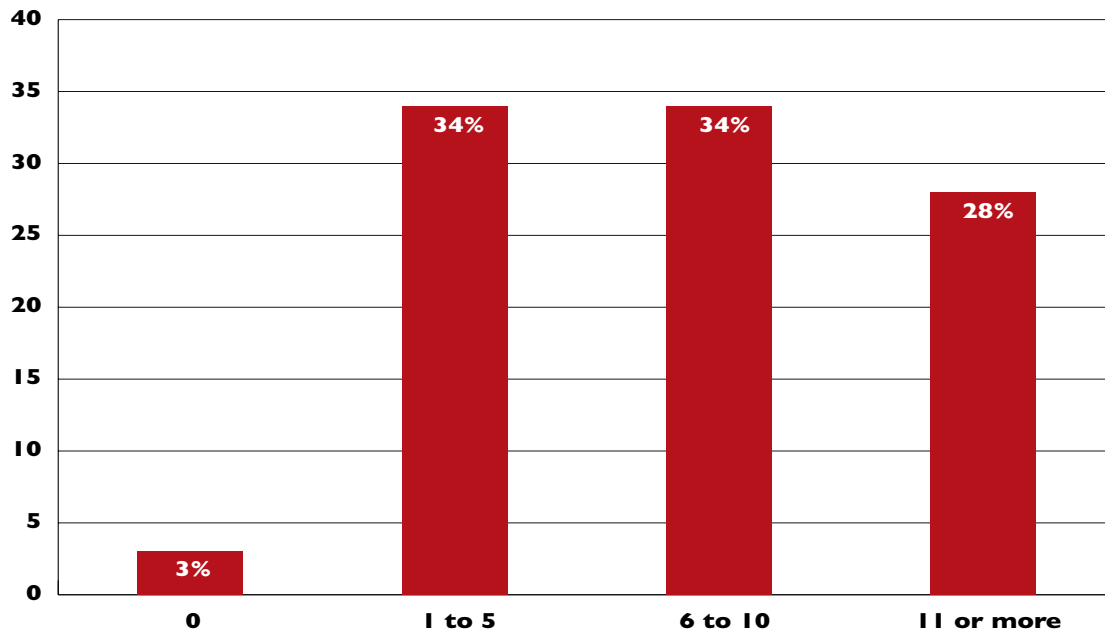
<sup>15</sup>Blunt force, multiple causes of death including burning, strangulation, and drowning.



## BREAKDOWN OF KNOWN RISK FACTORS



## PERCENT OF CASES BY TOTAL KNOWN RISK FACTORS PRESENT



# STATUS OF PRIOR RECOMMENDATIONS

Interventions to enhance safety for survivors and their children and strengthen perpetrator accountability related to recommendations made by the statewide team were implemented during the ten years of the team's existence. The status of the following projects highlights the importance of the fatality review process in creating systemic responses that support community collaboration to reduce and prevent intimate partner homicides in Florida.

## **Child Survivors of Intimate Partner Homicide Project**

**Status:** In 2016-2017, FCADV convened a child survivor workgroup and designed and administered a survey to assess the capacity and needs of local communities to provide trauma-focused services to child survivors of intimate partner homicide (IPH) and their caregivers. The results of the survey were applied to trauma-informed program development and training opportunities for increasing the capacity of local communities to respond to the needs of child survivors of IPH. A total of 115 community partners including advocates, mental health professionals, child welfare professionals, and community stakeholders participated in six regional one-day training sessions in 2018 through funding awarded to FCADV by the Office of the Attorney General (OAG). Conducted by FCADV, the training content included information related to empowerment-based and trauma-informed practices, the importance of establishing a collaborative network of service providers, and the skills necessary to provide counseling services to children and their caregivers to minimize the long-term effects of the complex trauma that occurs after the loss of a parent, sibling, or loved one to intimate partner homicide. FCADV also developed the structure for a community collaboration pilot project to address the immediate needs of child survivors of intimate partner homicides and their caregivers. Implementation of the pilot project in a local community is in the preliminary planning stages.

## **Online Domestic Violence Resource Guide for Media Professionals**

**Status:** FCADV completed a domestic violence resource guide for media professionals that provides guidance on publishing news stories that improve the general public's understanding of domestic violence, and reporting domestic violence incidents and homicides from a non-victim-blaming perspective. The media resource guide may be accessed on the FCADV website.<sup>16</sup> Certified domestic violence center executive directors shared the link to the resource guide with their local media outlets during Domestic Violence Awareness month in October 2018.

## **Expansion of the Injunction for Protection Project**

**Status:** FCADV implemented its Injunction for Protection (IFP) Project in 2016 with a Victims of Crimes Act (VOCA) funding award from the Florida Office of the Attorney General. Seventy-seven attorneys throughout the state of Florida currently assist survivors of domestic violence, dating violence, sexual violence, and stalking with completing and filing injunction for protection petitions as a result of the program's subsequent expansion. The attorneys also provide representation to survivors at final injunction and violation of injunction hearings. IFP Project attorneys meet with survivors referred by partnering agencies including certified domestic violence centers, clerk and court staff, law enforcement, state attorneys, and other organizations, to determine whether filing for an injunction is a safe and appropriate legal action. IFP Project attorneys represent survivors from the temporary petition stage through the final injunction hearing, as well as in civil contempt hearings for injunction violations. The attorneys also represent survivors in other injunction-related proceedings that impact their safety, such as defending against a perpetrator's motion to dismiss a final injunction.

## Focused Deterrence Initiatives

**Status:** Focused deterrence models identify chronic and repeat perpetrators of domestic violence, dating violence and sexual violence and encourage local law enforcement and community partners to target perpetrators with extensive criminal records, with a coordinated criminal justice system collaborative response, to hold these perpetrators accountable for their violence. FCADV's Law Enforcement Enhanced Response Statewide Initiative collaborated with Marcus Bruning, M.Ed., a nationally recognized trainer and law enforcement administrator, to conduct a total of 25 trainings on "Investigation and Response: Coordinating Efforts in Domestic Violence" for law enforcement agencies throughout Florida in Fiscal Year 2018-2019. Various law enforcement agencies throughout the state have also implemented systems to identify repeat or violent offenders who commit domestic violence and to rank the severity of the offenses. Training on focused deterrence models and the identification and management of high-risk offenders was provided to law enforcement personnel, advocates and community partners at FCADV's 2019 Statewide InVEST Institute. FCADV also conducted statewide training for stakeholders on high-risk indicators for domestic violence homicide, use of risk assessments, evidence-based prosecution and prosecution of sex crimes.

## Ongoing Domestic Violence Training for Community Partners

**Status:** FCADV provides in-depth training, technical assistance, and education to certified domestic violence centers, collaborative community partners, agencies, and service providers throughout the state. The following initiatives highlight examples of the partnerships between FCADV and allied partners related to comprehensive domestic violence training linked to statewide team recommendations:

- FCADV collaborates with the Office of the Attorney General to conduct training on the complex safety needs of survivors who are cyberstalked by abusers, with an emphasis on safety planning and cyberstalking evidence collection.
- In conjunction with Florida Sheriffs Association, Florida Police Chiefs Association and Florida Department of Law Enforcement, FCADV conducts onsite domestic violence training for law enforcement organizations, and created a video training series on topics including collecting photographic evidence, the use of risk assessments, excited utterances, the use of body cameras, trauma-informed interviews, and school resource officers' role in addressing teen dating violence.
- FCADV, certified domestic violence centers, and community partners are currently utilizing innovative strategies to expand outreach to immigrant communities including Spanish language fotonovelas, domestic violence information available on local Spanish and Creole radio stations, and sharing information regarding the FCADV/Florida Legal Services, Inc. Legal Hotline with agencies and partners that provide services to immigrant communities. Additional innovative outreach opportunities include information-sharing gatherings at local restaurants frequented by immigrant survivors living in the community. The Roaming Attorney Project is a collaboration between FCADV and Voices for Immigrant Defense and Advocacy (VIDA) to provide legal services for intimate partner survivors in need of legal remedies related to their immigration status. The project has comprehensively served over 100 survivors since its inception in 2016.
- FCADV conducts annual training related to screening and responding to domestic violence for healthcare professionals and its medical advocacy workgroup continues to focus on domestic violence training for healthcare professionals.

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<sup>16</sup><https://www.fcadv.org/media-guide>

# STATEWIDE DOMESTIC VIOLENCE FATALITY REVIEW TEAM MEMBERS

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# IN MEMORIAM

MATTHEW DALE 1959 – 2018

We are deeply saddened at the loss of Matthew A. Dale, who passed away in August 2018. Matthew served as the Director of the Montana Department of Justice Office of Consumer Protection and Victim Services for the seventeen years proceeding his death. Matt was a frequent visitor to Florida conducting training and technical assistance to the Florida statewide and local fatality review teams for over 15 years as a consultant with the National Domestic Violence Fatality Review Initiative (NDVFRI). He also contributed his knowledge on domestic violence fatality review for the 2017 FCADV publication, "Domestic Violence Fatality Review: A Guide for Florida's Domestic Violence Fatality Review Teams." Matthew Dale shared his knowledge, wisdom, and sense of humor with all of us.


He will be greatly missed.



# THANK YOU

**The statewide team would like to acknowledge the hard work and dedication of Florida's local domestic violence fatality review teams in the following counties:**

Alachua  
Bay  
Brevard  
Broward  
Collier  
Duval  
Escambia  
Hernando  
Highlands  
Hillsborough  
Indian, Martin, St. Lucie, Okeechobee  
Lee  
Leon, Gadsden, Wakulla  
Manatee  
Miami-Dade  
Orange  
Osceola  
Palm Beach  
Pasco  
Pinellas  
Polk  
Santa Rosa  
Sarasota  
Seminole  
St. Johns



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*Sponsored by FCADV and the State of Florida, Department of Children and Families.*