# FACES OF FATALITY

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





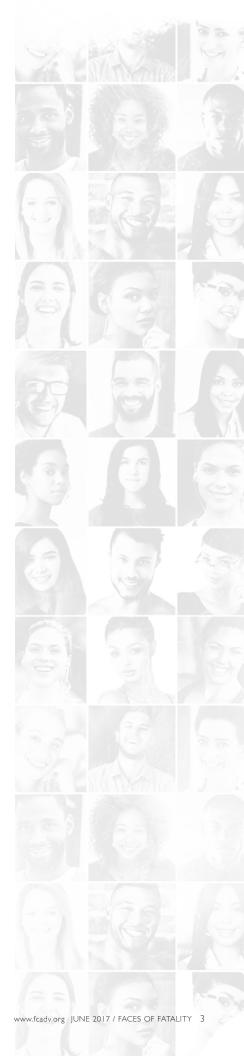
This report is dedicated to the women, children and men who were killed by an act of domestic violence in Florida, to their loved ones, and to those who work every day to prevent these unthinkable deaths.

"The work our domestic violence fatality review teams do is so important in understanding these tragic homicides and improving the safety of the citizens of Florida. These teams honor the lives that were lost by providing information that may help prevent future deaths. I am pleased to partner with the Florida Coalition Against Domestic Violence in co-chairing the Statewide Domestic Violence Fatality Review Team and commend our great law enforcement agencies, prosecutors, and team members who play such a critical role in the fight against domestic violence."

—Attorney General Pam Bondi

"Tragically, every year approximately one in five homicides in Florida are the direct result of domestic violence. It is difficult to imagine that 20 percent of our state's homicides are perpetrated by a current or former partner or family member. Reducing domestic violence homicides requires the collaboration of entire communities working diligently toward this goal. The Statewide Domestic Violence Fatality Review Team, developed through a partnership between the Florida Coalition Against Domestic Violence and the Office of the Attorney General, is critical in this continuous effort by identifying systemic gaps and providing potential solutions that increase domestic violence awareness while strengthening the State's response to this heinous crime. The Florida Coalition Against Domestic Violence remains steadfast in our work with the statewide team and the 25 local fatality review teams to find solutions that help survivors and their children remain safe, reduce homicides and hold perpetrators accountable for their violence."

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



## CONTENTS

- Executive Summary 4
  - Findings 6
- Recommendations 8
  - Fatality Review 10
- Local Fatality Review Team Data Analysis 12
  - Breakdown of Known Risk Factors 19
    - Notable Comparisons 20
  - Status of Prior Recommendations 21
- Local Fatality Review Team Data Analysis 22 Five-Year Summary from 2009-2014
  - Summary 32

Domestic violence homicides continue to occur at alarming numbers. The 2016 Semi-Annual Uniform Crime Report (UCR)<sup>1</sup> statistics released by the Florida Department of Law Enforcement (FDLE) in November 2016, reflected a 3.5% increase in domestic violence murders in the initial six months of 2016. Conversely, homicides caused by manslaughter decreased by 63% during the same time period. While the overall domestic violence statistics reflected a 4.6% decrease, the increase in murders in the first half of 2016 is of great cause for concern. Since the publishing and subsequent release of 2016 Faces of Fatality report, there were a total of 292 domestic violence related homicides in Florida.<sup>2</sup>

In 2009, the Florida Attorney General's Statewide Domestic Violence Fatality Review Team was formed after the rise in domestic violence homicides in our State. During the past eight years, the team has reviewed 328 domestic violence fatalities and introduced interventions and recommendations that strengthen systemic responses to domestic violence while increasing public awareness of domestic violence. These recommendations consider the immediate and ongoing safety needs of survivors and their children while striving to hold perpetrators accountable for their violence utilizing a coordinated community response approach. The team convenes four times each year to conduct a comprehensive review of domestic violence homicides that occurred in Florida, with the goal of enhancing Florida systems that contribute to the prevention of such fatalities. Attorney General Pam Bondi and the Florida Coalition Against Domestic Violence (FCADV) co-chair the statewide team. 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, healthcare providers and the defense bar.

Currently, there are also 25 local teams that review domestic violence homicides and near homicides in rural and urban communities throughout Florida. Florida's approach of one statewide team in addition to local teams is a model utilized in only nine other states. The teams follow a solution oriented "no blame, no shame" philosophy that focuses on communities working together to prevent domestic violence homicides. All teams comply with statutory mandates to maintain the confidentiality and public records exemptions when reviewing fatality related information.<sup>3</sup>

In 2014, the United States Department of Justice, Office on Violence Against Women awarded a three-year grant to the Florida Department of Children and Families (DCF) that enabled FCADV to provide comprehensive training and technical assistance to local fatality review teams and allied partners. The training content focused on identifying the risk indicators that often precede a domestic violence homicide, improving team sustainability and strengthening community collaborations to prevent domestic violence. The purpose of these trainings are to enhance the fatality review process and provide support to the local teams. To date, over 700 advocates, law enforcement officers, clerks of court, judges, emergency responders and others involved in Florida's domestic violence response were trained through this grant.

The 2017 Faces of Fatality VII report includes two new distinct components. This year's annual report is comprised of the statewide team's review of a 2016 murder/suicide and data analysis of domestic violence homicide reviews completed by local fatality review teams from March 2016 through December 2016. In an attempt to coordinate the Faces of Fatality annual report with information available from FDLE's Annual UCR, and to complete data analysis within the calendar year in the future, the time frame for data collection was reduced to nine months this year. Therefore, the annual report released in June 2018 will include cases reviewed between January 2017 and December 2017, reflecting an entire calendar year. The second component of this report includes a summary of the fatality review analysis compiled between 2009 and 2014. The Statewide Domestic Violence Fatality Review Team conducted the five-year summary to examine the trends of risk indicators over an extended defined timeframe. As a result, the summary data continues to support overarching themes related to risk indicators and events that led up to domestic violence homicides.

Data reviewed by local teams includes a demographic profile of the lives and experiences of the decedents and perpetrators in these homicides. Of the cases reviewed in the annual report, 86% of the perpetrators were male and 83% of decedents were female. Data from the local teams' reviews indicate disparities between perpetrators and decedents in age, occupational status, and the years of formal education. On average, perpetrators were slightly younger than the victims, were more likely to be unemployed, and less likely to have completed high school and/or college. In the case reviewed by the statewide team, the victim was eight years older than the perpetrator.

Clusters of high-risk indicators that often precede domestic violence homicides were identified in the data extracted by local team reviews. Risk-factors identified in these cases included the perpetrator's prior history of domestic violence, use of weapons, and extreme jealousy. More than 50% of perpetrators possessed a known history of prior domestic violence, substance abuse, and non-domestic violence criminality. More than 60% of perpetrators were known to carry a weapon and 33% of perpetrators were using substances at the time of the homicide.

The decedent having children from a prior relationship is another risk indicator for domestic violence homicide. A total of 67% of decedents had children at the time of the homicide and 65% of those children were from the decedent's previous relationships. There were known child witnesses in 10% of the deaths. Forty percent (40%) of decedents or their family members had contact with the Department of Children and Families prior to the homicide. Of the homicides reviewed, 63% occurred in a residence shared by the perpetrator and decedent. Fifty-two percent (52%) of family members reported knowing about prior incidents or threats of domestic violence made by the perpetrator.<sup>4</sup> In 31% of the reviewed cases, there were known allegations of death threats made by the perpetrator toward the decedent prior to the homicide.

The strong correlation of the local fatality review team findings and identified evidencebased high-risk indicators requires the attention of all community and system partners in addressing domestic violence homicide. A proactive coordinated community response effort increases the likelihood of successful interventions that enhance safety for survivors and their children and support domestic violence responses that effectively and collectively hold offenders accountable for their violence. Fatality review is a systemic and collaborative process in which gaps in domestic violence services and responses can be efficiently addressed to aid in the prevention of future homicides. Through fatality review recommendations, both state systems and local communities have the opportunity to develop policies and intervention strategies that continue to enhance services and reduce the likelihood of homicide. This report includes information for legislators, state agencies, social service organizations, and communities to assist in the ongoing efforts to address systemic gaps, enhance policy development and implement practices that reduce and prevent domestic violence homicides in Florida.

<sup>&</sup>lt;sup>1</sup> http://www.fdle.state.fl.us/cms/FSAC/UCR/2016/2016SA\_CIF.aspx

<sup>&</sup>lt;sup>2</sup>The eighteen month total includes data from the 2015 UCR annual report released on May 20, 2016 and the 2016 UCR semi-annual report released in November 2016.

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

<sup>&</sup>lt;sup>4</sup>Information was obtained through media articles, police reports and/or interviews with family members.

## FINDINGS



The 2017 Faces of Fatality report contains descriptive statistics of domestic violence homicides based on data collected by Florida's local fatality review teams between March 2016 and December 2016. These deaths occurred between 1995 and 2016, with the majority of fatalities occurring from 2010-2016. Local fatality review teams entered data extracted from 30 cases that informed the 2017 report.

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 family or friends of the deceased. The information provides a contextual view of the perpetrators' behaviors and the survivors' experiences prior to and leading up to the homicides. Additionally, the local teams utilize a uniform data collection tool to gather and report information about the characteristics of perpetrators, known domestic violence histories, criminal records, and a range of observable evidence-based risk factors.

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 whom he dated during the previous year. The victim was attempting to end the relationship for six months. The perpetrator slept on her back porch the night before the homicide and when she found him the next morning, she asked him to leave. The victim informed the perpetrator that she planned to seek an Injunction for Protection later that day and then left the residence. While she was gone, he broke into her home and when she returned a short time later, he then murdered her. The perpetrator then committed suicide after the murder of the victim. During the investigation, a friend of the victim stated that the suspect was "very abusive and controlling" and accused the victim of having an affair. A week before the homicide he drove a golf cart past the victim's house and upon finding the victim and her male friend, punched him in the forehead. Despite her attempts to leave the relationship, the perpetrator stalked, harassed and threatened her. This loss of life is a tragic reminder of the great need for systemic and cultural changes to the response of the crime of domestic violence. The Faces of Fatality annual report seeks to honor the victim's memory through the development of recommendations that provide hope for those experiencing domestic violence in the future.

#### Findings from the 2016-2017 local fatality reviews highlight several themes regarding victim and perpetrator profiles, as well as factors that suggest a heightened risk of lethality:

- 35% of perpetrators were unemployed at the time of the homicide.
- 55% of perpetrators were reported to have substance abuse histories.
- 28% of perpetrators were reported to have a professionally diagnosed mental health disorder.

- In 28% of the fatilities, there was known prior stalking<sup>5</sup> behavior on the part of the perpetrator.
- In 50% of the fatalities, there was at least one of the following indicators present prior to the homicide: history of prior domestic violence, substance abuse, and/or non-domestic violence criminal history by the perpetrator.
- 62% of perpetrators were known by family or friends to carry or possess a weapon.
- 42% of decedents and perpetrators were separated at the time of the homicide and the average length of separation when known, was approximately 2.9 years.
- 31% of fatalities had known prior death threats made by the perpetrator towards the decedent, based on victim reporting.
- 57% of perpetrators had a known non-domestic violence-related criminal history.
- 55% of perpetrators had a known criminal history of domestic violence and in 31% of fatalities, there were known prior reports to the police by the decedent alleging domestic violence by the perpetrator.
- 66% of perpetrators had a known criminal history of any kind, domestic violence-related or otherwise, based on criminal records and narrative reports.
- In 52% of the fatalities, family members reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator.
- In 31% of the fatalities, there was a known criminal order of no contact issued against the perpetrator.
- In 17% of the fatalities there was a known permanent Injunction for Protection filed against the perpetrator by the decedent; in 17% there was a known permanent Injunction for Protection filed against the perpetrator by someone other than the decedent.
- 21% of perpetrators completed suicide and an additional 14% attempted, but did not complete suicide.

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

There were several indicators of increased risk for lethality including:

- The perpetrator had access to weapons.
- The victim was attempting to end the relationship with the perpetrator.
- The perpetrator repeatedly showed up at the decedent's home uninvited (stalking).
- The perpetrator's use of violence escalated one week prior to the homicide.

<sup>5</sup>See s. 784.048, F.S., for the definition of stalking.

## RECOMMENDATIONS

Law enforcement agencies should include the Florida Domestic Violence Hotline and information regarding certified domestic violence centers in the victim rights information distributed to all adult and juvenile victims of crime, particularly criminal mischief, property damage, trespassing or other lesser crimes to ensure domestic violence survivors who are victims of these crimes receive information regarding the availability of life saving domestic violence services. FCADV should partner with the Florida Department of Law Enforcement, Florida Sheriffs Association and Florida Police Chiefs Association to create a card that contains the Florida Domestic Violence Hotline phone number and other relevant information that can be included with the general victim rights brochure for distribution on-scene by law enforcement. The inclusion of this information will help increase access to domestic violence resources for domestic violence survivors.

The homicides reviewed by the Statewide Domestic Violence Fatality Review Team during the past two years have included charges against the perpetrators for criminal mischief, property damage or trespassing against the victim prior to the homicide. It is not uncommon for perpetrators of domestic violence to commit crimes against survivors that do not meet the criteria for an arrest or report under Florida's domestic violence statute section 741.29, F.S. This statute includes a provision requring law enforcement to provide victims of domestic violence a rights and remedies brochure that includes information about the certified domestic violence center in their area and their legal rights.

Perpetrators of domestic violence often commit crimes of criminal mischief, trespassing and property damage as a tactic to maintain control over their current or former partners. Florida statute section 960.001 requires that law enforcement officers provide information to all crime victims on scene regarding crisis intervention services, supportive or bereavement counseling, social service support referrals, and community-based victim treatment programs available to adult and juvenile victims. Section 960.001, F.S. does not require that all crime victims receive information specific to domestic violence that could link them to certified domestic violence centers.<sup>6</sup> The information provided to all victims of crime, particularly victims of property crime, trespassing and criminal mischief, should also include the Florida Domestic Violence Hotline and certified domestic violence center information.

FCADV, certified domestic violence centers, and other stakeholders including law enforcement and community based programs should develop and distribute informational materials and/or conduct community outreach activities related to the dynamics and tactics of domestic violence, intervention strategies and available resources for staff and residents representing the 55 and older population.

In this year's data, the maximum age of decedents was 70 and maximum age of perpetrators was 78. There are 317 residential communities for people age 55 and

over in Florida,<sup>7</sup> yet few of these survivors seek domestic violence services or assistance from law enforcement. Social myths regarding people in later life, such as the perception that they are fragile and physically abused by caretakers but not their intimate partners,<sup>8</sup> can contribute to the stigma surrounding intimate partner violence and increase the isolation experienced by older victims of domestic violence. In addition, active adult communities are often viewed as secure and safe environments, where residents do not need to be concerned with personal safety or the safety of others in the community.<sup>9</sup> As identified in this year's case review, intimate partner violence, including stalking and harrasment does occur in these communities. As such, it is important that staff and residents of residential communities receive information and training on the prevelance of domestic violence in later life, signs of abuse and resources that are available to survivors. In order to create culturally appropriate material for these populations, FCADV will host survivor listening groups with survivors aged 55 and older that will guide the development of outreach materials on the topic of intimate partner violence in later life. FCADV will ensure the availability of these materials to local community partners for distribution.

In collaboration with partners such as the Department of Elder Affairs, The Office of the Attorney General, Division of Victim Services and the Department of Children and Families, FCADV should create a training curriculum related to Intimate Partner Violence in Later Life for dispatchers, mental health professionals, physicians, law enforcement officers, victim advocates, first responders and staff of the 55 and older living communities. Training topics should focus on tactics of coercive control used by perpetrators of intimate partner violence in later life, signs of intimate partner violence and the relationship between elder abuse and intimate partner homicide.

Collaboration among those who interface with the age 55 and older population is necessary to ensure seamless coordination and assistance for survivors of intimate partner violence. Survivors may be reluctant to disclose the violence to physicians, healthcare providers or to law enforcement due to several factors including, but not limited to: fear that disclosure will generate an abuse report, fear that their families will find out, feelings of shame and embarrassment at disclosing the abuse and/or a belief that domestic violence should not be publicized. Professionals and bystanders need the knowledge and skills to identify intimate partner violence in later life in order to provide appropriate referrals and resources. Training a diverse audience on topics related to the specific cultural dynamics and needs of older communities is necessary to identify intimate partner violence and hold perpetrators accountable for their violence. Training topics should include recognizing dynamics of coercive control in later life, screening for intimate partner abuse, special concerns of survivors, specific outreach strategies for the later in life population and how to respond when intimate partner violence is occuring within the 55 and older community.

## FATALITY REVIEW

The statewide team convened four meetings during the 2016-2017 fiscal year. In addition to reviewing data from the local teams and discussing recommendations, the team conducted a review of a 2016 murder/suicide. This review is based on information from law enforcement, including police reports, media reports and the statewide team's interview with the law enforcement agency that investigated the homicide/suicide.

In May 2016, P.L., age 60, was murdered in the garage of her home in a 55 and older community by W.N., age 51, a man she dated in the past. P.L. was attempting to end her relationship with W.N. during the six months preceding her death. As P.L. entered the garage, W.N. shot her. P.L. ran out of the garage after being shot and collapsed on the lawn. Although she was transported to a hospital, she was unable to be resuscitated. W.N. was found inside of the home; he had completed suicide using the same gun. P.L. is remembered as a sweet, friendly, and upbeat person who is deeply missed by her friends and family due to this horrific tragedy.

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

- P.L. and W.N.<sup>10</sup> dated intermittently for over a year. At the time of the homicide, P.L. was attempting to permanently end her relationship with W.N.
- They did not reside together at the time of the fatality, but may have lived together in the past.
- W.N. was named a respondent in a temporary Injunction for Protection filed by one of his previous wives. The order was dismissed due to insufficient evidence.
- P.L. filed criminal mischief and petit theft charges against W.N. in October 2015 after he smashed the front glass door of her house and stole her cell phone. He then fled before law enforcement arrived on the scene. The case was closed two days later when P.L. informed law enforcement that W.N. had returned her phone and agreed to pay for the repairs to the door.

<sup>10</sup>Out of respect for the victim, the perpetrator, and their families, the initials of the victim and perpetrator have been changed.

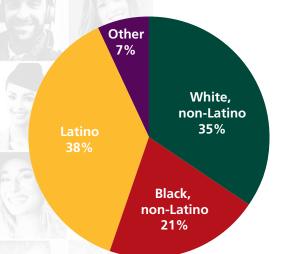
- Three weeks after the criminal mischief report, P.L. reported to law enforcement that her firearm was missing. P.L. suspected W.N. had stolen the firearm. In December 2015, P.L. informed law enforcement that the weapon was returned. This was the weapon W.N. used to kill P.L. and himself in May 2016.
- After the homicide, P.L.'s neighbors reported that W.N. exhibited jealousy, possessiveness and controlling behaviors toward P.L. The neighbors reported hearing frequent arguments between W.N. and P.L., and were aware that W.N. smashed the door six months prior to the homicide. Additionally, a week before the homicide W.N. drove a golf cart past the victim's house and upon finding the victim and her male friend outside the home, punched the male friend in the forehead.
- W.N. stalked and harassed the victim in the 55 and over community. He convinced an employee of the community association to tell him whether she was home and if her male friend was with her.
- W.N. asked his sister to drive him to P.L's house the morning of the homicide. When she declined, he informed her that if anything happened to him to check with P.L. and her male friend.
- On the morning of the homicide, P.L. found W.N. asleep on her porch. She left the home and sent him a text message stating that she was going to obtain an Injunction for Protection later that day. While she was gone W.N. broke into her home and killed her when she returned to the house.
- W.N.'s toxicology report indicated positive for cocaine.

## LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

The descriptive statistics in the 2017 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 deaths. When possible, the data points are based on information collected from all 30 reviews submitted by local teams. In some instances however, statistics are based on different totals. This is either due to non-applicability or 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. In one out of the 30 cases reviewed this year, the reviewers identified the perpetrator of the homicide as acting in self-defense to domestic violence. This review was excluded in the descriptive statistics that inquire about specific details of perpetrators or decedents because of the unique circumstances surrounding that homicide.

The evidence-based research on known risk factors is based on cases of femicide, which are male perpetrated homicides on their female partners. Therefore, information on the breakdown of known risk factors contains data on the 24 deaths that were a result of femicide.

YEAR OF INCIDENT	# OF REVIEWS
1995	1
2010	2
2012	6
2013	4
2014	8
2015	2
2016	4
Not specified by reviewers	3
Total	30



#### PERPETRATOR RACE/ETHNICITY

#### **PERPETRATOR CHARACTERISTICS**

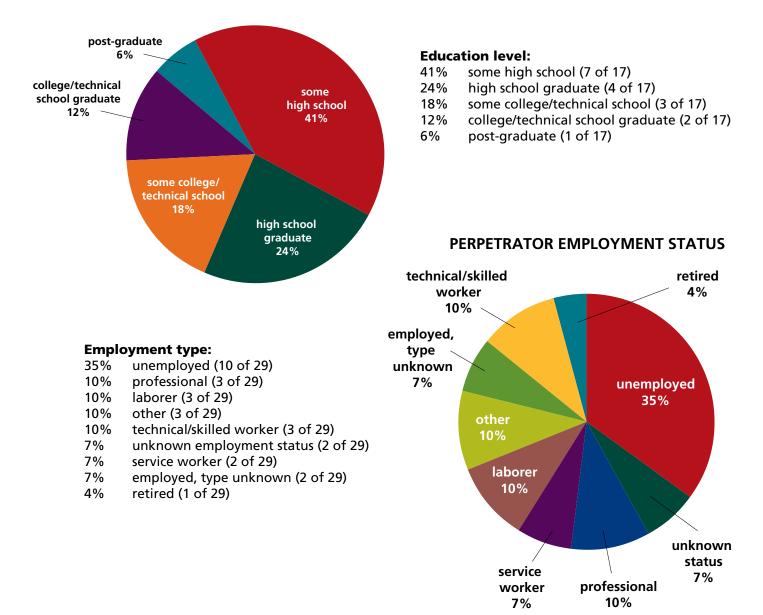
Gender: 86% male (25 of 29), 14% female (4 of 29)

#### Race/ethnicity:

- 38% Latino (11 of 29)
- 35% White, non-Latino (10 of 290)
- 21% Black, non-Latino (6 of 26)
- 7% Other (2 of 29)

Average age: 43 (min: 20, max: 78)

#### PERPETRATOR EDUCATION LEVEL

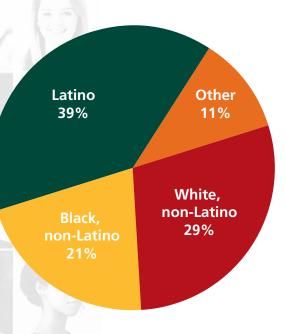


#### **Other known perpetrator characteristics**

- Reviewers reported that 55% (16 of 29) of perpetrators had known substance abuse based on various sources (e.g., driving under the influence records, police reports, substance abuse services, personal narratives from self, family, friends, or co-workers).
- Reviewers reported diagnosed mental health disorders in 28% (8 of 29) of perpetrators.
- Reviewers reported that 28% (8 of 29) of perpetrators exhibited prior stalking behavior.
- Reviewers reported that 62% (18 of 29) of perpetrators were known by family or friends to carry or possess a weapon.

## LOCAL FATALITY REVIEW TEAM DATA ANALYSIS

#### **DECEDENT RACE/ETHNICITY**



#### **Decedent Characteristics**

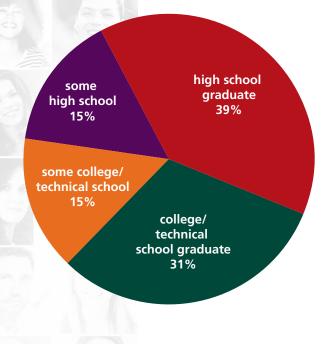
Gender: 17% male (5 of 29), 83% female (24 of 29)

#### **Race/ethnicity:**

- 39% Latino (11 of 28)
- 29% White, non-Latino (8 of 28)
- 21% Black, non-Latino (6 of 28)
- 11% Other (3 of 28)

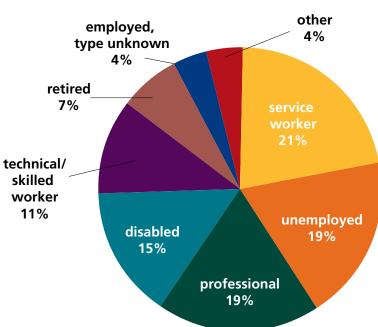
Average age: 41 (min: 23, max: 70)

#### **DECEDENT EDUCATION LEVEL**



#### **Education**:

- 39% high school graduate (5 of 13)
- 31% college/technical school graduate (4 of 13)
- 15% some college/technical school (2 of 13)
- 15% some high school (2 of 13)



#### DECEDENT EMPLOYMENT STATUS

#### **Employment type:**

- 21% service worker (6 of 27)
- 19% unemployed (5 of 27)
- 19% professional (5 of 27)
- 15% disabled (4 of 27)
- 11% technical/skilled worker (3 of 27)
- 7% retired (2 of 27)
- 4% employed, type unknown (1 of 27)
- 4% other (1 of 27)

#### **Relationship Characteristics**

#### 67% of decedents (20 of 30) had children:

35%	1 child	(7 of 20)
-----	---------	-----------

30%	2 children	(6 of 20)	)

- 15% 3 children (3 of 20)
- 15% 4 children (3 of 20)
- 5% 6 children (1 of 20)

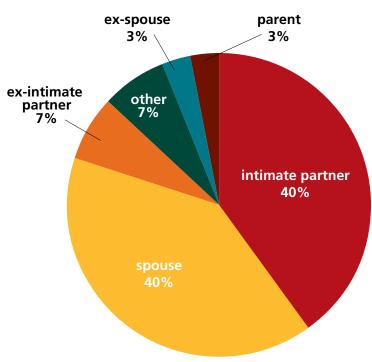
Of decedents with children, 65% (13 of 20) were known to have children outside of their relationship with the perpetrator.

#### Relationship of perpetrator to decedent:

- 40% intimate partner, unmarried (12 of 30)
- 40% spouse (12 of 30)
- 7% ex-intimate partner (2 of 30)
- 7% other (2 of 30)
- 3% ex-spouse (1 of 30)
- 3% parent (1 of 30)

#### Mean length of relationship:

10.4 years (min = .025,<sup>11</sup> max = 50)



<sup>11</sup>The minimum length of separation was entered into the data collection tool as .025

## RELATIONSHIP TYPE

## LOCAL FATALITY REVIEW TEAM DATA ANALYSIS



- 63% (19 of 30) of couples were known to have previously lived together full time, 33% (10 of 30) of couples were known to have lived together "off and on," and 3% (1 of 30) of couples were not known to have lived together at any point.
- 67% (16 of 24) of couples were known to have been living together at the time of the fatality. 33% (8 of 24) of couples were known to have lived together previously, but not living together at the time of the death.
- 42% (10 of 24) of couples were known to be separated (marital, separate households, or both) at the time of death.
- The average length of relationship separation, when known, was approximately 2.9 years (min = 0, max = 15).
- There were known allegations of death threats made by 31% (9 of 29) of the perpetrators towards the decedent, prior to the incident.
- There was known harassment of the decedent by 24% (5 of 21) of perpetrators at the decedent's workplace.

## **CRIMINAL RECORDS**

#### **Perpetrator:**

- 66% (19 of 29) of perpetrators had a known criminal history of any kind, domestic violence related or otherwise, based on criminal records and narrative reports.
- 57% (16 of 28) of perpetrators had a known non-domestic violence related criminal history.
- 55% (16 of 29) of perpetrators had a known criminal history of domestic violence.
- 31% (9 of 29) of perpetrators had known prior reports to the police by the decedent, alleging domestic violence by the perpetrator.
- 52% (15 of 29) of family members reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator.
- 31% (9 of 29) of perpetrators had a known criminal order of no contact issued against the perpetrator.
- 17% (5 of 29) of perpetrators had a known permanent Injunction for Protection filed against them by the decedent.
- 17% (5 of 29) of perpetrators had a known permanent Injunction for Protection filed against them by someone other than the decedent.
- 4% (1 of 29) of perpetrators had a known Injunction for Protection violation arrest.

#### **Decedent:**

- 21% (6 of 29) of decedents had a known history of domestic violence based on criminal records and narrative reports.
- 7% (2 of 29) of decedents had a known criminal order of no contact issued against them.
- 7% (2 of 29) of decedents had a known permanent Injunction for Protection filed against them by the perpetrator.

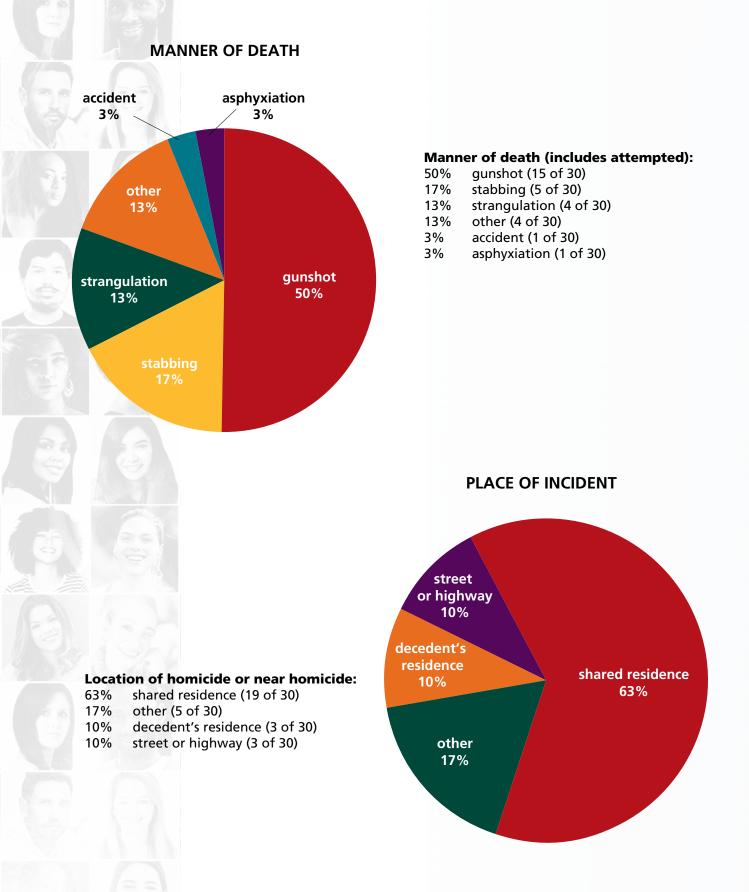
#### **Domestic Violence and Social Services**

- 40% (12 of 30) of decedents or their family had known contact with the Department of Children and Families.
- 17% (5 of 29) of decedents had known contact with victim support services.
- 7% (2 of 29) of decedents had known contact with a certified domestic violence center.
- 20% (3 of 15) of perpetrators with a prior history of domestic violence were currently or were previously enrolled in a batterers' intervention program (BIP).

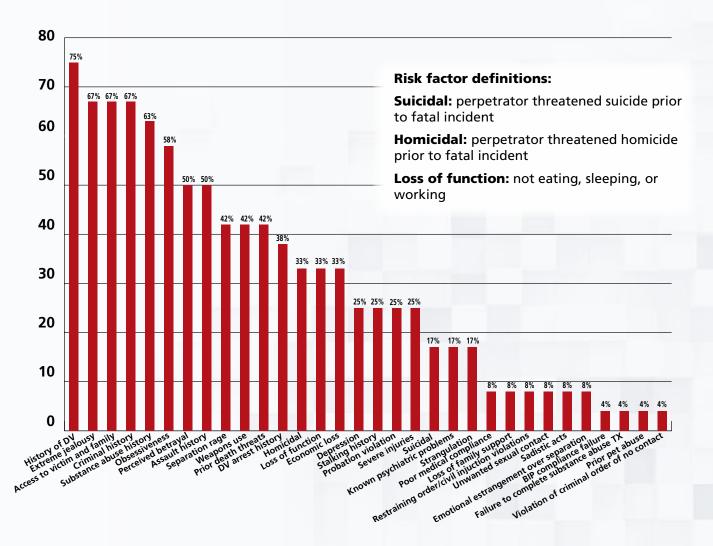
#### **Characteristics of the Fatality**

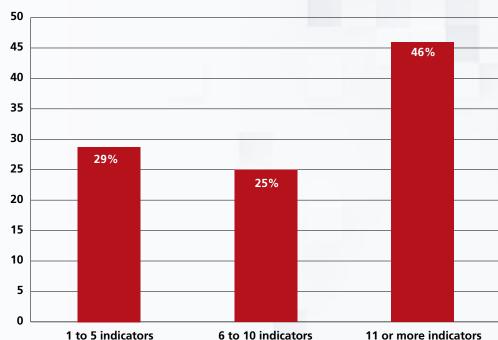
- 21% (6 of 29) of perpetrators completed suicide and an additional 14% (4 of 29) attempted but did not complete suicide.
- At the time of the fatality, there was known substance use by 33% of perpetrators. This information is based on the perpetrator's self-reports and/or medical toxicology reports. The breakdown is as follows:
- 13% alcohol (4 of 30) 10% drugs (3 of 30) 10% drugs and alcohol (3 of 30)
- 67% no known documented substance abuse (20 of 30)
- 14% (4 of 29) of fatalities had a collateral victim (i.e., a victim other than the decedent; does not include perpetrator suicides).
- There were known child witnesses in 10% (3 of 30) of the fatalities.

## LOCAL FATALITY REVIEW TEAM DATA ANALYSIS



#### **BREAKDOWN OF KNOWN RISK FACTORS**





PERCENT OF CASES BY TOTAL KNOWN RISK FACTORS PRESENT

cases reflected significantly higher rates of multiple risk factors than in 2016, including the history of domestic violence perpetration (75% in 2017 vs. 63% in 2016), extreme jealousy (67% in 2017 vs. 42% in 2016) and criminal history (67% in 2017 vs. 50% in 2016).

Many of this year's

## NOTABLE COMPARISONS



- The 2017 assessment of risk indicators focuses on the 24 femicides compared to the 30 total reviewed fatalities.
- Perpetrators were known to carry a weapon substantially more (62% compared to 35% in 2016).
- Guns continued to be the weapon used to perpetrate domestic violence homicides (50% compared to 45% in 2016).
- The number of perpetrators and decedents who were separated at the time of the fatality was higher in 2017 (42% compared to 23% in 2016).
- A shared residence of a perpetrator and decedent continued to be the most common location of the fatality (63% compared to 68% in 2016).
- The current reviews identified a higher rate of contact by the decedent family members with the Department of Children and Families (40% compared to 20% in 2016).

## STATUS OF 2016 RECOMMENDATIONS

FCADV should develop a pilot project that will enhance the Intimate Violence Enhanced Service Team (InVEST) model to increase participation by states' attorneys office victim advocates in the ongoing review of domestic violence police reports and partner with prosecutors on cases where risk factors were identified.

**Status:** FCADV contracted with a Florida assistant state attorney to conduct six InVEST regional trainings on the topic of Prosecution and Offender Accountability. The training content focused on methods prosecutors can use to prepare for a domestic violence criminal prosecution without the participation/testimony of the survivor. Three similar trainings were conducted for law enforcement officers. In 2017, FCADV will partner with offices of the state attorney to implement enhanced prosecution strategies. The Bay County InVEST Program continues to promote practices that serve as a model for Florida's prosecutors. In this last year, the Bay County Chief Prosecutor over misdemeanors advocated to ensure that the court sentenced offenders of misdemeanors to batterers' intervention programs and increased charges for repeat offenders at the misdemeanor level. Such practices encourage appropriate sanctions for offenders who often plea to reduced crimes or have charges dropped.

FCADV and the Statewide Domestic Violence Fatality Review Team should develop a domestic violence media guide for journalists and reporters to reduce and prevent framing domestic violence incidences and homicides with a victim blaming lens. The guide should include education regarding the role of victim-blaming statements and sentiments in perpetrating inaccurate stereotypes while simultaneously negating community efforts to hold perpetrators accountable for their crimes.

**Status:** FCADV developed the content for the media guide and will meet with members of the Statewide Domestic Violence Fatality Review Team Media Workgroup to finalize the guide in 2017.

The media guide will provide journalists information on the importance of utilizing language that properly identifies dynamics of intimate partner violence and refrains from victim-blaming. The guide will include referral numbers and resources such as the Florida Domestic Violence Hotline and local certified domestic violence center hotline numbers that can be used by media outlets throughout the state.

#### Florida's child welfare agencies should improve collaboration with community partners when there are surviving children.

Status: FCADV convened a workgroup in October 2016 with representatives from the National **Domestic Violence Fatality Review Initiative** (NDVFRI) and the Arizona Child and Adolescent Survivor Initiative (ACASI) on the ACASI traumainformed model of networked counseling services to children who experience the homicide of a parent. The workgroup identified a potential funding source that FCADV applied for to train advocates and mental health professionals to increase providers' capacity to serve child survivors of intimate partner homicide and their caregivers. FCADV and collaborative partners will develop and conduct a survey to assess the capacity and needs of local communities to provide traumainformed services to children and caregivers. The workgroup will establish pilot sites in which community stakeholders will be invited to attend FCADV's trainings. Participants will obtain information on trauma-informed practices, the importance of the collaborative network and develop the necessary skills 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 domestic violence homicide.

## LOCAL FATALITY REVIEW DATA ANALYSIS FIVE-YEAR SUMMARY FROM 2009-2014



In 2008, FCADV and the Fatality Review Steering Committee, which was funded by the federal Office on Violence Against Women Grants to Encourage Arrest award, outlined several goals for the implementation of Florida's Statewide Domestic Violence Fatality Review Team. Key representatives from state and local agencies convened to enhance the statewide delivery of services and increase communication and coordination between law enforcement, the court system, and other partners involved in the response to domestic violence homicides and review of these fatalities. These initial Steering Committee meetings were the genesis of Florida's current Statewide Domestic Violence Fatality Review Team.

Since 2009, the Statewide Domestic Violence Fatality Review Team has been co-chaired by the Attorney General and FCADV. This five-year summary includes data collected by local fatality review teams from 2009 through 2014. The data was combined to provide a long-term examination of the risk factors and characteristics of domestic violence homicides in Florida. The summary presents an overview of descriptive statistics to identify patterns or changes that occurred during a five-year period, with the purpose of revealing trends that were developed over time and illustrate the importance of the recommendations for systemic and legislative changes, as well as the ongoing need for training. The summary data outlines the prevalence of risk indicators presented in the previous statewide team annual reports, up to 2015. The status update for the 2015 and 2016 recommendations are included in Part One of the 2017 Faces of Fatality VII report.

There were 207 reviewed deaths that were recorded in prior statewide team annual reports included in the summary report. The reviews included both intimate partner homicides and other domestic violence related deaths, such as sibling or parent homicides. As with the statewide team annual reports, the summary data is generated from both quantitative and qualitative sources. The local teams gathered information primarily from public records, media reports, and conversations with proxy informants, such as family or friends of the deceased. The information gathered provides a contextual view of the perpetrators' behaviors and the survivors' experiences leading up to the homicides. The local teams utilize a uniform data collection tool to gather and report information regarding the characteristics of perpetrators, known domestic violence histories, criminal records, and a range of observable evidence-based risk factors.

The five-year summary parallels findings from individual statewide team annual reports with 90% of perpetrators being male and 85% of decedents being female. Several risk indicators from individual annual reports were also similar in the five-year summary: 54% of perpetrators were known to carry a weapon and 52% of perpetrators were using substances at the time of the homicide. Forty-nine percent (49%) of perpetrators had a known history of prior domestic violence and 46% had a history of known nondomestic violence criminality. A total of 71% of decedents had children at the time of the homicide and 57% of those children were from the decedent's previous relationships (not the perpetrators' children). There were known child witnesses in 19% of the deaths. Twenty-seven percent (27%) of decedents or their family members were in contact with DCF prior to the homicide. Of the homicides reviewed, 59% occurred in a residence shared by the perpetrator and decedent. Family members reported knowing about prior incidences or threats of domestic violence by the perpetrator in 48% of the deaths. In 25% of the cases there were known allegations of death threats made by the perpetrator toward the decedent prior to the homicide. The five-year analysis indicated 42% of perpetrators completed suicide and an additional 6% attempted but did not complete suicide.

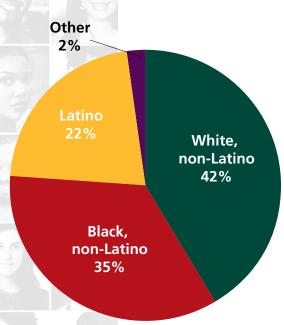
When possible, the data points are based on information collected from all 207 reviews submitted by local teams. In some instances, however, statistics are based on different totals, either due to non-applicability or missing information for any given review/case. The total number of cases used to calculate each indicator are reflected in parentheses. The five-year summary included five of the 207 total reviews for which reviewers identified the perpetrator of the homicide as acting in self-defense to domestic violence. These reviews were excluded in the descriptive statistics that inquire about specific details of perpetrators or decedents because of the unique circumstances surrounding those deaths.

The evidence-based research on known risk factors is based on cases of femicide, which are male perpetrated homicides on their female partners. Therefore, information on the breakdown of known risk factors contains data on the 172 deaths that were a direct result of femicide.

YEAR OF INCIDENT	# OF REVIEWS	
2009	26	
2010	45	
2011	22	
2012	48	
2013	38	
2014	28	
Total	207	

## LOCAL FATALITY REVIEW DATA ANALYSIS FIVE-YEAR SUMMARY FROM 2009-2014

#### **PERPETRATOR RACE/ETHNICITY**



#### **PERPETRATOR CHARACTERISTICS**

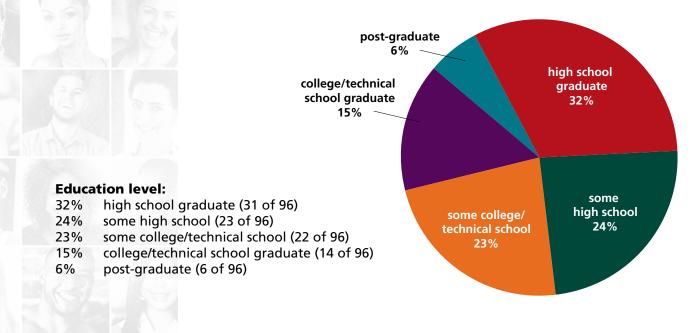
90% male (179 of 200), 11% female (21 of 200)

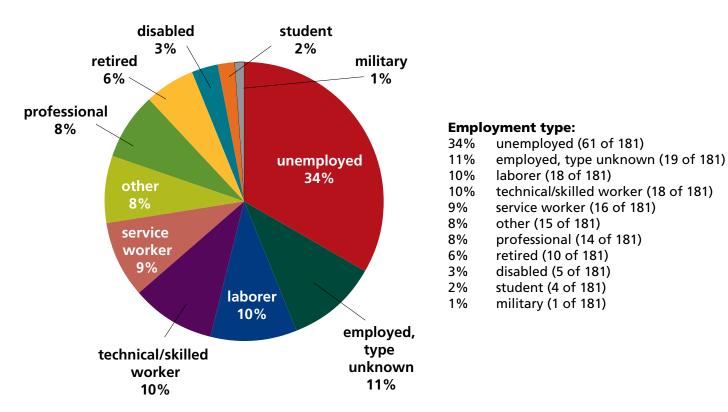
#### **Race/ethnicity:**

42%	White, non-Latino (83 of 199)
35%	Black, non-Latino (69 of 199)
22%	Latino (43 of 199)
2%	Other (4 of 199)

Average age: 42 (min: 15, max: 86)

#### PERPETRATOR EDUCATION LEVEL





#### PERPETRATOR EMPLOYMENT STATUS

#### **Other known perpetrator characteristics**

- 58% (96 of 166) of perpetrators had known substance abuse based on various sources (e.g., driving under the influence records, police reports, substance abuse services, personal narratives from self, family, friends, or co-workers).
- Reviewers reported diagnosed mental health disorders in 38% (58 of 153) of perpetrators.
- Reviewers reported that 26% (43 of 168) of perpetrators exhibited prior stalking<sup>12</sup> behavior.
- Reviewers reported that 54% (84 of 155) of perpetrators were known, by family or friends, to carry or possess a weapon.

<sup>&</sup>lt;sup>12</sup>See s. 784.048, F.S.

## LOCAL FATALITY REVIEW DATA ANALYSIS FIVE-YEAR SUMMARY FROM 2009-2014

## DECEDENT RACE/ETHNICITY Other 4% Latino White, non-Latino 20% Black, non-Latino 28%

#### **Decedent Characteristics**

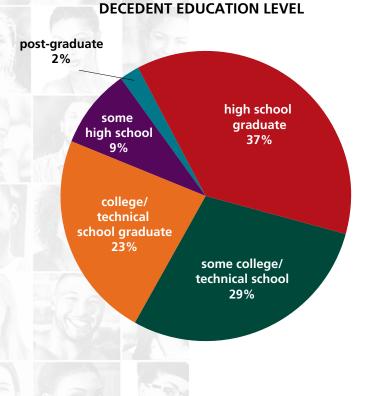
#### Gender:

15% male (30 of 200), 85% female (170 of 200)

#### **Race/ethnicity:**

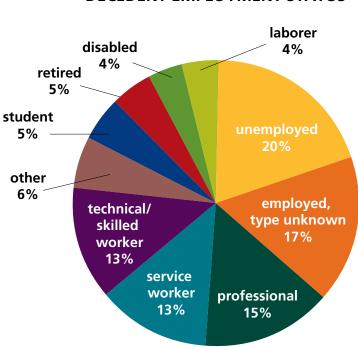
48% White, non-Latino (96 of 199)
28% Black, non-Latino (56 of 199)
20% Latino (40 of 199)
4% Other (7 of 199)

Average age: 41 (min: 6, max: 92)



#### **Education Level:**

- 37% high school graduate (34 of 92)
- 29% some college/technical school (27 of 92)
- 23% college/technical school graduate (21 of 92)
- 9% some high school (8 of 92)
- 2% post graduate (2 of 92)



#### DECEDENT EMPLOYMENT STATUS

#### **Employment type:**

- 20% unemployed (38 of 190)
- 17% employed, type unknown (32 of 190)
- 15% professional (28 of 190)
- 13% service worker (24 of 190)
- 13% technical/skilled worker (24 of 190)
- 6% other (10 of 190)
- 5% retired (10 of 190)
- 5% student (9 of 190)
- 4% disabled (7 of 190)
- 4% laborer (8 of 190)

#### **Relationship Characteristics**

#### 71% (139 of 196) of decedents had children:

27%	1 child (53 of 196)
24%	2 children (46 of 196)

- 12% 3 children (23 of 196)
- 6% 4 children (11 of 196)
- 2% 5 children (4 of 196)
- 1% 6 children (2 of 196)
- 1 70 0 children (2 OT 196)

Of decedents with children, 57% (79 of 196) were known to have children outside of their relationship with the perpetrator.

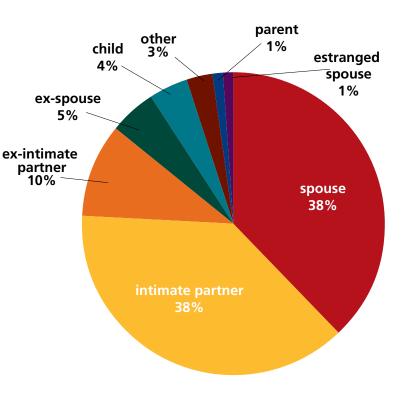
#### Relationship of perpetrator to decedent:

- 38% spouse (79 of 207)
- 38% intimate partner (79 of 207)
- 10% ex-intimate partner (21 of 207)
- 5% ex-spouse (11 of 207)
- 4% child (8 of 207)
- 3% other (6 of 207)
- 1% estranged spouse (1 of 207)
- 1% parent (2 of 207)

#### Mean length of relationship:

11 years (min = 0, max = 63)

#### **RELATIONSHIP TYPE**



## LOCAL FATALITY REVIEW DATA ANALYSIS FIVE-YEAR SUMMARY FROM 2009-2014



- 71% (143 of 202) of couples were known to have previously lived together full time, 22% (45 of 202) of couples were known to have lived together "off and on," and 7% (14 of 202) of couples were not known to have lived together during any point.
- 71% (127 of 178) of couples were known to have been living together at the time of the fatality. 29% (51 of 178) of couples were known to have lived together previously, but not to have lived together at the time of the death.
- Reviewers found evidence of separation at time of death (marital, separate households, or both) in 35% (63 of 178) of couples.
- The average length of separation, when known, was approximately 1 year (min = 0, max = 12).
- There were known allegations by 25% (50 of 200) of decedents of death threats made by the perpetrator towards the decedent, prior to the incident.
- There was known harassment of the decedent, by 9% (15 of 172) of perpetrators at the decedent's workplace.

### **CRIMINAL RECORDS**

#### **Perpetrator:**

- 49% (97 of 197) of perpetrators had a known, non-domestic violence-related criminal history.
- 46% (92 of 200) of perpetrators had a known criminal history of domestic violence.
- 63% (125 of 200) of perpetrators had a known criminal history of any kind, domestic violence related or otherwise, based on criminal records and narrative reports.
- 34% (67 of 200) of perpetrators had known prior reports to the police by the decedent, alleging domestic violence by the perpetrator.
- 48% (96 of 199) of family members reported knowing about prior incidents or prior threats of domestic violence on the part of the perpetrator.
- 27% (53 of 197) of perpetrators had a known criminal order of no contact issued against the perpetrator.
- 14% (28 of 200) of perpetrators had a known permanent Injunction for Protection filed against them by the decedent.
- 18% (35 of 199) of perpetrators had a known permanent Injunction for Protection filed against them by someone other than the decedent.
- 3% (5 of 200) of perpetrators had a known Injunction for Protection violation arrest.

#### **Decedent:**

- 16% (31 of 200) of decedents had a known history of domestic violence, based on criminal records and narrative reports.
- 6% (12 of 200) of decedents had a known criminal order of no contact issued against them.
- 2% (4 of 200) of decedents had a known permanent Injunction for Protection filed against them by the perpetrator.

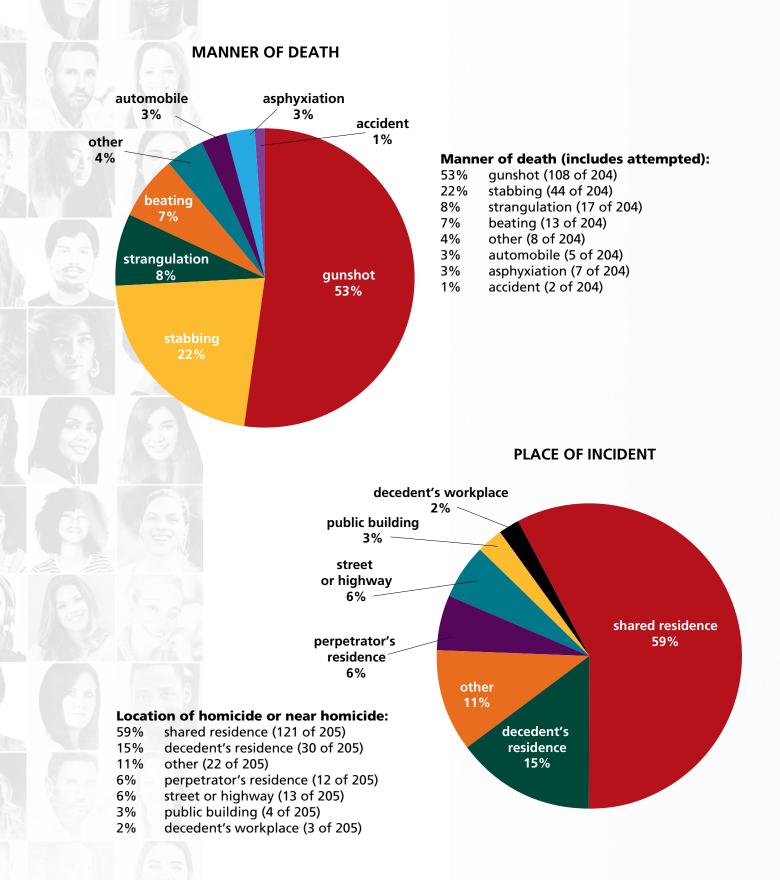
#### **Domestic Violence and Social Services**

- 27% (55 of 205) of decedents or their family had known contact with DCF.
- 14% (27 of 199) of decedents had known contact with victim support services.
- 4% (7 of 200) of decedents had known contact with a certified domestic violence center.
- 19% (20 of 107) of perpetrators with a prior history of domestic violence were currently or had previously been enrolled in a batterers' intervention program.

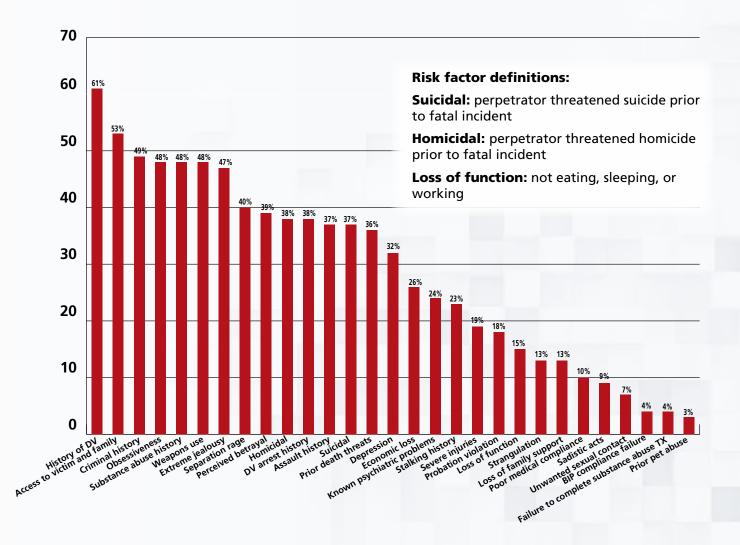
#### **Characteristics of the Fatality**

- 42% (83 of 200) of perpetrators completed suicide and an additional 6% (11 of 200) attempted but did not complete suicide.
- At the time of the fatality, there was known substance use by 52% of perpetrators. This information is based on self-reports by the perpetrator and medical toxicology reports. The breakdown is as follows: 26% alcohol (36 of 137) 16% drugs (22 of 137) 10% drugs and alcohol (13 of 137) 48% no known documented substance abuse (66 of 137)
- 12% (24 of 200) of fatalities had a collateral victim (i.e., a victim other than the decedent; does not include perpetrator suicides)
- There were known child witnesses in 19% (39 of 207) cases.

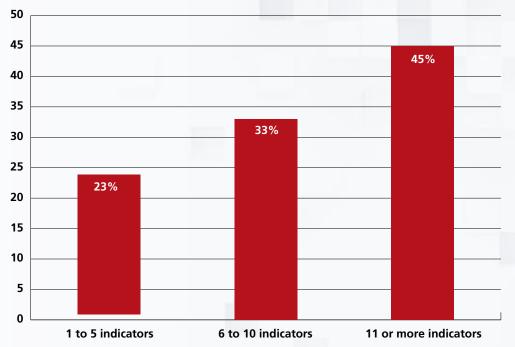
## LOCAL FATALITY REVIEW DATA ANALYSIS FIVE-YEAR SUMMARY FROM 2009-2014



#### **BREAKDOWN OF KNOWN RISK FACTORS**



PERCENT OF CASES BY TOTAL KNOWN RISK FACTORS PRESENT



Recommendations for systemic change are considered one of the most important aspects of domestic violence fatality review and serve as a blueprint for enhancements to survivor safety and perpetrator accountability. Thoughtfully crafted recommendations based on the data analysis from team reviews can help shape policy changes and interventions in the coordinated response to domestic violence. The work of the Statewide Domestic Violence Fatality Review Team, since 2009, demonstrates the powerful effect such recommendations can have in enhancing statewide and local community domestic violence services and response.

Fatality review recommendations focus on a wide range of short and long term goals, including training to meet the specific needs of community partners such as screening for domestic violence in medical communities, safety planning considerations for domestic violence advocates, law enforcement trainings related to the use of risk assessments, evidence collection and victim interviewing, training for prosecutors on enforcing and enhancing offender accountability, and training on effective batterers' intervention programs for judges and courts. In addition to training, statewide team recommendations have included proposed changes to Florida Statutes, implementation of statewide policies regarding domestic violence services, and public campaigns that raise awareness about domestic violence in an effort to increase the responses of bystanders witnessing or having knowledge of the occurrence of domestic violence in their families and communities.

#### Statewide Domestic Violence Fatality Review Team Recommendations Have Resulted In Some of the Following Specific Accomplishments:

• Senator David Simmons and Representative Holly Raschein introduced and successfully passed SB 342 during the 2015 Florida Legislative Session that amended s. 903.047, Florida Statutes, Conditions of Pretrial Release. Governor Scott signed the bill into law on May 14, 2015. The amended statute provides that an order of no contact is effective immediately, and authorizes the court to prohibit the following acts: communicating orally or in written form, either

in person, telephonically, electronically, or in any other manner, either directly or indirectly through a third person, with the victim or any other person named in the order, unless the order specifically allows indirect contact through a third party; having physical or violent contact with the victim or other named person's residence, even if the defendant and the victim or other named person share the residence; and being within 500 feet of the victim's or other named person's vehicle, place of employment, or a specified place frequented by such person. Importantly, this change in legislation permits law enforcement and prosecutors to increase charges on perpetrators of domestic violence who make contact with victims through jail house calls after the order of no contact was issued. Perpetrators often use intimidation and threats to coerce victims into dropping charges while they are in jail.

- FCADV funded certified domestic violence center, Aid to Victims of Domestic Abuse, Inc. and the Legal Aid Society of Palm Beach County to implement a collaborative anti-stalking project in 2013. The project allowed community stakeholders to increase resources, services, and advocacy available to survivors of stalking. The collaborative partners enhanced survivor safety through cooperative efforts to develop materials, training, and capacity building in Palm Beach County. This project serves as a model for other communities.
- FCADV applied for and received a three-year grant, awarded to the Department of Children and Families by the United States Department of Justice, Office on Violence Against Women to provide training on high risk indicators, risk assessment protocols, conducting safety checks and making appropriate charging decisions to more than 700 participants from law enforcement, emergency response and victim advocates prior to ending in June 2017. The need to expand training to these community partners was identified in the 2014 Faces of Fatality Report recommendations. In addition to the trainings, FCADV's Fatality Review Coordinator provides ongoing technical assistance to local fatality review teams on risk indicators and the use of risk assessments by certified domestic violence centers and other allied partners.

- FCADV collaborates with the Florida Sheriffs Association, Florida Police Chiefs Association and Florida Department of Law Enforcement to identify ways to enhance law enforcement collaboration and training opportunities. In addition to conducting statewide domestic violence training for law enforcement officers, FCADV created a comprehensive video training series related to the following topics: collecting photographic evidence, the use of risk assessments, excited utterances, the use of body cameras and school resource officers' role in addressing teen dating violence. These training tools are made available to all law enforcement agencies through the FCADV website.<sup>13</sup>
- In collaboration with the Office of the Attorney General, FCADV conducts Advocacy, Technology, and Safety trainings that focus heavily on safety planning and evidence collection in cyberstalking cases throughout the state of Florida. The increased use of technology and the ever-growing access to phone and computer applications that can be used to cause harm require that all service providers possess an in-depth understanding of the way perpetrators use technology to stalk, harass, intimidate and isolate victims. Increasing survivors' knowledge regarding the ability of perpetrators to stalk them through various forms of technology increases their knowledge regarding implementing safety measures to protect themselves and their children.
- FCADV annually conducts trainings for medical professionals related to screening for and responding to domestic violence. FCADV trains doctors, nurses and other medical responders on the importance of providing information to survivors, often serving as a safe and trusted confidant for their disclosures of abuse. A medical advocacy workgroup continues to convene quarterly to develop recommendations for state level training and to promote prevention strategies within primary care medical settings.
- In 2014, the Florida Legislature passed resolutions designating January as Stalking Awareness Month in Florida. According to the Stalking Resource Center, 76% of intimate partner femicide victims were stalked prior to the

homicide.<sup>14</sup> The Legislative resolutions brought needed attention to the crime of stalking and increases the opportunity for successful public awareness campaigns. FCADV utilizes this month to highlight stalking crimes and provide training regarding stalking and cyberstalking throughout the state.

- The statewide team convened a victim-blaming workgroup to increase public education on the adverse impact of victim blaming. The workgroup will continue to focus on educating the media through the development of a guide that assists journalists, reporters and bloggers with identifying and utilizing language that recognizes intimidation and coercion in domestic violence and focuses on perpetrators' responsibility for their crimes.
- In 2016, FCADV applied for and was awarded Victims of Crime Act (VOCA) funding to implement a statewide Injunction for Protection Project to provide attorneys to assist survivors of domestic, dating and sexual violence and stalking with completing and filing Injunction for Protection petitions, and to represent survivors at final injunction and violation of injunction hearings.

These accomplishments highlight the collaborative nature of Florida's state and local fatality review teams, as well as the successful outcomes of the collaborative process. Effective interventions increase safety and promote justice for survivors and their children. The Faces of Fatality VII report and the five-year summary data confirm the ongoing necessity for a coordinated and comprehensive statewide response to domestic violence. Evidencebased risk indicators highly prevalent in each year's report mirror the trends in the five-year data. The Statewide Domestic Violence Fatality Review Team and the 25 local teams are committed to seeking ongoing solutions that disrupt the patterns and reduce the risk of homicide for all domestic violence survivors and their children. The success of the state and local FRTs on implementing the recommendations described in this report is due to the support and determination of the various stakeholders, involved in the teams, whose dedication and commitment to survivors helps to saves lives every day in Florida.

<sup>13</sup>http://fcadv.org/projects-programs/law-enforcement

<sup>14</sup>Stalking Resource Center Fact Sheet, http://victimsofcrime.org/docs/default-source/src/stalking-fact-sheet-2015\_ eng.pdf?status=Temp&sfvrsn=0.994206007104367

## STATEWIDE DOMESTIC VIOLENCE FATALITY REVIEW TEAM MEMBERS

Nina Zollo, Esq. Florida Coalition Against Domestic Violence

#### **Emery Gainey**

Director of Law Enforcement Relations Victim Services and Criminal Justice Programs Florida Office of the Attorney General

Sergeant David Bradford Palm Beach County Sheriff's Office

**Lieutenant Koren Colbert** Bay County Sheriff's Office

Samantha Curry Orange County Probation Intensive Supervision Team

**Sharon Denaro, Esq.** Victim Response Inc./The Lodge

Grace Diez-Arguelles Office of the State Attorney, 15th Judicial Circuit

Sergeant Erick Dominguez Palm Beach Sheriff's Office

Megan Ford, Esq. Office of the State Attorney, 14th Judicial Circuit

Joseph P. George, Jr., Esq. Law Offices of Joseph P. George, Jr., P.A. Civil Defense Counsel

**Dr. Michael Haney, Ph.D., NCC, CISM, LMHC** Forensic and Mental Health Consultant

Christina Harris Bureau of Advocacy and Grants Management Florida Office of the Attorney General

Richard F. Joyce, Esq.

**Cecille Lucero** Florida Legal Services

#### Mary Marotta, LCSW Florida Department of Children and Families

Tabitha Krol Florida Sheriffs Association

**Amy Mercer** Florida Police Chiefs Association

**Dr. Leonel Mesa, Jr., Psy.D. LMHC** Next Era Energy, Inc.

Karen Oehme, JD Florida State University Institute for Family Violence Studies

#### Elizabeth Parker, Esq.

**Tena Pate** Tena Pate & Associates, LLC.

Kelly Sinn, LCSW Sunrise Domestic and Sexual Violence Center

Kathleen Tailer Office of the State Courts Administrator

**Pastor J. R. Thicklin** Destiny by Choice, Inc.

Lauren Villalba, MPA Miami-Dade County Domestic Violence Administrative Office of the Courts

Iris Williams, MSW Florida Department of Education

Keith Wilmer Florida Department of Law Enforcement

Data Analysis Consultant Joshua Cochran, Ph.D., School of Criminal Justice, University of Cincinnati

#### Florida Coalition Against Domestic Violence Staff Support

Jodi Russell, Cynthia Rubenstein, Reisha Williams, Bob Smedley and Gary Lippman

#### Former Statewide Domestic Violence Fatality Review Team Members 2011-2016

The Statewide team would like to thank former team members for their service toward increasing safety and justice for survivors of domestic violence and their children and holding perpetrators accountable for their violence.

Lt. Mark Alexander Brenda Canady, LCSW Adrienne Celaya Mary Beth Copeland April Cross Nancy Daniels Gria Davison\* Jason Dimitris Teresa Drake Suzanne Estrella Donna Fagan John Feliu Sheldon Gusky Sqt. Kyle Haas Nancy Hardt, M.D. Ed Hardv Gene Hatcher John Hogenmuller Rov Hudson Jean Itzin Barry Krischer, Esg. Lauren Lazarus Vincent Mazzara\* Chief Nolan Mcleod\* Trula Motta **Charles Murphy Deputy Chief Chris Nelson** Cyndee Odom Rose Patterson Ann Perko, Esq. Rod Reder Major Connie Shingledecker Ellen Siler Nancy Slater Tim Smith Special Agent Terry Thomas Chief Philip Thorne Chief Jerome Turner Barbara Wolf, M.D. Mark Zadra \*Former Members Gria Davison, Vincent Mazzarra and Chief Nolan Mcleod passed away and continue to be greatly missed by the Statewide Domestic Violence Fatality

Review Team members.

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







This project was supported by Grant No. 2014-WE-AX-0012 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the state or the U.S. Department of Justice, Office on Violence Against Women.

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

